Published in final edited form as:

AIDS Educ Prev. 2014 April ; 26(2): 158–169. doi:10.1521/aeap.2014.26.2.158.

“I AM PROUD OF MYSELF, JUST THE WAY I AM” (MWEN FYÈ DE TÈT MWEN, JAN MWEN YE YA): A QUALITATIVE STUDY AMONG YOUNG HAITIAN WOMEN SEEKING CARE FOR SEXUALLY TRANSMITTED INFECTIONS (STIS) IN HAITI

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Abstract

Haitian women are twice as likely as men to have HIV/AIDs. Factors underlying the feminization of HIV are complex. Self-esteem is an important correlate of sexual behavior. However, its meaning and impact on health behaviors may be influenced by cultural factors. This qualitative study took place in Haiti 4 months after the 2010 earthquake and examines the meaning of self-esteem among young Haitian women seeking treatment for a recurrent sexually transmitted infection (STI). The meaning of self-esteem was derived from a sense of gratitude and was rooted in their ability to provide for family. This may have led to behaviors such as not using condoms or

having sex with partners in concurrent relationships. This article highlights the resilience and resourcefulness of Haitian women, provides insight into how women with apparent positive self-images were led to make choices that placed them at high risk for contracting HIV, and concludes with recommendations for future interventions.

The “feminization of HIV” is a term that is used to reflect the increasing trend of HIV among women (Haller, 1992; Iobst & Gandhi, 2009). Of the 42 million people worldwide who are living with HIV/AIDS, more than half are women (Quinn & Overbaugh, 2005; World Health Organization, 2011). Women in sub-Saharan Africa and the Caribbean fare worse in this epidemic. In Haiti, a Caribbean country with one of the highest rates of HIV/AIDS infections, the prevalence of HIV/AIDS for young adults ages 15 to 24 is 1.1% and 0.4% for women and men, respectively (World Health Organization, 2011). The feminization of HIV may be closely linked to the feminization of poverty (Decosas, 1996; Shisana, Rice, Zungu, & Zuma, 2010). Haiti is the poorest nation in the Western Hemisphere. One half of Haitians live on less than \$1 per day, and approximately 80% live on less than \$2 per day (World Bank, 1998, 2007). The average annual income is \$400 US dollars (Haiti Health Ministries, 2014). Women are less likely to be employed and are more likely to drop out of school (Lamaute-Brisson, 2013). The economic and social vulnerability of these women may also place them at higher risk for nonconsensual sex, which also increases their chances of contracting HIV (Smith Fawzi et al., 2005).

The socioeconomic conditions in Haiti further deteriorated after the earthquake of January 2010 that killed over 200,000 people and left approximately 2 million homeless and displaced (Polonsky et al., 2013). After the earthquake, many young Haitian women were left homeless, without food, and without the support of their parents or guardians. These conditions placed many women at risk of being raped and acquiring new sexually transmitted infections (STI), including HIV. As a result of the loss of medical infrastructure, many cases of STIs were left untreated (Logie, Daniel, Newman, & Loutfy, 2012; UNICEF, 2011). One study of patients presenting to a primary care clinic in Leogane, Haiti, reported that after the earthquake, 18% of the presenting health problems were related to an STI. In that study, women represented 93% of the patients (Neuberger et al., 2012). The postearthquake violence and devastation that besieged many Haitian women serves as a clarion call for further intervention. There is a need for public health research that identifies and better characterizes factors that promote risk taking as well as factors that are protective and mitigate risky behaviors.

Low self-esteem is an important predictor of risk-taking behaviors (Salazar et al., 2005; Sterk, Klein, & Elifson, 2004). Studies have found that self-esteem is particularly relevant to risk-taking behavior among women who live under vulnerable socioeconomic circumstances (Sterk et al., 2004). Lower self-esteem has been linked to age of sexual debut, increased number of sexual partners, and a higher risk of contracting an STI. Higher self-esteem has been linked to more positive attitudes about condom use, the perception of fewer barriers to using condoms, and greater self-efficacy for negotiating condom use (Salazar et al., 2005). There is no consensus on the conceptualization of the measurement of self-esteem. Terms that have been used when measuring the concept of self-esteem include self-worth, value,

respect, and social acceptance (Rosenberg, Schooler, Schoenbach, & Rosenberg, 1995). The Rosenberg Self-Esteem Scale, the most commonly used measure of global self-esteem, captures some of these terms and adds other terms. The Rosenberg Self-Esteem Scale is a 10-item scale with a 4-point response format ranging from *strongly agree* to *strongly disagree*. In this scale, terms that address self-satisfaction, self-respect, pride, perception of usefulness, and self-worth are used to provide an overall measure of self-esteem (Rosenberg, 1965).

This article presents a close examination of the concept of self-esteem in the lives of women in Haiti. The idea for the article was conceived in the process of developing an intervention to reduce risky sexual behaviors among Haitian women attending an STI clinic for a persistent or new STI infection. The goal of the intervention was to bolster self-esteem of women and provide them with skills that would decrease sexual risk taking. During the formative phase of the intervention, we asked some attendees of the clinic as well as the clinical staff, which included an STI specialist and nurses, to review the items on the Rosenberg Self-Esteem Scale and to assist with translation. These steps were taken prior to administering the scale to the study participants. This exercise generated a lot of discussion on the meaning of self-esteem in the Haitian culture. In particular, there was disagreement on how to best translate the more self-deprecating items on the scale, which include “All in all, I am inclined to feel that I am a failure,” “I feel I do not have much to be proud of,” “I certainly feel useless at times,” and “At times I think I am no good at all.”

Self-esteem may be influenced by cultural norms and belief systems (Hewitt, 2009). This notion has raised concerns among researchers about the degree to which self-esteem transcends cultures and to explore the potential for errors in syntax in the translation process (Cheng & Hamid, 1995). Schmitt and Allik (2005) translated the Rosenberg Self-Esteem Scale into 28 languages and tested its psychometric properties across 53 nations. They found that it demonstrated good internal reliability and factor structure across many languages and different cultures. However, several studies have described variations in interpretation of the negatively worded items, which raises the question of how self-esteem is evaluated in different cultures (Brown, Cai, Oakes, & Deng, 2009; Schmitt & Allik, 2005; Urbán, Szigeti, Kökönyi, & Demetrovics, 2013; Wu, 2008). Taking into account cultural norms and capturing the specifics of the target population became relevant to successfully implementing the study.

It was important for us to further evaluate this concept in light of the social and economic context of the lives of young Haitian women. The concern was raised that simply adapting existing characterizations of self-esteem to this population could lead to invalid or spurious results. Therefore, the objective of this article is to characterize the meaning of self-esteem and to examine the intersection between concepts of self-esteem and risk taking among young Haitian women seeking care at an STI treatment center in Haiti. The long-term goal is to use this information to inform future interventions that are targeted at reducing risky sexual behavior and therefore reduce the risk of contracting HIV.

METHODS

This study was part of a larger effort to acquire data that will inform the development of an HIV prevention study. Therefore, the eligibility criteria were that participants had to be HIV negative. Participants in the study were included because they were deemed as high risk for contracting HIV. Participants had a history of recurrent STIs, which indicated that they were having unprotected sex, and thus at risk for HIV and other STIs. Participants in this qualitative study were drawn from a group of women who were known to the STI clinic for prior visits and now were undergoing treatment for recurrent STI symptoms. The study was conducted at the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO), a center in Haiti dedicated to research, outreach, and treatment for HIV and other STIs. Qualitative research was selected as the methodological approach because it allowed for a more nuanced understanding of the meaning of self-esteem in the context of the lives of Haitian women. In preparation for conducting a larger intervention to prevent HIV, this qualitative study was conducted to capture the meaning of self-esteem among Haitian women. At this stage, the Rosenberg Self-Esteem Scale had not been administered.

This study used a grounded theory approach for data collection and analysis. This process is iterative and involves exploring new, evolving theory in the context of existing data until no new findings emerge (Charmaz, 2001). All interviews were conducted in Creole by a bilingual qualitative researcher and translated into English for these analyses. The researcher received formal training in qualitative research as part of her Master's in Clinical Epidemiology program. The training involved 6 weeks of didactic course work on the history and basic tenets of qualitative research as well as course work in qualitative data analysis. In addition, the interviewer had opportunity to practice qualitative interviewing skills through role play with other students in the class.

All interviews were conducted at GHESKIO. The duration of each interview was approximately 2 hours. The interviews began with a general discussion of HIV/AIDS. Participants were asked the following questions: "What is HIV and AIDS?"; "What do you think are some of the ways a person can become infected with HIV?"; and "What can a woman do to protect herself from becoming infected with HIV?" These questions provided a segue to discussions on the role of self-esteem in sexual behaviors.

Participants were then provided with an operational definition of the word *self-esteem* as it related to this study. Participants were told "self-esteem" is a term to describe a person's overall sense of self-worth or personal value. In addition, participants were told that perceptions of self-esteem could be either high or low. Participants were then asked to describe how they felt about themselves, their general self-esteem, self-satisfaction, pride, and other aspects of their daily lives that influenced their self-perception. Specific questions included: "In general, how do you feel about yourself, your life, and current situation?" When a participant responded with one word such as "proud," she was asked to elaborate and asked, "Can you tell me a little more why you used this word to describe yourself?" Women were also asked to describe their relationships with their family and friends and to describe how these relationships affected how they perceived themselves. Women who were

involved in a relationship were asked to describe the relationship and circumstances that led to the relationship. All responses were aggregated in pool fashion and analyzed.

All interviews were conducted in Creole by a bilingual researcher and translated into English for these analyses. Transcripts were reviewed by three bilingual researchers to assure consistency of translation. Data analysis occurred in the following steps: data immersion, creation of codes, and categorization (Green et al., 2007). First, all transcripts were read line-by-line and assigned codes, which are descriptive labels or tags that represent key concepts. Similar codes were then grouped into categories. In order to ensure trustworthiness of data, detailed notes of the interview and coding process were maintained as field notes; all categories were reviewed by a second reviewer for corroboration. When there were discordant views regarding the interpretation of findings, the raw data were reviewed until a consensus was reached (Boutin-Foster, 2005; Graneheim & Lundman, 2004). Institutional Review Board approval was obtained for this study at GHESKIO and Weill-Cornell Medical College. All of the participants provided informed consent.

RESULTS

The study was conducted 4 months after the earthquake, from May 2010 to November 2010. During this time, 193 women ages 18 to 24 were seen at the STI clinic for the evaluation of a possible STI. The eligibility criteria included being sexually active with a documented history of a prior STI and being HIV negative. Forty-nine women fulfilled these criteria; 21 gave informed consent; 19 completed the qualitative study. Of the two participants who dropped out, one developed a time conflict and the other changed her mind before being interviewed.

The average age was 21 years; 38% had never attended school, 76% were unemployed, 52% were living with their parents, none were married, and 38% had at least one child. All had a documented history of a prior STI; the most common was trichomoniasis (76%), followed by syphilis (19%) and gonorrhea (10%). While none of the women reported having multiple partners themselves, 24% stated that their partners were involved in other relationships. Of the respondents, 58% viewed themselves as being at high risk for contracting another STI and 43% reported never using condoms with their partner. The qualitative discussions provided a rich narrative on their characterization of self-esteem and provided insight into the socioeconomic context in which they lived. Table 1 provides examples of patient responses.

APPRECIATION AND GRATITUDE FOR WHAT THEY HAD

All 19 women who completed the qualitative study had a history of at least one STI. They were seeking treatment for a new or recurrent STI and all had a negative HIV test at the time of the interview. The state of being “free of HIV” was a tremendous source of satisfaction, accomplishment, and pride. Statements included: “I feel good with myself because I do not have the virus in my blood. I feel good with myself for not being infected by the virus”; and “I am pleased with myself now that I know I am free of HIV.” Not receiving a diagnosis of HIV was equated with being healthy despite having an STI. Examples of what participants stated included: “Yes, I am satisfied with myself; I do not have the AIDS virus; I am not

sick”; “I am not sick and my kid is not sick”; “I am satisfied. I am not sick and my kid is not sick, even if [otherwise] things are not good for me”; “God is with me because I am not sick.” The word “sick” was used to express having HIV or AIDS.

When asked to further describe how they felt about themselves, most of the participants expressed positive self-images and a sense of pride because they managed to remain free of HIV. Terms such as loving yourself, having pride, and being satisfied were used to describe how they felt about themselves. Examples of these responses included: “Everything considered, I am satisfied with myself, except on the economic part.” Another response was, “I see myself in a positive way; I am proud of myself.” Similar sentiments were echoed, such as “I feel quite good about myself”; and “I love myself; I like the way that I am living, and I do not have much problems because I am not sick.”

When asked to elaborate on the reasons for how they felt, the sentiment was that things could be worse and they were appreciative of what they had. One woman said, “There is nothing in my daily life that makes me feel less satisfied about myself because I am not ugly and I am not dumb.” The things that are often taken for granted, such as sleeping and waking up or having a partner who actually comes home to sleep, were a source of satisfaction for these women. As one woman said, “I am happy when my man comes home from work; he eats, and lies down. That’s what life is all about—that’s a beautiful life.” Many felt that the presence of God in their lives contributed to how they felt: “What makes me happy every day is that God gave life to my family and me.” Another woman said, “I am aware of the fact that God gave me intelligence; with even thirty, forty dollars I can manage.”

There was tremendous gratitude for what little financial resources or means they had. Making the distinction between having absolutely nothing and something, no matter how small, was important in maintaining a positive sense of self: “If I had absolutely nothing, then I would be unhappy. I have something so I am obligated to be happy.” Despite their circumstances, there was also a general obligation to be happy or satisfied. As one participant stated, “What makes me happy every day with myself is the fact that I sleep and I wake up.” Being alive gave them hope that things would get better. The concept of sleeping and waking up resonated with a lot of the women. Another woman said, “What makes me happy with myself is the fact that I sleep and wake up and that I have a future.”

OBLIGATION AND COMMITMENT TO FAMILY

In discussing how they felt about themselves, there was a lot of discussion of their relationships with their parents. There was a strong sense of obligation to care for their family. Sense of self was deeply rooted in their parents’ perceptions of them and their ability to fulfill their role as caregivers and providers for their parents, siblings, and children. One participant said, “Being the first, I had to provide for my other siblings.” Another participant stated, “I have to help my mother with whatever I own or earn.” While the majority expressed positive self-images, those who did not focused on their inability to help their family: “What makes me feel unhappy with myself is the fact that I want to help myself, my family, but I am unable to do so. That’s what bothers me every day”; another woman said, “I do not respect myself enough. I have a boyfriend and my parents don’t know about him.”

Another participant stated, “The way I am living, staying over at a stranger’s home is not proper. I am not living with my mother.” One participant who was unable to provide for her family said, “I am not quite satisfied because I was supposed to work and I could not find any. I see myself as a failure, without a plan for the future. I am unable to do anything for myself or my family.”

DETERMINATION TO MAKE ENDS MEET BY ANY MEANS NECESSARY

The inability to support themselves or their family led some women to make choices that placed them at higher risk for HIV and other STIs. Some women acknowledged that they entered into nonmonogamous relationships out of economic necessity: “If your parents cannot give you what you need, economic deprivation can lead you to do what is not acceptable for money.” Another respondent said, “When someone can give you a hundred gourdes (equivalent to \$2.3 U.S. dollars) or meet your economic needs, even if you would not have freely chosen him, you do your best to live with him.” This financial dependence on men was made worse by the overwhelming loss of life and displacement that occurred after the earthquake: “I had to quit school after January 12th. I am staying over someone’s home (a man)”; “My mother and my father are not present, they are dead. I should have been living with them, not with a husband”; “I would like to be fine, well dressed, eating; I do not find all that, if I had the means, I would not have chosen him.”

Their relationships were sometimes difficult; however, some felt they had no alternative: “Life is difficult with my man. We argue a lot, I do not like his friends, he drinks and smokes”; “He thought that giving me one or two hundred dollars gave him the rights to me. It is only when I am hungry that I miss him.” One participant said of a previous partner, “He did not know how to talk to me properly, and he thought that one or two hundred dollars gave him the right to have sex with me.” Approximately one fourth of the women stated that they were involved with men who had concurrent partners, which provided an opportunity to further delve into the dynamics of these relationships. Some of the responses that characterized these relationships included: “He spends the day out. He might be spending time over some other woman’s place”; and “I would like to change my man so that I could be the only woman in his life.”

The women had a general understanding that the use of condoms prevents HIV infections. However, despite this understanding, approximately 40% of the women reported that they did not use condoms. Reasons for not using a condom included “I am allergic to condoms”; “it was only one time”; condoms are for prostitutes and I am not a prostitute”; “He doesn’t want me to use a condom”; or “He uses condoms with his other partners.” These findings demonstrate the misconceptions about condoms and the power dynamics in these sexual relationships.

DISCUSSION

Tremendous strides have been made in Haiti toward the reduction of HIV despite its complicated social and political infrastructure (Deschamps et al., 2009; Dévieux et al., 2004). The 2010 earthquake created an environment of great vulnerability, especially for the women in Haiti, that may threaten these gains. This study highlights the tremendous

resilience and self-esteem among a group of young Haitian women and discusses how their overwhelmingly positive outlook can be used as a resource for HIV prevention. Data drawn from this study helped to explain the fundamental question of why women with apparent high self-esteem and such positive views of themselves engaged in high risk-sexual behavior. Three themes emerged from this qualitative study that help to answer this question: (a) the tremendous appreciation and gratitude for what had enabled these women to maintain a high level of self-esteem in the midst of hardship; (b) self-esteem and self-image were deeply rooted in their loyalty and strong obligation to help their family; and (c) a combination of these factors made them resilient and determined to make ends meet, by any means necessary, and often resulted to behaviors that placed them at high risk for contracting HIV.

The women in this study expressed tremendous gratitude for what they had and did not bemoan their existence. Although they had little monetary means, they maintained their self-satisfaction and a sense of self-pride by focusing on things such as their health and the fact that they did not have HIV. The importance of religion and spirituality in the lives of many Haitians also may have influenced their perspective on self-esteem. The belief in God may have made some feel obligated to be happy or satisfied with what they had; as one participant said, "I have something so I am obligated to be happy." Therefore, interventions must also understand the influence that religion and spirituality have on the lives of many Haitians (Miller, 2000).

The women in this study were particularly susceptible to contracting HIV because of their prior history of STIs (Chirgwin, DeHovitz, Dillon, & McCormack, 1991). In this study, approximately 24% were aware that their partner was involved in another relationship and 43% said they never used condoms. They were aware of the fact that their behaviors placed them at increased risk, as indicated by the fact that 58% viewed themselves at high risk because of their partners. In a study of adolescents and young adults ages 13 to 25 attending a voluntary testing and counseling STI center in Haiti, the diagnosis of HIV was made in 6.3% of the females compared to 5.5% of the males. The prevalence of HIV was greatest in women who presented with an STI or who were involved in relationships with men who had concurrent partners (Dorjgochoo et al., 2009).

Previous studies have demonstrated the need for delivering health messages and combating misperceptions about HIV transmission (Dévieux et al., 2009). In our study, a misperception held by the women was that as long as they did not have HIV they were well. Thus, the potential link between an STI and HIV was omitted. Remaining free of HIV was something that gave these women a sense of pride. This highlights the importance of interventions at the time of voluntary testing and counseling that emphasize the correlation between having an STI and contracting HIV. More interventions are needed at the time of voluntary testing and counseling, especially when a negative diagnosis is delivered (Fitzgerald, Maxi, Marcelin, Johnson, & Pape, 2004). These women were proud of themselves for remaining HIV free; thus this would provide an opportune time for intervention. Reflecting on these proud moments may help to decrease defensive reactions to health messages, may make them more receptive to the message, and may increase their intention to engage in safe practice (MacDonald & Martineau, 2002; D. K. Sherman & Cohen, 2006).

Self-esteem was rooted in the obligation to provide for their family. This may reflect the societal norm for women to care for family while the men do labor outside of the home. The theory of Gender and Power provides a framework for further evaluating this finding. This theory describes the unequal distribution of labor, power, and emotional and affective factors that dictate sexual relationships (Connell, 1987). The women generally had a tendency to want to nurture and care for their families. A woman reported, “Being the first, I had to provide for my other siblings”; another said that “I help my mother with the least that I own, whenever I have it.” These gender-based practices may be entrenched in the society and will require discussions that include both men and women. The importance of educating young women also needs to be reinforced with their parents.

More than one third of the women did not have any formal education, which leaves them with limited options for sustaining themselves financially. Creating programs that provide women with education and skills can provide them with the independence that may prevent sexual risk taking. Providing women with loans through microfinance programs has promise (Dworkin & Blankenship, 2009). One example, the JEWEL program (Jewelry Education for Women Empowering Their Lives), is an integrated HIV prevention program for drug-using sex workers in Baltimore, Maryland, that assists participants in making and selling jewelry (S. G. Sherman, German, Cheng, Marks, & Bailey-Kloche, 2006). This program demonstrated a reduction in the number of sexual partners. Another example is the IMAGE program (Intervention for Microfinance and Gender Equity) in South Africa, which demonstrated a reduction in intimate-partner violence (Pronyk et al., 2006). These are examples of programs that can be used to expand microfinance programs for women in Haiti.

Another factor that was tied to participants’ sense of self was maintaining the relationship with a partner who often had multiple other sexual partners. Several responses from the study highlighted the compromising choices that were made in order to satisfy basic needs such as food and shelter. Previous studies conducted in Haiti have described these relationships (Malow, Rosenberg, Lichtenstein, & Dévieux, 2010; Maynard-Tucker, 1996). In Haitian culture, the term *plase* means placed with and *plasaj* refers to a long-term sexual relationship not formalized by a religious or civil ceremony, which often results in children and is commonly not monogamous. In one study conducted in Haiti’s rural Artibonite Valley, this living arrangement was noted by over half of the participants (Fitzgerald et al., 2000). Women in *plase* relationships are almost twice as likely to have an STI compared with women who are married (Smith Fawzi et al., 2003). Therefore, attention must be paid to holding men responsible for their actions and having open discussions that involve men about the impact of having multiple sexual partners and the importance of condom use. This study also provides insight into why some women were reluctant to use condoms while it also reinforces the need for multidimensional interventions. Fewer than half of the women reported using condoms consistently in this study, despite their knowledge of not being in a monogamous relationship. Empowering women with negotiating skills to mandate condom use from their partners provides another approach for decreasing the risk of HIV and other STI transmission.

The implications of this study are important for future interventions; however, there are limitations that should be noted in interpreting our data. One limitation is that the study did not include men to provide their perspective on self, which may help to explain sexual behaviors. The inclusion of men would provide a contrast to the perceptions of women and provide the basis for a gender-based evaluation. The women all came from one STI clinic; however, this is a particularly high-risk group where the need for intervention is greatest. The sample size was small; however, this is generally acceptable for qualitative studies (Guest, Bunce, & Johnson, 2006) and reflects the circumstances in which the study was conducted.

CONCLUSION

Our findings provide important avenues for future interventions that are designed to reduce the feminization of the HIV epidemic in Haiti. This effort requires a multifaceted approach. The social, structural, and political factors must be addressed as well as more proximal solutions such as education, housing, and food security (Farmer, Nizeye, Stulac, & Keshavjee, 2006). HIV prevention must be viewed beyond the personal risk factors. Broadening our understanding of the cultural mores that lie beneath the surface of the HIV epidemic is important to developing sustainable solutions. Efforts to combat this epidemic must consider how self-schemas are constructed and preserved. These women have a positive sense of self-esteem, which they describe as self-worth and high satisfaction with themselves. This view stems from their positive outlook on life in spite of unfathomable tragedies. The self-schemas that they created enabled them to be resilient and resourceful. Recognizing this strength while creating infrastructures that enable them to be self-sufficient and that enhance their self-esteem is critical to stemming the HIV epidemic among women in Haiti.

Acknowledgments

This publication was made possible by the following grants: NIH NIMHD 1P60MD003421, NIH NIAID grant AI098627, and NIH Fogarty International Center grants TW009606 and TW009337. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NIH. We would also like to express our gratitude to the women of Haiti for their willingness to share their stories. Without their resilience and courage this study would not have been possible.

References

- Boutin-Foster C. In spite of good intentions: Patients' perspectives on problematic social support interactions. *Health and Quality of Life Outcomes*. 2005; 3:52.10.1186/1477-7525-3-52 [PubMed: 16143038]
- Brown JD, Cai H, Oakes MA, Deng C. Cultural similarities in self-esteem functioning: East is East and West is West, but sometimes the twain do meet. *Journal of Cross-Cultural Psychology*. 2009; 40(1):140–157.
- Charmaz, K. Grounded theory: Methodology and theory construction. In: Neil, JS.; Paul, BB., editors. *International encyclopedia of the social and behavioral sciences*. Oxford, UK: Pergamon; 2001. p. 6396-6399.
- Cheng ST, Hamid PN. An error in the use of translated scales: The Rosenberg Self-Esteem Scale for Chinese. *Perceptual and Motor Skills*. 1995; 81(2):431–434.10.2466/pms.1995.81.2.431

- Chirgwin K, DeHovitz JA, Dillon S, Mc-Cormack WM. HIV infection, genital ulcer disease, and crack cocaine use among patients attending a clinic for sexually transmitted diseases. *American Journal of Public Health*. 1991; 81(12):1576–1579. [PubMed: 1746652]
- Connell, RW. *Gender and power: Society, the person and sexual politics*. Stanford, CA: Stanford University Press; 1987.
- Decosas J. HIV and development. *AIDS*. 1996; 10(Suppl 3):S69–S74. [PubMed: 8970714]
- Deschamps MM, Noel F, Bonhomme J, Dévieux JG, Saint-Jean G, Zhu Y, Malow RM. Prevention of mother-to-child transmission of HIV in Haiti. *Revista Panamericana de Salud Pública*. 2009; 25(1): 24–30. [PubMed: 19341520]
- Dévieux JG, Deschamps MM, Malow RM, Jean-Gilles M, Saint-Jean G, Saint-Jean G, Pape JW. Knowledge, attitudes, and behaviors among a sample of HIV-positive and HIV-negative females visiting an urban VCT center in Haiti. *Journal of Health Care for the Poor and Underserved*. 2009; 20(2):554–568.10.1353/hpu.0.0141 [PubMed: 19395849]
- Dévieux JG, Malow RM, Jean-Gilles MM, Samuels DM, Deschamps MM, Ascencio M Jr, Pape JW. Reducing health disparities through culturally sensitive treatment for HIV+ adults in Haiti. *ABNF Journal*. 2004; 15(6):109–115. [PubMed: 18399360]
- Dorjgochoo T, Noel F, Deschamps MM, Theodore H, Dupont W, Wright PF, Pape JW. Risk factors for HIV infection among Haitian adolescents and young adults seeking counseling and testing in Port-au-Prince. *Journal of Acquired Immune Deficiency Syndrome*. 2009; 52(4):498–508.10.1097/QAI.0b013e3181ac12a8
- Dworkin SL, Blankenship K. Microfinance and HIV/AIDS prevention: assessing its promise and limitations. *AIDS and Behavior*. 2009; 13(3):462–469.10.1007/s10461-009-9532-3 [PubMed: 19294500]
- Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Medicine*. 2006; 3(10):e449.10.1371/journal.pmed.0030449 [PubMed: 17076568]
- Fitzgerald DW, Behets F, Caliendo A, Roberfroid D, Lucet C, Fitzgerald JW, Kuykens L. Economic hardship and sexually transmitted diseases in Haiti's rural Artibonite Valley. *American Journal of Tropical Medicine and Hygiene*. 2000; 62(4):496–501. [PubMed: 11220766]
- Fitzgerald DW, Maxi A, Marcelin A, Johnson WD, Pape JW. Notification of positive HIV test results in Haiti: can we better intervene at this critical crossroads in the life of HIV-infected patients in a resource-poor country? *AIDS Patient Care and STDs*. 2004; 18(11):658–664. [PubMed: 15635748]
- Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*. 2004; 24(2):105–112.10.1016/j.nedt.2003.10.001 [PubMed: 14769454]
- Green J, Willis K, Hughes E, Small R, Welch N, Gibbs L, Daly J. Generating best evidence from qualitative research: The role of data analysis. *Australian and New Zealand Journal of Public Health*. 2007; 31(6):545–550.10.1111/j.1753-6405.2007.00141.x [PubMed: 18081575]
- Guest G, Bunce A, Johnson L. How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*. 2006; 18(1):59–82.10.1177/1525822x05279903
- Haiti Health Ministries. Haiti at a glance. 2014. Retrieved from <http://www.haitihealthministries.org/haiti/>
- Haller KB. The feminization of AIDS. *Journal of Obstetrics, Gynecology, and Neonatal Nursing*. 1992; 21(2):84.
- Hewitt, JP. The social construction of self-esteem. In: Snyder, CR.; Lopez, SJ., editors. *Oxford handbook of positive psychology*. New York: Oxford University Press; 2009. p. 217-224.
- Iobst S, Gandhi M. The feminization of an epidemic. *Women and HIV in the United States*. *Positively Aware*. 2009; 20(4):34–39. [PubMed: 19653375]
- Lamaute-Brisson, N. *Social protection systems in Latin America and the Caribbean: Haiti*. Santiago, Chile; United Nations: 2013.
- Logie CH, Daniel C, Newman PA, Loutfy MR. An HIV/STI prevention intervention for internally displaced women in Leogane, Haiti: Study protocol for an N-of-1 pilot study. *BMJ Open*. 2012; 2(4)10.1136/bmjopen-2012-001634

- MacDonald TK, Martineau AM. Self-esteem, mood, and intentions to use condoms: When does low self-esteem lead to risky health behaviors? *Journal of Experimental Social Psychology*. 2002; 38(3):299–306. <http://dx.doi.org/10.1006/jesp.2001.1505>.
- Malow R, Rosenberg R, Lichtenstein B, Dévieux JG. The impact of disaster on HIV in Haiti and priority areas related to the Haitian crisis. *Journal of the Association of Nurses in AIDS Care*. 2010; 21(3):283–288. [PubMed: 20416497]
- Maynard-Tucker G. Haiti: Unions, fertility and the quest for survival. *Social Science & Medicine*. 1996; 43(9):1379–1887. [PubMed: 8913007]
- Miller NL. Haitian ethnomedical systems and biomedical practitioners: Directions for clinicians. *Journal of Transcultural Nursing*. 2000; 11(3):204–211. [10.1177/104365960001100307](https://doi.org/10.1177/104365960001100307) [PubMed: 11982109]
- Neuberger A, Tenenboim S, Golos M, Pex R, Krakowsky Y, Urman M, Schwartz E. Infectious diseases seen in a primary care clinic in Leogane, Haiti. *American Journal of Tropical Medicine and Hygiene*. 2012; 86(1):11–15. [10.4269/ajtmh.2012.11-0426](https://doi.org/10.4269/ajtmh.2012.11-0426) [PubMed: 22232443]
- Polonsky J, Luquero F, Francois G, Rousseau C, Caleo G, Ciglenecki I, Checchi F. Public health surveillance after the 2010 Haiti earthquake: The experience of Medecins Sans Frontieres. *PLoS Curr*. 2013; 510.1371/currents.dis.6aec18e84816c055b8c2a06456811c7a
- Pronyk PM, Hargreaves JR, Kim JC, Morison LA, Phetla G, Watts C, Porter JD. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: A cluster randomised trial. *Lancet*. 2006; 368(9551):1973–1983. [10.1016/S0140-6736\(06\)69744-4](https://doi.org/10.1016/S0140-6736(06)69744-4) [PubMed: 17141704]
- Quinn TC, Overbaugh J. HIV/AIDS in women: An expanding epidemic. *Science*. 2005; 308(5728):1582–1583. [10.1126/science.1112489](https://doi.org/10.1126/science.1112489) [PubMed: 15947174]
- Rosenberg, M. *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press; 1965.
- Rosenberg M, Schooler C, Schoenbach C, Rosenberg F. Global self-esteem and specific self-esteem: Different concepts, different outcomes. *American Sociological Review*. 1995; 60(1):141–156. [10.2307/2096350](https://doi.org/10.2307/2096350)
- Salazar LF, Crosby RA, DiClemente RJ, Wingood GM, Lescano CM, Brown LK, Davies S. Self-esteem and theoretical mediators of safer sex among African American female adolescents: Implications for sexual risk reduction interventions. *Health Education and Behavior*. 2005; 32(3):413–427. [10.1177/1090198104272335](https://doi.org/10.1177/1090198104272335) [PubMed: 15851547]
- Schmitt DP, Allik J. Simultaneous administration of the Rosenberg Self-Esteem Scale in 53 nations: Exploring the universal and culture-specific features of global self-esteem. *Journal of Personality and Social Psychology*. 2005; 89(4):623–642. [10.1037/0022-3514.89.4.623](https://doi.org/10.1037/0022-3514.89.4.623) [PubMed: 16287423]
- Sherman, DK.; Cohen, GL. The psychology of self defense: Self affirmation theory. In: Mark, PZ., editor. *Advances in experimental social psychology*. Vol. 38. New York: Academic Press; 2006. p. 183–242.
- Sherman SG, German D, Cheng Y, Marks M, Bailey-Kloche M. The evaluation of the JEWEL project: An innovative economic enhancement and HIV prevention intervention study targeting drug using women involved in prostitution. *AIDS Care*. 2006; 18(1):1–11. [10.1080/09540120600838480](https://doi.org/10.1080/09540120600838480) [PubMed: 16282070]
- Shisana O, Rice K, Zungu N, Zuma K. Gender and poverty in South Africa in the era of HIV/AIDS: A quantitative study. *Journal of Women's Health (Larchmont)*. 2010; 19(1):39–46. [10.1089/jwh.2008.1200](https://doi.org/10.1089/jwh.2008.1200)
- Smith Fawzi MC, Lambert W, Singler JM, Koenig SP, Leandre F, Nevil P, Farmer PE. Prevalence and risk factors of STDs in rural Haiti: Implications for policy and programming in resource-poor settings. *International Journal of STD and AIDS*. 2003; 14(12):848–853. [10.1258/095646203322556200](https://doi.org/10.1258/095646203322556200) [PubMed: 14678595]
- Smith Fawzi MC, Lambert W, Singler JM, Tanagho Y, Léandre F, Nevil P, Farmer PE. Factors associated with forced sex among women accessing health services in rural Haiti: Implications for the prevention of HIV infection and other sexually transmitted diseases. *Social Science & Medicine*. 2005; 60(4):679–689. <http://dx.doi.org/10.1016/j.socs-cimed.2004.06.010>. [PubMed: 15571887]

- Sterk CE, Klein H, Elifson KW. Self-esteem and “at risk” women: Determinants and relevance to sexual and HIV-related risk behaviors. *Women’s Health*. 2004; 40(4):75–92.
- UNICEF. Children in Haiti: One year after—The long road from relief to recovery. Geneva, Switzerland: United Nations Children’s Fund, Haiti Country Office; 2011.
- Urbán R, Szigei R, Kökönyi G, Demetrovics Z. Global self-esteem and method effects: Competing factor structures, longitudinal invariance, and response styles in adolescents. *Behavior Research Methods*. 2013 Advance online publication. 10.3758/s13428-013-0391-5
- World Bank. Haiti: The challenges of poverty reduction. Vol. 1. Washington, DC: Author; 1998.
- World Bank. Social resilience and state fragility in Haiti. Washington, DC: Author; 2007.
- World Health Organization. Global HIV/AIDS response: Epidemic update and health sector progress towards universal access—Progress report 2011. Geneva, Switzerland: Author; 2011.
- Wu CH. An examination of the wording effect in the Rosenberg Self-Esteem Scale among culturally Chinese people. *Journal of Social Psychology*. 2008; 148(5):535–551.10.3200/SOCP.148.5.535-552 [PubMed: 18958975]

TABLE 1

Examples of Comments Made by Patients That Described Positive and Negative Views of Themselves

Positive Comments	Negative Comments
"I feel good with myself; I do not have the virus in my blood. I feel good with myself for not being infected by the virus."	"What makes me feel unhappy with myself is the fact that I want to help myself, my family, but I am unable to do so. That's what bothers me every day."
"I am pleased with myself now that I am free of HIV."	"I do not respect myself enough. I have a boyfriend and my parents don't know about him."
"Yes, I am satisfied with myself, I do not have the AIDS virus, and I am not sick, even if things are not good for me."	"I am not quite satisfied because I was supposed to work and I could not find any. I see myself as a failure, without a plan for the future."
"God is with me because I am not sick."	"I am unable to do anything for myself or my family."
"Everything considered, I am satisfied with myself, except on the economic part."	"If your parents cannot give you what you need, economic deprivation can lead you to do what is unacceptable for money."
"I see myself in a positive way; I am proud of myself."	"When someone can give you a hundred gourdes [equivalent to \$2.3 U.S. dollars] or meet your economic needs, even if you would not have freely chosen him, you do your best to live with him."
"I feel quite good about myself."	"I had to quit school after January 12th. I am staying over someone's home [a man]."
"I love myself, I like the way that I am living, and I do not have much problems because I am not sick."	"He thought that giving me one or two hundred dollars gave him rights to me. It is only when I am hungry that I miss him."