

**A COMPARISON OF THE GIRLFRIENDS PROJECT TO THE SOCIAL COGNITIVE
THEORY AND THE THEORY OF GENDER AND POWER**

by

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B.S., Carlow University, 2007

Submitted to the Graduate Faculty of
Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Public Health

University of Pittsburgh

2011

UNIVERSITY OF PITTSBURGH

Graduate School of Public Health

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This paper is an examination of the potentially efficacy of a group based intervention called the Girlfriends Project, which specifically targeted African American women for HIV and STI education in the home. The premise of the project was that by having HIV discussions in an environment where women did not feel judged or intimidated, and where they were surrounded by “girlfriends,” that the stigma attached to sex and HIV would be diminished. Because African American women suffered disproportionality for HIV and STIs, interventions that could effectively reduce the rate of infection among that population were greatly needed. Therefore, the public health significance of this essay was to evaluate whether the Girlfriends Project was an intervention that could fill that need. The hypothesis of this paper was that because the Girlfriends Project addressed a majority of the elements designated as necessary for behavioral change by the Social Cognitive Theory and the Theory of Gender and Power, the Girlfriends Project would be effective in reducing the incidence of HIV and STI among African American women by increasing the use of risk-reduction behaviors.

In this paper the components of the Girlfriends Project were compared to each of the individual elements of the Social Cognitive Theory and the Theory of Gender and Power. From this comparison it was found that the components of the Girlfriends Project were in fact congruent with the elements of the both theories. From the apparent congruency, it was

concluded that there appeared to be evidence that if widely disseminated the Girlfriends Project had the potential to be effective in changing the attitudes and social norms of African American women, which in turn would lead to behavior change that would reduce the incidence of HIV and STI among African American women.

While the evidence supported the hypothesis of the efficacy of the Girlfriends Project there were several gaps in the Girlfriends Project where it could have more fully addressed the elements of the SCT and the TGP. Recommendations were provided which would allow the Girlfriends project to fill those gaps and more effectively achieve their goal.

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ACKNOWLEDGMENTS

I would like to take this opportunity to thank the people who have helped me the most through this process. I would first like to thank my mother for whom I owe all of strength and determination, and my father whose tireless efforts showed me what hard work truly means. I would like to thank Lisa Dukes coordinator of the Girlfriends Project for all of her support and endless generosity. I would like to thank Mark Hawk, for introducing me to the Girlfriends Project, and allowing me to be a part of such a worthwhile endeavor. I would like to thank my friends Alonna Carter, Kavita Ishwad, and Ruhiyyih Degeberg for their consistent encouragement and endless patience through this process. I would like to thank the members of my thesis panel Dr. Christopher Keane and Dr. John Marx for taking the time to help me through a process so crucial to my development. And finally I would like to dedicate a special thank you to my thesis advisor Dr. Beth Nolan whose direction, encouragement, and genuine devotion to her students made this paper possible.

1.0 INTRODUCTION

Marian Wright Edelman wrote that “it is utterly exhausting being black in America” (Valentine, 2008, p. s23).” One example that epitomizes this idea is the historically dramatic rate of human immunodeficiency virus (HIV), Acquired immune deficiency syndrome (AIDS) and sexually transmitted infection (STI) in African Americans compared to other racial groups. According to the Center for Disease Control and Prevention (2009), in 2007 African Americans represented only 12% of the US population, but accounted for 51% of new HIV/AIDS diagnosis (CDC, 2009b). African Americans also accounted for 70% of gonorrhea cases, 48% of chlamydia cases, and 46% of all syphilis cases reported that year (CDC, 2009a). Although this disparity was alarming, even more striking was that within this disproportionately affected population, one group’s infection rate was increasing at a greater rate than another. In 2007, it was reported that African American females had the highest rates of both chlamydia and gonorrhea of any group (CDC, 2009a). Moreover, the diagnosis rate of AIDS among African American females was 22 times higher than that of Caucasian females (CDC, 2009b). This disparity was even more dramatic when one took into account that the diagnosis rate of AIDS for African American males was only eight times that of Caucasian males (CDC, 2009b). Healthy People 2010 suggested that this clear disparity needed to be corrected (U.S. Department of Health and Human Services, 2000). In order to make that correction, it was necessary that behavioral change interventions were applied in a manner that was culturally competent in order to truly be effective (Crepaz et

al., 2009). Interventions seeking to decrease the rate of HIV and STIs in African American women needed to address risk factors specific to the experience of that particular group.

The Girlfriends Project attempted to reduce the rate of HIV and STI among African American women by addressing the risk factors specific to the experience of African American women. The Girlfriends Project was a group-based intervention specifically targeting African American women age 17 and older who lived in South Western Pennsylvania, for culturally relevant HIV and STI prevention education. At the time that this thesis was written, the project was undergoing evaluation to determine its effectiveness. Although there was a lack of quantitative data to indicate that the project was indeed effective in lowering the rate of HIV and STIs in African American women, the comprehensive nature of the project suggested its potential.

Because the Girlfriends Project suggested potential for reducing the rate of HIV and STIs among African American women, this paper examined the extent of the potential. To measure the project potential, the components of the Girlfriends Project were compared to the elements of two theories of behavior change that are known to be effective; namely the Social Cognitive Theory (SCT) and the Theory of Gender and Power (TGP). Specifically, the hypothesis of this paper is that because the Girlfriends Project addressed a majority of the elements designated as necessary for behavioral change by the SCT and the TGP, the Girlfriends Project would be effective in reducing the incidence of HIV and STI among African American women by increasing the use of risk-reduction behaviors. In other words, it is hypothesized that if the Girlfriends Project addressed the necessary elements of the SCT and the TGP then it could successfully change the attitudes and social norms of African American women.

1.1 BACKGROUND

This section provides background information which is essential for effectively comparing the components of the Girlfriends Project to the elements of the SCT and the TGP. The first section will discuss some of the stressors that increase the risk of HIV and STI infection among African American women. The second section details the structure of the Girlfriends Project. The third section provides an overview of the SCT. The final section of the background gives an overview of the TGP. With this information an analysis of the potential effectiveness of the Girlfriends Project was performed.

1.1.1 Stressors

The literature of African American women and HIV/STIs revealed that while there had been no definitive explanations for the disproportionately high rates of HIV and STIs among African American females, many of the reasons suggested target negative sexual behaviors. These negative sexual behaviors include, for example, non-consistent condom use, multiple sexual partners, and drug dependency. Although prevention strategies have attempted to address these behaviors directly, inadequate integration of social and environmental determinants of behaviors have made these interventions ineffective (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009; Purcell & McCree, 2009). An example of an intervention that fails to consider the environmental determinants of behavior would be a condom intervention that focuses solely on educating the public about the benefits of condom use. Without considering the environment of the population of interest, the underlying assumption being made is that all sex is consensual, which is not the case for many women (Purcell & McCree, 2009). This demonstrates the idea that simply

knowing information about behavioral change is insufficient to precipitate action. Knowledge may be the prerequisite for change, but the environment has to be conducive to change for it to actually occur. Therefore, it is necessary to consider not only sexual behaviors, but the circumstances surrounding those behaviors. Some of the environmental stressors that have been shown to have an effect on the sexual behaviors of African American females can be characterized as: interpersonal relationships, social norms, and external stressors (El-Bassel et al., 2009).

1.1.1.1 Description of Stressors

The following sections will describe each of the three characterizations of environmental stressors. As was stated those stressors were: interpersonal relationships, social norms, and external stressors (El-Bassel et al., 2009). By first analyzing these stressors, one can then evaluate how effectively the Girlfriends Project helps African American females to negotiate these realities in order to reduce their risk of HIV and STI infection.

1.1.1.1.1 Interpersonal Relationships

Interpersonal relationships frequently have a dramatic effect on the sexual behavior of African American females. This is exemplified in those relationships involving intimate partner violence (IPV). According to the Bureau of Justice Statistics, in 2007 African American women experienced the second highest rate of IPV compared to other groups (Catalano, 2007). One reason for that may be that many African American women were economically and socially disadvantaged (West, 2004). Economic disadvantages lead to IPV because those with limited resources tended to live in areas of high violence. Therefore, their chances of being exposed to

violence are increased (El-Bassel et al., 2009). African American women's social disadvantages in this example refer to the historical way they have been viewed by society. Throughout much of history, African American women have been labeled as sexually promiscuous. Although in 2011, this thinking was not as prevalent, the view of African American females as the sexually promiscuous temptresses had carried into the unspoken beliefs of the mainstream. This led some to the belief that African American women were less respectable victims, thereby increasing their chances of abuse (West, 2004). Because this was the reality for many African American females, women developed coping mechanisms to reduce their chances of being victimized in their relationships. These strategies often involved sacrificing positive sexual behaviors, which increased their chance of infection.

One study found that IPV significantly decreased the ability of women to negotiate positive sexual behaviors such as condom use (Raiford, Diclemente, & Wingood, 2009; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003; Wyatt et al., 2002). One reason for this is that women who are physically abused for making a request in their sexual relationship tend to stop making request. In order to avoid violence, they forgo safe sexual practices. This is solidified with reoccurring abuse, which can instill in women a feeling of unimportance and unworthiness of protecting themselves (El-Bassel et al., 2009). This decrease in self-esteem leaves African American women with an increased risk for HIV and STIs, especially if her partner is involved in high risk behaviors (Raiford et al., 2009; Wingood et al., 2006). Because African American women in relationships involving IPV are stripped of their ability to choose whether or not to engage in safe sex practices, it is ineffective to promote behavioral interventions that do not take that into account.

An example of African American women being stripped of their ability to choose whether or not to engage in safe sex practices was demonstrated when the results of a study conducted by Raiford and colleagues (2009) found that, under conditions of high fear, inconsistent condom use was positively related to STI knowledge. Apparently, the women in this study used the knowledge of STI transmission gained from the intervention to assess their partner's risk, and weighed it against the threat of abuse for requesting condom use. This example tells us that simply promoting positive sexual behaviors is not enough. These women knew how to protect themselves; they just didn't have the means to do it. Therefore, interventions must be designed to do the following: build negotiation self-efficacy to increase the use of condoms, increase risk reducing skills, and to provide strategies needed to increase the safety in the relationships of African American women (Crosby et al., 2001; El-Bassel et al., 2009). Although by 2011 some interventions had recognized the need for HIV and STI interventions to incorporate IPV, many had failed to provide dual strategies for risk reduction (El-Bassel et al., 2009).

1.1.1.1.2 Social Norms

When developing responsible sexual behavior interventions, it is essential to incorporate social norms and the way those norms affect the behavior of African American women. According to Aral, Adimora, and Fenton (2008), a national survey analyzing the intersection of sexual behaviors, gender, and race revealed that although African American women had the highest prevalence of HIV and STIs, their level of risk behavior was not the highest when compared to other groups. This national survey found that when compared to Caucasian women, African American women were less likely to have four or more partners in a year, and less likely to have

15 or more partners in their lifetime. In a separate study, African American women also reported greater condom use than Caucasian women (Wyatt, 2009). One of the reasons behind this inverse relationship is that the high prevalence of HIV and STIs in the African American community increased the risk of infection even if African American women were using low-risk behaviors (Aral, Adimora, & Fenton, 2008). Because impoverished urban neighborhoods tended to be racially segregated, African American women were more likely to choose a partner of the same race (Andrinopoulos, Kerrigan, & Ellen, 2006; Aral et al., 2008; Crosby et al., 2000). This increased the occurrence of sexual mixing of high risk and low risk groups, which helped to further the spread of disease (Aral et al., 2008).

The increased mixing high risk and low risk behaviors would increase when those with low risk behaviors discontinued their positive sexual behaviors. Although African American women were more likely to make condom-related decisions independent of their partner, the decision they often chose was to discontinue use (Wyatt, 2009). A study conducted by Crosby and colleagues (2000) found that with increased familiarity and time spent with a partner, African American females became less concerned with risk of STIs. By forgoing condom use, African American women felt that they were sending a message of trust and commitment (Crosby et al., 2000; Valentine, 2008). Basically, African American women would change their sexual behavior based on the way they believe their partner would evaluate that behavior. However, forgoing condom use was problematic because African American men were more likely than African American women to have concurrent sexual partnerships (Aral et al., 2008). African American men's increased incidence of concurrent sexual partnerships indicates that STI safety cannot be assessed based on assumed monogamy.

In order to be effective, interventions that promoted responsible sexual behaviors needed to incorporate the conditions fostered by the environments of African American women. Interventions that simply promoted positive sexual behaviors were inefficient because many African American women were already using them. In many cases, promotion should have focused on continued use of positive sexual behaviors even within long term relationships. Interventions should have been communicated that STI safety cannot be determined using partner familiarity (Crosby et al., 2000). Often, the word of one's partner that they do not have an STI is inefficient because due to the asymptomatic nature of many infections, their partner may be unaware that they have an STI (Crosby et al., 2000). Interventions needed to stress consistent responsible sexual behaviors especially in the absence of HIV and STI testing.

The abandonment of safe sex behaviors was further exacerbated by the imbalance of power created by the sex ratio inequality: for every 100 single African American women there were an estimated 70 single African American men; that estimate was excluding those men removed from the population due to incarceration (Wyatt, 2009). When one factors in the number of African American men that were missing from the population due to the high rate of incarceration, the imbalance in the sex ratio was exacerbated even further (Aral et al., 2008; Thomas, 2006). The United States had the world's highest rate of incarceration partially due to stricter drug laws (Andrinopoulos et al., 2006; Thomas, 2006). Drug laws resulted in African American men having been incarcerated at a rate six times that of Caucasian men (Thomas, 2006). Thus greater than one in four African American men were incarcerated during their lifetime and almost one in three men aged 20 to 29 were either in prison, on probation, or on parole in 2001 (Thomas, 2006). That reduction in the dating pool placed African American women at a disadvantage; because African American women feared losing their partner and not

being able to find another, they were more willing to compromise their power in their relationships (El-Bassel et al., 2009). Thus African American women were left with a decreased perceived ability to negotiate safe sex practices such as condom use and monogamy.

A decreased perceived ability to negotiate safe sex practices was indicated in several studies, where some African American women expressed the belief that the power imbalance in their relationship reduced their control over condom use (Crepaz et al., 2009). When there is an imbalance of power in a relationship, those with less power tend to determine their behavior based on the views of those with more power. If a woman believes that her partner will be insulted and possibly end the relationship if she asks to use condoms, she may be unwilling to ask. In these situations, the fear of losing one's partner outweighs the perceived risk of infection. The idea of fear outweighing the perceived risk of infection also applies to the increased acceptance of infidelity in relationships with a power imbalance. If a woman fears that confrontation over suspected unfaithfulness will cause the end of her relationship, she may be unwilling to address it. In this situation outcome expectancy leans in favor of ignoring the problem. The perceived benefits of being in a relationship (emotional intimacy, social status, etc.) outweigh the possible risk of infection; especially if the woman has a negative view of her ability to find a partner that is monogamous (Andrinopoulos et al., 2006).

Although social norms are very complex and interconnected, it was necessary to incorporate these social norms into positive sexual behavior promotion. Interventions may not have been able to increase the sex ratio; however, they could have taken steps to assure that women understood the relationship between the imbalanced sex ratio, fear of losing their partner for insisting on condom use, and the way these factors relate to increased risk (El-Bassel et al., 2009). By discussing this link with African American women, a level of comfort would have

been developed that would have allowed them to effectively weigh the pros and cons of remaining in an unsafe relationship verses ending the relationship. Furthermore, helping women to empower themselves by recognizing their self-worth would have helped women to recognize that they deserved to be in relationship where their needs were acknowledged and valued by their partner. This dialogue, in conjunction with building safe sex negotiation skills, would have helped to increase their confidence regarding their ability to use safe sex practices consistently. It would also have helped them to realize the benefit of negotiating the practice of safe sex behaviors outweighs the possibility of losing the relationship.

1.1.1.1.3 External Stressors

External stressors are those environmental forces that have an effect on the sexual behaviors of African American females. One example of an external stressor that has been critical to consider when developing positive sexual behavior interventions is barriers to testing. Testing for HIV and STIs was essential to the success of these interventions because in 2009, the majority of the new cases of infection were transmitted by individuals who were undiagnosed (Swenson et al., 2009). Furthermore, those who were tested and made aware of their STI status were more likely to adopt safe sex behaviors (Swenson et al., 2009). Therefore, when one reflects on the infamously high prevalence of HIV and STIs experienced by the African American community, if knowledge of one's STI status affects safe sex behaviors the spread of infection could have been slowed. Because the lack of testing was such an important factor in the spread of HIV and STIs, barriers to HIV and STI testing, such as lack of access to quality health services and stigma associated with the health care system, needed to be explored.

Access to quality health services had long been a problem in the African American community. In an article which reviewed health service literature from 1985 to 2000, found that African Americans did not have access to healthcare services at the same rate as Caucasians (Mayberry, Mili, & Ofili, 2000). Reasons for this may have been that many African Americans of low economic status did not have insurance, or that for those who did have insurance, it may not have covered necessary preventative STI and HIV services (El-Bassel et al., 2009; Swenson et al., 2009). Lack of access directly affected the sexual behavior of African American females. As was mentioned previously, those individuals that knew their STI status were more likely to adopt and maintain safe sex behaviors (Swenson et al., 2009). Therefore, without access to quality health care services, women with negative sexual behaviors were more likely to maintain those behaviors and increase their morbidity in the process.

Although restricted access to healthcare was an important environmental determinant of behavior, stigma associated with the healthcare system was also an important determinant (Bogart & Thorburn, 2005; Foster, 2007). African Americans have a long, disturbing history with the healthcare system. Betrayals of trust such as the Tuskegee experiment and medical experimentations on African Americans prisoners in Holmesburg prison affected the relationship between the medical community and the African American community (Bogart & Thorburn, 2005; Washington, 2006). Because of this history, many African American men and women developed an extreme distrust of the healthcare system (Valentine, 2008). For instance, a survey conducted in San Bernardino, California found that 27% of African American adults believe that “HIV/AIDS is a man-made virus that the federal government made to kill and wipe out black people” (Bogart & Thorburn, 2005, p. 213). Although these types of conspiracy theories were misguided, they demonstrated the level of mistrust that African Americans had for the healthcare

system. These beliefs were solidified by the fact that African Americans often received treatment that was of inferior quality when compared to the care received by their Caucasian counterparts (El-Bassel et al., 2009). If African American women did not believe that the healthcare system was working in their best interest, what motivation would they have had to utilize the facilities designated to monitor their sexual health? African American women who did not believe that healthcare services would increase their health benefits often would not use them (El-Bassel et al., 2009).

Sexual behavior interventions needed to recognize that lack of access to quality health services and stigmas associated with the health care system are powerful determinants of sexual behavior. While promoting HIV and STI testing is acceptable, because African American women often did not have access to testing, and/or mistrusted healthcare providers, they were not likely to adopt the behavioral change fostered by testing. In order to reduce these barriers, interventions needed to improve their ability to communicate to their participant's information regarding resources which would have provided them with greater access to low-cost or free health care services. Low-cost or free health care service information would have provided the option of STI testing for those who wanted to know their status but had no insurance or inadequate insurance. Moreover, interventions needed to make greater efforts to assure that those conducting interventions promoting safe sexual behaviors were culturally competent (El-Bassel et al., 2009; Valentine, 2008). Much like with health care providers, when the facilitator of an intervention was perceived by participants as being judgmental or hostile, it only helped to solidify the preconceived notions that many African Americans had about research and the healthcare system (Kinsler, Wong, Sayles, Davis, & Cunningham, 2007; Valentine, 2008). Increased distrust would

only work to decrease the likelihood that the participants would be open to the messages being communicated in health promotion interventions, thereby, reducing their effectiveness.

1.1.1.2 Changing Culture

The strategy of promoting responsible sexual behaviors in order to reduce the risk of STIs proposed by Healthy People 2010 was a wise approach to HIV and STI prevention (U.S. Department of Health and Human Services, 2000). Negative sexual behaviors were a major contributing factor to the spread of HIV and STIs. Therefore, targeting sexual behavior for an intervention was a reasonable route to take. However, as one can tell from the previous sections, behavioral interventions needed to be designed to address the environmental determinants of health specific to the population of interest. For African American women of lower economic status, determinants surrounding interpersonal relationships, social norms, and external stressors played a major role in their ability to change their sexual behavior. And although elements of these stressors can often seem conflicting, it is important that interventions be able to provide solutions to all of the problems mentioned. For example the idea of forgoing condom use to save a relationship and the idea that women turning a blind eye to poor behavior such as infidelity in order to save a relationship (Andrinopoulos et al., 2006; Crosby et al., 2000; Valentine, 2008). The conflicting nature of the stressors demonstrates the variation in African American women's experiences. The conflict shows that thinking processes and mechanisms of rationalization are not the same for every African American woman. Therefore, by creating behavioral interventions that addressed all of the determinants of behavior in a culturally competent manner, promotion of responsible sexual behaviors was more likely to be successful in reducing the spread of HIV and STIs.

Although it is true that the causal factors that increased the risk of infection for African American women needed to be addressed in order to create a substantial change in the rate of HIV and STIs, it is also true that those causal factors were quite complex. For many of the examples of determinants provided, it would have taken substantial policy change to directly counteract the effects of those circumstances. Unfortunately, addressing these complex determinants was well beyond the scope and capabilities of most interventions. However, there were ways to indirectly address these problems. The majority of the determinants previously mentioned could have been addressed by working to change certain aspects of the culture of African American women. Changing the entire culture of African American women because of the assets inherent in their culture is neither necessary nor wise. Although thus far the problems that have been discussed occur in the African American female culture, African American women also have a rich history of pride, perseverance, and creativity that has helped to shape U.S. culture as a whole. These are not qualities that need to be changed, but respected. The benefits afforded by being part of, and/or influenced by, the African American female culture far outweigh cost. Therefore, a delicate balance needs to be maintained when trying to institute change in this particular community. Instead of attempting to change the entire culture, one must find specific areas in African American female culture where the seeds of change can be planted. These seeds will help to precipitate the use of positive sexual behaviors without disregarding the positive aspects of the culture. One intervention that attempted to do just that was the Girlfriends Project.

1.1.2 The Girlfriends Project

The Girlfriends Project was an intervention for HIV and STI prevention education, targeting African American women age 17 and older, who lived in south western Pennsylvania. This project was based out of the Pittsburgh AIDS Task Force (PATF) whose mission was to “support and empower all individuals living with HIV/AIDS and preventing the spread of infection” (“Vision, Mision, & Values,” n.d.). The Girlfriends Project was created by Lisa Dukes, Girlfriends Project Coordinator while working with the Sisters Informing Sisters About Topics on AIDS (SISTA) Project. The SISTA Project was a peer-led group intervention whose goal it was to reduce risky sexual behavior among African American women through HIV education and a focus on gender and ethnic pride. The intervention took place in a community based setting and was composed of five two-hour sessions (“SISTA Project Overview,” n.d.). Although the SISTA Project was found to be effective for reducing sexual risk behaviors among African American women, when working on the project, Lisa Dukes felt that African American women needed an intervention that focused on their needs but that did not require such a lengthy time commitment. She believed that by creating a one-time, group-centered intervention that focused on the realities of the African American female experience, more women could be reached in a shorter period of time. With that idea in mind, she created what were called “Girlfriends’ parties” and modeled them after a Tupperware® party format. All subsequent information regarding Girlfriends parties is attributed to Lisa Dukes. More information is available through the PATF (“PATF Prevention Programs,” n.d.).

1.1.2.1 Girlfriends' Parties

Girlfriends' parties were informal, health education parties conducted in the privacy of participants' homes. The premise of the project was that by having HIV discussions in an environment where women did not feel judged or intimidated, and where they were surrounded by "girlfriends," that the stigma attached to sex and HIV would be diminished. This format would create a more open and candid discussion regarding HIV and STIs which would provide the facilitator with an avenue for altering the understanding of African American women regarding HIV and STIs. Trained African American women facilitators conducted the interventions in order to maintain a gendered and cultural group dynamic.

Each intervention began by the participant or "hostess" inviting at least six of her African American female friends (17 and older) to her home for the intervention. The hostess chose the day and time of the party; this assured that the intervention was as convenient as possible for both the hostess and her friends. On the day of the party, the facilitator brought food, drinks, and utensils. The facilitator discussed food items with the hostess prior to the day of the party. By taking the time to talk to the hostess about what she and her guest would enjoy the most, the facilitator essentially set the tone of the party. With that small act, the facilitator communicated to the participants both that she wanted them to enjoy themselves, and that their needs took precedence.

During the intervention, the facilitator presented information about HIV, STIs, safe sex practices, and domestic violence formatted for the cultural context of the African American female experience. The format of the Girlfriends' parties was designed to start as a presentation by the facilitator, and then develop into more of a discussion. The women were encouraged to participate and ask questions throughout the presentation in a safe, supportive environment,

focused on the women's issues. The facilitator helped guide the discussion in such a way that reflected the women centered design of the Girlfriends Project. The discussion was focused in a way that was positive, solution-focused, and involved minimal time spent on "man-bashing." The format of the presentation is outlined in the following sections.

1.1.2.1.1 Distribution of Information Folders

Upon arrival to the party, each participant received a folder containing information on HIV/AIDS and domestic violence. The facilitator explained to the participants that the folder was created so that they would have information about HIV/AIDS and domestic violence that they can take home with them. The facilitator explained that the documents in the folder covered all of the main points in the presentation and also provided a list of resources the participants could use if they are in need of additional services, such as STI testing, drug abuse counseling, mental health services, or domestic violence shelters.

1.1.2.1.2 Distribution of the Pre-Quiz

After the folders had been handed out, each participant was given a pre-test. The pre-quiz consist of 22 questions assessing HIV knowledge. The pre-quiz measured the level of knowledge concerning HIV among the participants before the intervention. Either the facilitators or I would eventually compare those results to the post- quiz that was distributed toward the end of the party. The quizzes utilized for this intervention were constructed from: 1) several quizzes that were found to be effective for gauging critical HIV knowledge, and 2) focus groups with African American women conducted to assure that the questions were comprehensible, culturally

relevant, and also to ascertain if there were any pertinent questions that may have been missing from the quiz. Once the quizzes were handed out, the facilitator explained to the participants the reasons that they were being asked to complete the quiz, how their responses would be used, and informed them that all quiz information would remain completely confidential.

1.1.2.1.3 Distribution of the Initial Assessment

After all of the pre- quizzes were completed, each participant was asked to complete an initial assessment. The initial assessment was a five page questionnaire used to collect demographic information and data regarding sexual behaviors related to HIV and STI risk. The assessment utilized for this program was constructed from: 1) several assessments that have been found to be effective for assessing HIV and STI risk, and 2) focus groups with African American women were conducted to assure that the questions were comprehensible, culturally relevant, and also to ascertain if there were any pertinent questions that may have been missing from the assessment. Before there participants began filling out the assessment, the facilitator would explain to the participants what the assessment was, why the participants were being asked to fill it out, how their responses would be used, and that all information collected from the assessment would remain completely confidential.

1.1.2.1.4 Introduction / Ice breaker

The official introduction and ice breaker were the next steps in the intervention. The facilitator introduced herself and explained the purpose and goals of the Girlfriends' party. Following her personal introduction she had each participant introduce themselves and briefly mention why they

chose to attend the Girlfriends' party. This ice breaker allowed for the facilitator to become more familiar with the group, while gaining a better understanding of what the participants wanted to gain from the party. This practice not only set the foundation for an open discussion by demonstrating to the women that their thoughts and opinions were an essential part of the intervention but it also allowed for the facilitator to tailor the presentation to the needs of each individual group.

1.1.2.1.5 Presentation of HIV Information

Following the icebreaker, the facilitator began the presentation by discussing HIV/AIDS and its impact on African American women specifically. The facilitator started the presentation by presenting the women with basic HIV/AIDS information; what HIV and AIDS are, how they are different, modes of transmission, and symptoms. Following this, the facilitator discussed the high rate of infection among African American women in comparison to other groups. Reasons for this elevated infection rate including several of those mentioned in the previous sections of this paper were brought to the attention of the participants. Once some of the causes of the high incidence of HIV/AIDS among African American women were discussed the facilitator transitioned the conversation into a brief mention of prevention methods which would be expanded upon later in the presentation. The strategies mentioned however would include but were not restricted to; abstinence, use of sexual barriers, and safer drug use.

The purpose of that section of the presentation was not only to provide basic HIV/AIDS information pertinent to African American women but also to dispel common misconceptions about HIV/AIDS and to de-stigmatize infection. These two factors act as barriers to HIV/AIDS

prevention and therefore needed to be addressed. Encouraging questions from the participants was essential in that regard.

1.1.2.1.6 STI Information

The STI information section of the presentation covered basic STI information such as biological agent, mode of transmission, symptoms (or lack thereof), and treatment for a variety of STIs. During the discussion of these infections, a visual aid was used to show the women how each STI is manifested physically in both female and male genitalia. As the facilitator went through each STI in the visual aid, she highlighted those STIs that were affecting African American women more so than other groups. Again reasons for this elevated infection rate were presented which led to conversations concerning STI prevention methods.

1.1.2.1.7 Prevention Information

The next section of the presentation was the discussion of the various preventative measures to protect against HIV and STI's. This discussion was essentially broken up into four sections: abstinence, barrier/lubricant effectiveness, various barriers and lubricants available, and barrier application.

Abstinence. Abstinence was presented as method of HIV and STI prevention that African American women could utilize. Abstinence was explained as not simply refraining from engaging in sexual intercourse but all sexual activity including oral and anal sex. Abstinence was highlighted as the most effective method of HIV and STI prevention.

Barrier/Lubricant Effectiveness. In the barrier/lubrication effectiveness section, the facilitator discussed what was meant by the term “barrier” and why they are essential to HIV prevention. The three main types of barriers (male condoms, female condoms, and dental dams) were introduced and the effectiveness of each method was discussed. The facilitator also introduced the group to personal lubricants. She discussed what they are and why using them during intercourse could increase the effectiveness of condoms.

The facilitator showed the participants the variations in barriers and lubricants available. When discussing the male condom, the facilitator displayed several of the available styles, for instance; latex, polyurethane, extra-large, flavored, glowing the dark, etc. The choice of condoms that would be displayed was left to the discretion of the facilitator. The idea was to make the women aware that there were options available to them. With this in mind, the facilitator brought a wide variety of condoms to display so that the differences between them, where they could be obtained, and the average cost could be discussed. Furthermore, when discussing the male condom, some of the common excuses used by men for why they don’t want to wear a condom were presented. This portion of the discussion provided the participants with an opportunity to see examples of how one can creatively negotiate condom use when they know their options.

When introducing the female condom, the facilitator discussed what material female condoms are made of and how long they can be worn. Moreover, the pros and cons of using the female verses the male condom were explained. For instance, it was stressed that using the female condom is an excellent way for women to take control of their sexual health. When using the female condom, there is no need to rely on one’s partner to have a condom, or to try to convince them to use a condom because it is not the male that needs to wear it. Much like in the discussion of the male condom, common excuses used by men for why they want to have

unprotected sex were presented. As before, it was explained that knowing ones options can help to combat these excuses.

One obstacle that was mentioned in the intervention was the cost of female condoms. The facilitator explained that female condoms are typically more expensive and harder to find than the male condom. However, the benefits of the female condom far outweigh the cost were stressed. Moreover, the participants were provided with local, reputable health facilities where they could obtain both male and female condoms for free, including the Pittsburgh AIDS Task Force.

The discussion of the dental dam included what they are, how they are used, what infections they protect against, how effective they are, product availability, and variety. Because of the limited availability of dental dams in stores, the participants were told that dental dams also could be obtained for free from the Pittsburgh AIDS Task Force, or that several items can be converted into a dental dam if one wants their partner to perform oral sex on them and a dental dam is not readily available (condoms, rubber gloves, and clear plastic wrap).

The final item under discussion in this section of the presentation was lubricants. For this topic, the facilitator discussed some of the more typical forms of lubricants available (water based, silicone based, oil based, and flavored. The facilitator explored how they are different, which can or cannot be used with condoms, and which lubricants can be used during which sex acts (vaginal, anal, and/or oral sex). The participants were told that, in addition to increasing the effectiveness of condoms, the incorporation of different sex lubricants into ones sexual repertoire can act as an effective way to persuade ones partner to use safe sex practices.

Barrier Application. Following the presentation of barriers and lubricants, the facilitator demonstrated how to properly apply the male condom, female condom, and dental dam. Using a

phallic model, the facilitator first demonstrated incorrect male condom application, followed by correct male condom application. After the demonstration, the facilitator encouraged participants to try and properly apply a condom to the model and she provided them with feedback on their technique. By having the women participate, the facilitator assured that the participants left the party having hands-on experience with proper condom application. The women were not required to attempt applying a condom to the model; however, they were greatly encouraged.

This same hands on procedure was followed for both the female condom and dental dam using a female pelvic model. The facilitator walked through the steps of inserting the female condom and applying the dental dam, and then offered the women the option to attempt the procedure themselves.

1.1.2.1.8 Domestic Violence Information

The domestic violence section of the presentation presented information on the definition of domestic violence and its impact African American women. The facilitator used the power control wheel to explain what constitutes abuse and how abuse works in a cyclical manner (“Wheel Gallery,” 2008). In addition, the facilitator emphasized how domestic violence increases one’s risk of HIV infection and the reasons behind the increased risk. Once domestic violence was discussed, the facilitator communicated to the women that if they are currently in a relationship where domestic violence was occurring, that it could be detrimental to her safety to try and utilize the negotiation tactics learned in the intervention. The facilitator then offered tips that one could use to reduce their risk of contracting HIV and/or STIs while in a relationship

with domestic violence, how to escape an abusive relationship, and provided resources they could contact if they found themselves in an abusive relationship.

1.1.2.1.9 Presentation Wrap-Up

During the conclusion, the facilitator reviewed the main points of the presentation, placing particular emphasis on HIV transmission and prevention. After the short review, the facilitator answered any questions that the participants had and reminded them to read over the resources provided in the folders. Lastly, each participant was given a gift bag containing male condoms, female condoms, dental dams, personal water based lubricant, a condom case, and male/female condom instructions.

1.1.2.1.10 Post- Quiz

Following the presentation wrap-up, each person was asked to take a post- quiz and post-assessment. The post- quiz was identical to the pre- quiz. Using an identical test allowed the program directors to gage the level of knowledge about HIV among the participants after the intervention. The post-assessment was identical to the pre-assessment, except that sections regarding sexual risk behavior, experience with the Girlfriends' party, and demographic information were added to the post-assessment as feedback.

1.1.2.1.11 HIV Testing

While the post- quiz and assessment were being filled out, the facilitator offered the women the option to be tested for HIV. The facilitator explained that testing was optional, completely free, and that only a painless cheek swab was required. For those women who wished to be tested, they were required to fill out a consent form. Once the form was completed, each woman was tested individually in a separate area of the home in order to assure confidentiality. The women were counseled to assess their risk and also provided information regarding what to expect. Each woman's sample was assigned a number so that the people conducting the test could not know to whom the sample belonged. Following testing, the facilitator explained when to expect the results and that each person's results would be delivered by hand, on a day, time, and place of their choosing as long as it was a private location. Once the results were back from the lab at the Allegheny Health Department, the facilitator personally delivered the result to the participants on the specified day and time. This was positive because it was convenient for the participants and it provided the opportunity for the participants to have immediate HIV counseling if the situation required.

1.1.2.1.12 Three Month Post-Assessment

Three months following the intervention, each participant was mailed an assessment identical to the initial-assessment. The participants were asked to fill them out and mail them back within two weeks. To increase compliance, the women were offered the opportunity for their name to be entered into a raffle for a prize, if they returned the form within two weeks. Upon receiving the returned three month assessments, the assessments could then be compared to the results of

the post- and pre-assessments. The comparison would allow the Girlfriends Project to determine if behavior change occurred following attendance of Girlfriend parties.

1.1.2.1.13 Participant Recruitment

Participant recruitment for the Girlfriends Project was accomplished through word of mouth, incentives, and agencies. Much like the Tupperware ® party format that Girlfriends parties were modeled after, recruitment was largely accomplished at the Girlfriend parties themselves. Following attendance of a Girlfriends' party, the women were often eager to host their own party. The facilitator actually collected the contact information of all women at the party who showed an interest in having a party themselves and, within the week, contacted them to make arrangements. To assure that with each party, the Girlfriends Project was educating a completely new group of women, it was made clear that no women from the party she attended as a guest could be invited to a party where she was the hostess.

Incentives also aided in recruitment for this project. If a woman decided to host a party, she received a \$50 gift certificate to Giant Eagle grocery store for the use of her home. The guests that attend the party and got tested for HIV received a \$20 gift certificate to Giant Eagle, and as was mentioned previously, those who returned the three month post-assessment got their name placed into a drawing for a large prize. The amount of money given as an incentive provided a nice balance: the large prize was enough money so that the women participating in the intervention knew that their time and energy was appreciated, but not so much that the motive for participation was to receive the incentive, instead of receiving risk reducing information.

Another recruitment method for this project was through agencies such as women's shelters. Occasionally agencies such as Womanspace East, an emergency shelter for women and children, would request that the Girlfriends Project hold a party for the women in the shelter. Because many of those women were victims of domestic violence, homelessness, and drug abuse, the content of the Girlfriends parties was well suited for their consumers. The focus on risk reduction instead of complete risk elimination, which is much harder to accomplish, provided useful information for those women who were not quite ready or capable of changing their circumstances.

1.1.1.3 Potential Effectiveness of the Girlfriends Project

The Girlfriends Project was a complex and multifaceted intervention. The project had great potential for success in increasing the use of safe sex practices among African American women because the content was designed to address empirically identified culturally relevant circumstances. At the time this paper was written, the Girlfriends Project was still being evaluated. Because the data collection process had not yet begun, there was no statistical data to support the effectiveness of the project. Nevertheless, the hypothesis was that if widely disseminated, the Girlfriends Project would be effective in reducing the incidence of HIV and STI among African American women by increasing the use of risk reducing behaviors. The hypothesis of the present paper was that because the Girlfriends Project fulfilled a majority of the elements designated as necessary for behavioral change by the SCT and the TGP, this intervention should prove to be effective in changing attitudes and social norms which, in turn, lead to behavior change that will reduce the incidence of HIV and STI among African American women.

1.1.3 The Social Cognitive Theory

The Social Cognitive Theory (SCT) is a complex integration of concepts from several disciplines including cognitive psychology, sociology, political science, and humanistic psychology, that works in combination to advance the scientific understanding of how behavioral learning is cognitively processed and shaped within the context of one's physical and social environment (McAlister, Perry, & Parcel, 2008). The pinnacle of the SCT is the idea of reciprocal determinism. Reciprocal determinism is the acknowledgement that not only does one's environment shape behavior but that people have the potential to shape their environment as well (McAlister et al., 2008). This dynamic view of the interactions between the personal, social, and physical environments makes this theory unique. Other behavioral and social theories tend to focus only on the environment's ability to influence individual or group behavior (McAlister et al., 2008). Such a narrow focus is problematic because although the influence of the environment is important, by exploring the environmental influence alone, theories are ignoring a valuable resource for change. Often, the actions of people individually and collectively ultimately become the greatest assets in the efforts to alter or construct an environment suitable for change. For this reason, the SCT emphasizes the exploration of the manner by which potential behavioral change is processed at both the individual and social level. The analysis of this cognitive process allows for the perceived needs and perceived capacity for change to be ascertained, which can then be utilized to devise methods for empowering people to influence their environments in ways that will allow for sustainable behavioral change to occur.

Besides the principle of reciprocal determinism, there are several other elements that make up the SCT. According to McAlister, Perry, and Parcel, authors of the SCT chapter in the book *Health Behavior and Health Education*, (2008), the key elements of the SCT are grouped

into five categories: psychological determinants of behavior, observational learning, environmental determinants of behavior, self-regulation, and moral disengagement. These categories are outlined in the following sections.

1.1.3.1 Psychological Determinants of Behavior

There were two main individual-level psychological determinants of behavior described in the SCT: outcome expectations and self-efficacy. Outcome expectations have been defined as “beliefs about the likelihood of various outcomes that might result from the behaviors that a person might choose to perform, and the perceived value of those outcomes” (McAlister et al., 2008, p. 172). Outcome expectations are an essential part of the SCT because they emphasize the idea that values and expectation are subjective. People not only base their actions on reality but what they perceive reality to be (McAlister et al., 2008). The idea of perception is an important concept because if one can positively alter a person’s perception of the outcome associated with a particular behavior, there is a greater likelihood that the person will adopt the new behavior. The notion of altering perception to influence behavior change is perpetuated in the SCT’s emphasis on foresight (Bandura, 2001). An individual’s capacity for foresight contributes to their ability to resist the immediate benefits of maintaining poor behavior while enduring the immediate cost of changing that behavior. The ability to see foresee that the benefits of behavioral change far outweigh the cost is what motivates people to continue working toward a goal of sustainable behavioral change (McAlister et al., 2008; Bandura, 2001). In other words, if a person believes that they will be better off in the long-term by changing their behavior, they will ignore the short term discomfort or pleasures in exchange for long-term benefits. Utilizing outcome expectations basically allows for the manipulation of the basic human principle of maximizing benefits and minimizing cost.

Within the category of outcome expectations, there are two other kinds of expectations, social outcomes and self-evaluative outcomes. Social outcome expectations are those beliefs about how other people view our decisions and how those views influence our behaviors (McAlister et al., 2008). The SCT, highlight social outcome expectations because it speaks to the idea of social norms. For instance, if a person perceives that their social network views a behavior unfavorably they may be less inclined to perform that behavior. It is in this capacity that social outcome expectations can play a vital role in behavioral change. Bandura (2001) asserts, that “social influences operating in selected environments continue to promote certain competencies, values, and interest long after the decisional determinant has rendered its inaugurating effect” (p. 10). Therefore, if alterations can be made to the outcome expectations of the larger group, the resulting group expectation could greatly influence the perceived social outcome expectations of the individual.

Self-evaluative outcome expectations are essentially the expectation of how one would feel about themselves if they chose to change or not to change a behavior (McAlister et al., 2008). The SCT hypothesizes that self-evaluative outcome expectations are mechanisms aside from external rewards which allow people to bare the short term cost that accompany behavioral change and are able to resist the short term benefits that are a result of maintaining poor behaviors (McAlister et al., 2008). In *Social Cognitive Theory: An Agentic Perspective (2001)*, Bandura states, “If actions were performed only on behalf of anticipated external rewards and punishments, people would behave like weather vanes, constantly shifting direction to conform to whatever influence happened to imping upon them at the moment” (p. 7). In other words people do not make decisions based on external forces alone; they also operate based on “self-direction” (Bandura, 2001, p. 7). For many, the need to achieve their own standards of

appropriate conduct outweighs the need for social approval and instant gratification. Because self-evaluative outcome expectations are such a powerful determinate of behavior, altering self-evaluative outcome expectations can act as a vector for behavioral change. If one's self-evaluative outcome expectations regarding a particular behavior can be improved, there is a greater likelihood that the targeted behavior will be adopted.

Aside from the outcome expectations described above, there is another individual-level psychological determinate of behavior in the SCT; self-efficacy. Self-efficacy, in the SCT is described as “a person's beliefs about her capacity to influence the quality of functioning and the events that affect her life” (McAlister et al., 2008, p. 172). Self-efficacy is an essential component of the SCT because it tells us that not only do people need to feel that behavioral change is positive but that it is also possible. According to Bandura (2002), self-efficacy regulates those mechanisms which determine “whether individuals think in self-enhancing or self-debilitating ways; how well they motivate themselves and persevere in the face of difficulties” (p. 270-271). If a person does not feel that they are capable of behavioral change, even if they feel that the change would be beneficial, they are less likely to change their behavior. Therefore, by assessing self-efficacy, it is possible to determine what is necessary to increase one's perceived ability for behavioral change and determine strategies to achieve that increase.

Assessment of efficacy is important not only at the individual level but at the group level as well. Collective efficacy, the belief in the ability of people to work together for change that will benefit the entire group, is an important element of the SCT because many of the problems that people want changed are problems that can only be addressed when people work together (McAlister et al., 2008; Bandura, 2002). According to Bandura (2002) collective efficacy is not

just the combined individual efficacy beliefs of the members, but a group level belief in the ability to jointly enact change. That is not to say that the self-efficacy of the individuals is separate from a sense of collective efficacy. Individual members must feel equipped to handle their own lives and to effect social change in order to have a positive belief in collectively-efficacy (Bandura, 2002). In order for high collective-efficacy to be achieved, the group members have to believe not only in themselves but in the group as a whole. Only then can group goals be achieved.

1.1.3.2 Observational Learning

According to McAlister and colleagues (2008), the human capacity for observational learning is central to the SCT. It is often the mechanism by which public health professionals are able to influence behavior. The effectiveness of observational learning is determined by four processes: attention, retention, production and motivation (Bandura, 1986).

Attention, the first process, is the ability to keep one's mind focused on a particular subject so that information can be absorbed and later recalled. Attention involves access to models and the value of outcome expectations. In order for a person to learn via observation, they must first have models to learn from, such as family, friends, or media (McAlister et al., 2008). Also, as was discussed in the previous section on outcome expectations, the person observing needs to believe that the behavior that they are modeling has value. If they do not believe that the behavior has value then they are less likely to pay attention to the behavior being modeled (Bandura, 1986).

Retention, the second process, is the ability to retain information learned. Retention is a determinate of observational learning because if one does not have the cognitive capabilities to retain the behavior being modeled, observational learning will be ineffective (McAlister et al.,

2008; Bandura, 1986). Retention makes it important to choose the mode of modeling communication carefully. If the mode chosen to communicate the modeling process is beyond the cognitive capacity of the intended audience then their ability to successfully model the behavior will be inhibited.

Production, the third process, is the actual performance of the modeled behavior. Production depends both on the person's actual ability to perform a behavior (i.e. physical ability) and the person's self-efficacy for performing the modeled behavior (i.e. belief in one's ability to perform the behavior). It is not enough for the person to be physically able to model the behavior; the person must also believe that their circumstances will enable them to perform the behavior as well (McAlister et al., 2008).

Lastly, motivation, the mechanism which pushes people toward goal fulfillment, is an important part of the observational learning process. Motivation is what makes a person want to model the behavior. Outcome expectations play an important part in creating motivation for behavioral modeling by allowing for a cost benefit analysis to be established. Outcome expectations are used to determine if benefits of modeling a new behavior outweighs cost (McAlister et al., 2008; Bandura, 1986).

1.1.3.3 Determinants of Behavior

Although the SCT places great emphasis on the capacity of individuals to influence their environment, the impact that the environment can have on the individual is an important concept as well. The SCT postulates that "no amount of observational learning will lead to behavioral change unless the observers' environment supports the new behavior" (McAlister et al., 2008, 173). Thus environmental determinants of behavior are a critical element of the SCT. Even if one knows that behavior change would benefit them, if their environment is such that behavioral

change is not possible, it is unlikely the new behavior will be sustainable. An example of this would be if a person was told that they needed to eat fresh fruits and vegetables to improve their health, but there was no grocery store in their community where they could purchase them. The person in this scenario may want to improve their health by eating fresh fruits and vegetables; however their environment does not support that behavior change. The environment, in which the person lives, therefore places constraints on the behaviors that a person can perform.

The SCT offers two methods for altering unsuitable environments: incentive motivation and facilitation. Incentive motivation is a system of rewards or punishments to make behavioral change more favorable (Bandura, 1986). Rewarding people for behavioral change has been found to be an effective method in this regard. For instance, providing people that participate in an intervention with a financial incentive is a commonly used strategy (McAlister et al., 2008). Providing a reward shows participants that you appreciate their participation, and if the incentive is staggered throughout the intervention, the incentive can help to facilitate intervention completion.

Utilizing a system of punishments can be more problematic. There are many instances where punishing behavior in order to stimulate behavioral change has resulted in unexpected negative consequences (McAlister et al., 2008). For instance, in the 1980s punitive laws were instituted which punished mothers who used drugs during their pregnancy. The laws were intended to be a deterrent against prenatal drug use; however, the laws ultimately resulted in prejudice against minority women. The law's punishing mothers who used drugs during their pregnancy mostly targeted crack cocaine users. The targeting of crack cocaine users was evident not only in the number of crack cocaine vs. powdered cocaine arrest and convictions, but also by the difference in the severity of prison sentences received by crack vs. powdered cocaine users.

Focusing on crack cocaine users was problematic because: 1) there was almost no chemical difference between crack and powdered cocaine, and 2) at the time Minorities were the main consumers of crack cocaine and Whites the main consumers of powdered cocaine. Thus the focus on enforcing punitive measures for crack cocaine use as opposed to powdered cocaine use resulted in Minority women bearing the brunt of drug prosecution (Logan, 1999). This example is not meant to insinuate that using punishment as a mechanism to decrease undesired behaviors will always produce a negative result, simply that this demonstrates that if one chooses to use punishment as their incentive motivation, caution must be taken in order to avoid unintended consequences.

The second method offered by the SCT for making environments more suitable for behavioral change is facilitation. Facilitation is the process of providing resources and/or removing structural barriers to behavior change (McAlister et al., 2008). This is an important element of the SCT because it is not attempting to control change, only to make it easier to accomplish. Incentive motivation is a mechanism of controlling the behavior others behavior; facilitation allows people to control their own behavior (McAlister et al., 2008). The removal of barriers to performing desired behaviors empowers people to make behavioral changes if they so choose. Facilitation is a core element of not only the SCT but many other behavioral theories as well.

1.1.3.4 Self-Regulation

Self-regulation is the mechanism by which the individual influences their own behavior. As was mentioned previously, the SCT places great emphasis on the human capacity to withstand short term cost in favor of positive long term outcomes. The SCT postulates that self-regulation is the method by which human capacity is possible. Personal determination is not the determining

factor in enduring short term cost but learning self-management skills (McAlister et al., 2008). The SCT offers six specific skills for regulating one's own behavior: self-monitoring, goal setting, feedback, self-reward, self-instruction, and enlistment of social support (McAlister, et al., 2008). Each of these six methods for achieving self-regulation are briefly described below:

- Self-monitoring is paying regular attention to one's own behavior (McAlister et al., 2008). When one is not actively conscious of the behavior they are supposed to be performing, they may revert back to their original behavior more easily
- Goal setting is the establishment of a particular objective for which one wishes to achieve. When goal setting, it is important to have both short-term and long-term goals (McAlister et al., 2008). Short-term goals are essential in goal setting because short-term goals make long-term goal easier to achieve. Setting short-term goals helps people to build self-efficacy for maintaining a particular behavior and also provides a sense that progress is being made toward the achievement of their long-term goals. Long-term goals often can feel over whelming and so far removed from the here and now that there is little incentive to resist the short-term benefits of maintaining old behaviors. Long-term goals that feel overwhelming or too distant are more readily abandon (Bandura, 2001). Creating short-term goals that allow the person to experience the benefits of behavior change as the work towards their end goal can act as a great motivator.
- Feedback is the process of receiving constructive criticism from others or making personal observations regarding one's performance of a behavior. Constructive feedback includes information surrounding what was done well and what could be

improved. Feedback helps to build self-efficacy through reinforcing proper behavioral performance (McAlister et al., 2008).

- Self-reward is similar to the idea of incentive motivation, however it is more intrinsic. The person performing the behavior rewards themselves for working consistently on their goal instead of the reward coming from an outside source. A system of personal rewards for maintaining behavioral change can encourage people to continue on toward their long-term behavioral goals (McAlister et al., 2008).
- Self-instruction is the process of reciting the steps of a complex behavior as, or before, one performs that behavior (McAlister et al., 2008). This act can help to build self-efficacy by reassuring the person that the steps of the behavior are being performed correctly and in the proper order.
- Enlistment of social support is a person's recruitment of trustworthy people to encourage them in their efforts to maintain positive behaviors (McAlister et al., 2008). Enlisting social support is closely related to the idea social outcome expectations. When people believe that those they trust will view the outcomes of their behavioral change favorably they are more likely to maintain that behavior (McAlister et al., 2008). The idea of enlisting social support simply goes a step further and uses positive social outcome expectations to actively encourage positive behavioral change.

The SCT places such importance on developing self-regulation because without self-regulation it is difficult to maintain behavioral changes. Without the skills which allow one to endure the short term cost of behavioral change, the scale which weighs long term outcomes with greater importance is likely to tip.

1.1.3.5 Moral Disengagement

The final element in the construction of the SCT is the concept of moral disengagement. According to the SCT, people have the ability learn moral behaviors which are ultimately used for self-regulation. Those learned moral behaviors prevent people from treating others with cruelty. Moral disengagement is the mechanism by which people are able to justify violating those moral standards (McAlister et al., 2008; Bandura, 2001; Bandura, 2002). There are several mechanisms of moral disengagement listed by the SCT: euphemistic labeling which is the use of words to make a harmful or violent acts seem less offensive; dehumanization and attribution of blame which is the act of blaming the victim because they are racially or ethnically different; diffusion and displacement of responsibility which is blaming those perceived to have more power (i.e. groups and authority figures) for your behavior; and lastly perceived moral justification which is the defense of harmful or violent acts by claiming that they were necessary (McAlister et al., 2008; Bandura, 2002).

Understanding the mechanisms of moral disengagement is an important aspect of the SCT because disengaging from moral standards has an effect on potential behavior change both for those being judged, and those doing the judging. For instance, those who believe that certain behaviors changes are necessary only for those they deem immoral, may be less willing to adopt that behavior. Therefore, it is essential to determine where perspective modifications to peoples' cognitive processing of behavior justification can be made (McAlister et al., 2008).

1.1.4 The Theory of Gender and Power

The Theory of Gender and Power (TGP) is the compilation of the critical components of various theories dealing with gender, power, and sexual inequality. From these theories, Robert Connell

sociologist and creator of the TGP, was able to develop a three part structure to explain the structural inner workings of relationships between men and women. According to Connell gendered relationships between men and women can be characterized by: 1) the sexual division of labor, which describes the way that gender roles determine occupational and economic opportunities and the value of male vs. female work, 2) the sexual division of power, which describes the way that power is distributed and wielded in male female interactions, and 3) the structure of cathexis, which describes the development of social sexual norms and the attachment of those norms to unrelated social concerns (Wingood & DiClemente, 2000; (Connell, 1987). Together these structures describe the gender roles that men and women are expected to adhere to and the resulting inequality for women. The TGP is only one of numerous theories dealing with the topics of gender and power. Each of the other theories has contributed much to our knowledge regarding the power dynamic between men and women. However, the TGP is a particularly noteworthy theory in this area of gender and power, most familiar to readers. Thus, for the purposes of this essay the TGP will be used as the standard for comparison with the Girlfriends Project.

One important aspect of this theory is that although the sexual division of labor, the sexual division of power, and the structure of cathexis are distinct from each other, they greatly overlap. The complexity of this interconnectedness caused Connell to assert that these three structures cannot be independent from each other; that all three components are necessary in order to explain gender inequity (Wingood & DiClemente, 2000). Not one of the three structures alone can maintain gender roles efficiently enough to secure gender inequality without the other two structures working as reinforcement. Although these structures individually do result in

gender inequality, in order to maintain a social hierarchy where men are consistently on top all three of these structures have to be in place.

Another important aspect of the TGP involves the scope of the three structures and the persistent nature of their affects. The sexual division of labor, the sexual division of power, and the structure of cathexis can be observed at both the societal and institutional level. The societal level, which is the higher of the two levels, is where the structures are defined (Wingood & DiClemente, 2000). According to Wingood and Diclemente (2000), “The three structures are rooted in society through numerous abstract, historical, and sociopolitical forces that consistently segregate power and ascribe norms on the basis of gender-determined roles” (p. 540). Basically, the societal level describes an overall view of labor, power, and cathexis that has been established over time. The overall view of the structures however does not describe the mechanism by which the structures of the TGP are maintained. Maintenance of the persistent gendered norms that are produced on the societal level are maintained on the institutional level. Societal level norms are institutionally upheld using various social and physical environmental mechanisms. The institutional maintenance of gendered norms can be seen in all three structures of the theory (Wingood & DiClemente, 2000).

As for the longevity of the resulting gender inequality produced by these structures, according to Wingood and Diclemente (2000) “As society slowly changes, these structures remain largely intact at the societal level over a long period of time (p. 540).” In other words, sexual division of labor, sexual division of power, and cathexis are so deeply engrained in society that even as society changes the gender norms constructed by these structures remain virtually the same.

Institutionally the persistence of gender norms is also resistant to change. As society has advanced, efforts have been made to prevent gender inequality; however current a survey of women's power relative to men (economically, politically, socially, etc.) reveals that gender inequality is still very prevalent. The prevalence of gender inequality during times of great efforts to advance equality demonstrates that although change occurs more rapidly at the institutional level, the progress toward gender equity is still by all definitions slow acting (Wingood & DiClemente, 2000).

In order to further understand the TGP each of the three structures will be discussed individually and at both the structural and institutional levels in the following sections. Examples mechanisms for the maintenance of gender roles within each structure are provided; however, possible mechanisms are not limited to these examples.

1.1.4.1 The Sexual Division of Labor

The sexual division of power at the societal level describes the societal belief that men and women should be designated to certain positions, and that the positions assigned to men are more valuable (Connell, 1987). The historical view of the roles of men and women is that men are responsible for providing for the family economically, and women are responsible for taking care of the home. Because what has been deemed "women's work" namely domestic responsibilities, were not economically beneficial, the value placed on the work performed by women was less than that of the work performed by men (Wingood & DiClemente, 2000). The devaluation of women work has translated beyond the home into the workplace and has resulted in the segregation of women to certain positions. Furthermore, society's belief that men are supposed to provide economically has resulted in the continuation of the value of women's work being considered less than that of men (Connell, 1987). Because of the devaluation of women's

work, the economic opportunities available to women are often constrained thereby allowing men to maintain economic control (Wingood & DiClemente, 2000; Connell, 1987).

Although at the institutional level there have been many advancement toward labor equality such as affirmative action and maternity leave, the sexual division of labor is still maintained in a variety of ways. Some of those ways are through hiring and promotion decisions in the workplace that favor men, discrimination in pay, segregating women to domestic responsibilities and jobs with relatively low pay, and practices that favor male educational achievement over female education achievement in the home, in the work place, and in schools (Wingood & DiClemente, 2000; (Connell, 1987).The institutional enforcements of the labor expectations of women and men ultimately result in economic inequity for women, and a power imbalance in male/female relationships that favors men. For instance, restricting women to domestic positions and discriminating against them in matters of pay and hiring practices reduces the potential economic mobility of women (Connell, 1987). The reduction in economic opportunities can lead to women being economically dependent on their partner. Once dependent, there is potential for a shift in relationship dynamics where the power in relationship is skewed toward the man instead of being balanced between both parties (Wingood & DiClemente, 2000). This increase in power gives men leverage in their relationships, which affords them final say over relationship decisions; decisions which could include the way that women express their sexuality. The imbalance in power resulting from the sexual division of labor therefore restricts women's sexual autonomy.

Economic inequality creating an imbalance in power between men and women is also the result when the educational attainment of men is favored over that of women. Because increased educational attainment is associated with employment and economic opportunity, practices that

actively encourage men to continually seek educational advancement but fail to do so for women set the stage for economic inequality (Wingood & DiClemente, 2000). In this scenario, men are pushed toward economic prosperity, while women are left in a position where they either have to self-motivate or settle for an educational level that may limit their economic advancement. Essentially, the sexual division of labor works to assure that men can maintain a dominate position relative to women.

1.1.4.2 The Sexual Division of Power

Societal level sexual division of power explains inequality in power between men and women. Power being defined in this instance as the ability to influence the actions of others; to have control over others and/or a desired outcome (Wingood & DiClemente, 2000). At the societal level, men tend to be the beneficiaries of power inequality. Men tend to hold positions where they are able to influence the actions of women. Although society has advanced over the years, the historical view of women as secondary to men has persisted, and resulted in contemporary mechanisms instituted to maintain that hierarchy. Two of the institutional level mechanisms that accomplish this are physical dominance and negative media.

Physical dominance acts as a mechanism for maintaining power inequality between men and women by one partner obtaining compliance through fear. Men's will often use their physical advantage to influence the decisions of women. Women with a history of IPV comply with the wishes of their partner because they fear the possible consequences. Physical domination limits the control that women perceive themselves to have over their actions (Raiford et al., 2009; Andrews & Buchanan, 2009). In these situations, men have control over relationship decision including how women express their sexuality. Essentially, women are literally beaten into a subordinate position.

Media acts as a mechanism for maintaining a power imbalance skewed in men's favor by associating women's worth with their sexuality. Sexually degrading images of women help to solidify the idea that women are meant to be in a position subordinate to men. The normalization of images showing scantily clad, hypersexual women being fawned over by men leads women to believe that they are empowered because they are able to foster male attention; however, in actuality it is only validating the idea that women are there for men's amusement (Littlefield, 2008; Wingood et al., 2003; Andrews & Buchanan, 2009). Degrading images of women imply that the wants and needs of men come first, an idea that places men in a position of power. Furthermore, the actual images of women's bodies literally being controlled by men, contributes to the validation of the social norm which assert that women's sexuality needs to be controlled. Specifically, that women's sexuality needs to be controlled in ways that are determined by men (Littlefield, 2008; Wingood et al., 2003).

1.1.4.3 The Structure of Cathexis

At the societal level, the structure of cathexis basically establishes how women's sexuality is constricted because of social norms; social norms being the beliefs held by a society regarding what behaviors are appropriate. According to Wingood and Diclemente (2000), cathexis "constrains the expectations that society has about women with regard to their sexuality and, as a consequence, shapes our perceptions of ourselves and others and limits our experiences of reality (p. 544)." The restrictive nature of social norms limits women's sexual options and causes people to associate the value of a person with their adherence to the norm. Viewing women's sexuality through a lens defined by socially constructed ideals however causes people to assign value in ways that are not reflective of reality.

An example of this is the way that women's sexuality is regularly attached to social constructs which are not directly related to sexuality. The most common example of this is the association of sexual suppression with purity and morality, and the association of sexual indulgence with impurity and immorality (Wingood & DiClemente, 2000). Because of the attachment of women's sexuality to these constructs, women expressing their sexuality in ways that deviate from the social expectation are deemed somehow immoral and unclean. The view of women who fail to conform to the social expectations for women's sexuality as immoral can be seen in women in the labels associated with women who for instance: have sex before marriage, have multiple sexual partners, and who masturbate (Wingood & DiClemente, 2000). Because sexual behaviors are linked to purity and morality, the women who engage their sexuality in ways deemed socially unacceptable are often called "sluts", "hoes", "dirty", "nasty", and a variety of other derogatory names which place them into the category of morally deficient (Andrews & Buchanan, 2009). According to Andrews and Buchanan, because of gender norms surrounding sex "an empowered independent young women with her own active sexual desires, who seeks sexual pleasure and sexual safety on her own terms, is not a "normal" feminine women, but often seen as sexually and socially deviant" (Andrews & Buchanan, 2009, p. 35). Men's sexuality however is not constrained in this way because men's sexuality is not associated with morality to the same extent. As was postulate by Connell (1987), "the double standard, permitting promiscuous sexuality to men and forbidding it to women, has nothing to do with greater desire on the part of men; it has everything to do with greater power" (p. 113). Because men have had more power than women for so long, men's indulgence in their sexual urges has become a perceived part of the social norm and thus men's sexual behavior does not receive the same social scrutiny as women's sexuality. The differential treatment regarding men and

women's sexual expression again places women at a disadvantage relative to men. Because women's sexuality is restricted ways that men's sexuality is not women's sexual autonomy is stunted (Wingood & DiClemente, 2000; Andrews & Buchanan, 2009).

At the institutional level the social norm of restricting women's sexual expression is enforced through people's bias regarding women's behavior. Biases are enforced using a variety of mechanisms. Two of those mechanisms are family influence and partner selection.

Family influence is important because family is where values are shaped. The values we are taught from infancy can have a powerful influence on the decision people make in the future. Families that are disapproving of certain behaviors among women are likely to encourage or demand the women in their family to conform to the desired belief (Wingood & DiClemente, 2000). Failing or refusing to conform to certain behaviors designated expectable by their family, be they positive or negative, could result in negative repercussions for women such as isolation from the family and family resentment.

Partner selection plays an important role in the suppression of female sexuality because sexual practices are often influenced by sexual attraction (Wingood & DiClemente, 2000). In order to maintain sexual relationships, women often will determine their sexual behavior based on how they believe their partner will evaluate that behavior (Crosby et al., 2000; Valentine, 2008). This idea is validated by the by social norm which tells women that sexual decisions should be made by men. According to El-Bassel and colleagues (2009) "African American women are often socialized to be sexually passive and taught to defer to men when it comes to decision-making regarding sexual activities" (p. 998). The belief that men should be in charge of sexual decision making constricts women sexuality and places men in a position of power. When women relinquish sexual decision making to men or decide their sexual behaviors based on how

they believe men will feel about that behave, women are placing the needs of men above their own and thereby reinforcing women's secondary status.

2.0 METHODS

In order to make the argument that the Girlfriends Project would be effective in reducing the incidence of HIV and STI among African American women, it was necessary to compare the components of the Girlfriends Project to the elements of the SCT and TGP. Both the SCT and the TGP have been regularly utilized as the theoretical foundation for HIV and STI interventions and research for African American women (Wingood & DiClemente, 2000; Moor, Harrison, & Doll, 1994) Because they have been found effective for changing the attitudes and behaviors of African American women regarding HIV and STIs the SCT and the TGP worked well as a standard. Each element of the SCT and TGP were compared individually to various component of the Girlfriends Project. This comparison would demonstrate that the components of the Girlfriends Project were indeed congruent with those of the SCT and TGP which have been found to be effective in altering attitudes and behavior.

3.0 RESULTS

The results section of this paper contains a detailed comparison between the Girlfriends Project and the SCT, and the Girlfriends Project and the TGP. Each element of the SCT and TGP were address individually. The analysis begins with the SCT and ends with the TGP.

3.1 THE GIRLFRIENDS PROJECT COMPARED TO THE SOCIAL COGNITIVE THEORY

The purpose of this section is to demonstrate that the components of the Girlfriends Project are congruent to the elements of the SCT. Therefore, in the following sections the Girlfriends Project will be deconstructed using the elements of the SCT to establish that the elements of the Girlfriends Project are essentially those of the SCT. The elements of the Girlfriends Project will be examined using each concept in the SCT, in other words: reciprocal determinism, outcome expectations, efficacy, observational learning, incentive motivation, facilitation, self-regulation, and moral disengagement.

3.1.1 Reciprocal Determinism

Reciprocal determinism, which emphasizes the influence that people can have on their environment, was an essential element of the Girlfriends Project. One of the main objectives of the project was to empower women to take control of their sexual health. As was mentioned previously, there were a variety of environmental factors that contributed to the increased risk of HIV and STI infection among African American women. Because of this, the Girlfriends Project worked to teach African American women ways to not only to combat those environmental influences but to decrease the influence of the environment over all.

The main method utilized for this purpose was education. The Girlfriends Project was mostly an educational program. The project provided HIV and STI information to African American women in a way that helped them to realize how HIV and STIs affected them, and why they should take action. Providing this information was necessary because before one can provide solutions, one must assure that the audience recognizes the severity of the problem. The Girlfriends Project in essence attempted to increase women's perceived need for HIV and STI prevention strategies. To educate African American women about HIV and STIs the Girlfriends Project used: 1) general facts about HIV and STIs, 2) statistics demonstrating how African American women specifically are suffering from infection, and 3) insight into the reasons behind the disparity. By providing this information to African American women, the Girlfriends Project attempted to increase the likelihood the women would consider adopting the prevention strategies that followed the education portion of the program. The education component of the Girlfriends Project curriculum essentially worked to convince women that they had to regulate their own behavior if they were going to prevent infection.

Furthermore, because of the supportive group setting created by the Girlfriends' party structure, the women were empowered to share what they knew about HIV and STIs, and what they learned about navigating sexual relationships from their own experiences. The group structure of the Girlfriends Project helped women to become more comfortable with talking about HIV, STIs, and sex so that after the party, the women could share the information they learned with their friends and family. In the language of the SCT, their perceived capacity for change was increased (McAlister et al., 2008). By helping to break the silence and shame surrounding those topics the Girlfriends Project ultimately helped to reduce the effects of an environment of ignorance surrounding this topic.

In addition to an education strategy, the Girlfriends Project also utilized one of the root causes of many of the environmental factors that contributed to the increased HIV and STI rates among African American women, that being an imbalance in power. As was discussed in the section concerning the TGP, many of the environmental influences that increase African Americans women risk of infection stemmed from a lack of power relative to men (Wingood & DiClemente, 2000). Because of this, it was important that the idea of power was acknowledged as an important factor in increased HIV and STI risk. The Girlfriends Project addressed the imbalance in power between men and women in a very empowering way. The project acknowledged that in many ways African American women were at a disadvantage in relation to men. However, as the Girlfriends Project acknowledged the power imbalance they worked to alter the narrative that nothing could be done to achieve equality, or that the positions that society assigned women had no power. The project highlighted the power that African American women have over their lives and in their relationships. They emphasized that women always have choices. The Girlfriends Project acknowledged that the choices may not always be easy but

that there are choices that would allow them to protect their health and the health of their partner. By provided the women with options such as carrying their own condoms, wearing a female condom, and/or making clear to one's partner that sex without a condom is unacceptable, the Girlfriends Project helped to further increase the perceived capacity for change.

3.1.2 Outcome Expectations

Outcome expectations are extremely important to the success of an intervention because outcome expectation are what help people to resist immediate benefits of maintaining poor behaviors while enduring the immediate cost of changing behavior (McAlister et al., 2008). If one doesn't believe that a particular behavior change will be beneficial, what motivation do they have for adopting that behavior? Because of this, the Girlfriends Project worked to increase over all outcome expectations regarding the adoption of risk reduction behaviors, social outcome expectations, and self-reflective outcome expectations. Behavioral outcome expectations were increased by the Girlfriends Project by increasing the participants' knowledge concerning HIV, STIs, and prevention methods. The group discussion of that new information increased social outcome expectations by showing that among their peers it was acceptable to use the safe sex behaviors that were being encouraged by the Girlfriends Project. And self-reflective outcome expectations were increased by focusing on empowerment.

Education was necessary for increasing behavioral outcome expectations because there were many misconceptions surrounding HIV and STIs. By educating the participants and resolving those misconceptions, the actual HIV and STI infection risk for African American women was revealed to be much higher than the perceived risk. Informing participants of the actual risk of HIV and STI infection for African American women was intended to lead

participants to the conclusion that the cost of maintaining risky sexual behaviors was greater than the benefits. Because the natural inclination is to maximize benefits and minimize cost, increasing the participants' expectation that changing their behavior would lead to a more beneficial outcome than maintaining their behavior would increase the likelihood of adopting the new behaviors (McAlister et al., 2008).

The conclusion that changing risky sexual behaviors would lead to beneficial outcomes was further emphasized by providing HIV and STI prevention strategies which would allow the women to reduce their risk even if they chose not to eliminate behavior. In cases, where the cost benefit analysis did not result in an outcome expectation that favored risk elimination; the alternative methods increased the expectation that slightly altering their behavior would be more beneficial than continuing the behavior unmodified. For many, complete risk elimination is not a favorable option. Therefore, alternatives are necessary to decrease the risk of HIV and STIs as much as possible for those women who wish to maintain those behaviors that were not excluded by their personal cost benefit analysis.

An example of this was evident during the portion of the Girlfriends' party where STI photographs were displayed. During my internship with the Girlfriends Project, I observed that often the women found it difficult to look at the pictures because the physical symptoms of STIs were so unappealing. The visual representation of the various STIs helped them to see that the possible benefits of having unprotected sex did not outweigh the possible cost. However, for many of the women, abstinence was not an option they were willing to consider. Therefore, offering the women alternative methods for reducing risk was necessary. It increased their expectation of a positive health outcome, but allowed them to continue their chosen behavior.

Social outcome expectations were also increased by discrediting the common misconceptions associated with HIV and STIs. Because the parties were group based, when common stereotypes about HIV, STIs, and the people the contract them were discredited, that revelation not only affected the way that the individual viewed those subjects, the information also changed the feelings of the group as a whole concerning those topics. Listening to others in the group confirm that certain sexual behaviors were acceptable and/or necessary decreased the negative stigma associated with the behavior, and show the participants that socially the behavior was acceptable. Because the SCT informs us that the opinions of others have an impact on our behavior, the women expressing a positive view of the behaviors suggested in the intervention made it easier for those behaviors to be adopted by individual members of the group (McAlister et al., 2008). For instance, in one party several women were apprehensive about using the female condom. There were several concerns about discomfort inserting it, potential noise, and how their partner might feel about it. However, after listening to women in the group shared their experiences using female condoms, many of those who expressed concerns showed an interest in learning more about the condoms. In this scenario, the women in the group validated the idea that using the female condom was expectable. This increased the individual expectation that if they were to adopt that particular behavior it would not be frowned upon by their peers.

Self-evaluative outcome expectations were increased by the focus on empowerment and taking control of one's own sexual health. As was discussed in the section on the division of sexual power, the imbalance in power between men and women has often left women feeling that it is the man place to make decisions regarding sexual activities. Furthermore, that the sexual needs of men are the priority (Wingood & DiClemente, 2000). The Girlfriends Project focused on showing women that in a relationship a woman's needs and a woman's health is just as

important as their partners. The idea of the benevolent self-sacrificing nurturer that women are taught they should be was pointed out as one that can be debilitating to the health of women. That is not to say that that particular gender role is not beneficial in many ways; however, when women disregard their needs to please other it can be very detrimental. Moreover, it was pointed out that it is difficult to take care of other when one is not taking care of themselves. Showing women that not only is it their right but their obligation to protect their own health was meant to help increase the belief that taking control of their own health would make the women feel better about themselves.

3.1.3 Efficacy

Efficacy was an extremely important aspect of any intervention because having knowledge is not enough to assure behavior change. If the audience one is addressing does not believe that they are capable of making the suggested changes they are less likely to do it. The person has to believe that they are equal to the task (McAlister et al., 2008). The Girlfriends Project addressed both self-efficacy and collective-efficacy in their intervention. Self-efficacy was fostered through condom application, risk reduction techniques, and increased information about IPV. Collective-efficacy was fostered through the creation of social support.

The condom demonstrations increased self-efficacy because they confirmed for people that they could properly put on a condom. By not only allowing the participants to observe the proper steps to putting on a condom but allowing them to perform the steps themselves the Girlfriends Project was increasing the participant's self-efficacy. Allowing them hands on experience with the task worked to either confirm for the participants they were in fact performing the steps correctly, or allowed for them to receive feedback that would help them to

perform the steps correctly. In either scenario the women left the party with a concrete skill and an increased belief in their ability to perform condom application competently.

The risk reduction strategies also helped to increase participant self-efficacy by giving the participants options as to how they could reduce their HIV and STI risk. As a public health professional, one cannot make people change their behavior. One can suggest risk elimination as a way of best increasing one's health outcome. Public health professionals can even attempt to alter the environment to make it more suitable for change. However, beyond those efforts, the decision as to which behaviors to adopt is up to the individual to decide. Because of this, alternative options for increasing health outcomes are necessary just in case the person chooses not to eliminate their risk. The Girlfriends Project recognized this and made an effort to provide alternatives to their participants. The Girlfriends Project provided the women with ways to lower their risk of contracting HIV and STIs if they chose to continue certain risky behaviors.

For instance, for drug users who used needles and were not prepared to stop using drugs, the Girlfriends Project suggested: 1) not sharing needles, 2) "shooting" first if one must share needles, 3) cleaning needles with bleach, and 4) utilizing the needle exchange. Obviously, discontinuing drug use would have been the preferred HIV prevention strategy in this scenario. Intravenous drugs use increases one's risk of contract HIV and STI not only through blood contamination but also through a decreased the ability to assess risks and to utilize negotiations skills. These impairments raise the chances of contracting HIV and/or an STI by increasing the likelihood of having unwanted sexual intercourse, unprotected intercourse, and/or the chances of having intercourse with multiple sexual partners (El-Bassel et al., 2009). Therefore, eliminating drug use would greatly decrease one's infection risk. However, as was said, one can't make people comply; one can only help them to make the healthiest choice they are willing to make.

Acknowledging every individual's right to choose, and the willingness to help people be healthy in their choices was central to achieving the mission of the Girlfriends Project. Other prevention strategies offered by the Girlfriends Project that emphasized risk reduction choice included but was not restricted to: incorporating condoms into foreplay, using a female condom, and using clear Saran™ Wrap for oral sex if a condom or dental dam is unavailable.

The section of the Girlfriends' party regarding HIV and IPV increased self-efficacy by educating the women as to: 1) why women in relationships involving IPV have greater risk of HIV and STI infection, 2) how to recognize the signs, and 3) how to get help. Informing the women of the ways in which HIV and IPV are connected, worked to make the women aware of the reasons that women in these relationships are at such high risk. Informing the women of the signs of IPV helped women to be able to recognize when they, or women they know, are in an unsafe relationship; a particularly important dimension of the IPV section because often women don't classify what they are experiencing as IPV (Mitchell, 2009). Lastly, by letting the women know that they did not have to remain in relationships where they felt they had no control, that there were places they can go for help, the women were helped to realize that there are actions they can take even if they were not ready to take them.

Increasing African American women's knowledge regarding IPV increased self-efficacy by helping women in relationships involving IPV to know that they do have options and that they have the power to make their own choice. The focus on IPV was an important element of the Girlfriends Project because it acknowledged that simply telling women to use condoms doesn't mean that they are in a situation that will enable them to do so. That for women in IPV situations, certain measures needed to be taken in order to secure their safety. Furthermore, the time devoted to the subject of IPV communicated the Girlfriends Project's belief that the

experiences of African American women are not all the same, but that they are equally important. The IPV segment demonstrated their dedication to seeing all African American women health and safe.

As for collective-efficacy, the group dynamic of the Girlfriends Project was meant to foster this. The idea behind making the Girlfriends Project a group intervention was that a group format would allow for collective beliefs to be altered and for African American women to leave the party having a social support group to help them sustain their healthy behavioral changes. By designing the Girlfriends parties so that the women attending would be friends and family members, the Girlfriends Project was trying to create a friendly judgment free environment where the women were literally girlfriends. The atmosphere of friendship allowed the Girlfriends Project to foster the idea that “girlfriends” stick together and help each other along; an idea that they would eventually extend beyond interpersonal friendships, to African American women as a whole. The project worked to convince women that all African American women are “girlfriends” and thus they need to stick together and help each other along. By nurturing the idea of camaraderie among all African American women, specifically in the area of HIV and STI prevention, the Girlfriends Project helped to increase the women’s belief that HIV and STIs were not only their issue but every African American woman’s issue. The Girlfriends Project worked to help African American women recognize and believe that when they stood together and educated each other about HIV/STI risk and prevention, that they could effect change.

3.1.4 Observational Learning

Because part of the objective of the Girlfriends Project was to make sure that African American women had the tools they needed to reduce their risk of HIV and STIs, observational learning

was an essential part of the party. The observational learning element of the project came in the form of condom application through peer modeling. After educating the women to increase their perceived HIV and STI risk, the Girlfriends' party facilitator then demonstrated how to properly apply the male condom, female condom, and dental dam using models of male and female genitalia. Increasing perceived risk through HIV and STI education was necessary prior to doing the condom demonstration in order to increase the outcome expectations regarding condom use. That increased outcome expectation would then foster motivation for the participants to model the condom and dental dam application demonstrated (McAlister et al., 2008).

The demonstration conducted at the Girlfriends party not only taught the participants the steps for proper condom and dental dam application, but also gave them the opportunity to perform those steps. After the facilitator gave a proper demonstration, the participants were encouraged to attempt applying a condom to the models themselves. Allowing the participants to actually perform the steps on the genital models helped to reinforce the condom application procedure not only for the person performing the behavior but for the entire group. Part of the point of having the women practice applying the condoms to the models was to allow the women to obtain feedback from their peers. The women watched their peers perform the behavior and provided comments about what they did right and what could be improved. This step was beneficial for the observers of the behavior as well as for the performers because as the women watched their friends and family go through the steps of applying the condom, they had to think through the steps themselves in order to provide an accurate critique. Therefore, the participants received both cognitive and physical practice performing the behavior. The Girlfriends Project afforded the women a supportive environment where they could both give and receive positive

feedback, which allow the women to leave the party knowing that they were performing condom application properly.

3.1.5 Incentive Motivation

As was stated previously, incentives were utilized in different stages of the Girlfriends Project. The first incentive was for being the host of a Girlfriends' party. If a woman hosted a party, she received a \$50 gift certificate to Giant Eagle as a thank you for opening her home to the intervention. In addition to being a sign of appreciation, the incentive was also encouragement to take the initiative to share HIV and STI information with the women they cared about. The incentive helped to increase ones desire to host a party so that the prevention message could be shared. The second incentive came in the form of a \$20 gift certificate to Giant Eagle for guests that attend the party and got tested for HIV. This particular incentive was clearly to encourage women to find out their HIV status. As was mentioned previously, in 2009 the majority of the new cases of infection were transmitted by individuals who were undiagnosed (Swenson et al., 2009). Therefore, getting women to know their status was essential to the goal of reducing the rate of HIV and STI's among African American women. Incentivizing this task enabled the Girlfriends Project to more efficiently pursue their goal. Lastly, those who returned the three month post-assessment got their name placed into a drawing for a large prize. The purpose of that incentive was to increase the chances the participants would return their three month post-assessment which the project needed to evaluate the effectiveness of the intervention.

As stated earlier, the amount of money given as an incentive provided a nice balance. It was enough money so that the women participating in this intervention knew that their time and

energy was appreciated but not so much that the motive for participation was to receive the incentive instead of receiving risk reducing information.

3.1.6 Facilitation

The Girlfriends Project facilitated the adoption of HIV and STI risk reducing behaviors by reducing barriers that make it difficult to adopt safe sex behaviors. One way that the Girlfriend Project reduced the barriers to adoption of HIV and STI risk reducing behaviors was directly providing them with some of the materials they would need to perform the behaviors. For instance, each participant was given a gift bag containing male condoms, female condoms, dental dams, personal water based lubricant, a condom case, and male/female condom instructions. Furthermore, it was made clear that anyone could get free condoms from the Pittsburgh AIDS Task Force when needed. Offering women free condoms prevented them from having to worry about not having money to purchase them. Although, many may consider male condoms relatively inexpensive, for those with limited economic means, providing free condoms could remove a significant barrier of adopting safe sex behaviors. This is especially true for those who prefer the female condom, which can be a bit more expensive than the male condom.

Providing African American women with free condoms also increased comfort. Offering women a variety of different kinds of condoms afforded women the opportunity to find a brand or style that they were comfortable using. For instance, if a woman is allergic to latex it is more likely that she will not use condoms if no other option is available. By offering the women the option of using polyurethane condoms it increases the likelihood of condom use. Furthermore, with condoms differing in size, color, texture, and shape, offering the women different condom

styles increases the chances that they would find a condom style that increases pleasure for both them and/or their partner; thereby increasing the chances of consistent use (CDC, 2009d).

The gift bag containing risk reducing paraphernalia also helped to decreased African American women's reliance on men. The Girlfriends Project providing women with their own condoms, as well as a way to discreetly carry those condoms (condom cases), prevented women from having to hope that their partner had a condom when a sexual situation occurred. Because women have been taught to defer to men when making sexual decisions, and because men are the ones that actually wear the male condom, the belief is often that it is a man responsibility to carry the condoms (El-Bassel et al., 2009). However, a common excuse used by men in order to have unprotected sex is that they forgot a condom. Women having and carrying their own condoms can effectively combat that excuse; thereby decreasing the chances of having unprotected sex because they assumed that their partner would have a condom and they did not.

Another way the that Girlfriends Project reducing barriers that make it difficult to adopt safe sex behaviors was by providing referral to services not associated with the scope of the project. For instance, as was mentioned, the Girlfriends Project incorporated a section on IPV education in relation to HIV and STI infection into the curriculum. The IPV section explained the ways the IPV increased women's risk of infection, and taught women to recognize the signs of an abusive relationship. However, the Girlfriends Project itself did not handle IPV cases. Therefore, the facilitators of the Girlfriends' parties provided referrals to agencies and shelters that were trained to handle IPV cases. The women were provided a list of the agencies and shelters that they could call when they wished, but they were also given the option of allowing the Girlfriends Project facilitator to work with them to make those connections. The latter option prevented the women from having to navigate the system alone. Providing referrals was an

extremely important form of facilitation for the Girlfriends Project because one can provide women with all the condoms they wish, but if they are not in a position to use them, that effort will be fruitless.

Lastly, the Girlfriends Project facilitated the adoption of risk reducing behaviors by providing free HIV testing. At the end of the party, the women were offered the option of getting a free HIV test right there in the home. Offering testing at the party made it easier for women to get tested in several ways. One way is that when offering testing in people's homes the Girlfriends Project has to use test that do not require that blood be drawn. That is beneficial because using test that only requires a cheek swab removes some of the fear of taking the test; therefore increasing the likelihood that people will get tested. Another way that offering testing in the home made it easier for women to get tested was that by testing in a home setting, the Girlfriends Project removed some of the shame that often may accompany going to a clinical setting to get tested. Moreover by offering to deliver the result of the test to each person individually, the Girlfriends Project again removed the potential shame of being seen going into a clinic, while also making receiving results convenient for the women. Lastly, by providing the testing free of charge, the Girlfriends Project made it possible for those who could not afford to be tested to know their status.

3.1.7 Self-Regulation

Self-regulation is an important element of the SCT because interventions can provide information but they can't make people comply. It is up to the individual to monitor their own behavior (McAlister et al., 2008). Interventions can however provide the skills and/or alter the environment to make that easier. The Girlfriends Project did not explicitly provide skills for self-

regulation such as goal setting or self-reward as designated by the SCT; however, they did place great emphasis of the need for women to self-monitor their behavior (McAlister et al., 2008). At the core of taking control of one's own sexual health was the idea that one needs to be regularly thinking about how ones sexual behaviors may be affecting their health. In the intervention, part of the discussion was about safe sex practices and partner familiarity. Because often with increased familiarity and time spent with a partner African American women will stop using safe sex practices, it had to be communicated to the participants that even when one starts to feel comfortable with their partner they still need to use safe sex behaviors (Crosby et al., 2000). The need to consistently utilizes the risk reducing strategies offered in the intervention was clearly verbalized

Furthermore, they did lay the foundation for women to enlist social support. The supportive group format of the Girlfriends Project was meant to foster self-monitoring and feedback. The rationale was that by having frank discussions about sex, HIV and STIs in an environment where those participating were all loved ones, which upon leaving the party that openness would remain intact. That each participant would leave the group as part of a social circle of women that they knew would not judge them if they needed to talk about issues surrounding HIV and STIs. A social circle that could provide encouragement as the women worked to apply and maintain the safe sex behaviors learned at the Girlfriends' party.

3.1.8 Moral Disengagement

As was discussed, the SCT asserts that people have the ability to learn moral behaviors which can then ultimately be used for self-regulation. However, people often utilize mechanisms of moral disengagement in order to justify violating those moral standards (McAlister et al., 2008;

Bandura, 2001; Bandura, 2002). One of the goals of the Girlfriends Project was to disable the main mechanism of moral disengagement associated with HIV and STI prevention; that mechanism being dehumanization and attribution of blame, which is the act of blaming the victim because they are different racially, ethnically, and morally (McAlister et al., 2008, Bandura, 1986). In short, the main mechanism utilized is the stigmatization of HIV, STIs, and the people who contract them. Moral disengagement was a crucial aspect of the Girlfriends Project because moral disengagement feeds the stigma which keeps African American women unaware of their true risk for HIV and STI infection.

The Girlfriends Project through group discussion worked to address and discredit common misconceptions about HIV, STIs, and those at risk for infection. Some of the more common stigmatizations associated with HIV and/or STIs were: 1) that HIV is a disease that affects gay males and drug users, 2) that people with HIV and/or STIs were conducting themselves in a way that is morally repugnant, and 3) that one can tell by looking whether someone has HIV or an STI (Foster, 2007; Valentine, 2008). Each of these stigma associated HIV and STIs with being immoral, or in some way negatively different. The view of infection as immoral allowed African American women to place those who contract HIV or an STI in the category of other; thereby allowing themselves to believe that they could not be at risk (Foster, 2007). Furthermore, the shame that accompanied these stigmas made people afraid to both know their HIV and STI status, and to inform their partner about their infection. Both of these resulted in the increased spread of infection (Valentine, 2008).

During the Girlfriends' parties these stereotypes were actively addressed. The facilitators made it a point to inform women that: 1) although HIV was usually associated with gay men, that for the last decade it has become a major hazard for African American women, 2) that

having HIV does not make you immoral and that it is contracted most frequently through heterosexual intercourse, and 3) that one cannot tell by looking at a person whether or not they have an infection (Foster, 2007; Valentine, 2008). By attempting to reduce the women's ability to morally disengage through exposing these and other falsehoods, the program helped to increase perceived risk and decrease the shame surrounding HIV and STI infection.

3.2 THE GIRLFRIENDS PROJECT COMPARED TO THE THEORY OF GENDER AND POWER

The purpose of this section is to demonstrate that the components of the Girlfriends Project are congruent to the elements of the TGP. When comparing the TGP to the work of the Girlfriends Project, one is assessing: 1) how the inequalities created by the TGP increase African American women's HIV and STI risk, and 2) methods of reducing the risk associated with those inequalities. Unlike with the SCT where the Girlfriends Project addresses the elements of the theory directly, when addressing the TGP the Girlfriends Project addresses the elements of the theory indirectly. The Girlfriends Project focuses more so on risk reduction than on eliminating the inequality articulated by the TGP. The focus is risk reeducation instead of risk elimination because as was previously described, gender inequality has clearly been weaved into the fabric of this society. Gender inequality has been propagated historically through various institutional mechanisms, and the process of changing the beliefs associated with gender roles and gender norms has been less than gradual (Wingood & DiClemente, 2000). The likelihood that a project as small and focused as the Girlfriends Project would be able to suddenly undo centuries of structurally enforced gender inequity is unlikely. Therefore, the application of this theory in

regards to the Girlfriends Project could only serve in the capacity of risk reduction. With this in mind, in the following sections the elements of the Girlfriends Project will be applied to each structure in the TGP in order to show that the Girlfriends Project does indeed address each structure in the TGP.

3.2.1 Sexual Division of Labor

The TGP is important for assessing the potential effectiveness of the Girlfriends Project because inequalities resulting from the structures described by the TGP increase the risk of HIV and STIs for African American women in several ways. For instance, in a previous section it was stated that the sexual division of labor leads to economic inequality for women. This economic inequality was evident in the poverty rates reported by the U.S. Census Bureau in 2008. According to the U.S. Census Bureau (2008), women overall were more likely to live in poverty than men, and African American women specifically suffered disproportionately not only to men but to their White counterparts. As was previously noted, increased poverty was found to lead to the increased likelihood of having to live in impoverished segregated neighbors, which increased HIV and STI risk for African American women because the incidence of infection was particularly high in the African American community (Aral et al., 2008; El-Bassel et al., 2009). In addition to this, living in poverty was found to decrease African American women's ability able to afford prevention materials which would decrease their risk of infection, and increase the likelihood of not having health insurance or having health insurance that did not adequately cover necessary services for HIV and STI prevention/care. Having insufficient health insurance increased infection risk by preventing African American women from receiving the services they need (El-Bassel et al., 2009). The way that the Girlfriends Project addressed these risk exposures

which resulted from the sexual division of labor was by: 1) encouraging consistent condom use, 2) offering free testing, and 3) making referrals to other resources where free services could be obtained.

The first way that the Girlfriends Project addressed the risk exposures resulting from the sexual division of labor was by encouraging consistent condom use. As abstinence continues to become a less appealing option in the U.S., condoms have become one of the most effective defenses against HIV and STI infection (CDC, 2009d). Because of this, the Girlfriends Project focused a great deal on proper and consistent condom use. As was explained in some detail in the previous sections on modeling and facilitation, the Girlfriends Project took steps to assure that women: 1) knew the benefits of consistently using condoms in and out of relationships, 2) could see that their peers were not opposed to using condoms, and 3) had access to free condoms and health services related to HIV and STI prevention and treatment. The focus of condoms was meant to help to protect women living in an environment that increases their risk of infection.

The second way that the Girlfriends Project addressed the sexual division of labor was by offering free HIV testing at the party. Because the majority of new infections in 2009 were transmitted by individuals who were undiagnosed, and because the infection rate in impoverished segregated neighborhoods was so high, knowing one's status was extremely important (Swenson et al., 2009; Aral et al., 2008; El-Bassel, 2009). Offering free testing allowed people to know their status which would not only show the spread of infection but also get people into treatment sooner if needed. Furthermore, because impoverished African American women often had an increase in the likelihood of not having health insurance offering free testing made it possible for women to get tested who may have otherwise not been able to afford it. (El-Bassel et al., 2009).

Lastly, the Girlfriends Project addressed the risk exposures resulting from the sexual division of labor by offering referrals to resources that handled issues beyond the scope of the intervention. Because the Girlfriends Project was a relatively focused intervention there were serviced related the HIV and STI risk that were beyond their capabilities. For instance, although STI are a major component of the intervention, the Girlfriends Project does not actually test for infections other than HIV. However, for those who want STI testing the Girlfriends Project referred them to other organizations that provided that service at a reduced rate or free of charge, that way women could access the resources they would need to continue to protect themselves.

3.2.2 Sexual Division of Power

The imbalance in power created by the sexual division of power is enforced through various mechanisms that increase risk of HIV infection. Two of those mechanisms are IPV and an imbalance in the sex ratio. As was discussed, IPV creates an imbalance in power that favors male dominance by instilling fear in there partner (Wingood & DiClemente, 2000). Women who fear that their objections to their partner’s wishes will result in violence against them are less likely to speak up. The fear of physical violence places women in the position where they feel that they cannot use safe sex behavior that would reduce their risk of HIV and STI infection. Not feeling in control of their own sexual behavior greatly increases African American women’s risk of infection; especially if the women’s partner uses high risk behaviors such as intravenous drug use or sleeping with multiple sexual partners without using protection (Raiford et al., 2009; Wingood et al., 2006).

The Girlfriends Project addressed this exposure mostly through education and resources. As was discussed, education on IPV and HIV/STIs was a very important component of the

project. Because women's physical risk was at stake, it was made clear that for women in relationships that involved IPV many of the risk reduction behaviors, which involved some level of negotiation, could potentially place them at risk for violence. Because of this, the Girlfriends Project highlighted the reasons that relationships involving IPV placed women at greater risk for HIV and STIs, and how to recognize the signs of an unsafe relationship. By providing the women with information and facilitating a discussion about the link between risk and IPV: awareness of the problem was increased, women were able to discuss why abuse is not the women's fault, and women were able to hear from their peers that all women deserved better. The supportive environment and discussion of information surrounding IPV increased the likelihood that women in relationships involving IPV would begin to consider utilizing the resources for shelters and crisis centers provided by the Girlfriends Project. Utilization of those resources would help them to alter their circumstances so that their sexual health could be made a priority.

The imbalance in the sex ratio was another mechanism of the sexual division of power which perpetuated the gender inequality. As was discussed in the section on social norms, the limited number of African American men compared to African American women, caused women to fear losing their partner and not being able to find another. Because they feared losing their partner, African American women often felt that they had to compromise their needs in order to keep their partner from ending the relationship (El-Bassel et al., 2009; Andrews & Buchanan, 2009). The perceived need to relinquish decision making power to men placed men in a position where they controlled women's behaviors, sexual and otherwise. The skewing of power toward men was further exacerbated by negative media images of African American women. The hypersexualization of women in the media misled women into believing that it was

through sexual submissiveness that they could maintain their partner's attention (Littlefield, 2008; Wingood et al., 2003; Andrews & Buchanan, 2009). The notion of sexual submissiveness being socially acceptable helped to validate the perceived need to relinquish sexual decision making power to their partner.

Fear of abandonment and false representations of African American women's sexuality, left women with a decreased perceived ability to negotiate safe sex practices such as condom use and monogamy. The decreased ability to negotiate increased African American women's risk for contracting HIV and STIs because sexual behaviors were determined based on their partners desires instead of the need to protect their own sexual health (Andrews & Buchanan, 2009).

Girlfriends Project addressed the increased risk of HIV and STIs due to the fear and false representations of sexuality propagated by the sexual division of power by emphasizing the self-worth of African American women, and by offering risk reduction options. The Girlfriends Project acknowledged the concerns held by African American women regarding their fear of losing their relationships. Acknowledging that fear was important because to disregard that very real concern would have made it less likely that the women would adopt the behaviors. If the women did not believe that what they were learning would address their concerns they would have no motivation to use them (McAlister et al., 2008). Moreover, along with acknowledging that it can be difficult to find an acceptable partner, the Girlfriends Project communicated that African American women needed to place their health first, and that their needs were just as important as their partners. It was also communicated that any man who did not take their needs into consideration was worth the effort.

In addition to the strategy of encouraging self-esteem and health centered decision making, the Girlfriends Project also offered tips for negotiating safe sex to reduce risk. For

instance, the Girlfriends Project suggested wearing a female condom if a woman's partner was opposed to male condoms. They suggested incorporating condoms into foreplay. Also, the Girlfriends Project suggested that if a woman does not want to have sex without a condom but her partner is insistent, to supplant vaginal sex with oral sex because the likelihood of getting HIV from oral sex is lower than that of vaginal sex (CDC, 2009c). Risk reducing tips such as those were necessary to communicate because those women who were in a relationship where they felt that they were at a disadvantage but were not willing to demand change, needed methods that would reduce their risk without requiring them to confront the power imbalance before they were ready.

3.2.3 Structure of Cathexis

The social norms described by the final structure, the structure of cathexis also increase the African American women's risk of HIV and STIs in various ways. Those ways are found by examining the mechanisms which perpetuate the structure of cathexis. Two of those mechanisms are: mistrust of the medical system and gender roles regarding condoms.

Mistrust of the medical system was a major contributor to the increased incidence of HIV and STIs among African American women. As was discussed previously, the very complicated history between the African American and medical community has resulted in African American's being cautious when it comes to the health care system. African American women who did not believe that healthcare services would increase their health benefits often would not use them (El-Bassel et al., 2009). Because of this, those women may have avoided health services that they needed to prevent and treat HIV and STIs. The Girlfriends Project effectively worked against this notion by conducting the intervention in the homes of the African American

women, and making the experience as entertaining as possible through methods such as providing food and doing icebreakers at the beginning of the party. The more personable feel of having an intervention in the home was meant to reduce the discomfort and feelings of judgment that might normally accompany going to clinical setting. Furthermore, having the women invite their friends and family to the party helped to validate for the guest that the Girlfriends Project was an intervention whose goal is to help, not harm. Basically, recruiting people through the host of the party was meant to help to increase comfort and trust among of the guest.

The other mechanism by which the social norms discussed by the structure of cathexis increased the HIV and STI risk of African American women was through gender roles regarding condoms. Gender roles speak to the imbalance between men and women, in that historically those roles designated for women have been ones deemed less important, or ones where women's voices were secondary to those of men (Wingood & DiClemente, 2000). This notion of women's roles having a secondary status is visible in the expectation of carrying condoms. Because buying and carrying condoms has been deemed a man's responsibility, women are at a disadvantage in that they were reliant on their partner to have and agree to wear a condom (El-Bassel et al., 2009). Because African American women are often taught that it is men who should make decisions regarding sexual activities, men seem to have the final say when it comes to condom use. Thus if a woman's partner is opposed to condoms, the woman's risk of HIV and STI infection is increased if he refuses to wear condoms.

The Girlfriends Project acknowledged that women in many ways were at a disadvantage because society said that condoms were man's domain. However, the Girlfriends Project also acknowledged that just because society deemed condoms a man's responsibility didn't mean that women were absolved. The Girlfriends Project emphasized that condoms were also a woman's

responsibility because her health was also at risk. It was made clear that although women were at a disadvantage, they did not have to remain that way. Though not explicitly stated, the underlying message of the program was that by taking control of ones' own sexual health they were rejecting the subordinate position to which they had been designated by social norms. By taking such actions as carrying their own condoms, wearing a female condom, and/or making clear to one's partner that sex without a condom was unacceptable they decreased the impact of cathexis on their sexual health.

4.0 DISCUSSION

The SCT and the TGP are two well know theories that articulate the connection between the physical and social environment and behavior. These theories have been applied to a great number of HIV and STI interventions targeted specifically to African American women and have been found to be affective (Wingood & DiClemente, 2000; Moor, Harrison, & Doll, 1994). It is for this reason that applying these two theories to the Girlfriends Project indicates that the project should be successful in reducing the rate of HIV and STI among African American women. After this examination of the Girlfriends Project using both the SCT and the TGP one can see that the curriculum of the Girlfriends Project fulfills the majority of the elements required by these two theories to be effective in altering behavior. Because the elements of the Girlfriends Project are congruent with those of theories that have been proven to be effective in changing attitudes and behavior, it is not unreasonable to assert that the Girlfriends Project would be effective as well in that regard.

4.1 GAPS IN THE GIRLFRIENDS INTERVENTION COMPONENTS

Although it is argued that the Girlfriends Project was sufficiently congruent with the SCT and the TGP, there were flaws when applying the Girlfriends Project to those theories. There were

several gaps in the Girlfriends Project curriculum when comparing its components to the elements SCT and the TGP. Those gaps are described in the following sections.

4.1.1 Gaps in the Girlfriends Intervention When Compared to the Social Cognitive Theory

The most notable gap in the Girlfriends Project when compared to the SCT was the failure to incorporate all of the methods for self-regulation. As one can see from Appendix A, the Girlfriends Project incorporated self-monitoring, feedback, and enlistment of social support into their intervention; however goal-setting, self-reward, and self-instruction were not addressed. It was important that all of the methods be incorporated because self-regulation is what helps people to sustain behaviors changes. Goal-setting could have been incorporated into the intervention by encouraging the women to set a goal for reducing their infection risk. At the end of the intervention, the facilitator could have challenged the women to go home and write down what they want to change about their sexual behaviors long term and short term and then write down the steps they would need to take to achieve their goals. Self-reward could have been incorporated into the Girlfriends project by encouraging the women to, as they are working on the goals they set for themselves, occasionally reward themselves for their progress. As for self-instruction, the Girlfriend Project could have incorporated that element of self-regulation by having the women recite the steps of condom application as they applied the condoms to the genital model.

Although as one can see from Appendix A, the Girlfriends Project did address all other element of the SCT, there were certain areas where the Girlfriends Project curriculum could have more fully addressed the theory. For instance, as was mentioned the Girlfriends' parties actively

tried to educate African American women about HIV and STIs and to discredit any stigma associated with those topics. Increased education was meant to foster reciprocal determinism, increase all outcome expectations, increase collective and self-efficacy, and to decrease moral disengagement. To assess if the women had learned the basic information needed to accomplish these goals, the participants were given a quiz both before and after the intervention to see if their knowledge increased. Although this was an extremely necessary component of the intervention, the Girlfriends Project could have more fully achieved their goal of educating women by going over the answers to the quiz. Going over the answers following quiz collection would have verified that the quiz results were not tainted, while assuring that the women did not leave the party with misconceptions.

The last area where the Girlfriends Project could have more fully addressed the elements of the SCT was in the categories of self-efficacy and facilitation. The elements of the Girlfriends Project that fulfilled these requirements of the SCT for the most part had to do with effectively and consistently using condoms. Although, these ideas are extremely important, for them to be affective there needed to be more emphasis on verbal condom negotiation. Because one's ability to negotiate safe sex behaviors is a major determinant as to whether condoms are used, it is a very important factor in risk reduction (El-Bassel et al, 2009). There was some discussion on verbal condom negotiation incorporated into the Girlfriends' party but more emphasis could have been added. One way that the Girlfriends Project could have incorporated more verbal condom negotiation would have been to include a method utilized by an intervention called VOICES/VOCES which has been verified by the CDC to be effective in reducing the number of new STI's (CDC, 2009d). In the VOICES/VOCES intervention, as a group, participants were asked to name some of the common excuses used by men for not using condoms and then to

come up with responses to those excuses. Following this, the participants were asked to role play using the excuses and possible responses that were produced by the group (CDC, 2009d). This activity gave the participants experience with combating excuses for not using condoms that way they could have greater success in successfully persuading their partner to use condoms when the need arose.

4.1.2 Gaps in the Girlfriends Intervention When Compared the Theory of Gender and Power

When attempting to apply the Girlfriends Project to the TGP, one can see from Appendix B that the Girlfriends Project addressed all three structures described by the theory. While all three structures were addressed, much like with the SCT, there were ways that the Girlfriends Project could have addressed the structures more thoroughly. For instance, when addressing the sexual division of labor, although the Girlfriends Project obviously could not fix the problem of economic inequality for women, they could have spoken more about the need for economic independence. Because African American women were so disproportionately affected by poverty, there was a need to make sure that the reason for the disparity is very clear (U.S. Census Bureau in 2008). Although the Girlfriends Project goal was to indirectly decrease the risk that poverty contributes, a direct call for economic independence for African American women along with a list of sources for job training may have more directly reduced the imbalance in power between men and women that resulted from economic inequality.

The second way that the Girlfriends Project could have addressed the structures of the TGP more thoroughly would have been to talk specifically about the role of media in HIV and STI risk. Because media images play such a large role in how African American women view

their sexuality, media influence should have been discussed more during the interventions. Having a group discussion about how the media affects the way African American women expressed their sexuality would have helped to better show how false cultural norms added to their risk of contracting HIV and STIs; thus more fully addressing the risk exposures resulting from the sexual division of power.

4.2 LIMITATIONS

One significant limitation of this paper is that there is no quantitative data to support the qualitative claim that the Girlfriends Project should be effective in changing attitudes and behavior. Because at the time this paper was written the Girlfriends Project was in the process of being evaluated, there was no numerical data to substantiate the claim. Therefore, a possible direction for future research would be to compare the qualitative results of the evaluation of the Girlfriends Project to the theoretical conclusion offered in this analysis.

5.0 CONCLUSION

With the rate of HIV and STIs among African American women during the time this essay was written, interventions that could effectively reduce the rate of HIV and STI in this population would have been extremely valuable. There is evidence that the Girlfriends Project was likely one of those interventions. The Girlfriends Project addressed HIV and STI risk in a way that was culturally competent and socially relevant. Furthermore, the Girlfriends Project was congruent with the elements of the SCT and the TGP that had been found to be effective in facilitating behavioral change. After examining the Girlfriends Project in the context of the SCT and the TGP there appears to be support for the claim that if widely disseminated the Girlfriends Project had the potential to be effective in changing the attitudes and social norms of African American women, which in turn would lead to behavior change that would reduce the incidence of HIV and STI among African American women.

When looking at the Appendix A and B one can visually see how closely the components of the Girlfriends Project correlated with the elements of the SCT and the TGP. This correlation however is not by chance. The reason that the Girlfriends Project was able to address the elements of the two theories so thoroughly was because of the way the project addressed the stressors that increased the HIV and STI risk for African American women. The Girlfriends Project rejected the idea of a one size fits all intervention with a design that took into consideration the varying experiences of African American women and the numerous

environmental determinants that increase their risk of infection. Within the intervention, the determinants surrounding interpersonal relationships, social norms, and external stressors were all addressed in ways that empowered women with awareness regarding the severity of the problem and methods to combat the negative influences of those stressors. By holding the intervention in the home of African American women and creating a judgment free atmosphere, the Girlfriends Project helped women to be comfortable enough to open up; to express themselves and to ask questions. As a result, the stigma attached to sex and HIV could be diminished, and the environmental stressors increasing African American women's HIV and STI risk addressed candidly and with a focus on solutions.

The focus on the empowerment of African American women that was so central to the Girlfriends Project curriculum was also central to the project's efficacy in addressing the environmental stressors which increased HIV and STI risk. Because all of the environmental stressors previously mentioned were the result of an imbalance in power, be it due to gender and/or race, it was important to help women realize their power even in situations where it may seemed limited. The belief that one does not have control of their own experience was what allowed those stressors to flourish. By altering the mindset of those experiencing oppression, the power wielded by oppressive structures is reduced. Therefore, by helping African American women to feel empowered regarding their ability to control their sexual health, the power of those environmental stressors was reduced.

Although it is this researcher's belief that it is due to the Girlfriends Project thorough evaluation of risk increasing environmental stressors that allowed the project to match so well with the elements of the SCT and the TGP, there were areas for possible improvement. Based on

the findings of this analysis, these are the recommendations that this author would make to PATF to strengthen the Girlfriends Project.

The first recommendation would be to incorporate goal-setting, self-reward, and self-instruction into the intervention in order to address all elements necessary to successfully self-regulate. Although the Girlfriends project did address three out of the six methods of self-regulation it needed to address them all. Because self-regulation is what helps people to sustain behaviors changes, it is important that all of the methods be addressed. Without all of the self-regulating mechanisms, it would be harder for participants to maintain the behaviors they learned in the intervention. Each of the three unaddressed self-regulatory mechanisms could be incorporated in to the intervention in the following ways: Goal-setting can be incorporated by encouraging women to set a goal for reducing there infection risk. Self-reward can be incorporated by encouraging the women to reward themselves for the progress they make toward reaching their goals. Lastly, self-instruction can be incorporated by having the women recite the steps of condom application as they applied the condoms to the genital model.

The second recommendation would be to go over the answers to the quizzes with the participants at the end of the intervention. Reviewing the answers to the quiz would more fully address reciprocal determinism, outcome expectations, collective-efficacy, self-efficacy, and moral disengagement. Because HIV and STI education was meant to reduce stigma and misinformation surrounding sex, HIV, and STIs, it is important to assure that the women did not leave the party with misunderstandings. Although the quizzes are important for determining how effective the intervention was, it was more important to make sure that the women left the party with the information they needed. By going over the quizzes, any confusion regarding HIV and STI could have been cleared up before the women left the party.

The third recommendation would be to incorporate more verbal condom negotiation skills as a mechanism of increasing self-efficacy and facilitation. Although the Girlfriends Project did a good job of physically demonstrating the use of protective barriers, additional modeling could be used to increase self-efficacy for negotiating condom use. For instance one way that the Girlfriends Project could have incorporated more verbal condom negotiation would be to include aspects of the VOICES/VOCES intervention. Aspects of the VOICES/VOCES intervention could be utilized by the facilitator during the party in order to increase participants ability to negotiate condom use with partners.

The fourth recommendation would be to talk more about the need for economic independence for African American women in order to better address the sexual division of labor. Because African American women were so disproportionately affected by poverty, there was a need to make sure that the reasons for the disparity were very clear (U.S. Census Bureau in 2008). A direct call for economic independence for African American women, along with a list of sources for job training, could more directly reduced the imbalance in power between men and women that results from economic inequality.

The final recommendation would be to talk specifically about the role of media in HIV and STI risk as a way of addressing more fully the sexual division of power. Because media images play such a large role in how African American women view their sexuality, media influence should be discussed more during the interventions. Having a group discussion about how the media affects the way African American women expressed their sexuality could show how false cultural norms add to increased HIV and STIs risk.

Because the Girlfriends Project is only a 90 minute intervention, it may be difficult to incorporate all of these recommendations into the curriculum and still provide enough depth for

African American women to gain the tools necessary to reduce their risk of contracting HIV and STIs. However, if the Girlfriends project can find a balance that allows them to address these gaps in the program, it is this researchers belief that not only will the Girlfriends Project more fully address the element of the SCT and the TGP, but that they will more fully address the stressors that increase African American women's risk of infection.

APPENDIX A

COMPARISON OF THE COMPONENTS OF THE GIRLFRIENDS PROJECT TO THE ELEMENTS OF THE SOCIAL COGNITIVE THEORY

Elements	Definition (McAlister et al., 2008)	Girlfriends Project Example / GAP in the Girlfriends Project
Reciprocal Determinism	The understanding that the environment has an influence on the behaviors of individuals and groups, but that individuals and groups can also influence the environment.	<ul style="list-style-type: none"> • Provided HIV/STI information to African American women about how HIV/STIs affected them, and why they should take action. • Group setting allowed African American women to become more comfortable talking about HIV/STIs, and sex so that participants could share information with friends and family. • Provided options such as carrying their own condoms, wearing a female condom, and/or making clear to one's partner that sex without a condom is unacceptable. • GAP – could have gone over the answers to the post-quiz with the women.
Outcomes Expectations	The likelihood of a particular outcome occurring and the value placed on that outcome.	<ul style="list-style-type: none"> • Provided HIV/STI information to African American women in order to discredit misconceptions regarding HIV/STIs which could decrease their perceived risk. • Provided HIV/STI prevention strategies to allow women to reduce their risk even if they chose not to eliminate behavior. • GAP – could have gone over the answers to the post-quiz with the women.
Social Outcomes Expectations	Feelings regarding how one believes others will value certain behavior outcomes.	<ul style="list-style-type: none"> • Discredited common HIV/STI misconceptions increased group's perceived risk of infection for African American women. • Group format helped participants confirm that certain sexual behaviors were acceptable and/or necessary and decreased stigma associated with the behavior, and that socially risk reducing behaviors were acceptable.

Self-Efficacy	The belief in one's ability to perform a behavior.	<ul style="list-style-type: none"> • Participants offered hands on experience with inserting/applying condoms to the genital models. • Provided various risk reduction strategies to allow participants to decide how they could most effectively reduce their HIV/STI risk. • Educated women about the link between HIV/STIs and IPV, emphasized choices, and provided them with resources. • GAP – could have incorporated more verbal safe sex negotiation skills. • GAP – could have gone over the answers to the post-quiz with the women.
Collective-Efficacy	The belief in the ability of a group to work together for the achievement of a particular outcome.	<ul style="list-style-type: none"> • Group setting allowed African American women to develop a social support group to help them sustain healthy behaviors. • Nurtured idea of African American women camaraderie in the area of HIV/STI prevention to increase women's belief that HIV/STIs were not only their issue, but every African American woman's issue. • GAP – could have gone over the answers to the post-quiz with the women.
Observational Learning	Learning to perform a particular behavior by watching one's peers	<ul style="list-style-type: none"> • Taught proper male/female condom application using genital models and allowed participants to try application on models. • Women watched peers perform condom insertion/application and provided comments positive and corrective feedback.
Incentive Motivation	The use of rewards or punishment to alter behavior.	<ul style="list-style-type: none"> • Party hosts received \$50 Giant Eagle gift certificate; certificate incentivized hosting and sharing HIV/STI information with loved ones. • Guests tested for HIV received \$20 Giant Eagle gift certificate; incentive encouraged women to find out their HIV status. • Three month post-assessment participants were eligible for a large-prize drawing; incentive designed to increase assessment return rate.

Facilitation	Reducing barriers to behavior change by providing the materials or resources one would need to perform the behavior.	<ul style="list-style-type: none"> • Participants received gift bags containing male and female condoms, lubricants, condom case, condom instructions, and dental dams. • Participants told where free condoms were available. • Provided referral to services not associated with the scope of the project. • Offered free HIV testing at party and used HIV test that only required a cheek swab; delivered test results individually to each participant. • GAP – could have incorporated more verbal safe sex negotiation skills.
Self-Regulation	<p>Controlling one's own actions through:</p> <ul style="list-style-type: none"> • Self-Monitoring- paying attention one's own behavior. • Goal setting- the creation of long and short term goals. • Feedback- receiving constructive criticism. • Self-Reward- providing oneself incentives. • Self-Instruction- verbalizing the steps of a behavior. • Enlistment of Social Support- asking trusted peers to support their new behavior. 	<ul style="list-style-type: none"> • Self-monitoring <ul style="list-style-type: none"> - Core concept of control of one's own sexual health was that one needs to be regularly thinking about how ones sexual behaviors may be affecting their health. - Participants told that safe sex behaviors necessary regardless of comfort with partner. • Feedback <ul style="list-style-type: none"> - Group setting allowed African American women to develop a social support group for feedback after the party. • Enlistment of Social Support <ul style="list-style-type: none"> - Group setting allowed African American women to develop a social support group to help sustain healthy behavior • GAP – did not address goal setting, self-reward, or self-instruction.
Moral Disengagement	The cognitive mechanisms by which people are able to justify violating moral standards	<ul style="list-style-type: none"> • Common misconceptions about HIV/ STIs, and those at risk for infection were addressed and discredited in group discussions. Discrediting stereotypes increased women's perceived risk and decreased shame surrounding HIV/STI infection. • GAP – could have gone over the answers to the post-quiz with the women.

APPENDIX B

COMPARISON OF THE COMPONENTS OF THE GIRLFRIENDS PROJECT TO THE ELEMENTS OF THE THEORY OF GENDER AND POWER

Elements	Definition (Wingood & DiClemente, 2000)	Problem	Girlfriends Project Solution / GAP in the Girlfriends Project
The Sexual Division of Labor	Described how gender roles determine occupational and economic opportunities; value of male vs. female work	<ul style="list-style-type: none"> • Poverty leads to: <ul style="list-style-type: none"> - Living in impoverished neighborhoods - Increased rates of HIV/STIs - Inability to afford prevention materials to decrease infection risk. - Increased likelihood of being un- or under-insured. 	<ul style="list-style-type: none"> • Encouraged consistent condom use even when one is in a relationship. • Provided free condoms. • Hands-on condom application experience. • Offered free HIV testing. • Offered free or reduced price service referrals. • GAP – could've addressed the need for economic independence more.
The Sexual Division of Power	Described the way that power is distributed and wielded in male female interactions	<ul style="list-style-type: none"> • IPV resulting in reduced ability to negotiate safe sex behaviors. • Imbalance in sex ratio resulting in reduced perceived ability to negotiate safe sex behaviors. • African American women media images resulted in the belief that sexual submissiveness is appropriate for women. 	<ul style="list-style-type: none"> • Highlighted reasons that IPV-relationships placed women at greater risk for HIV/STIs, • Explained signs of unsafe relationships. • Provided referrals domestic violence cases. • Acknowledged African American women's fears, yet communicated need to place their own needs & health first. • Gave safe sex negotiation tips to reduce risk. • GAP – could have discussed media's influence on HIV and STI risk.
The Structure of Cathexis	Described development of social sexual norms and attachment of norms to unrelated social concerns	<ul style="list-style-type: none"> • Mistrust of the medical system leading to women avoiding health services that they needed to prevent and treat HIV and STIs. • Gender roles which say that condoms are a man's responsibility. 	<ul style="list-style-type: none"> • Conducting the intervention in the home of the African American women and making the experience as entertaining as possible. • Recruiting people through the host of the party to increase guest comfort and trust. • Emphasized condoms are woman's responsibility because her health was at risk.

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