Georgia State University
Digital Archive @ GSU

Psychology Dissertations | Department of Psychology

5-3-2007

HIV Infection, Negative Life Events, and Intimate Relationship Power: The Moderating Role of Community Resources for Black South African Women

Bethany Ketchen
Georgia State University

Follow this and additional works at: http://digitalarchive.gsu.edu/psych_diss

Recommended Citation
Ketchen, Bethany, "HIV Infection, Negative Life Events, and Intimate Relationship Power: The Moderating Role of Community Resources for Black South African Women" (2007). *Psychology Dissertations.* Paper 27.

This Dissertation is brought to you for free and open access by the Department of Psychology at Digital Archive @ GSU. It has been accepted for inclusion in Psychology Dissertations by an authorized administrator of Digital Archive @ GSU. For more information, please contact digitalarchive@gsu.edu.

HIV INFECTION, NEGATIVE LIFE EVENTS, AND INTIMATE RELATIONSHIP POWER: THE MODERATING ROLE OF COMMUNITY RESOURCES FOR BLACK SOUTH AFRICAN WOMEN

by

BETHANY R. KETCHEN, M.A.

Under the Direction of Lisa Armistead, Ph.D.

ABSTRACT

Background: Black South Africans were forced to live under the oppressive regime of apartheid for more than four decades. This system of government not only restricted the economic and educational opportunities for Blacks, but it also marginalized women by encouraging the preservation of a violent, patriarchal society. As a result of a long history of nationalized oppression, Black women in South Africa continue to be an economically and socially vulnerable group. Their vulnerability is translated into limited intimate relationship power, which confers a host of health and safety risks. Thus, the current study explored whether negative life events and/or HIV infection related directly to women's intimate relationship power or was moderated by community-level variables (knowledge, helpfulness, and use of resources). **Method:** Participants were 104 women living with HIV and 152 non-infected women, who were recruited in and around Pretoria, South Africa. Two aspects of intimate relationship power were considered: relationship control (e.g. Partner controls what I wear) and decision making dominance (e.g. Who usually decides when you have sex?). Decision-making dominance was divided into three subscales (male dominant, female dominant and mutual). **Results:** For

relationship control, fewer undesirable life changes were associated with more control. For decision-making dominance, several main and interaction effects were observed. Negative serostatus and women's *knowledge* of community resources were directly associated with more mutual decision-making. However, more frequent family *use* of community resources was related to less female dominated decisions. For *helpfulness* of resources, a significant interaction revealed that women living with HIV/AIDS perceived their male partners as less dominant when they perceived their community resources to be more helpful. **Conclusions:** Power in intimate relationships may enhance the quality and length of life for Black South African women; thus, it is important to identify factors that promote or compromise power. The results of this study suggest that undesirable life changes, HIV infection, and great reliance on community resources (i.e. frequent use) are negatively associated with perceived relationship power. Alternatively, the current study identified the perceived helpfulness of community resources as one possible factor that promotes relationship power.

INDEX WORDS: HIV/AIDS, South Africa, women, relationship power

HIV INFECTION, NEGATIVE LIFE EVENTS, AND INTIMATE RELATIONSHIP POWER: THE MODERATING ROLE OF COMMUNITY RESOURCES FOR BLACK SOUTH AFRICAN WOMEN

by

BETHANY R. KETCHEN, M.A.

A Dissertation Presented in Partial Fulfillment of Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2007

Copyright by
Bethany Reneé Ketchen, M.A.
2007

HIV INFECTION, NEGATIVE LIFE EVENTS, AND INTIMATE RELATIONSHIP POWER: THE MODERATING ROLE OF COMMUNITY RESOURCES FOR BLACK SOUTH AFRICAN WOMEN

by

BETHANY R. KETCHEN, M.A.

Major Professor: Lisa Armistead
Committee: Sarah Cook
Marci Culley
Greg Jurkovic

Electronic Version Approved:

Office of Graduate Studies
College of Arts and Sciences
Georgia State University
August 2007

TABLE OF CONTENTS

LIST OF TABLES vi

LIST OF FIGURES vii

LIST OF ABBREVIATIONS viii

CHAPTER

1 INTRODUCTION 1

Women in South Africa: Socio-cultural Context 1

The South African Context 2

Gender and Relationship Power 6

HIV/AIDS and Women's Power in Intimate Relationships 9

Stressful Life Events and Women's Power in Intimate Relationships 12

Community Involvement and Perceived Power 17

Summary and Hypotheses 20

2 METHODS 24

Participants 24

Measures 24

Procedures 29

3 RESULTS 32

Preliminary Analyses 32

Data Analysis Plan 38

Outcome Variable: Perceived Relationship Control 40

Outcome: Perceived Male Decision Making Dominance 40

Outcome Variable: Perceived Female Decision Making Dominance 41

Outcome Variable: Mutual Decision Making 42

4 DISCUSSION 43

Implications 48

REFERENCES 49

LIST OF TABLES

Table 1. Demographic Characteristics of Participants by HIV Status 32

Table 2. Means (M) and Standard Deviations (SD) for Demographic Variables, IVs, and DVs 33

Table 3a. Correlations for Demographic Variables, IVs (Relationship Control) and DVs 34

Table 3b. Correlations for Demographic Variables, IVs (He Dominates) and DVs 35

Table 3c. Correlations for Demographic Variables, IVs (She Dominates) and DVs 36

Table 3d. Correlations for Demographic Variables, IVs (Mutual) and DVs 37

Table 4. Summary of Regression Analyses for all DVs 39

LIST OF FIGURES

Figure 1. Interaction between HIV Status and Perceived Helpfulness of Community Resources on Perception of Male Dominated Relationships 41

LIST OF ABBREVIATIONS

1. Human Immunodeficiency Virus (HIV)
2. South African Institute of Race Relations (SAIRR)
3. Center for the Study of Aids (CSA)
4. Non-Governmental Organizations (NGOs)
5. Household Economic and Social Status Index (HESSI)
6. Socioeconomic Status (SES)
7. Tuberculosis (TB)
8. Life Stressor Checklist (LSC)
9. Sexual Relationship Power Scale (SRPS)

CHAPTER 1

Introduction

Women in South Africa: Socio-cultural Context

Black women in South Africa have historically been and continue to be an economically and socially vulnerable group, which is the result of a confluence of social, political, and cultural factors. Although the policy of apartheid was institutionalized in 1948, the segregation and oppression of native South Africans extends back to the 17th century when the first white settlers arrived (Martineau, 1997). The institutionalization of the system of apartheid resulted in a systemic marginalization of the Black majority that permeated all segments of their lives (Abdi, 2003; Murray, 1997). Under apartheid, Blacks were forcibly removed from their homes, forced to live in government-designated "homelands", and denied the rights of land ownership (Gilbert, 1996). In addition, apartheid limited Black South African's educational and employment opportunities, as well as health care services (Motsemme, 2002; Mabokela & Mawila, 2004).

In many ways apartheid was also used to relegate Black women to second class citizenship by restricting their involvement in certain activities and by encouraging violence and the preservation of a conservative, patriarchal society (Albertyn, 2003; Mabokela & Mawila, 2004). Previous research conducted in the United States and South Africa suggests that the social and economic vulnerabilities of women in the public sector (i.e. workplace) result in women having limited power in intimate heterosexual relationships, particularly with respect to sexual activity (Albertyn, 2003; Hoosen & Collins, 2004; Zierler & Krieger, 1997). The current investigation will examine Black South African women's power in intimate relationships.

Specifically, the predictive role of negative stressful life events and HIV status will be considered. Moreover, the extent to which involvement in community based organizations serves as a mechanism to enhance power will also be addressed. Although the current research focuses on Black South African women, gender-based inequalities impact women throughout the world (Sen, 2001; Hankins, 1996). Gender biases in higher education, employment, and property ownership can be observed even in the wealthiest countries (Sen, 2001; UNAIDS, UNFPA, UNIFEM, 2004). As such, many of the hardships experienced by women in South Africa are experienced by women worldwide, including relationship violence, poverty, and HIV/AIDS (UNAIDS, UNFPA, UNIFEM, 2004).

The South African Context

The 46 years that Black South Africans were forced to live under the rule of apartheid created a cycle of economic disadvantage and violence for many Black South African women (Oberhauser & Pratt, 2004). Their current vulnerability may also be partially linked to the migrant labor policies demanded by the apartheid system (Albertyn, 2003; Outwater, Abrahams, & Campbell, 2005). These policies required husbands to find work away from home, visiting their families only occasionally (Outwater, Abrahams, & Campbell, 2005). Thus, women-headed households became quite common (Albertyn, 2003).

It has been argued that the migrant labor policies, coupled with forced segregation, damaged the African family structure and communities in a way that further marginalized African women (Albertyn, 2003; Spangenberg & Pieterse, 1995). Specifically, researchers have postulated that, by making women the heads of the household, apartheid forced shifts in the traditional gender roles of men and women (Motsemme, 2002). It has further been postulated that these shifts may play a role in the high rates of intimate partner violence as a result of men's

needs to assert their masculinity in at least one domain (Outwater, Abrahams, & Campbell, 2005).

Apartheid ended in 1994 and political power shifted from a government ruled by the white minority to a democratically elected government (Albertyn, 2003). The transition to democracy resulted in the development of a progressive Constitution that named all South Africans equal members of society, stating that women should be freed of all oppression (Office of the President, 1994). Despite the lofty goals of the Constitution, women's daily lives still remain unchanged in many ways (Albertyn, 2003).

Several factors combine to perpetuate the lesser status of Blacks in South Africa and Black women in particular. First, since the end of apartheid in 1994, the unemployment rate has reached 26.2% (Statistics South Africa, 2002), and the gap between the poor and non-poor has continued to widen (Albertyn, 2003). Although South Africa has the second highest national income in sub-Saharan Africa, 35% of South Africa's population lives on less than $2.00 per day (World Bank, 2001). According to the World Bank, approximately 53% of the population lives in impoverished conditions, with only 25% of those families having access to electricity and running water, and 50% having only a primary school education (World Bank, 2002). According to reports, efforts to increase employment have stalled, and in place there has been a steady decrease in jobs (Campbell & Mzaidume, 2001). As such, there is minimal employment for women with low educational attainment (Campbell & Mzaidume, 2001).

Second, Blacks have been traditionally undereducated in South Africa (Abdi, 2003). Past educational injustices under the apartheid policies have created generations of Black South Africans who lack formal schooling (Abdi, 2003; Murray, 1997). According to research conducted by the South African Institute of Race Relations (SAIRR, 1998), approximately

19.3% of Blacks over age 20 have received no formal schooling. Further, approximately 30% of Blacks are literate compared to 97% of their White counterparts (Abdi, 2001). Although the government supports and encourages Black women's movement into more lucrative fields of employment, the lack of formal education prohibits many women from obtaining high level employment (Murray, 1997). As such, many women continue to work in low paying jobs including domestic work, farm labor, or low-paying factory work (Gilks, Floyd, Haran, Kemp, Squire, & Wilkinson, 1999; Oberhauser & Pratt, 2004). This is not to suggest that Black women have not made huge strides in terms of educational and job advancement. However, compared to their white female counterparts, Black women in South Africa are six times more likely to be unemployed (SAIRR, 1997). Thus, many Black women are either dependent upon male partners for financial support or work in low paying jobs (Fox, 2003; Oberhauser & Pratt, 2004).

In addition to limited educational and employment opportunities, the third factor contributing to the low status of Black South African women is that many are serving the dual roles of sole income provider and sole caregiver to their children (Ackermann & de Klerk, 2002). More specifically, many Black men, particularly those in rural areas, continue to have to find work away from home. Many of those men are unwilling or unable to contribute financially to their households, leaving women to find ways to generate revenue while caring for children and the home (Ackermann & de Klerk, 2002). In fact, research suggests that approximately 31% of households across both rural and urban areas of South Africa are headed by women, and that many of these women-headed households are among the poorest in the country (Ackermann & de Klerk, 2002; Gilks, Floyd, Haran, Kemp, Squire, & Wilkinson, 1999). The challenges of serving in two demanding roles, primary provider and primary caregiver, likely limits women's

opportunities for furthering their education or developing the skills required to obtain higher paying employment.

Due to the limits on employment and educational opportunities, along with the sometimes limited support a woman can expect to receive from her husband or partner, many South African women may be dependent upon other men to fulfill their immediate needs for food and shelter (Oberhauser & Pratt, 2004). Meeting these needs may be of more immediate importance than a potential long-term risk of physical harm or contracting an illness (Hoosen & Collins, 2004). Therefore, women may engage in risky sexual behaviors or may remain in violent relationships to avoid the risk of their partner leaving them, which would leave them unable to care for themselves or their children (Heron, Twomey, Jacobs, & Kaslow, 1997; Hoosen & Collins, 2004). Further some women have come to rely on transactional sex to gain resources (e.g. food, shelter, money) or other desired goods (e.g. clothes, cell phones). The concept of transactional sex is relatively new, and the term is frequently used to describe the gray area between purely recreational sex and frank sex work (Dunkle, et al, 2002). The increased visibility of transactional sex in South Africa has been partially explained by the rising incomes of certain sectors of male society, which may encourage men to buy sex as a symbol of wealth and power (Hoosen & Collins, 2004). In sum, several factors combine to perpetuate the lesser status of Black South African women. Namely, the legacy of apartheid with respect to the migrant labor policies, as well as the limited educational and employment opportunities afforded to all Black South Africans, seem to intersect to create a cycle of vulnerability for Black South African women.

Preliminary research suggests that women’s economic independence, may improve women’s relationship power (Pettifor, Measham, Rees, & Padian, 2004). Research conducted in

the United States, Botswana, and Zimbabwe found that women's educational level and level of economic independence was strongly connected to their relationship power (Greig & Koopman, 2003; Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002). As such, it is clearly important to consider a woman's personal financial assets when conducting domestic violence research (Wyatt, Axelrod, Chin, Carmona, & Loeb, 2000).

Gender and Relationship Power

Given the financial dependence of many Black South African women on their male counterparts, several researchers have explored women's position in their romantic relationships, particularly in terms of sexual negotiation (e.g. Ackermann & de Klerk, 2002; Fox, 2003; Shefer, Strebel, & Foster, 2000; Wood & Jewkes, 1997). The current study explored predictors of perceived power in the intimate relationships of Black South African women. Specifically, the current study examined two components of intimate relationship power, which have been previously defined: relationship control and decision-making dominance (Emerson, 1981). Relationship control has been defined as the degree to which one partner controls their own and their partner's actions, while decision-making dominance refers to the partner who controls the majority of the decisions made in the relationship.

There are several conceptions of interpersonal power (e.g. Charmes & Wieringa, 2003; Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002; Pulerwitz, Gortmaker, & DeJong, 2000). However, for the purpose of the current study, the Theory of Gender and Power (Connell, 1987) will be used to understand interpersonal power and its intersection with gender in the South African context. The Theory of Gender and Power focuses on gender-based power imbalances that are built into societal structures (Connell, 1987). This theory purports that economic inequalities, male partner control within the relationship (i.e. sexual division of power), and

societal gender roles result in the disproportionate distribution of power in society. As previously mentioned, the apartheid system was a social structure that has resulted in lesser status for Black South African women, relative to men, through restricted opportunities, the encouragement of violence, and the presence of a patriarchal society (Maboleka & Mawila, 2004). This vulnerable economic and social position further strengthens men's relatively powerful position, leaving many women unable to assert themselves in relationships. Moreover, women who do assert themselves place themselves at risk for violence or abandonment.

With respect to the societal gender roles aspect of the Theory of Gender and Power, the social and cultural constructions of what it means to be a man or a woman may be one factor that significantly influences interactions in intimate relationships (Charmes & Wieringa, 2003). Within the South African context, men are traditionally viewed as the protectors, providers, and decision makers of the family (Motsemme,
2002). Men are often believed to be more intelligent and superior to women, which results in men having more power and control over many aspects of women's lives (Gupta, 2000). Conversely, women are viewed as nurturers and are valued for their ability to bear children and care for the home (Outwater, Abrahams, & Campbell, 2005; Varga, 2003). Women who are perceived as acting outside of their expected roles may be may be labeled as "menacing witches, cigarette-smoking whores, or frustrated lesbians (Motsemme, 2002)." These women are thought to be disturbing the traditional gender roles and thus breaking apart the family system and African community (Mostsemme, 2002).

Cultural traditions have also resulted in barriers to open sexual communication between men and women and have instead placed men at the helm for sexual decision-making. In many relationships, men decide the timing of sex and what happens during sex (Albertyn, 2003; Lewis,

2003). Research in South Africa exploring women's ideas about who should make decisions about sex within a relationship has suggested that many women view men as the authority figures (Hoosen & Collins, 2004). Men were viewed as having more power and as having a need to control women's lives (Hoosen & Collins, 2004). These beliefs about men's superiority place women in a position to accept men's decisions about whether or not the couple will engage in safer sex practices (i.e. condom use), potentially placing women at risk for contracting sexually transmitted diseases such as HIV.

Women's risk for HIV is also increased by a culture in which masculinity is intertwined with sexual prowess (Jobson, 2003). Men are frequently viewed as having a "natural and biological need" for sex, which makes it acceptable for them to have multiple sexual partners and which obligates women to submit to men's sexual urges and desires (Shefer, Strebel, & Foster, 2000). When women do resist the sexual advances of male romantic partners, they are often forced to engage in sexual intercourse (Outwater, Abrahams, & Campbell, 2005). Coercion or violence is frequently used against women in sexual relationships. However, these acts are rarely labeled rape, but rather viewed as a woman's duty in a relationship (Fox, 2003; Wood et al., 1998). Thus they are rarely reported to the authorities (Fox, 2003).

In summary, The Theory of Gender and Power serves as a framework for understanding Black women's power in South Africa at a societal level and at the level of their intimate relationships. Given their limited power at multiple levels, Black South African women are at risk for negative outcomes across a wide range of domains, including health and safety. Thus, it is important to better understand the factors that are associated with power, in particular circumstances that enhance power for these women.

Despite a rich body of literature that conceptualizes the potential factors contributing to one's empowerment (e.g. economic and educational equality), there is little research that empirically explores predictors of perceived power. The current literature review yielded only one study that explored predictors of power for women in romantic relationships. This study, conducted by Harvey and Bird (2004) with 22 African American couples found several contributors to women's perception of power, including educational and economic resources, a sense of expertise or competency, providing sexual satisfaction to their mate, and feeling they are part of a loving and secure relationship. Further, approximately two-thirds of the women reported that they would perceive themselves to be powerful if they had control over their partner (i.e. telling partner what to do and having them comply), were able to act independently, and/or were the dominant decision-maker in the relationship. The current research aimed to add to the literature by identifying factors that influence women's experiences of power in intimate relationships within the South African context. In particular, a woman's educational and employment history, her HIV status, and her history of negative life events are explored as factors that may decrease her power in intimate relationships.

HIV/AIDS and Women's Power in Intimate Relationships

The first cases of HIV in South Africa were observed in the early 1980s (Jennings, Mulaudzi, Everatt, Richter, & Heywood, 2002; Outwater, Abrahams, & Campbell, 2005) and were similar to the pattern of HIV infection in the United States. Specifically, approximately 87% of reported HIV infections in the early and mid 1980s were among homosexual or bisexual men (Jennings, Mulaudzi, Everatt, Richter, & Heywood, 2002). However, the current pattern of HIV transmission is typically through heterosexual intimate contact (Ackermann & de Klerk, 2001). It is estimated that approximately 4.7 to 5.3 million people in South Africa are currently

living with HIV/AIDS (Outwater, Abrahams, & Campbell, 2005; Department of Health, 2002). This represents approximately 20% of the adult population (UNAIDS, 2000). Similar to the United States, HIV/AIDS is disproportionately impacting historically oppressed groups, with Black South African women of reproductive age being the most highly affected group (Douglas, 2000). Statistics show that the highest prevalence rates are for women between the ages of 20-30, with 32% of HIV infections occurring in women between 25-29 years of age (Nelson Mandela HSRC Report, 2002).

Research on stigma and discrimination experienced by people living with HIV/AIDS in South Africa suggests that these individuals are vulnerable to social and economic consequences (Jewkes, Levin, & Penn-Kekana, 2003; Lawson, 1999). Individuals living with HIV may be rejected or shunned by family members, dispossessed from their homes, forced to use only certain utensils, or rejected by friends (Carr & Gramling, 2004; Southern African Regional Poverty Network, 2002). Furthermore, many employers view individuals with HIV as a poor investment (UNAIDS, 2000). As such, many individuals may lose their jobs and become unemployable due to their HIV status (UNAIDS, 2000). In addition to rejection experienced from the external community, many people living with HIV isolate themselves due to the fear of experiencing discrimination or out of concern for their families (Strebel, 1996). As a result, some people living with HIV choose to not access the community resources available to them or refuse to apply to jobs as a way to protect their family and friends from being stigmatized (Carr & Gramling, 2004).

Within the South African context, women, relative to men, are at particular risk for experiencing stigma and discrimination as a result of being infected (Jennings, Mulaudzi, Everatt, Richter, & Heywood, 2002). Because HIV testing is frequently done during antenatal

screening and, thus serves as the first time a family member is diagnosed, women are commonly blamed for bringing the virus into the home (Ackermann & de Klerk, 2002; LeClerc-Madlala, 2001). Blaming women for their HIV infection, and the overall stigma and discrimination associated with HIV, may result in a variety of external negative consequences, all of which can serve to decrease women's power in relationships. Specifically, infected women may have difficulty maintaining or attaining employment, experience violence from their partner, and/or become isolated from friends, family, or their communities.

As a result of an HIV diagnosis, many women also experience internal negative consequences. Specifically, women may undergo a shift in their sense of self, including decreased self-esteem (Carr & Gramling, 2004). Individuals with HIV may view themselves as having less value than people without the virus. Their poor self-image makes HIV-infected women vulnerable to a variety of forms of maltreatments (Lewis, 2003) and may result in some tolerating powerlessness in their relationships rather than discontinue those relationships (Gilks, Floyd, Haran, Kemp, Squire, & Wilkinson, 1999). In addition to the influence of HIV on self-image, a woman living with HIV may choose to tolerate less power in intimate relationships because of limited alternative forms of social support. In summary, the discrimination people with HIV experience from employers, friends, and family, as well as their own changing self-perceptions may result in women staying in unhealthy relationships. Further, and in accordance with the Theory of Gender and Power, Black South African women are viewed as being vulnerable as result of the division of labor and relationship power, as well as due to culturally sanctioned gender role beliefs that benefit men. Specifically, although women have less control over sexual decision-making (e.g. condom use), they are frequently blamed for bringing HIV into the home, which, in turn, reduces their social support network and ability to generate

income. Because of the already tenuous economic and social position of women in South African society, being HIV positive leaves many women in a particularly precarious position (Fox, 2003; Teljeur, 2002). As such, the current study aims to explore the relationship between HIV infection and perceived relationship power.

Stressful Life Events and Women's Power in Intimate Relationships

With the high prevalence of violence and crime in South Africa, and particularly within Black South African communities, researchers are becoming increasingly interested in exploring the impact of negative life events on the well-being of Black South Africans (Spangenberg & Pieterse, 1995). Many Black South Africans have been plagued by multiple stressful life events as a result of high crime rates, unemployment, and political unrest (Gilbert, 1996; Spangenberg & Pieterse, 1995). The current study examines the potential relationship between stressful life events and women's power in intimate relationship.

There are several ways of conceptualizing stressful life events. Most generally, stressful life events have been defined as circumstances that are capable of eliciting a stress response from an individual. Categories have included victimization experiences (e.g. rape, assault), undesirable life changes (i.e. death of loved one, job loss), recurring life events (i.e. daily hassles, conflicts, or annoyances), and continuous life events (i.e. poverty, pollution, discrimination, chronic illness, marital problems, and financial problems) (Jenkins, 2002; Kendler, Hettema, Butera, Gardner, & Prescott, 2003; Spangenberg & Pieterse, 1995). The current study will focus on the impact of victimization experiences and undesirable life changes on women's perceptions of relationship power. These two categories were chosen because they seemed most likely to impact women's relationship power due to both the unpredictability of the events and their practical (i.e. economical) and psychological implications. With respect to victimization

experiences, there is empirical support for the negative relationship between victimization experiences and power in intimate relationships (Jewkes, Levin, & Penn-Kekana, 2002; Wingood & DiClemente, 1996). Less research has examined the relationship between undesirable life changes (e.g. divorce, car accident) and women's power in intimate relationships. However, given women's economic vulnerability in South Africa, any incident that renders women more financially dependent on a romantic partner would likely result in them feeling less powerful in that relationship.

Over the past several years, South Africa has been recognized as a country in which crime has become a major concern (Gilbert, 1996). Reports indicate that 16% of deaths are associated with trauma in South Africa, as compared to the global figure of 5.2% (Strydom, 1993). Indeed, current statistics indicate that crime and violence have become commonplace in the lives of many South Africans (Dinan, McCall, & Gibson, 2004). Over the past 10 years carjacking, assault, rape, and murder have all become more prevalent in South African society than they were previously (Gilbert, 1996).

In addition to crimes that affect all South Africans, the incidence of violence against women is also on the rise, with South Africa now having the highest prevalence rates of rape per capita (United Nations Office on Drugs and Crime, 2003). In a study conducted with 864 youth younger than 20 years old, Swart-Kruger and Richter (1997) found that 28% of the females in their sample had been forced to engage in sexual intercourse. Further, several studies have queried men about the incidences of forced sexual intercourse. One large-scale survey of 37,000 South African men found that one in four had perpetrated forced sexual relations by age 18. The same survey revealed that eight out of ten of those men felt that the women were responsible for

sexual violence, and two in ten thought that the women enjoyed being raped (Outwater, Campbell, & Abrahams, 2005).

In addition to sexual violence, Black South African women report high rates of witnessing and experiencing other types of traumatic experiences as compared to women from less economically disadvantaged groups. Dinan and colleagues (2004) conducted a study with 90 Black and colored South African women seeking help for dealing with violent events. All of the women were from a community in Cape Town with high levels of reported community and domestic violence. Of the women participating in the study, 59 (66%) reported witnessing or experiencing at least one traumatic event in the past year, with the mean number of events experienced being 26. It is important to note that this number includes outliers. The median number of traumatic events in this sample was nine, which may more accurately reflect the experiences of the women. Of the experiences being reported by the women in the Dinan et al. (2004) study, 50% reported witnessing a murder or a serious injury, 19% reported being attacked or threatened with a weapon, and 16% reported being beaten.

In addition to crime outside of the home, Black South African women are also vulnerable to violence within families or relationships (Wood & Jewkes, 1997). Research suggests that physical violence and sexual coercion are a part of many romantic relationships from as early as the teenage years (Jewkes, Levin, & Penn-Kekana, 2002). In fact, domestic violence has almost become a normalized and expected part of women's lives (Jewkes, Levin, & Penn-Kekana, 2002; Varga, 2003; Woods & Jewkes, 2001) and this society appears fairly tolerant of gender-based violence (Jewkes, Levin, & Penn-Kekana, 2002). Police are reluctant to pursue domestic violence cases (Jewkes & Abrahams, 2002); older members of society view some forms of gender-based violence as characteristic of normal boys' dating behaviors (Wood & Jewkes,

2001); and women are often reluctant to leave violent partners (Jewkes, Levin, & Penn-Kekana, 2002). Forms of intimate partner violence fall on a continuum from "slapping, sexual coercion, threatening to beat, hitting with sticks or other objects, pushing, assaulting with fists, violent rape, stabbing with a knife, or shooting (Woods & Jewkes, 2001);" and statistics suggest that as many as five women are killed per week as a result of domestic violence in South Africa (Gilbert, 1996). In a study of 1366 women attending antenatal clinics in Soweto, Dunkle and colleagues (2004) found that a full 55% (n=756) reported a history of physical or sexual assault from a romantic partner.

Stressful life experiences such as physical abuse and sexual coercion can impact individuals in a variety of ways (Fox, 2003). Related to the current study, research with African American women who have had traumatic experiences in childhood suggests that one psychological impact of victimization is feeling powerless (Jewkes, Levin, & Penn-Kekana, 2002) and becoming vulnerable to future sexually exploitive relationships (Beadnell, Baker, Morrison, & Knox, 2000; Rhodes, Ebert, & Myers, 1993; West, 2002). For example, Wingood and DiClemente (1996) found that women with a history of childhood sexual abuse were more likely to have been battered in the previous three months than women without a history of childhood sexual abuse. Additionally, sexually abused women in this sample were more likely to have partners who reportedly became abusive when asked to use condoms. Other potential consequences of early victimization include increased self-blame and decreased self-efficacy (Diehl & Prout, 2002) or fear of continual victimization (Fox, 2003).

Experiences of victimization are common in the lives of many women (Ackermann & de Klerk, 2002; UNAIDS, UNFPA, & UNIFEM, 2004); however, there is little research exploring the impact of traumatic events on women's perceptions of power in their intimate relationships

and no empirical research on this topic with South African women. As such, the current study aims to explore the potential link between victimization experiences and women's perceived power in romantic relationships.

Even less research has been conducted to examine the potential relationship between undesirable life changes (e.g. job loss, car accident) and women's power in intimate relationships. The current literature review revealed no studies that directly examined the relationship between undesirable life changes and power. However, there is a vast body of literature that has established a relationship between undesirable life changes (e.g. housing and interpersonal problems, financial strain, and loss) and psychological sequelae (e.g. depression and anxiety) in diverse samples of women (Franko et al., 2004; Kendler, Hettema, Butera, Gardner, & Prescott, 2003; Kendler, Karkowski, & Prescott, 1999; Kubany et al., 2000). Further, there is also evidence to suggest a relationship between undesirable life changes and perceived power specific to condom negotiation (Wyatt & Dunn, 1991). Although the current study is not specifically focused on condom negotiation, there is a well-established link between women's perceived power in intimate relationships and their ability to negotiate condom use with a romantic partner (e.g. Albarracín, Kumkale, & Johnson, 2004; Cabral et al., 2004; and Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002). As such, it is possible that undesirable life changes may influence women's perceptions of power in their relationships in areas other than condom negotiation (i.e. decision-making dominance and control). The current study aims to expand the literature by investigating the relationship between women's experiences of undesirable life changes and their perception of power within their intimate relationships.

The Theory of Gender and Power postulates that gender-based power imbalances partially result from social norms that place men in a position of power. Of particular relevance

to the South African context and to the current study, is the fact that gender-based violence, especially within the context of a sexual relationship, is often accepted. Given the unpredictable nature of violence, and the broad range of physical and psychological sequelae as a result of experiencing or witnessing stressful life events, the current study explored the relationship between stressful life events and intimate relationship power.

Community Involvement and Perceived Power

There is no question that many Black South African women face a variety of challenges associated with under- or lack of employment, limited educational opportunities, and the challenges associated with serving the dual roles of provider and primary caregiver. Moreover, some are further compromised by a positive HIV serostatus and/or experiences of trauma or undesirable life changes. As such, the second aim of the current study was to investigate whether community involvement moderates the relationship between HIV and power, as well as stressful life events and power. Although there is limited research exploring predictors of power, a few studies have found that community involvement increases one's sense of empowerment (Becker, Israel, Schulz, Parker, & Klem, 2002; Itzhaky & York, 2000; Peterson & Hughey, 2004). These studies, however, have employed broader definitions of power than those used for the current study. Specifically, the concept of empowerment has been described as one's sense of personal power, as well as an individuals' sense of his/her power to effect social change (Gutierrez, 1990). For example, Peterson and Hughey (2004) conducted a study exploring the relationship between community involvement and empowerment in a diverse sample of men and women from the United States. The researchers derived their definition of empowerment from Zimmerman and Zahniser (1991), who defined empowerment in terms of political efficacy and perceived leadership competence. For both men and women, Peterson and Hughey found that community

participation predicted higher scores on both components of power: political efficacy and perceived leadership.

Similar results were found in a second study that explored predictors of perceived control in a sample of urban African American women. Becker and colleagues (2002) found that participation in change-related organizations (e.g. church, neighborhood crime watch, neighborhood cleanup) was associated with higher scores on measures of individual, organizational, and community empowerment (Becker, Israel, Schulz, Parker, & Klem, 2002). One additional study found similar results in a sample of community activists in Israel (Itzhaky & York, 2000). Researchers in the latter study were interested in exploring whether gender moderated the relationship between community participation and empowerment. Empowerment in the Itzhaky and York (2000) study was conceptualized as personal and community control (e.g. the amount of control over decisions in one's own life and residents' influence on community decisions), as well as control over services (e.g. parents' control over services provided to their children). In this study women with higher empowerment scores tended to participate more in organizations and participate in organizational decision-making. Of particular interest to the current study was the finding that women experienced greater degrees of personal control when they participated in community organizations. The current study will explore the moderating role of women's community involvement for Black South African women.

One theory that has been postulated to explain the link between community participation and perceived power for women is the self-in-relation theory proposed by Miller (1986). The self-in-relation theory suggests that, "the relational self is the core of self structure in women and the basis for their growth and development" (Miller, 1986). Miller purports that women's identities are grounded in the motivation to make and enhance relationships with others. As such,

it has been hypothesized that participation in community organizations provides women with a sense of connectivity to other individuals in their community and to their community as a whole. It is possible that the relational aspect of community organizations can partially explain this hypothesized link between community participation and relationship empowerment for women.

In addition to the self-in-relation theory, other researchers have suggested that community involvement provides all women with a sense of control over their lives and a feeling that they can improve their life circumstances (Becker, Israel, Schulz, Parker, & Klem, 2002). Further, involvement in the community may provide women with additional social support and knowledge about available community resources. These benefits of community involvement may be particularly important for women who are HIV-infected or who have a history of negative life events. Specifically, women who are HIV-infected may experience rejection from family members and long-time friends, may feel stigmatized or be mistreated by healthcare providers, and may experience a shift in their self-image. As such, involvement in community organizations may provide those women with much-needed social support opportunities, as well as a sense of mastery over their lives. Similarly, women with a history of negative life events may also gain a sense of control over their lives through involvement with community organizations, which they might otherwise not experience given the unpredictable nature of crime. Further, women who have a history of negative life experiences may benefit from access to other women who can empathize with their experiences (Lincoln, Chatters, & Taylor, 2003).

Specifically, the current study explored three distinct aspects of community involvement: knowledge, frequency of use, and perceived helpfulness. Though limited in number, all of the previous studies in this area have focused on women’s participation in community resources. In addition to exploring the potential impact of participation (i.e. frequency of use), the current

study was interested in exploring other factors related to community involvement that could potentially influence women's sense of intimate relationship power. In particular, the current team explored the possibility that one's knowledge of available community-based resources was enough to enhance women's intimate relationship power. Perhaps one's awareness of resources, that is knowing services are available to meet their individual and family needs, is enough to positively impact relationship power. The third aspect of community involvement explored in the current study was the perceived helpfulness of the available community resources. As mentioned above, community involvement may help women feel a sense of mastery over their lives and their circumstances (Becker, Israel, Schulz, Parker, & Klem, 2002). It is possible that knowledge and use of resources alone may not be sufficient to increase women's experiences of relationship power, but that perceived power is only enhanced if women's experiences of the organizations were positive. As such, the current research team felt it was important to explore perceived helpfulness to address the possibility that women experience this sense of mastery only when they perceive the available community resources to be helpful in meeting their individual and familial needs.

Summary and Hypotheses

The first aim of the current study was to explore the impact of women's HIV status and negative life events (i.e. trauma history and undesirable life changes) on their perceived power in romantic relationships. Although there is a vast body of literature that describes the components of and emphasizes the importance of power, there is a paucity of literature that empirically identifies predictors of power. Identifying factors that are associated with Black South African women's sense of power may prove useful when developing interventions designed for women, particularly those focused on HIV prevention. For the purpose of this study, power was defined

as an individual's decision-making dominance, one's ability to engage in behaviors against a partner's wishes, and one's ability to control a partner's actions.

Empowerment research conducted with African American women in the United States and Black women in South Africa has identified economic and educational equality as important components of women's sense of empowerment (Charmes & Wieringa, 2003; Pulerwitz, Gortmaker, & DeJong, 2000). Black women in South Africa have traditionally been undereducated, which has limited their access to higher paying employment opportunities. The economic hardship that many women face keeps them reliant on male partners to fulfill their immediate needs for food and shelter, which in turn places women in a vulnerable position in their intimate relationships. Thus, it appears that the link between women's perception of power in relationships and their employment and education status has been well established. Given that, the current project focused on less studied predictors of power, namely women's HIV status and women's histories of negative life events. Specifically, the current study statistically controlled for the effects of women's education and employment on perceived power and instead explored what HIV status and women's histories of negative life events contribute to power after accounting for education and employment.

Research conducted in South Africa has detailed the impact of HIV on the lives of individuals infected with the virus. Individual's with HIV are frequently discriminated against by employers and rejected by friends and family. In addition to the economic and social consequences experienced by people living with HIV/AIDS in South Africa, individuals infected with HIV may also experience shifts in their self-esteem and self-concept that also place them at risk for having less power in romantic relationships (Carr & Gramling, 2004). Thus, I

hypothesized that women who are HIV infected reported feeling less powerful in intimate relationships than non-infected women.

The second factor predicted to influence a woman's sense of power is her experience of negative life events (i.e. traumatic events & undesirable life changes). Unfortunately, the lives of many South African women have been plagued by the occurrence of negative life events as a result of high crime rates, cultural norms, unemployment, and political unrest (Spangenberg & Pieterse, 1995). Although there is a paucity of research exploring the impact of traumatic events on the lives of Black South African women, research conducted with African American women who reported having childhood experiences of trauma suggests that the psychological impact of victimization can result in women experiencing increased self-blame (Diehl & Prout, 2002) and feeling powerless (Jewkes, Levin, & Penn-Kekana, 2002). As such, the current study aimed to add to the literature by exploring the impact of traumatic experiences and undesirable life events on women's perceptions of power in their intimate relationships. It was anticipated that women with more experience of negative life events will perceive less power in their relationships.

The final aim of this research was to examine whether community involvement serves a protective role with respect to women's sense of empowerment. A few studies have found that community participation increases one's sense of empowerment (Becker, Israel, Schulz, Park, & Klem, 2002; Hughes & Peterson, 2004; Itzhaky & York, 2000). These studies, however, have employed broader definitions of empowerment that include not only personal empowerment, but one's perception of his/her empowerment to enact social change. Despite the absence of research that directly links community involvement to perceived power in intimate relationships, it did not seem unreasonable to hypothesize that women who are HIV infected or have a history of negative life events feel more powerful if they are involved in their communities.

In sum, we hypothesized that women who were non-HIV infected would perceive themselves to have more power in their intimate relationships. We also hypothesized that women who have experienced fewer negative life events in their history would have greater power. Finally, we examined the moderating role of community involvement (i.e. knowledge of resources, frequency of use, and helpfulness) in the associations between negative life events and HIV with power. Specifically, while we expect that community involvement will be protective for all women, it will be most protective for women with HIV and/or histories of negative life events.

CHAPTER 2

Methods

Participants

Participants were recruited from Hammanskraal, Mamelodi and the area surrounding Kalafong Hospital, which are three urban or rural communities on the outskirts of Pretoria, South Africa. All participants were part of a larger study focused on the impact of women's HIV infection on psychosocial functioning of mothers and children. Interviews were conducted with 104 mothers who self-identified as HIV infected and 152 mothers who self-identified as HIV negative. Eligibility criteria for the participants were as follows: women must have at least one biological child between the ages of 11 and 16, and the child must have lived with the mother for at least the past year.

Participants were primarily recruited by a staff member of the Center for the Study of Aids (CSA), a community-based volunteer, and by the director of research at Kalafong Hospital, all of whom served as community liaisons for this project. The community liaisons recruited potential participants from areas around the communities where women often spend their time (e.g. markets), as well as community organizations, non-governmental organizations (NGOs), clinics, and hospitals in the three sites. Several advertisement strategies were used including word-of-mouth, distributing flyers to the local organizations, and presenting the project to community leaders.

Measures

Prior to the start of participant recruitment, several steps were taken to assure the cultural relevance of the measures in the current study. First, the U.S. based research team met with the

investigators from the University of Pretoria and colleagues from the Center for the Study of Aids (CSA) to conduct an item-by-item review of all of the measures initially identified to assess the study constructs. Second, the research team conducted three focus groups, with a total of 19 participants. The focus groups were conducted to assure the relevance of several study constructs (e.g. use of community resources) and to address issues with study procedures (i.e. recruitment and compensation). The final step included piloting the existing measures with women who were demographically similar to the target population. As a result of both of these processes, several of the measures were modified to improve their comprehensibility and appropriateness for the study.

Once finalized, all measures and measurement tools were translated from English into Afrikaans and Northern Sotho thereby allowing participants to be interviewed in their preferred language. Although South Africa has 11 official languages, Northern Sotho, English, and Afrikaans are the most commonly spoken South African languages in the target communities. Measure translation into Afrikaans was completed by a member of the research team whose primary language is Afrikaans. Measure translation into Sotho was conducted by a translation service. Once measures were translated into the target languages (Afrikaans and Sotho), they were back-translated to assure their equivalence. The process of back-translation included translating the measures from the source language (English) to the target language (Sotho, Afrikaans) and then translating from the target language (Sotho, Afrikaans) back to the source language (English). The two English versions were then compared for equivalency.

Demographic Variables

Demographic information was gathered using the Household Economic and Social Status Index (HESSI; Barbarin & Khomo, 1997). The HESSI is a self-report measure designed for use

with South African families. This measure provided age and health status information about the mother and family. Information regarding the women's socioeconomic status (SES) (e.g. income, housing quality), educational level, and employment status was also obtained. Items pertaining to a woman's employment status (e.g. Who in the family earns money and what is their job?) were used as proxies for SES.

HIV Status

Participants' HIV status was obtained through women's self-report on a single item (What major health problems do you have? For example cancer, asthma, diabetes, HIV, hypertension, TB). Although the limitations of relying on self-report were understood by the current research team (e.g. misreporting HIV status due to lack of knowledge or fear of disclosure), it was beyond the financial and practical scope of this study to test each participant. However, it was the expectation of the current research team that disclosure of HIV status would be facilitated by placing the item toward the end of the interview, subsequent to the establishment of good rapport. Further, the current research team's experience during the focus groups and piloting provided some preliminary evidence that HIV-infected women were willing to disclose their seropositive status to the investigators.

Adult Life Stressor Checklist

Women's experiences of stressful life events were assessed using a modified version of the Life Stressor Checklist (LSC; Wolfe & Kimerling, 1997). The LSC was modified for the current study by eliminating one of the original 22 items and adding two additional questions that were more relevant to the experiences of South African women (i.e. "You were forced to live with in laws and they treated you badly;" "Someone made you/ forced you to have sex by threatening or bribing you"), resulting in a 23-item measure. The original questionnaire consisted

of 22 items that screened for the occurrence and the impact of stressful events that are experienced primarily by women. The scale consists of items that represent undesirable life changes (e.g. “Your parents separated or divorced while you lived with them;” “You were separated or divorced”), and items that represent severe trauma (e.g. “You’ve been mugged, robbed, or attacked by someone you did not know;” “Someone physically forced you to have sex but you did not want to”).

Each item represents a single event. For the purpose of the current study, the occurrence of an event was coded 0 if the event had not occurred and 1 if the event had occurred. If a participant endorsed an event, they were then asked how much the event upset them. Response options were on a 4-point Likert-type scale and ranged from (1) Not at all to (4) Very. The current study will use the occurrence score to examine the potential association between stressful life events and relationship power. Scores on the occurrence scale ranged from 0-23, with higher scores representing the occurrence of a greater number of stressful events. The original measure has been used with low income, HIV-infected African American women.

Community Based Organizations Questionnaire

Participants’ level of involvement in community-based resources was assessed using a measure created by the current research team through consultation, focus groups, and piloting. The scale consists of six categories of community-based resources (Government, Religious, Clinics/NGOs, Mental Health Facilities, Social Services/Activities, and Other) that reflect the existing resources that may be available to the target communities. Three subscales were developed to assess participants’ community involvement (knowledge, frequency of use, and perceived helpfulness). To assess knowledge of community-based resources, participants generated a list of resources for each category of community-based resources. The Knowledge

subscale was created by summing the list of distinct resources each participant generated across all six categories of community-based resources. With respect to the Frequency of Use, response options were on a 4-point Likert-type scale with options ranging from (1) Never to (4) About once a week. Total scores were dependent on the number of community resources each participant generated, with higher scores representing more frequent use of community-based resources. Responses on the Perceived Helpfulness subscale were also on a Likert-type scale, with options ranging from (1) Not at All to (4) Very. Higher scores represented more perceived helpfulness and total scores were dependent on the number of resources generated. Mean scores were calculated for both the Frequency of Use and Perceived Helpfulness subscales.

Sexual Relationship Power Scale

Relationship power was assessed using 22 of the 23 items on the Sexual Relationship Power Scale (SRPS; Pulerwitz, Gortmaker, & DeJong, 2000). One of the 23 items was eliminated because it was determined to be less relevant to Black South African women. Several items on the SRPS were revised to facilitate translation and maximize participants' comprehension of the items. The SPRS contains two subscales that measure Relationship Control (e.g. If I asked my husband/boyfriend to use a condom he would hurt me) and Decision-Making Dominance (e.g. Who usually decides when you have sex). Response options on the Relationship Control subscale are provided on a Likert-type scale and range from (1) Never to (4) Always. Total scores on the Relationship Control subscale can range from 15-60 with lower scores representing higher levels of perceived relationship control. With respect to the Decision-Making Dominance subscale, participants' responses to these items about who makes decisions in various aspects of the couples' lives were as follows: (1) Your husband/boyfriend, (2) Both of you together, and (3) You. Three different 2-point (0 or 1) scales were created (i.e. Male

Dominated, Female Dominated, and Mutual Decision Making). Possible total scores on each scale ranged from 0-7, with higher scores representing higher levels of decision-making dominance. Specifically, higher scores on the Male Dominated scale indicated that men made most of the decisions, and higher scores on the Female Dominated scale indicated that women made more of the decisions.

The original 23-item scale was designed and validated with a sample consisting of African American and Latina women. The internal validity of the measure within that sample was good (coefficient alpha= .84). A subset of questions from the SRPS has also been used in a sample of South African women aged 15-24. Internal reliability within the South African sample was adequate (Cronbach's alpha= .69; Pettifor, Measham, Rees, & Padian, 2004). Cronbach's alpha for the current sample was also adequate (alpha= .70).

Procedure

Data collection occurred over the course of three months. When a woman expressed interest in the project to an outreach worker, she completed a brief screening for eligibility. If the woman was eligible for the study, she was scheduled for an appointment. The interviews were conducted at the HIV clinic located in Kalafong Hospital and the Hammanskraal and Mamelodi campuses of the University of Pretoria.

When a woman arrived for her appointment, she was greeted by an interviewer who reviewed the screening form to assure eligibility. If a woman was not eligible for the study upon review of the screening form, she was given a snack bag and a small gift (lotion) for her time. If a woman was eligible for the study, she was given the same snack bag and gift and was asked what language she preferred to complete the interview in. An interviewer then explained the project to the woman in her preferred language. If the woman expressed interest in continuing

with the project, the consenting process began. During the consenting process, which also occurred in the women's preferred language, women were informed of the study design. Specifically, women were informed that they would be asked to answer questions about several topics related to parenting (e.g. relationship with the target child), as well as other questions (e.g. women's health, access to community resources). Women were also informed of the confidentiality policy, including an explicit description of the limits of confidentiality (e.g. disclosure of child abuse). Prior to asking the participants to provide their signatures on the consent form, the participants were given an opportunity to express any concerns or ask any questions they had about the study.

All questionnaires were verbally administered to participants in a one-on-one format in the participants' preferred language. Response cards with pictorial representations of response options were provided in all three languages (English, Afrikaans, Sotho) to facilitate the recall of the response options. To protect against order effects, the sequence of the individual measures were randomized. First, the individual measures were conceptually grouped (i.e. all demographic questionnaires were administered sequentially). Second, the conceptually grouped measures were randomized so that no single group of questionnaires was always administered at the end of the interview. Finally, the measure containing the item that asks a woman to disclose her HIV status was placed at the end of the interview. This was done to maximize the likelihood that a woman would disclose a seropositive status to the interviewer. The duration of each interview did not exceed 1½ hours and women were assured that they could stop the interview and take breaks as needed.

If a mother became distressed during the course of the interview, the interviewers spent additional time debriefing her at that moment. When needed, the interviewer provided the

participant with relevant community referrals. At the end of the interview, all participants received a list of community agencies and R70 ($10) for their time and participation.

The current research team consisted of graduate students in the clinical psychology program from Georgia State University and the University of Pretoria, one undergraduate student from the University of Pretoria, and one staff member from the Center for the Study of Aids. The interviewers were trained by conducting mock interviews with each other in order to standardize the administration of the questionnaires. Three of the interviewers were fluent in Afrikaans and two of the interviewers were Black South African women who were fluent in Northern Sotho. All interviewers were fluent in English.

CHAPTER 3

Results

Preliminary Analyses

Chi-square analyses for categorical variables and t-tests for continuous variables were conducted to examine the similarity of the HIV-infected and non-infected women on demographic characteristics. In summary, HIV-infected and non-infected women did not differ with respect to women's age, education, or relationship type (e.g. boyfriend or married). The most relevant descriptive statistics are presented in Table 1.

Table 1. Demographic Characteristics of Participants by HIV Status

	HIV- Infected		Non- HIV Infected	
Caregiver Variables	Mean	SD	Mean	SD
	n= 104		n= 144	
Education[1]	3.17	1.05	3.33	1.10
SES[2]	.24	.43	.26	.44
Relationship Type				
Married	n=31		n= 57	
Boyfriend	n=71		n= 84	

[1]Education was derived from women's report of the highest level of education completed
[2]SES was derived from women's report of current employment status

Additionally, means and standard deviations were calculated for all demographic, predictor variables, and dependent variables in Table 2. Of note, the knowledge of community resources and the perceived helpfulness variables were transformed as a result of non-normality.

Correlations between demographic variables, predictor variables, and outcome variables were conducted, and can be found in Table 3a-3d.

Table 2. Means (M), Standard Deviations (SD) for Demographic, Independent, and Dependent Variables

	Mean	**SD**
Outcome Variables		
Relationship Control	24.4	7.9
He Dominates	2.54	1.99
She Dominates	1.58	1.38
Mutual Decision Making	2.87	2.08
Predictor Variables		
Education[1]	3.26	1.08
SES[2]	.250	.434
HIV Status	HIV-Infected (n= 104)	
Trauma	.93	1.16
Undesirable Life Changes	3.17	1.93
Community-Level Moderators		
Knowledge	6.48	3.66
Frequency	3.17	.679
Helpfulness	3.54	.531

[1]Education was derived from women's report of the highest level of education completed
[2]SES was derived from women's report of current employment status

Table 3a. Bivariate Correlations for Demographic Variables, Independent, and Dependent Variables (Relationship Control)

	Relationship Control	SES	Education	Participant HIV	Trauma	Undesirable Life Changes	Knowledge of Resources	Frequency of Use	Perceived Helpfulness
Relationship Control	1	-.119*	-.168*	.145*	.065	.211*	-.046	.070	-.037
SES	-.119*	1	.119*	-.019	.106*	.070	.184*	.005	-.012
Education	-.168*	.119*	1	-.071	.030	-.009	.362*	-.040	-.019
Participant HIV	.145*	-.019	-.071	1	.183*	.120*	-.049	.128*	-.014
Trauma	.065	.106*	.030	.183*	1	.289*	.193*	.126*	-.108*
Undesirable Life Changes	.211*	.070	-.009	.120*	.289*	1	.080	.143*	-.096
Knowledge of Resources	-.046	.184*	.362*	-.049	.193*	.080	1	.009	.043
Frequency of Use	.070	.005	-.040	.128*	.126*	.143*	.009	1	-.004
Perceived Helpfulness	-.037	-.012	-.019	-.014	-.108*	-.096	.043	-.004	1

*. Correlation is significant at the 0.05 level.

**. Correlation is significant at the 0.01 level.

Table 3b. Bivariate Correlations for Demographic Variables, Independent, and Dependent Variables (He Dominates) con't

	He Dominates	SES	Education	Participant HIV	Trauma	Undesirable Life Changes	Knowledge of Resources	Frequency of Use	Perceived Helpfulness
He Dominates	1	-.091	-.249*	.110	-.062	-.001	-.211*	.092	.017
SES	-.091	1	.119	-.019	.106	.070	.184*	.005	-.012
Education	-.249*	.119	1	-.071	.030	-.009	.362*	-.040	-.019
Participant HIV	.110	-.019	-.071	1	.183*	.120	-.049	.128*	-.014
Trauma	-.062	.106	.030	.183*	1	.289*	.193*	.126*	-.108
Undesirable Life Change	-.001	.070	-.009	.120	.289*	1	.080	.143*	-.096
Knowledge of Resources	-.211*	.184*	.362*	-.049	.193*	.080	1	.009	.043
Frequency of Use	.092	.005	-.040	.128*	.126*	.143*	.009	1	-.004
Perceived Helpfulness	.017	-.012	-.019	-.014	-.108	-.096	.043	-.004	1

**. Correlation is significant at the 0.01 level.

*. Correlation is significant at the 0.05 level.

Table 3c. Bivariate Correlations for Demographic Variables, Independent, and Dependent Variables (She Dominates) con't

	She Dominates	SES	Education	Participant HIV	Trauma	Undesirable Life Changes	Knowledge of Resources	Frequency of Use	Perceived Helpfulness
She Dominates	1	.020	-.090	.045	.010	.046	-.044	-.115*	-.040
SES	.020	1	.119*	-.019	.106*	.070	.184*	.005	-.012
Education	-.090	.119*	1	-.071	.030	-.009	.362*	-.040	-.019
Participant HIV	.045	-.019	-.071	1	.183*	.120*	-.049	.128*	-.014
Trauma	.010	.106*	.030	.183*	1	.289*	.193*	.126*	-.108*
Undesirable Life Change	.046	.070	-.009	.120*	.289*	1	.080	.143*	-.096
Knowledge of Resources	-.044	.184*	.362*	-.049	.193*	.080	1	.009	.043
Frequency of Use	-.115*	.005	-.040	.128*	.126*	.143*	.009	1	-.004
Perceived Helpfulness	-.040	-.012	-.019	-.014	-.108*	-.096	.043	-.004	1

*. Correlation is significant at the 0.05 level.

**. Correlation is significant at the 0.01 level.

Table 3d. Bivariate Correlations for Demographic Variables, Independent, and Dependent Variables (Mutual) con't

	Mutual	SES	Education	Participant HIV	Trauma	Undesirable Life Changes	Knowledge of Resources	Frequency of Use	Perceived Helpfulness
Mutual	1	.073	.296*	-.134*	.046	-.031	.232*	-.008	.018
SES	.073	1	.119	-.019	.106	.070	.184*	.005	-.012
Education	.296*	.119	1	-.071	.030	-.009	.362*	-.040	-.019
Participant HIV	-.134*	-.019	-.071	1	.183*	.120	-.049	.128*	-.014
Trauma	.046	.106	.030	.183*	1	.289*	.193*	.126*	-.108
Undesirable Life Changes	-.031	.070	-.009	.120	.289*	1	.080	.143*	-.096
Knowledge of Resources	.232*	.184*	.362*	-.049	.193*	.080	1	.009	.043
Frequency of Use	-.008	.005	-.040	.128*	.126*	.143*	.009	1	-.004
Perceived Helpfulness	.018	-.012	-.019	-.014	-.108	-.096	.043	-.004	1

**. Correlation is significant at the 0.01 level.

*. Correlation is significant at the 0.05 level.

Data Analysis Plan

To explore predictors of power, the current study utilized a moderation design. Specifically, the control variables were women's education and employment status. As previously noted, the link between women's perception of power in relationships and their employment and education status has been well established. As such, the current project took these variables into account while focusing on less studied predictors of power. The independent variables were women's HIV status and history of negative life events (i.e. trauma, undesirable life changes). The moderators for the current study were frequency of use, helpfulness, and knowledge of community resources. Each of the community-level moderators was added in the third step and was regressed on the dependent variable in separate analyses. The outcome variables were relationship control and decision-making dominance (i.e. he dominates decision making, she dominates decision making, and mutual decision making). Hierarchical multiple regression analysis was used to explore the relationship between the independent and dependent variables. Prior to data analysis, variables were checked for normality and centered. Independent variables were entered in 4 blocks. The first block consisted of control variables (women's education and employment status). Women's histories of negative life events (i.e. trauma and undesirable life changes) and women's HIV status were added in the second block. Community-level resources (i.e. helpfulness, knowledge, frequency of use) were added in the third block. The final block consisted of the interaction terms. Results of the regression analyses can be found in Table 4.

Table 4. Summary of Regression Analyses for All Outcome Variables

	Relationship Control			***He Dominates***			***She Dominates***			***Mutual***		
Variable	***B***	***SE B***	***B***	***B***	***SE B***	***β***	***B***	***SE B***	***β***	***B***	***SE B***	***β***
Education	-1.17	.46	-.156**	-.160	.117	-.236**	-107	.084	-.083	.544	.120	.280**
SES	-1.92	1.13	-.107	-.300	.287	-.065	.086	.205	.027	.210	.295	.044
HIV Status	1.57	.995	.100	.424	.257	.105	.115	.184	.041	-.530	.263	-.126*
Trauma	.018	.44	.003	-.127	.113	-.074	.018	-.081	-.015	.131	.116	.074
Life Changes	.772	.261	.191**	-.006	.067	-.006	.048	.043	.066	-.035	.069	-.032
Knowledge	.126	.788	.011	-.351	.202	-.120*	-.078	.092	-.069	.433	.206	.143*
Frequency	.276	.720	-.029	.024	.185	.081	-.270	.132	-.133*	-.003	.190	.015
Helpfulness	.850	2.38	.022	-.120	.615	-.012	.285	.440	.042	-.230	.630	.715
[1]HIVxHelpfulness				-2.59	1.55	-.169*						
[2]Knowledge R^2 F	.069 3.02**			.064 2.85**			-.018 .506			.093 3.79**		
[2]Frequency R^2 F	.071 3.08**			. .052 2.40**			.003 1.09			. .074 3.18**		
[2]Helpfulness R^2 F	.070 3.06**			.069 3.01**			-.004 .895			.073 3.15**		

[1]Only significant interactions were included in table; [2]Signifies the final adjusted R^2 for each of the moderator variables; * denotes p<.05; ** denotes p< .01

Outcome Variable: Perceived Relationship Control

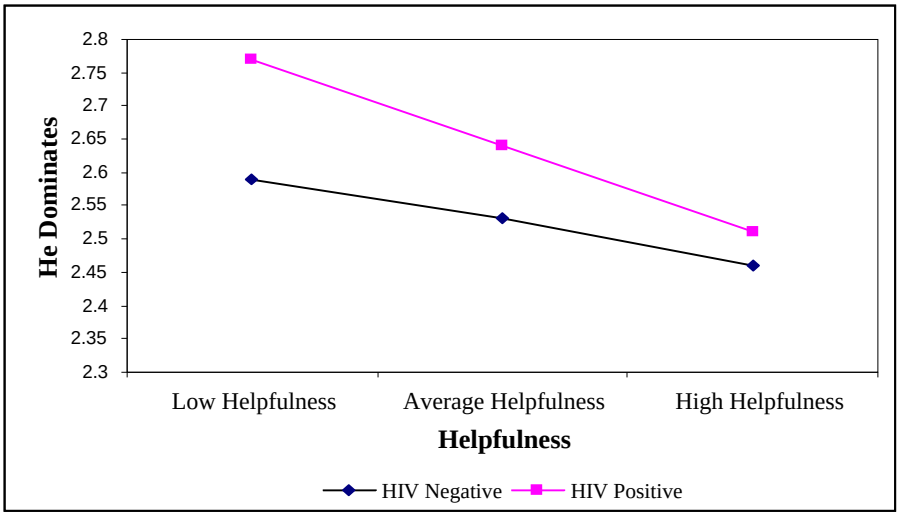
Women's level of education accounted for 3% of the variance in relationship control, with higher levels of completed education associated with women perceiving that they have more relationship control. The addition of women's HIV status, trauma, and undesirable life changes in step two resulted in the model accounting for an additional 4% [F(5, 240)= 4.87, p<.001] of the variance in perceived relationship control. Only women's experience of undesirable life changes was significantly associated with relationship control, indicating that the experience of undesirable life changes was detrimental to women's perceived relationship control. With respect to the third step, the addition of the community-level moderating variables did not significantly add to the model. Additionally, there were no significant interaction effects with relationship control as the dependent variable.

Outcome: Perceived Male Decision Making Dominance

Women's level of education accounted for approximately 6% of the variance [F(2, 243)= 8.3, p< .001] in women's perception that their male partners dominated decision making in their relationships, with women who have achieved higher levels of education perceiving their male partners as less dominant in decision making. The addition of HIV, trauma, and undesirable life changes in the second step did not contribute significantly to the model. The community-level moderators were added in the third step and only knowledge of community resources emerged as contributing significantly to the model. Specifically, knowledge of community resources was inversely related to women's perception of their male partners dominating decision making. The frequency with which women used community resources did not contribute significantly to the model, nor did a main effect emerged for women's perception of the helpfulness of community

resources. However, the addition of the interaction terms in the fourth block yielded a significant interaction between HIV status and women's perception of the helpfulness of community resources. See Figure 1. As predicted, perceived helpfulness of community resources mitigated the impact of HIV infection on perceived male dominance in decision making. When both groups of women perceived resources to be highly helpful, they perceived less male dominated decision making. However, particularly for HIV-infected women, as the perception of helpfulness decreased, male dominated decision-making increased. With helpfulness as the community-level moderator, the full model accounted for 7% of the variance [$F(9, 236)= 3.01$, $p< .01$].

Figure 1. Interaction between HIV Status and Perceived Helpfulness of Community Resources on Perception of Male Dominated Relationships



Outcome Variable: Perceived Female Decision Making Dominance

When women's perception of themselves as the dominant decision maker served as the dependent variable, only the frequency of use variable, added in the third step, was significant and only .3% of the variance in the dependent variable was explained. Specifically, women who

reported more frequent use of community resources viewed themselves as less dominant in relationship decision making. HIV, trauma, undesirable life changes, knowledge, and perceived helpfulness were not significantly associated with women perceiving themselves to be dominant decision makers in their intimate relationships.

Outcome Variable: Mutual Decision Making

With respect to the influence of demographic variables on women's perception that relationship decisions were reached mutually, only women's education was significantly associated with the dependent variable and accounted for approximately 8% of the variance [$F(2, 243)= 11.0$, $p< .001$]. Specifically, women who have achieved higher levels of education reported that relationship decisions were more likely to be reached mutually. With the addition of trauma, undesirable life changes, and HIV infection in the second block, only participants' HIV infection emerged as being significantly associated with mutual decision making. Specifically, non-HIV infected women reported that decisions were more likely to be reached mutually. Knowledge, frequency of use, and helpfulness of community resources were added in the third block in three separate regressions. Only knowledge of community resources was significantly associated with mutual decision making, indicating that women with more knowledge of community resources were more likely to view the decision making in their relationship as mutual. When the community-level moderator was knowledge, the full model accounted for approximately 10% of the variance in mutual decision making [$F(6, 239)= 5.3$, $p< .001$]. No interaction terms were significant for this dependent variable.

CHAPTER 4

Discussion

As a result of a confluence of social, political, and cultural factors, Black women in South Africa are an economically and socially vulnerable group. Previous research has found that Black South African women continue to be marginalized across educational, financial, and social domains. Further, societal gender role expectations place women in positions of lesser power in their intimate relationships. Given the potential health and safety consequences of women's lesser status, the current study aimed to identify potential predictors of intimate relationship power for Black South African women. Although best viewed as a preliminary exploration of the link between interpersonal and community-level variables, by conducting this study we have begun to fill a gap in existing research. Specifically, we have gained knowledge of the variables that contribute to women's sense of empowerment in their romantic relationships. Increasing our knowledge of this area is important not only within the South African context, but more broadly considering women's vulnerable status worldwide. Although the current research study focused solely on the experiences of Black South African women, their experiences reflect those of many women in the larger global community. Throughout the world, women are consistently undereducated, underemployed, and disproportionately impacted by violence and HIV/AIDS. As such, additional research in this area could contribute to research and interventions across several domains (e.g. intimate partner violence, HIV/AIDS).

For the purpose of the current study, intimate relationship power was defined as relationship control and decision-making dominance. Relationship control was conceptualized as the amount of control one individual in the relationship has over the other (e.g. my boyfriend

decides what I can wear). Decision-making dominance refers specifically to the partner who controls the majority of the couples' decisions (e.g. the partner who decides how the couple spends their money).

With respect to women's perceived relationship control, the hypotheses were only minimally supported. As expected, less formal education and the experience of undesirable life changes were found to be negatively associated with women's perceived relationship control. HIV, trauma, and the community-level variables did not significantly contribute to women's perceptions of control in their relationships. Though there was more support in the extant literature for associations between HIV and relationship power (Gilks, Floyd, Haran, Kemp, Squire, & Wilkinson, 1999), as well as trauma and relationship power (Jewkes, Levin, & Penn-Kekana, 2002), only undesirable life changes emerged as important. Undesirable life changes included events such as job loss, death of a loved one, and physical illness. These types of events might be particularly likely to result in chronic strain on psychological and tangible resources in a way that the occurrence of an acute traumatic event, for example, would not. Perhaps this chronic strain particularly diminishes a woman's ability to assert control in many areas of her life, including in her relationships.

In terms of understanding who women perceived as the decision makers in their romantic relationships, we considered the outcome in three ways: male dominated decision-making, female dominated decision-making, and mutual decision-making. With respect to perceived male decision-making dominance, women who had more formal education and who were knowledgeable of resources available in their communities were less likely to report that their male romantic partners dominated the decision making in their relationships. Further, as predicted, perceived helpfulness moderated the relationship between HIV infection and male

dominance. Specifically, HIV-infected women who viewed their community resources as helpful were less likely to report that their male partners dominated decision-making than HIV-infected women who did not perceive their resources as helpful. This finding speaks to the importance of ensuring that community-based resources are not just present, but also helpful to those seeking services; particularly women infected with HIV. Though not explored here, helpfulness might include characteristics such as service quality, accessibility, and relevance to the families in the community.

When dominance in decision-making was scored to reflect the level of female dominance, women who reported more frequent use of community resources viewed themselves as having less decision-making power in their relationships. One possible explanation for this unexpected finding is that heavy reliance on community-based resources might be indicative of families experiencing high levels of stress and/or who have fewer individual or family-based coping resources at their disposal. A second, and related, explanation might be that frequent use of certain resources (e.g. police station, trauma center) might also be reflective of the number and frequency of stressors families' experience. In fact, there is a positive correlation between use of resources and both trauma and undesirable life changes. Finally, a third potential explanation for this unexpected finding is that when women accessed the community organizations they were treated poorly or received inadequate service. As such this finding might reflect the disempowering nature of some of the community based organizations.

Finally, with respect to mutual decision-making, perhaps the ideal approach to decision-making in intimate relationships, women's level of education, HIV status, and knowledge of community resources were significantly and positively associated with mutual decision making. Specifically, these findings, which are consistent with the hypotheses, suggest that education,

HIV seronegativity, and knowledge of available community resources contribute to women feeling that they have decision-making capital. These findings also serve to reinforce the importance of formal education, HIV/AIDS prevention programs, and access to information about resources for Black South African women. Focusing specifically on education, it is possible that women who have more years of formal education are better able, internally and in their relationships, to combat misogynistic traditional beliefs about men's superior intelligence and, in turn, feel more empowered. As anticipated, HIV infection appears to interfere with mutuality in decision making, which is likely explained, at least in part, by the stigma associated with this disease. The fact that women are typically diagnosed before their partners, and thus perceived to have brought the illness into the family, may impede equitably shared decision making. Finally, the positive association between knowledge of community resources and mutual decision making might suggest that just making women aware of the available community-based resources enhances their decision-making power.

As previously mentioned, the Theory of Gender and Power suggests that limited opportunities, financial dependence, and traditional gender roles contribute to women feeling vulnerable in intimate relationships. Consistent with this theory, women with more years of education and women who were more knowledgeable about and pleased with the resources in their community, perceived themselves to have significantly more relationship power. It is possible that the educational opportunities and connections with community resources provide women with an external source of validation, which in turn empowers them in their relationships.

Interestingly, trauma did not impact perceived relationship power. One possible explanation is that the effects of trauma were minimized due to the frequency with which women in South Africa experience, or are exposed to, traumatizing events. Alternatively, it is possible

that the measure used to assess trauma was not optimal for addressing these research questions. Specifically, the current research team did not assess the date, frequency, or duration of the traumatic experiences. With respect to the recency of the traumatic experience, it is possible that women who have more recently experienced a trauma may be more vulnerable (i.e. have fewer coping emotional resources) and, as such, less likely to assert themselves in their relationships. Perhaps even recent traumas (i.e. rape) have been perpetrated by the woman's current partner in his attempt to assert power. Further, it is possible that women who have experienced frequent and/or repeated traumatic experiences might have more psychological and emotional sequelae than women who have experienced fewer and/or acute traumatic experiences. Women in this study only reported whether a traumatic event had ever occurred. As such, future research might consider exploring these additional variables and their potential impact on perceived relationship power. With respect to the minimal findings when relationship control served as the outcome variable and the relatively small percentage of the variance accounted for with all study outcomes, several factors are likely influential. First, women who were currently in relationships, as well as those not currently in relationships, were included in this study. Moreover, women who were married and those in non-marital partnerships were included. Perhaps considering each of these two groups of women individually would have yielded different results. In fact, with respect to marital status, anecdotal reports about romantic relationships in the South African context suggest that women who are married have less power in their relationships than unmarried women.

A further limitation of the current study is the cross-sectional design, which prohibits us from making any causal or directional statements. In addition to design-related constraints, there were a number of measurement challenges. There are few measures designed to assess the

challenges faced by Black South African women. As a result, it is possible that the measures used in this study did not adequately tap the constructs of interest for the current study. Specifically, the community-based organization availability measure was created for this study and has not been standardized. Additionally, several of the measures were modified to fit the South African context (e.g. Adult Life Stressor Scale), which may have altered the validity or reliability of the measures. Given the design and measurement limitations, the current study is best viewed a preliminary exploration of the predictors of intimate relationship power for Black South African women.

Implications

As the rates of domestic violence, poverty, and HIV/AIDS continue to climb among women in sub-Saharan Africa, it is clear that there is a need for research exploring factors that promote women feeling empowered in their intimate relationships. Given the general absence of research exploring predictors of power, future research should consider developing measures designed for this specific purpose. Additionally, the finding that women perceived less male dominated decision-making when they viewed their community resources to be highly helpful is exciting. As such, future research should explore aspects of community resources that women find helpful and put them into practice.

References

Abdi, A.A. (2001). Integrated education and black development in post-apartheid South Africa: Critical analysis. *Compare: A Journal of Comparative Education,* 31(2), 229-244.

Abdi, A.A. (2003). Apartheid and education in South Africa: Select historical analysis. *The Western Journal of Black Studies,* 27(2), 89-97.

Abrahams, N. (1996). Negotiating power, identity, family, and community: Women's community participation. *Gender and Society,* 10(6), 768-796.

Ackermann, L. & de Klerk, G.W. (2002). Social factors that make South African women vulnerable to HIV infection. *Health Care for Women International,* 23, 163-172.

Albarracín, D., Kumkale, G.T., & Johnson, B.T. (2004). Influences of social power and normative support on condom use decisions: A research synthesis. *AIDS Care,* 16(6), 700-723.

Albertyn, C. (2003). Contesting democracy: HIV/AIDS and the achievement of gender equality in South Africa, *Feminist Studies,* 29(3), 595-615.

Beadnell, B., Baker, S.A., Morrison, D.M., & Knox, K. (2000). HIV/STD risk factors for women with violent male partners. *Sex Roles,* 42, 661-689.

Becker, A.B., Israel, B.A., Schulz, A.J., Parker, E.A., & Klem, L. (2002). Predictors of perceived control among African American women in Detroit: Exploring empowerment as a multilevel construct. *Health Education and Behavior,* 29(6), 699-715.

Cabral, R.J., Galavotti, C., Stark, M., Gargiullo, P.M., Semaan, S., Adams, J., & Green, B.M. (2004). Psychosocial factors associated with stage of change for contraceptive use among

women at increased risk for HIV and STDs. *Journal of Applied Social Psychology*, 34 (5), 959-983.

Campbell, C. and Mzaidume, Z. (2001). Grassroots participation, peer education, and HIV prevention by sex workers in South Africa, *American Journal of Public Health*, 91(12), 1978-1986.

Carr, R.L. & Gramling, L.F. (2004). Stigma: A health barrier for women with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care*, 15(5), 30-39.

Charmes, J. & Wieringa, S. (2003). Measuring women's empowerment: An assessment of the gender-related development index and the gender empowerment measure. *Journal of Human Development*, 4(3), 419-435.

Connell, R. (1987). *Gender and Power*, Stanford, CA: Stanford University Press.

Department of Health (2001). Twelfth national HIV and syphilis sero-prevalence survey of women attending public antenatal clinics in South Africa. Pretoria: Department of Health.

Department of Health (2003). National HIV and syphilis antenatal sero-prevalence survey in South Africa 2002: Pretoria: Department of Health.

Diehl, A.S. & Prout, M.F. (2002). Effects of posttraumatic stress disorder and child sexual abuse on self-efficacy development. *American Journal of Orthopsychiatry*, 72(2), 262-265.

Dinan, B.A., McCall, G.J., 7 Gibson, D. (2004). Community violence and PTSD in selected South African townships. *Journal of Interpersonal Violence*, 19(6), 727-742.

Dolcini, M.M. & Catania, J.A. (2000). Psychosocial profiles of women with risky sexual partners: The National AIDS Behavioral Surveys (NABS). *AIDS and Behavior*, 4(3), 297-308.

Douglas, A. (2000). The South African AIDS epidemic: four organizations respond. Retrieved April 20th, 2003 from http://www.publicwelfare.org.publications/publications/southafricanaidsoverview asp.

Dunkle, K.L, Jewkes, R.K., Brown, H.C., Gray, G.E., McHIntyre, J.A., & Harlow, S.D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*, 363, 1415-1421.

Dunkle, K.L, Jewkes, R.K., Brown, H.C., McHIntyre, J.A., Gray, G.E., & Harlow, S.D. (2003). Gender-based violence and HIV infection among pregnant women in Soweto. A Technical Report to the Australian Agency for International Development, 2-57.

Emerson, R.M. (1981). Social exchange theory. In Rosenberg, M. & Turner, R.H. (Eds), *Social Psychology: Sociological Perspectives* (pp.30-65). New York: Basic Books.

Fox, S. (2003). Organisational responses to gender-based violence and HIV/AIDS in South Africa. Johannesburg, South Africa: Center for AIDS Development, Research, and Evaluation (CADRE) for the Department of Health, South Africa.

Franko, D.L., Striegel-Moore, R.H., Brown, K.M., Barton, B.A., McMahon, R.P., Schreiber, G.B., Crawford, P.B., Daniels, S.R. (2004). Expanding our understanding of the relationship between negative life events and depressive symptoms in Black and White adolescent girls. *Psychological Medicine*, 34, 1319-1330.

Gilbert, L. (1996). Urban violence and health- South Africa 1995. *Social Science Medicine*, 43, 873-886.

Gilks, C., Floyd, K., Haran, D., Kemp, J., Squire, B., & Wilkinson, D. (1999). Sexual health and health care: Care and support for people with HIV/AIDS in resource poor settings. Department for International Development.

Greig, F. & Koopman, C. (2003). Multilevel analysis of women's empowerment and HIV prevention: Quantitative survey results from a preliminary study in Botswana. *AIDS Behavior,* 7, 195-208.

Gupta, G.R. (2000, November). Gender, sexuality, and HIV/AIDS: The what, the why, and the how. *Women's Health Project Newsletter,* 36, 18-21.

Gutiérrez, L.M. (1990). Working with women of color: An empowerment perspective. *Social Work,* 19, 149-153.

Hankins, C. (1996). Recognizing and countering the psychosocial and economic impact of HIV on women in developing countries. In Catalan, J., Sherr, L., & Hedge, B. (Eds), *The Impact of AIDS and Social Aspects of HIV Infection* (pp. 127-135). United Kingdom: Harwood Academic Publishers.

Harvey, S.M. & Bird, S.T. (2004). What makes women feel powerful? An exploratory study of relationship power and sexual decision-making with African Americans at risk for HIV/STDs. *Women and Health,* 39 (3), 1-19.

Hoosen, S. & Collins, A. (2004). Sex, sexuality and sickness: Discourses of gender and HIV/AIDS among KwaZulu-Natal women. *South African Journal of Psychology,* 34(3), 487-505.

Itzhaky, H. & York, A.S. (2000). Empowerment and community participation: Does gender make a difference? *Social Work Research,* 24(4), 225-234.

Jenkins, E.J. (2002). Black women and community violence: Trauma, grief, and coping. *Women & Therapy,* 25, 29-44.

Jennings, R., Mulaudzi, J., Everatt, D., Richter, M., & Heywood, M. (2002). Discrimination and HIV/AIDS. Department of Health, South Africa.

Jewkes, R. & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science and Medicine,* 55(7), 1231-1244.

Jewkes, R., Levin, J., & Penn-Kekana, L. (2002). Risk factors for domestic violence: Findings from a South African cross-sectional study. *Social Sciences and Medicine,* 55, 1603-1617.

Jobson, M. (2003). The intersections of gender, HIV/AIDS and human rights. In D. Wyckoff Wheeler (Ed.) *Intersections and Constructions of Gender and HIV/AIDS* (pp.4-14). Pretoria: Center for Gender Studies.

Kendler, K.S., Hettema, J.M., Butera, F., Gardner, C.O., & Prescott, C.A. (2003). Life events dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety. *Archives of General Psychiatry, 60,* 789-796.

Kendler, K.S., Karkowski, L.M., & Prescott, C.A. (1999). Causal relationships between stressful life events and the onset of major depression. *American Journal of Psychiatry*, 146, 837-848.

Kimerling, R., Calhoun, K.S., Forehand, R., Armistead, L., Morse, E., Morse, P., Clark, R., & Clark, L. (1999). Traumatic stress in HIV-infected women. *AIDS Education and Prevention,* 11, 321-330.

Kubany, E.S., Haynes, S.N., Leisen, M.B., Owens, J.A., Kaplan, A.S., Watson, S.B., Burns, K. (2000). Development and preliminary validation of a brief broad spectrum measure of trauma exposure: The traumatic life events questionnaire. *Psychological Assessment,* 12, 210-224.

Lawson, A.L-G. (1999). Women and AIDS in Africa: Sociocultural dimensions of the HIV/AIDS epidemic. *International Social Science Journal,* 51 (161), 391-400.

LeClerc-Madlala, S. (2001). Demonizing women in the era of AIDS: On the relationship between cultural constructions of both HIV/AIDS and femininity. *Society in Transition,* 32(1), 38-46.

Lewis, M. (2003). Gendering AIDS: Women, men, empowerment, mobilization. VSO: South Africa.

Lincoln, K.D., Chatters, L.M., & Taylor, R.J. (2003). Psychological distress among Black and White Americans: Differential effects of social support, negative interaction and personal control. *Journal of Health and Social Behavior,* 44(3), 390-411.

Lyons, M., Smuts, C., & Stephens, A. (2001). Participation, empowerment and sustainability: (How) do the links work? *Urban Research,* 38(8), 1233-1251.

Mabokela, R.O. and Mawila, K.F.N. (2004). The impact of race, gender, and culture in South African higher education, *Comparative Education Review,* 48 (4), 396-416.

Manuh, T (1998). Women in Africa's development: Overcoming obstacles, pushing for progress, *Africa Recovery,* 11, 1-14.

Miller, J.B. (1986). *Toward a new psychology of women.* Boston: Beacon Press.

Motsemme, N. (2002). Gendered experiences of blackness in post-apartheid South Africa, *Social Identities,* 8(4) 647-673.

Murray, G. (1997). Opportunity-to-learn issues common to South Africa and the United States. *The Journal of Negro Education,* 66(4), 376-383.

Nelson Mandela/HRSC Study of HIV/AIDS (2002). South African national prevalence, behavioral risks and mass media household survey. Cape Town: HSRC Press.

Oberhauser, A.M. and Pratt, A. (2004). Women's collective economic strategies and political transformation in rural South Africa, *Gender, Place and Culture,* 11(2), 209-228.

Outwater, A., Abrahams, N., & Campbell, J.C. (2005). Women in South Africa intentional violence and HIV/AIDS: Intersections and prevention. *Journal of Black Studies*, 35(4), 135-154.

Peterson, N.A. & Hughey, J. (2004). Social cohesion and intrapersonal empowerment: gender as moderator. *Health Education Research*, 19(5), 533-542.

Pettifor, A.E., Measham, D.M., Rees, H.V., & Padian, N.S. (2004). Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases*, 10(11), 1996-2004.

Pulerwitz, J., Amaro, H., De Jong, W., Gortmaker, S.L., & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS Care*, 14, 789-800.

Pulerwitz, J., Gortmaker, S.L., and DeJong, W. (2000). Measuring sexual relationship power in HIV/STD research, *Sex Roles*, 42, 637-660.

Raphael, K.G., Cloitre, M., & Dohrenwend, B.P. (1991). Problems of recall and misclassification with checklist methods of measuring stressful life events. *Health Psychology*, 10, 62-74.

Rhodes, J.E., Ebert, L., & Myers, A.B. (1993). Sexual victimization in young, pregnant, and parenting African-American women: Psychological and social outcome. *Violence and Victims*, 8, 153-163.

Sen, A. (2001). Many faces of gender inequality, *Frontline*, 18 (22), 1-10.

Shefer, T., Strebel, A., & Foster, D. (2000). So women have to submit to that… Discourses of power and violence in students' talk on heterosexual negotiation. *South African Journal of Psychology*, 30(2), 11-20.

Southern African Regional Poverty Network (SARPN) (2002). FAO/SARPN workshop on HIV/AIDS and land. Retrieved April 20th, 2003 from http://www.sarpn.org.za/Activities/june2002/hiv/index.php.

Spangenberg, J.J. & Pieterse, C. (1995). Stressful life events and psychological status of Black South African women. *Journal of Social Psychology,* 135, 439-446.

Strebel, A. (1996). Prevention implications of AIDS discourses among South African women. *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education,* 8(4), 352-374.

Strydom, M. (1993). Trauma is a killer. *Trauma Review, 1,* 5.

Teljeur, E. (2002). Response of non-governmental organizations, community-based organizations, and communities. In K. Kelly, W. Parker, & S. Gelb (Eds.) HIV/AIDS, economics and governance in South Africa: Key issues in understanding response. \ Johannesburg, South Africa: Center for AIDS Development, Research, and Evaluation (CADRE) for the Department of Health, South Africa.

UNAIDS (1999). Gender and HIV/AIDS: Taking stock of research on gender and HIV/AIDS. Geneva, Switzerland.

UNAIDS (2000). A human rights approach to AIDS prevention at work: The South African development community's code on HIV/AIDS and employment. Geneva, Switzerland.

UNAIDS (2004). Africa's AIDS Challenge: Accelerating action against AIDS in Africa. Geneva, Switzerland.

UNAIDS, UNFPA, UNIFEM (2004). Women and HIV/AIDS: Confronting the crisis. Geneva, Switzerland and New York, NY.

Varga, C.A. (2003). How gender roles influence sexual and reproductive health among South African adolescents. *Studies in Family Planning,* 34(3), 160-172.

West, C.M. (2002). Battered, black, and blue: An overview of violence in the lives of Black women. *Women and Therapy,* 25, 5-27.

Wingood, G.M. & DiClemente, R.J. (1996). HIV sexual risk reduction interventions for women: A review. *American Journal of Preventive Medicine,* 12(3), 209-217.

Wood, K. & Jewkes, R. (1997). Violence, rape, and sexual coercion: Everyday love in a South African township. *Gender and Development,* 5, 41-46.

Wood, K. & Jewkes, R. (2001). Dangerous love: Reflections on violence among Xhosa township youth. In R. Morrell (Ed.). *Changing Men in South Africa.* University of Natal Press: Pietermaritzburg and Zed Books Ltd: London.

Wood, K., Maforah, F., & Jewkes, R. (1998). He forced me to love him: Putting violence on the adolescent sexual health agenda. *Social Science and Medicine,* 47, 233-242.

Wyatt, G.E., Axelrod, J., Chin, D., Carmona, J.V., & Loeb, T.B. (2000). Examining patterns of vulnerability to domestic violence among African American women. *Violence Against Women,* 6, 495-514.

Wyatt, G.E. & Dunn, K.M. (1991). Examining predictors of sex guilt in multiethnic samples of women. *Archives of Sexual Behavior,* 20, 471-485.

Zierler, S. & Krieger, N. (1997). Reframing women's risk: Social inequalities and HIV infection. *Annual Review of Public Health,* 18, 401-436.

Zimmerman, M.A. & Zanhiser, J.H. (1991). Refinements of sphere-specific measures of perceived control: Development of a sociopolitical scale. *Journal of Community Psychology,* 19, 189-204.