AFRICAN AMERICAN WOMEN'S FEARS, KNOWLEDGE, AND BEHAVIORS ABOUT HIV/AIDS

by

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DEDICATION

This dissertation is dedicated to my mother, Johnnie Mae Washington (February, 15, 1934-June 29, 1995), the greatest mother that will forever live in our hearts; we miss you so much. During this journey of completing my dissertation, I often remembered and reflected on this poem you gave me:

Don't Quit Poem
by anonymous

When things go wrong, as they sometimes will,
When the road you're trudging seems all up hill,
When the funds are low and the debts are high,
And you want to smile, but you have to sigh,
When care is pressing you down a bit,
Rest! if you must; but don't you quit.

Life is queer with its twists and turns,
As everyone of us sometimes learns,
And many a failure turns about
When he might have won had he stuck it out;
Don't give up, though the pace seems slow;
You might succeed with another blow.

Often the goal is nearer than
It seems to a faint and faltering man,
Often the struggler has given up
When he might have captured the victor's cup.
And he learned too late, when the night slipped down,
How close he was to the golden crown.

Success is failure turned inside out;
The silver tint of the clouds of doubt;
And you never can tell how close you are,
It may be near when it seems afar;
So stick to the fight when you're hardest hit;
It's when things seem worst that you mustn't quit.

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and neck rubs after the many hours I labored at the computer. I love you dearly. Thank you to the following organizations: Red Ribbon Charitable Foundation and Josh Menge and Community Information Network.

Rejoice in the Lord always. I will say it again: Rejoice!
5Let your gentleness be evident to all. The Lord is near.
6Do not be anxious about anything, but in everything, by prayer and petition
With thanksgiving, present your requests to God.
7And the peace of God, which transcends all understanding
Will guard your hearts and your minds in Christ Jesus.
8Finally, brothers, whatever is true, whatever is noble
Whatever is right, whatever is pure, whatever is lovely, and whatever is admirable
If anything is excellent or praiseworthy think about such things.
9Whatever you have learned or received or heard from me
Or seen in me put it into practice.
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ABSTRACT

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The purpose of this study was to explore the knowledge, beliefs, and fears of African American women about contracting HIV/AIDS with the aim of identifying any common themes of these variables. I used these findings to create recommendations for education and prevention strategies that are crucial for HIV/AIDS risk-reduction behaviors among African American women and teenage girls. Ten African American women participated in the case study.

To provide a focus for the study that would achieve the stated research goals, 5 research questions which aligned with a modified AIDS/HIV Questionnaire and AIDS/HIV Risk Assessment Interview were used. The findings from the study revealed that African American women are at the highest risk for exposure to and infection with the HIV virus. One of the main implications of these findings is that while African American women appear to be knowledgeable about HIV/AIDS to a certain degree, some continue to engage in high-risk sexual behaviors. African American women are becoming infected with the HIV virus and dying of AIDS at epidemic rates. The information from the 10 African American women participants in this study reinforces the seriousness for understanding how African American women are becoming one of the most affected

groups for contracting HIV/AIDS. Today, for many African American women, sexual encounters and relationships with men who are drug users, living in and out of prison systems or are living on the down low, continues to increase the number of Black women becoming infected.

CHAPTER I

INTRODUCTION

Globally, the number of people living with Human Immunodeficiency Virus (HIV) has risen to 42 million, up from 40 million at the end of 2001, according to an update by the Joint United Nations AIDS (UNAIDS) Programme and The World Health Organization (WHO) on the global HIV and Acquired Immunodeficiency Syndrome (AIDS) epidemic (UNAIDS, 2002). In 2002, five million people were newly infected and 3.1 million people died of the disease (UNAIDS). The Centers for Disease Control and Prevention (CDC) and its Global AIDS Program (GAP), reported more than 16 million people have died of AIDS, and more than 16,000 people become newly infected each day (CDC, 2004b). The epidemic continues to spread with ferocious speed in many parts of the world. We are only beginning to feel the true impact it will have on our people, communities, and nations. The HIV/AIDS epidemic has become one of the most important public health problems of the decade. The response to this epidemic is ravaging scarce resources and placing huge demands on already frail infrastructures, making it difficult for governments to deal with the problem alone (CDC, 2004b). According to UNAIDS, of the estimated 40 million adults and children who were living with HIV/AIDS at the end of 2003, 95% lived in developing countries and more than 90% were estimated to live in a country served by CDC’S GAP (CDC, 2004b).

The HIV/AIDS pandemic is entering its third decade and is challenging the foundations of the public health infrastructure and healthcare delivery systems in the

United States and throughout the world. According to the CDC (2002a), more than 40 million people have been infected with HIV worldwide since the onset of the pandemic (CDC, 2002A). Another report produced by the UNAIDS (2002) shows that approximately 50% of adults living with HIV/AIDS worldwide are women. Through 1999 women accounted for 21% of adult cases in Florida and 16% in northwest Florida (Escambia County Health Department, 2003). Florida currently ranks second in the United States (after New York) in the number of adult and adolescent females diagnosed with AIDS. Heterosexual contact currently accounts for 40% of United States AIDS cases in women (44% in Florida, 62% in northwest Florida) compared to 4% of cases in males (Escambia County Health Department).

The State of Florida HIV/AIDS Comprehensive Prevention Plan (2004) for the local area where the study takes place reports that 1 in 168 Floridians have HIV. The breakdowns of racial groups are as follows: 1 in 346 White residents, 1 in 46 Black residents, and 1 in 176 Hispanic residents have been diagnosed with HIV. An estimated 100,000 Floridians are living with HIV. Also, Florida ranks third in adult HIV cases (10.7% of United States total), second in pediatric AIDS cases (16.5% of United States total), and second in AIDS cases among women (14% of United States total). AIDS is currently the leading cause of death among African American men ages 25 to 44 years in the United States and the fourth leading cause of death among all Floridians ages 25-44 years (State of Florida HIV/AIDS Comprehensive Prevention Plan, 2004). United States HIV/AIDS cases are growing fastest among youth, minorities, women, and young men who have sex with men and heterosexuals. More than 70% of global HIV infections are attributed to heterosexual contact. Women represent almost one in three new HIV infections in the United States. The proportion of AIDS cases among women in the

United States increased from 7% in 1986 to 26% in 2001. By 2010, an estimated 25 million children globally will lose one or both parents to AIDS. An estimated 7,000 persons die daily of complications from AIDS in Africa.

Nationwide, African Americans make up roughly 12% of the United States population. However, according to the CDC (2007a) although blacks (including African Americans) make up less than 13% of the U.S. population, they accounted for 49% of new HIV/AIDS diagnoses in 2005. In 2005, blacks accounted for 18,510 (49%) of the estimated 38,096 new HIV/AIDS diagnoses in the United States (CDC, 2007a). The rate at which American women are developing AIDS has more than tripled since 1985, with African American women representing 64% of newly diagnosed HIV infections among women in the United States (Zook, 2003). Poverty, poor educational standards, and lack of access to health care are noted as some of the primary causes.

The 1999 CDC report outlines disproportionate infection rates among African Americans in the United States:

1. According to estimates, approximately half of all new infections occur among African Americans.
2. Approximately 1 in 50 African American men and 1 in 60 African American women are believed to be infected with HIV. By comparison, 1 in 250 White men and 1in 3,000 White women are believed to be infected.
3. Estimates of infection trends in the early 1990s indicate that half of all young adults (ages 18-22) infected during these years were African Americans.
4. A 1998 CDC study of entrants to the United States Job Corps found that young African American women were seven times more likely than their

> White counterparts and eight times more likely than Hispanics to be HIV infected.

In summary, the HIV/AIDS epidemic, although first recognized in significant ways approximately 20 years ago in the United States, has had a profound impact in many countries, states, cities, and communities. Millions of people globally and in the United States live with at-risk behaviors for contracting HIV through unsafe sex and drug use. More efforts must be established through methods such as testing, counseling, and intervention programs to reach all individuals living with and without HIV infection, including people who are infected with HIV but who have not been medically tested. HIV prevention programs and AIDS programs that have been historically based on behavioral risk factors and demographic characteristics such as race, ethnicity, gender, and age must be tailored to meet the needs of all people. Traditional HIV prevention efforts that have been found to change behaviors and decrease risk among high-risk HIV-negative individuals are essential to HIV prevention programs. Breaking the grip that HIV/AIDS has in the United States and across the world will require additional approaches not just for certain populations or ethnic groups or for those who can afford the medications, but for everyone.

Statement of the Research Problem

Current statistics show that African American women make up more than half of the number of cases of women with AIDS. Unfortunately, continuous progress for prevention, education, and treatment of HIV/AIDS for African American women has not progressed as much as it has for Caucasian and Hispanic women. According to Logan and Freeman (2000), many African American women still lack adequate knowledge regarding HIV/AIDS and equal access to treatment and research. It does not come as a surprise in the consistent reports and research which appears to indicate HIV/AIDS has been the leading cause of death in African American women between the ages of 25 and 40. Nor is it a surprise that health organizations have said that HIV risk-reduction interventions are desperately needed to reduce the risk for HIV/AIDS among African American women.

Knox and Sparks (1998) stated that there has been a dramatic shift in the United States regional patterns of AIDS cases. The South has had significant increases in reported cases among homosexual/bisexual men, women, and heterosexuals. Rural areas across the United States are no longer exempt from the presence of HIV/AIDS in their communities. Zook (2003) reported that in communities with fewer than 50,000 residents, the nation's highest incidence of HIV infection was found in Florida, the Carolinas, and Mississippi. In the South, the majority of women and adolescent girls with AIDS were exposed through heterosexual contact. Approximately 4 to 5 times more cases of HIV/AIDS were found in the South as compared to the Midwest and the West (CDC, 2001b). HIV/AIDS cases have also changed in the South by becoming increasingly associated with African Americans, rural citizens, heterosexuals, and females. According to The Henry J. Kaiser Family Foundation (2004), African Americans and Latinos account for significantly higher rates of reported new AIDS cases than Caucasians, with rates of 76.8 cases per 100,000 people for African Americans, 31.4 cases for Latinos, and 8.1 cases for Caucasians.

Zook's 2003 *Special Report* on *Saving a Southern Town in the grip of AIDS* explains that substance abuse and women sexually involved with men who have sex with men are also reasons for the spread of this epidemic. In their video *No More Secrets, No*

More Lies, (King, Brown, Grossman, Richardson, and Hatch, 2002), HIV/STD prevention activists, discuss the down-low syndrome. King explains the down-low syndrome as mainly pertaining to African American men who have sex with other men and do not identify themselves as bisexual or homosexual. These men keep their sexual activities a secret from their female sexual partners. King, who is bisexual, looks at the high-risk sexual behaviors of African American men who live double lives. He notes that this lifestyle is the number one reason that African American women are being infected with the HIV virus (King et al.). African American heterosexual women are at a very high risk for becoming infected from African American men who have had sex with men. The CDC Divisions of HIV/AIDS Prevention Report regarding HIV/AIDS among African American men indicates that African American women are most likely to be infected with HIV as a result of having sex with men who have had sex with men. The women may not be aware of the possible risks from their male partners’ past history of unprotected sex with multiple or bisexual partners, drug use, or HIV status (CDC, 2003a). Other reports suggest that the risk of African American women who are sexually active with bisexual partners is usually four times greater than it is for their White counterparts.

For many people in the criminal justice population, because illicit drug use and unsafe sexual practices are prevalent in their backgrounds, many are particularly at a high risk of being infected by HIV (Stevens, 1993). Unfortunately, a large percentage of African American men are either currently part of the judicial system or were processed through this system at one time. In a 1994 study, the United States Department of National Institute of Justice (NIJ) and the CDC (1996) conducted a national study of the Federal Bureau of Prisons system. The findings in this Morbidity and Mortality Weekly

Report underscore the need to take advantage of important missed opportunities to provide HIV/AIDS prevention programs in prisons and jails for adults and in confinement facilities for juveniles. These facilities are important settings for HIV/AIDS education and prevention efforts because of (a) high prevalence in their populations of HIV-infected persons and persons with risk factors for HIV infection, (b) demonstrated HIV transmission in these facilities through sexual activity and sharing of drug-injection equipment, (c) eventual release of almost all adult inmates and confined juveniles to the community, (d) high rates of reincarceration and reconfinement, and (e) feasibility of providing HIV/AIDS education and prevention programs in these facilities (CDC, 1996). Furthermore, various research studies over the last years suggest a relationship exists between high-risk African American males who have ties to the criminal justice system and their African American female partners testing positive for HIV.

Various present and past research studies indicates that many women and adolescent girls diagnosed with AIDS were exposed either through injection drug use or heterosexual contact with an HIV infected partner. Exposure through heterosexual contacts was a higher cause than injection drug use. Presently, the actual number of young African American women who are infected with HIV is unknown. According to the CDC (1999), in the past there was no national system in place at the CDC to track new HIV infections as AIDS cases were monitored. During the 1980s, AIDS cases alone provided an adequate picture of HIV trends because the time between infection with HIV and progression to AIDS was predictable (CDC, 2006b). However, the predictability diminished around 1996 because highly active antiretroviral therapy (HAART) became available. Access, adherence, and response to HAART affect if or when HIV progresses to AIDS. Thus, trends in AIDS cases alone no longer accurately reflect trends in HIV infection. AIDS trends do, however, continue to provide important information about where care and treatment resources are most needed (CDC, 2006b).

By April 2004, all states had adopted some system for reporting HIV diagnoses to CDC (2006b). Tracking HIV trends is challenging and depends on several factors, such as how often people are tested, when they are tested, whether and how test results are reported to health departments, and how case reports (with personal identifiers removed) are shared with the CDC (CDC, 2006b). Reports indicate African American women presently represent the largest percentage of AIDS cases in the United States. Unfortunately, an even greater possibility exists that many more women remain unaware that they are HIV positive. Yet many African American women fail to practice methods that will reduce the risk of the HIV infection, believing that contracting the HIV/AIDS virus will not happen to them. They fail to practice safe sex with their partners, believe the myths about the AIDS virus, or resist the message of HIV/AIDS prevention and education.

Significance of the Study

Zook (2003), in her special report of a small southern Florida town of 7,500 residents, reports that 130 residents are infected with the HIV virus. Of those infected residents, 117 are African Americans with the largest percentage being women. Many Black women in this Florida town still refuse to believe that HIV/AIDS can happen to them. Women of color, particularly African American women, bear a disproportional burden of HIV/AIDS in the United States. In 1998, an estimated 6,600 African American women were diagnosed with AIDS, representing 62% of all estimated AIDS cases among women in that year. Since the HIV/AIDS epidemic began in the United States, more than

64,000 African American women have been diagnosed with HIV/AIDS. It is now the second leading cause of death for African-American women between 25 and 44 years of age (CDC, 2002). HIV/AIDS is the third leading cause of death among Latina women of the same age group; it is the sixth leading cause of death for White women (CDC, 1996). The Henry J. Kaiser Family Foundation (2004) survey of African Americans on HIV/AIDS reports that younger African Americans, including children, have also been disproportionately impacted. African American teenagers and young adults (ages 13-24) account for one third (35%) of reported AIDS cases in this age group. Almost two thirds (63%) of new pediatric cases are among African Americans.

Injection drug use has been the key route of HIV transmission among African American women in the past; however, heterosexual transmission has become the leading cause. Many African American women suffer increased risk for HIV/AIDS because of disproportionate poverty, lack of access to quality health care, use of drugs, and sexual activity with HIV infected men. According to the CDC (2004b) an estimated 22 million HIV tests are performed each year. A large majority of people who are tested are at relatively low risk for HIV infection or are being retested after third seronegative results. CDC (2003b) reports indicate that African Americans are less likely to get tested for HIV. Most often, testing for HIV in African American women occurs at the time of diagnosis with AIDS. This diagnosis occurs too late for the women to gain optimum benefits from drug therapy.

With HIV being the second leading cause of death for Black women between the ages of 24 to 44, HIV risk interventions are urgently needed to reduce the risk for HIV/AIDS among African American women. It is imperative that African American women who have high HIV risk factors (e.g, who inject drugs, who have multiple sex partners, or who have sex with men who have sex with men) receive education and prevention strategies that reduce HIV transmission. Various research studies have documented the association between the injection of drugs and seroprevalence of HIV is well documented. Several controlled studies raise the hope that behavioral interventions emphasizing attitudes, knowledge, beliefs, and fears of African American women about contracting HIV/AIDS can reduce HIV sexual risk behaviors and incidence of sexually transmitted diseases (STD). However, for the most part, these studies have not focused on substance abusing African American women (Jemmott & Brown, 2003). Education and prevention strategies are crucial for the promotion of HIV/AIDS risk-reduction behaviors among African American women and teenage girls.

Purpose of the Study

The purpose of this study was to explore the knowledge, beliefs, and fears of African American women about contracting HIV/AIDS with the aim of identifying any common themes of these variables. I used these findings to create recommendations for education and prevention strategies that are crucial for HIV/AIDS risk-reduction behaviors among African American women and teenage girls. To provide a focus for the study that would achieve the stated research goals, five research questions were addressed:

1. What do African American women know about HIV/AIDS?
2. To what extent do African American women believe they engage in sexual behaviors that place them at risk of contracting HIV/AIDS?
3. Do African American women fear contracting HIV/AIDS?

4. To what extent do knowledge and fear affect African American women’s sexual behavior?
5. What themes and common threads are there in the practices and beliefs of African American women that place them at risk for HIV/AIDS?

Theoretical Framework

For this study, the health belief model (HBM) was used as a theoretical framework for framing the research design. The HBM was selected because the various behavioral components provide a mechanism for explaining why individuals fail to take necessary preventive measures in contracting HIV/AIDS despite the obvious health risks. HBM was developed during the 1950s by a group of social psychologists at the United States Public Health Service in their efforts to explain why individuals were reluctant to participate in public health programs that provided free tuberculosis (TB) health screening services (Hochbaum, 1958; Rosenstock, 1974). The model has been explored in relation to HIV/AIDS and is a model that emphasizes rational client cognition (Janz & Becker, 1984).

The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: (a) perceived susceptibility, (b) perceived severity, (c) perceived benefits, and (d) perceived barriers. These concepts were proposed as accounting for people's readiness to act. An added concept, cues to action, would activate that readiness and stimulate overt behavior. A recent addition to the HBM is the concept of self-efficacy or one's confidence in the ability to successfully perform an action. This concept was added by Rosenstock and others in 1988 to help the HBM better fit the challenges of changing habitual unhealthy behaviors (Glanz, Rimer, & Lewis, 2002). Perceived susceptibility or perception of risk acknowledges that a person’s perception of his or her risk for a health threat plays a significant role in his or her response to that risk (Sobo, 1995). For example, if a person perceives that he or she is at risk for a health problem, then more than likely that person will take more preventive measures. However, in the case of HIV/AIDS, research confirms that understanding the risks that might lead to HIV/AIDS does not automatically engender safer sex behaviors because no matter how well informed they are, people tend to underestimate their own risk for AIDS (Carovano, 1991; Hansen, Hahn, & Wolkenstein, 1990; Harrison et al., 1991). Perceived severity pertains to someone's opinion of the seriousness of a condition and its consequences and how contracting an illness or disease will impact the quality of life (Glanz et al.). This category includes risks such as death, discomfort, and pain. Perceived benefits refers to someone's belief in the efficacy of the advised action to reduce a risk, seriousness of the health risk, or the intrinsic or extrinsic rewards an individual will receive by not engaging in the risk behavior. Perceived barriers include things that interfere with someone having access to promoting healthier choices such as lack of time, money, or knowledge. Cues to action consist of strategies that serve as a catalyst to move a person into action. For example, a cue to action to guide individuals to lower their risk of contracting HIV/AIDS includes how to initiate an awareness campaign. Finally, self-efficacy, which was added to increase the explanatory power of the HBM, refers to confidence in one's ability to take action to reduce health risks (Carovano; Hansen et al.; Harrison et al.).

In this study, I considered the above defined components when framing my research questions and shaping my research design. I addressed five major research questions to learn more about the lives of African American women living in subsidized or low-income housing and their knowledge and fears of HIV/AIDS.

Definitions of Terms

Acquired Immunodeficiency Syndrome (AIDS). According to The World Book Encyclopedia (1995), final, life-threatening stage of infection with human immunodeficiency virus (HIV).

African American or Black. A person having origins in any of the black racial groups of Africa. These groups include people who indicate their race as black, African American, or Negro or provide written entries such as African American, Afro American, Kenyan, Nigerian, or Haitian (United States Census Bureau, 2000).

Centers for Disease Control and Prevention (CDC). Founded in 1946, the federal agency operating under the United States Department of Health and Human Services, Public Health Services, that is responsible for protecting the public health of the nation by instituting measures for the prevention and control of diseases, epidemics, and public health emergencies (Huber, 1993).

Down-low syndrome. Men having sex with other men but keeping the fact a secret from their female sexual partners (Zook, 2003).

Escambia County Health Department, Pensacola, Florida. Promotes healthy living by preventing the spread of disease by providing community health education and screenings, and by ensuring optimum environmental health for the residents of the county (Escambia County Health Department, 2003).

High-risk adolescents. Adolescents at high risk for HIV/AIDS including those who engage in unprotected sex, have multiple sexual partners, share needles and other injected drug equipment, or have sex with a high-risk person (Bowler, Sheon, D'Angelo, & Vermund, 1992).

High-risk African American females. Females at risk for HIV/AIDS include those who engage in injection drug use, unprotected sexual activity with infected bisexual partners or with heterosexual injection drug users, and those having a history of being sexually abused who turn to survival sex (Lynch, 2000).

*Human Immunodeficiency Virus (HIV).*The virus that causes AIDS. It is a retrovirus that infects the T4 lymphocyte cells, monocyte-macrophage cells, certain cell populations in the brain and spinal cord, and colorectal epithelial cells. HIV-infected cells weaken the immune system. Individuals infected with the HIV do not necessarily have AIDS. Previously called lymphadenopathy virus, human T-cell leukemia virus III, and human T-cell lymphotrophic virus III (Huber, 1993).

MSM. Men who have sex with men (CDC, 2003b).

Poverty. The United States Census Bureau cited in Wikipedia, has defined poverty in absolute terms as the threshold below which families or individuals are considered to be lacking the resources to meet the basic needs for healthy living; having insufficient income to provide the food, shelter and clothing needed to preserve health (as cited in Wikipedia, 2004). The definition varies by the size of the household and geographical area.

Rural areas .Those counties with a population density of fewer than 100 individuals per square mile or those counties classified as rural by the United States Census.

Sexual contact. Vaginal, oral, or anal sex.

Sexual partner. Someone a person has sex with.

Substance abuse. The *Diagnostic and Statistical Manual of Mental Disorders* Fourth Edition (American Psychiatric Association, 1994) criteria for substance abuse is as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:
    1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
    2. Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use).
    3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
    4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

World Health Organization (WHO). Founded in 1948, this international organization is the health agency of the United Nations. Its goal is to achieve the optimum level of health care for all people. Objectives of the WHO include directing and coordinating international health work, ensuring technical cooperation, promoting research, preventing and controlling disease, and generating and disseminating information. The organization (a) emphasizes and supports the health needs of developing countries; (b) establishes standards for biological, food, and pharmaceutical needs; and (c) determines environmental health criteria (Huber, 1993).

CHAPTER II

LITERATURE REVIEW

Introduction

According to Paniagua (2000), in 1981 the Centers for Disease Control (CDC) reported that the first case of Human Immunodeficiency Virus (HIV) was registered in the United States in a group of homosexual men residing in Los Angeles, California, and New York City. However, the virus that causes Acquired Immunodeficiency Syndrome (AIDS) was first identified in 1983-1984 (Gallo & Montagnier, 1988). Five years later in 1985, 11,000 cases were reported in the world that met the clinical criteria of the AIDS (Gallo & Montagnier, 1988). Six months later, at the beginning of 1986, the world total for the disease had doubled to over 22,000, with 2,500 new cases a month being diagnosed and probably at least as many again undiagnosed and unreported (Gallo & Montagnier, 1988).

The purpose of my study was to explore the knowledge, beliefs, and fears of African American women about contracting HIV/AIDS with the aim of identifying any common themes of these variables. I then used these findings to create recommendations for education and prevention strategies that are crucial for HIV/AIDS risk-reduction behaviors among African American women and teenage girls. I addressed five research questions:

1. What do African American women know about HIV/AIDS?

2. To what extent do African American women believe they engage in sexual behaviors that place them at risk of contracting HIV/AIDS?
3. Do African American women fear contracting HIV/AIDS?
4. To what extent do knowledge and fear affect African American women's sexual behavior?
5. What themes and common threads are there in the practices and beliefs of African American women that place them at risk for HIV/AIDS?

To help me frame my study, I organized the literature review into five major headings. First, I describe HIV and AIDS. Second, I summarize the current state of affairs of HIV/AIDS in our global world. Third, I reviewed the state of affairs and research of HIV/AIDS in the state of Florida. Fourth, I begin to shift the focus to how HIV/AIDS has affected women and then, specifically how HIV/AIDS affected African American women living in subsidized or low-income housing. Finally, the literature review concludes with a description of the research on the factors and influences that have facilitated the increase of HIV/AIDS among African American women.

According to Lynch (2000), HIV is a disease-causing agent or pathogen that primarily targets cells of the immune system, our bodies' natural defense against infection and disease. The immune system is the body's defense against diseases. If it is impaired, it allows otherwise controllable infections to invade the body and cause additional diseases (Mehr & Kanwischer, 2004). Over time, HIV causes the depletion of certain cells of the immune system; the infected individual loses the ability to resist certain common infectious diseases. These diseases are called opportunistic infections because they use the body's weakened defenses as an opportunity to flourish and cause disease. This diminished immune competence and these opportunistic infections together make up the basic characteristics of the disease called AIDS. According to the CDC (2003c), AIDS stands for Acquired Immunodeficiency Syndrome. *Acquired* means that the disease is not hereditary, but develops after birth from contact with a disease causing agent, in this case, the virus that causes HIV. *Immunodeficiency* means that the disease is characterized by a weakening of the immune system. *Syndrome* refers to a group of symptoms that collectively indicate or characterize a disease. In the case of AIDS, these can include the development of certain infections or cancers as well as a decrease in the number of certain cells in a person's immune system. Essentially, AIDS prevents the body's ability to fight off infection. Normally a diagnosis of AIDS is made by a physician using specific clinical or laboratory standards.

The Henry J. Kaiser Family Foundation (2004) describes the difference between HIV and AIDS as follows:

> HIV can weaken the immune system to a point where the body will develop opportunistic infections (OIs), which are illnesses that a healthy immune system would normally fight off. The United States Centers for Disease Control and Prevention (CDC) says that an HIV-infected person develops AIDS when he or she has either developed one of the many OIs that are typically seen in people with AIDS or experienced a major drop in T cells or CD4 count, which are used to measure white blood cells. Healthy people have between 500 and 1,500 CD4 cells in a milliliter of blood. When a person with HIV has fewer than 200 T cells (CD4 count), that means that he or she has progressed to AIDS. (¶ 3-4)

The progression of HIV infection in adults is classified into three categories or clinical stages according to the CDC (2006c). During the stage known as Category A, the infection may be asymptomatic or it may cause persistent swelling of the lymph nodes.

Category B is characterized by persistent infections by yeast that may appear in the mouth, throat, or vagina. Other physical symptoms include shingles, diarrhea, and fever, and certain cancerous or precancerous cervical conditions. The last stage, Category C, is the stage of clinical AIDS. The important AIDS indicators for Category C are yeast infections of the esophagus, bronchi, and lungs. Also, pneymocystis pneumonia, eye infections, tuberculosis, toxic invasion of the brain, and a rare form of cancer known as Kaposi’s sarcoma are common. An opportunistic infection ultimately results in the death of the AIDS patient (Tortora, Funke, & Case, 1998). As of 2007, there is no effective cure for AIDS. It leads to death caused by a massive infection such as pneumonia, tuberculosis, or diseases such as cancer (Mehr & Kanwischer, 2004).

Global Perspectives of HIV/AIDS

HIV can be passed on when a person has unprotected sex with a partner who has the virus. Unprotected sex means sex without a condom. The virus is most commonly passed by vaginal, anal, or oral sex. The virus is passed in blood semen (a man’s sexual fluids) and vaginal secretions (a woman’s sexual fluids). The virus can be passed through the sharing of needles and syringes or *works*. An infected person shoots up and then gives the *works* to another person to shoot up, thereby passing on the infection. Finally, infected women can pass the virus to their babies before, during, and even after birth for those women who breast feed their babies (Virginia Department of Health, 1997). No studies at this time indicate that HIV can be passed in sweat, saliva, tears, or urine. Additionally, no research indicates that one can get HIV from such actions as shaking hands, kissing, hugging, sneezing, crying, or coughing or from swimming pools, drinking glasses, silverware or dishes, toilet seats, phones, the air, massages, or masturbation.

In some parts of the world, such as Sub-Saharan Africa, Southern and Southeastern Asia, and the Caribbean, the primary mode of transmission of HIV/AIDS is heterosexual sexual contact (Mehr & Kanwischer, 2004). According to the World Health Organization report (WHO; 2003), an estimated 40 million people are living with HIV worldwide, including 2.5 million children under the age of 15. Globally, an estimated 5 million people were newly infected and about 3 million people died of AIDS in 2003. Sub-Saharan Africa, the most severely affected region of the world, accounted for over 3 million of these new infections and 2.3 million AIDS deaths. Every day in 2003, an estimated 14,000 people were newly infected with HIV. More than 95% of those live in low and middle-income countries (WHO, 2003).

According to the CDC (2005a), two datasets are used to track the HIV/AIDS epidemic in the United States: HIV surveillance and AIDS surveillance. First, monitoring trends in the HIV epidemic today requires collecting information on HIV cases that have not progressed to AIDS. Areas with confidential name-based HIV infection reporting requirements use the same uniform system for data collection on HIV cases as for AIDS cases. A total of 33 areas, the U.S. Virgin Islands and 32 states (Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming) have collected this data for at least 5 years, providing sufficient data to monitor HIV trends and to estimate risk behaviors for HIV infection (CDC, 2005a). Recently, nine additional areas have begun confidential name-based HIV surveillance, and data from these areas will be included in coming years (CDC, 2005). Second, with AIDS surveillance, AIDS diagnoses are reported to CDC by all states and territories in the United States. AIDS data can no longer be used to show trends in new HIV infections because of the lengthy interval between HIV infection and an AIDS diagnosis. AIDS data can show the continuing toll of HIV disease. These data are statistically adjusted for reporting delays and are used to look at AIDS trends in the United States (CDC, 2003a).

In the 20 years since its discovery, HIV has infected 55 million people worldwide (Stine, 2001). Although now treatable, AIDS remains a fatal disease. According to Bla Me (2000), six people are infected with HIV every minute. In 2003, an estimated five million people were newly infected with HIV and over three million died of AIDS. Developing countries are hardest hit, particularly those in Sub-Saharan Africa where AIDS has surpassed malaria as the number one killer (CDC, 2004).

The epidemic varies in scale or impact within regions. Some countries are more affected than others. Within countries, there are usually wide variations in infection levels between different provinces, states, or districts. The UNAIDS report (2004a) compares new estimates for 2003 with revised estimates for 2001 based on improved methodologies. They report that this method is the best way known to obtain a more accurate picture of the AIDS epidemic. Although the new global estimates are slightly lower than the previously published estimates, the actual number of people living with HIV has not decreased; rather, the epidemic continues to grow based on revised 2001 estimates. Achieving 100% certainty about the numbers of people living with HIV globally would require repeatedly testing every person in the world for HIV, a practice which is logistically impossible (UNAIDS, 2004a).

HIV/AIDS in Africa

In West Africa, no country has a prevalence of HIV/AIDS above 10%, and most have prevalence between 1% and 5% (UNAIDS, 2004a). The adult prevalence of HIV/AIDS in countries between central and east Africa range between 4% and 13% (UNAIDS, 2004a). Sub-Saharan Africa, Africa south of the Sahara Desert, is the term used to describe those countries of Africa that are not part of North Africa. Sub-Saharan Africa is also known as Black Africa or Dark Africa (Wikipedia, 2004). Sub-Saharan Africa is home to just over 10% of the world's population. In 2003, an estimated three million people became newly infected, and 2.2 million died in Sub-Saharan Africa (UNAIDS, 2004a). Sub-Saharan Africa populates 70% of the HIV/AIDS infected people worldwide. In 2003, 77% of all AIDS deaths were in this region (CDC, 2004a). Also in Sub-Sahara Africa, over 23 million adults and children are reported to be living with HIV/AIDS, and over 13 million have died, accounting for more than 80% of the world's deaths because of AIDS. According to UNAIDS, in Africa alone 10,000 people become infected with HIV each day (CDC, 2004a). In Zimbabwe, HIV/AIDS kills more than 2,000 people every week, and an estimated 3 out of 10 pregnant women are infected with the virus (CDC, 2003c). South Africa has an estimated population of about 40 million, and 20.1% of the population is living with HIV/AIDS, an estimated 13% of the world's total. It is estimated that about 600 people in South Africa die of HIV related illnesses each day (Pembrey, 2004).

HIV/AIDS and Orphans

Populations globally that are considered vulnerable for HIV/AIDS include women and children. In South Africa, reportedly 26.5% of pregnant women in 2002 were infected with HIV (Copson, 2005). The CDC (2001a) reports that in Rwanda, mother-to-child transmission has been found to be the most frequent mode of HIV transmission among the country’s population (CDC, 2001a). It is estimated that each year 40,000 to 50,000 babies are born to HIV positive mothers, of which 10,000 to 15,000 are infected. In Rwanda, one of the central eastern countries of Africa with high prevalence of HIV/AIDS, it is estimated that 400,000 people are living with the disease (CDC, 2001a).

Often HIV/AIDS strikes young people in their most productive years; therefore, the outcome can seriously impact families as well as overall productivity. HIV/AIDS strikes early in young people’s lives throughout the world, causing decreases in family earnings, increased expenditures on healthcare, and increased numbers of orphans, widows, and widowers who become increasingly dependent on society. In Africa and across the world, HIV/AIDS has, unfortunately, left many children living in poverty, and becoming homeless or orphaned. Many African children are losing their parents, leaving an entire generation of orphans to raise themselves (United States Agency for International Development, 2002). UNAIDS (2004a) defines AIDS orphans as children who before the age of 15 have lost either one or both parents to AIDS. In 2002, UNAIDS changed its definition of AIDS orphans to children who, before age of 15, have lost either their mother or both parents to AIDS. In Africa, AIDS has orphaned more children than anywhere else in the world. The AIDS epidemic has left behind an estimated 14 million orphans; 80% of the AIDS orphans live in Sub-Saharan Africa (Fredriksson & Kanabus, 2004). In Sub-Saharan Africa the total number of children orphaned since the HIV epidemic began is estimated to be over 11 million; the number of orphans globally because of HIV is 14 million. There are an estimated 1.8 million orphans living in North and Southeast Asia, 85,000 in East Asia and the Pacific, 330,000 in Latin America, 250,000 in the Caribbean, and 65,000 in North Africa and the Middle East (Fredriksson & Kanabus, 2004).

In a report for International News, *The Body* (2004), an AIDS and HIV information resource, James Morris, head of the World Food Programme, writes that the crisis of HIV, especially in Sub-Saharan Africa, is the most extraordinary humanitarian crisis in the world today. Morris indicates that HIV/AIDS has become the sinister element in hunger. He explains why millions of African farm workers have died of AIDS-related illnesses because of the continuous spread of HIV/AIDS in Africa. When young farm workers die of AIDS-related illnesses, a greater burden is placed on children and the elderly to produce food. In addition, people migrating in search of food increases the chances that HIV might be introduced into a new population increase (*The Body*). In Swaziland, an area where young farmers are greatly needed, it is estimated that the AIDS epidemic will cut life expectancy in the kingdom to 27 years old by 2010. Women also are at an increased risk of becoming HIV positive when they engage in commercial sex work to pay for food. A report produced by the Food and Agricultural Organization of the United Nations (2000) reports that besides the human suffering, AIDS threatens sustainable agriculture and rural development. Sickness and death of an adult family member can result in the inability of a household to cultivate the land. Tending the sick can take a considerable amount of time, which is then no longer available for agriculture. As a result, more remote fields tend to be left fallow where industry is switching from labor-intensive to less labor-intensive crops production. Thus, some families are forced to sell their livestock, lose their farms and rely on others while trying to take care of and provide for sick family members. The twin epidemics of HIV/AIDS and hunger in Africa and other countries throughout the world have trapped millions of people in a cycle of poverty, sickness, and death.

At the XVth International AIDS Conference (2004) in Bangkok, Thailand the AIDS programme of the International Labour Office (ILO) (2004) launched a new report that focuses on the effect HIV/AIDS is having on the workplace. The ILO report paints a grim picture of the impact of HIV/AIDS not only in Africa and on its workers, but also on the world of work. They estimate that more than two thirds of the nearly 40 million people living with HIV today are workers, either in the informal or formal economies. That statistic makes HIV/AIDS a major concern of the ILO. The epidemic affects (a) all constituent workers through loss of earnings and livelihoods; (b) employers and businesses through loss of skilled and experienced workers, reduced productivity, and a decline in profits; and (c) governments through declines in revenue and in overall economic performance (News-Medical.Net, 2004).

African Health Care and HIV/AIDS

In Africa, another major problem is on the rise as the HIV/AIDS epidemic increases. According to Ncayiyana (2004), the unremitting pressure on hospitals and other healthcare facilities and the disproportionate use of healthcare resources by the ever-increasing numbers of patients are threatening to undermine the capacity in areas such as South Africa to provide a comprehensive health safety net for the rest of the population. With the HIV/AIDS pandemic spreading across Africa, many problems have begun to form with regard to the potentially devastating impact of HIV and AIDS among health professionals on the capacity and integrity of the healthcare systems and staff. The increased loss of staff, themselves sick from complications of HIV/AIDS related illness, affects absenteeism and staff morale. The increased burden of patient load from care provided to HIV/AIDS patients affects an already strained health care system. As the mortality rates continue to increase, South Africa needs stronger health systems and ways to help deliver prevention and care of HIV and AIDS patients. Three waves have been described in the natural course of the HIV epidemic. First, new HIV/AIDS cases were expanding as the number of cases in South Africa peaked around 1998. Second, the increased prevalence of HIV/AIDS cases is thought to be peaking around now and finally, South African people are experiencing an increase in mortality rates (Ncayiyana, 2004).

HIV/AIDS in India

Predictions have been made that India, a country that has a massive population of mobile workers and the largest number of people living beneath the World Bank poverty line of $1 per day could become the major HIV/AIDS epidemic in the world, surpassing Africa. India will have the largest number of people infected with HIV/AIDS in the world (Center for Strategic and International Studies, 2004). When compared to Africa, India has a large population, and a mere 0.1% increase in the prevalence rate would increase the number of adults living with HIV/AIDS in India by over half a million persons. India now accounts for at least 10% of the world's HIV infections and is second only to South Africa in total numbers (Cohen, 2004). Some reports indicate that India has actually passed Africa in the actual number of new HIV cases. With a population of over one billion, it is estimated that the HIV epidemic in India will have a major impact on the overall spread of HIV/AIDS in Asia, the Pacific, and worldwide. One report by the National Intelligence Council (2002) predicts that India could have 25 million HIV cases by 2010. The government in India estimates that 4.58 million individuals, or slightly less than 1% of the adult population, are infected with the HIV virus. The number of actual positive cases registered is only about 60,000. Therefore, most of the people living with HIV do not know that they are infected (Center for Strategic and International Studies, 2004).

The World Bank Group (2004) lists several risk factors that put India in danger of experiencing a widespread epidemic if prevention and control measures are not scaled up and expanded throughout the country. In India, for example, sexual transmission is responsible for 84% of reported AIDS cases. HIV prevalence rates are highest among sex workers and their clients, injecting drug users, and men who have sex with men (many of whom are married). When surveyed, 70% of commercial sex workers in India reported that their main reason for not using condoms was that their customers objected (World Bank Group, 2004).

India has wretched poverty, and the number of women entering the commercial sex trade to provide food for their families and themselves is increasing. Reportedly, commercial sex workers are one of the potent sources for the fast spread of HIV/AIDS throughout India. India has a large population of migratory and mobile workers. That they are away from home extended periods of time which creates a problem by these workers being away from their families, communities, and their daily social environment. This absence can place them outside the usual normative constraints, often making it easier for them to engage in risky behaviors.

Also in India, studies show that injecting drug users (IDUs) are switching from inhaling to injecting drugs. This phenomenon is more localized in the northeastern states of India, and IDUs have started showing sharp increases in HIV prevalence. Forty-one percent of IDUs in a national survey reported injecting with used needles or syringes. Of those who cleaned their needles and syringes, only 3% used an effective method such as alcohol, bleach, or boiling water. Appropriate strategies are also needed to address the double impact of drug use and unsafe sexual practices (World Bank Group, 2004).

The vulnerability of HIV/AIDS for women and children in India is also increasing. The country’s low status of women, as expressed by limited access to human, financial, and economic assets, weakens women's ability to protect themselves and negotiate safer sex. Existing gender norms and gender gaps in India permit male infidelity and require the women to respond to their spouses' sexual urges, triggering their vulnerability to violence if they refuse. Many young women in India, often only teenage girls, are infected in their own homes by their own husbands. Increase in HIV among monogamous married women clearly necessitates an effective intervention that addresses issues around women's ability to protect themselves from HIV/AIDS in the context of domestic violence and provides them with necessary education, prevention, and social support. In the context of AIDS care in India, 81% of the 135 HIV positive women seen in a south Indian facility were housewives rather than sex workers or intravenous drug users (Newmann et al., 2000). Husbands are thought to be the main source of infection for this group (George et al., 1997). In the country's already difficult battle with HIV/AIDS, the disease becomes harder to control.

HIV/AIDS in Asia

The Asia-Pacific region is home to 60% of the world's population and to 19% of the men, women, and children living with HIV in 2004 (Family Health International, 2004). These infection rates are low compared with those on some other continents, particularly Africa. However, because the populations of many Asian nations are so huge, even low HIV prevalence means large numbers of people are living with HIV. The data indicate about 5.2 million men, 2 million women, and 168,000 children are living with HIV/AIDS in Asia (Family Health International, 2004). The rapid spread of HIV/AIDS in many regions, driven by IDUs and unsafe sex, is adding a new wave of HIV epidemics threatening areas like China, India, Indonesia, and Russia. The recent UNAIDS Report (2004a) presents many clear warning signs that Eastern Europe and Central Asia could become home to serious new HIV epidemics. Prevalence rates in these regions continue to grow and show no signs of abating (WHO, 2003). In the parts of the world previously mentioned, young people are among the hardest hit by HIV/AIDS. While young men still bear the brunt of the epidemic, 33% of those infected at the end of 2002 were women, up from 24% the year earlier. Despite the growing prevalence of HIV infection, too few prevention outreaches, such as safe sex education or adoption of safer injection techniques, are being employed in these areas. Recent rapid increases in HIV infections in China, Indonesia, and Vietnam show how suddenly an epidemic can erupt wherever significant levels of drug injecting occur.

HIV/AIDS in Brazil

A Joint United Nations Programme on HIV/AIDS (UNAIDS, 2004b) report on the Global AIDS epidemic commends the advances made by Brazil in the efforts to prevent the HIV/AIDS disease. The report highlights Brazil's progress in the treatment of carriers of the disease in Brazil. Of the 400,000 people around the world who have access to antiretroviral medicines, 140,000 live in Brazil. This number includes access for marginalized people in very poor areas and slums (UNAIDS). The 2004 Global Report on Drugs by the United Nations Office on Drugs and Crime (UNODC) cites Brazil as an international model in the fight against HIV virus infections among users of intravenous drugs (Lobo, 2004). According to Teixeria (2001), around 13 million people all over the world use injectable drugs, often leading to many people becoming infected with HIV. Because of the efforts by the Brazilian government to decrease HIV/AIDS, the incidence of HIV among IDUs dropped from 24.5% to 12.1% between 1994 and 2002 (Teixeria, 2001).

At the United Nations Special Session of the General Assembly on HIV/AIDS in 2004, the main strategy for HIV control was prevention. Often with prevention programs, there is no structure in place to provide care. However, according to Dr. Paulo Roberto Teixeira (2001), Director-General of the Brazilian Programme for HIV/AIDS, positive contributions by Brazil’s government in efforts for the fight against HIV/AIDS do not agree with prevention as the main focus. Teixeira explains Brazil’s belief on impacting the problem with HIV/AIDS is that to have an impact on the present AIDS pandemic, Brazil’s government believes that it is vital to maintain the link between prevention and treatment, including access to antiretroviral (ARV) drugs. They note it is impossible to mobilize communities, institutions, families, and HIV affected people if they are not provided with the necessary support for treatment. At the Special Session of the General Assembly on HIV/AIDS, according to Dr. Paulo Roberto Teixeira, the Brazilian government presented a proposal that addressed a global strategy which included a task force or international committee based at United Nations Headquarters. Their proposal suggests coordinating global agreements that would address questions about access to ARV drugs and treatment. Such a global agreement would include an international fund for providing drugs in developing and poor countries. The country’s proposal on ARV drugs would also include differential pricing. The task force, or other mechanism, would include all the main actors, including nongovernmental organizations, government representatives, drug companies, and United Nations agencies (Teixeira, 2001).

Even though the Brazilian policy on HIV/AIDS, which has been used successfully in several Latin American countries, has resulted in lower mortality rates, a positive cost-benefit ratio, and a dramatic increase in the quality of life for HIV-affected people, their policy for ARV has been criticized. International institutions and some developed countries claim that too much money was spent in treatment while prevention should be the priority. Brazilian representatives were surprised to learn that the United States Trade Representative indicated that the Brazilian position on patents was not related to Brazilian ARV drug policy (Teixeira, 2001). The representative from the United States also indicated that Brazil was using its AIDS policy to justify national interests that did not fall under agreements on patents and trade. Teixeira further explained that the United States' statement referred to some good AIDS programmes in the world that have made good progress in the area of prevention such as in Thailand, Senegal, and Uganda, but excluded Brazil. Apparently, these countries were mentioned because of their progress made in the area of prevention.

HIV/AIDS in the United States

The first United States cases of HIV/AIDS were reported in 1981 (Mehr & Kanwischer, 2004). The disease, never seen before, took the medical establishment and the rest of the world by surprise. From 1981 to 1998, at least 1.5 million people in the United States became infected with HIV; 600,000 were diagnosed with symptoms of AIDS; and more than 300,000 died (Mehr & Kanwischer, 2004). In the United States, many believed that cases of HIV/AIDS in heterosexuals were likely caused by some accident, such as a contaminated blood transfusion during a surgical procedure. In the 1980s, there were many well-publicized cases of children and adults who developed AIDS in this manner, leading to serious concerns about the safety of the United States medical blood supply. After aggressive public health action, including mandatory testing for HIV for blood donors, the risk of receiving a transfusion of HIV contaminated blood declined.

According to CDC (2002b), the number of cases and deaths among persons with AIDS increased rapidly during the 1980s. During 1981 through 2001, an estimated 1.3 to 1.4 million persons in the United States were infected with HIV, and 816,149 cases of AIDS and 467,910 deaths were reported to the CDC. During the late 1990s, after the introduction of combination antiretroviral therapy, the number of new AIDS cases and deaths among adults and adolescents declined substantially. From 1995 to 1998, the annual number of incident AIDS cases declined 38% from 69,242 to 42,832, and deaths from AIDS declined 63% from 51,670 to 18,823. The annual number of incident AIDS cases and deaths has remained stable since 1998 at approximately 40,000 and 16,000, respectively. The number of children affected by AIDS attributed to prenatal HIV transmission peaked in 1992 at 954 and declined to 101 in 2001. Since the early 1990s, an estimated 40,000 new HIV infections have occurred annually in the United States. During 1999 through 2001, in the 25 states that had HIV reporting since 1994, the number of persons who had an HIV infection newly diagnosed increased 14% among men who have sex with men and 10% among heterosexuals. The number of persons in the United States living with HIV continues to increase, and of an estimated 850,000 to possibly 950,000 persons living with HIV, an estimated 180,000 to possibly 280,000

(25%) persons are unaware of their serostatus (CDC, 2002b). In 2001, preliminary data show that the age-adjusted rate of deaths from HIV/AIDS was 5 per 100,000 for the total population, compared with 5.3 in 1999.

According to United States Department of Health (2003), the population subgroups with the highest rates of death from HIV/AIDS in 2001 were Blacks (23.2 deaths per 100,000), people with less than a high school education (18.4), high school graduates (12.6), males (7.5), and Hispanics (6.2). Blacks accounted for 54% of HIV/AIDS deaths in 2001, compared with 29% in 1990. Whites made up 60% of the total in 1990, compared with 30% in 2001. According to the United States Department of Health, the southeastern and Middle Atlantic States are the geographic areas with the highest death rates from HIV/AIDS reported in 2000.

At the end of 2002, approximately 384,906 persons in the United States were living with AIDS. By age group, 43% were in the 35-44 years group. By race or ethnicity, 42% were Black, 37% White, 20% Hispanic, and less than 1% each were Asian/Pacific Islander and American Indian/Alaska Native. By gender, 77% of adults living with AIDS were men. By region, 39% resided in the South, 29% in the Northeast, 19% in the West, 10% in the Midwest, and 3% in the United States territories. Of the 298,248 male adults and adolescents (greater than 13 years of age) living with AIDS, 58% were men who have sex with men, 23% were IDUs; 10% had been exposed through heterosexual contact; and 8% were men who have sex with men who were also IDUs. Of the 82,764 female adults and adolescents living with AIDS, 61% had been exposed through heterosexual contact, and 36% had been exposed through IDUs (CDC, 2002b). Black women in the United States are disproportionately affected by AIDS. Of the adult women cases reported through December 2003, Blacks accounted for 59%, Whites for 21%, and Hispanics for 21% (Florida Department of Health, 2004).

The CDC (2001b) estimates that nearly a million people in the United States are currently infected with HIV. Almost half of them are not being treated, either because they lack access to healthcare or because they have not been tested. Those who are unaware of their HIV status may unknowingly infect others. Each year in the United States, another 40,000 people are infected with HIV. Approximately one new infection occurs every 12 minutes in this country. More than half (54%) of all new HIV infections occur among African Americans even though they represent only 13% of the United States population (CDC, 2001b). Many studies on HIV indicate higher rates for Black male and females of all the new HIV infections. The disproportionate impact of HIV/AIDS on Black communities becomes clear when we consider that Whites make up approximately 75% of the population while Blacks comprise only 13%. In the United States more African Americans are becoming infected with HIV than all other racial and ethnic groups combined.

In 2005, New York City health officials reported a rare, highly drug-resistant strain of HIV that quickly progressed to AIDS. According to Brown (2005) in a Washington Post report, medical agencies were not aware of any other case like this one anywhere. In this strain of HIV, the onset of AIDS appears to have occurred possibly within 2 or 3 months and at most 20 months after infection. Dr. Thomas Frieden said the rare HIV strain is difficult or impossible to treat and indicated that the city’s health officials are working with the CDC to find other possible cases as cited in Netscape News (2005).

Summary of Global Perspectives

Infection with HIV, the primary causal factor of AIDS, has the potential to disrupt the lives of individuals, families, and communities severely. HIV infection is often characterized by shame, guilt, fear, loss of dignity, financial ruin, and abandonment (Sanders, 1998). Nelkin, Willis, and Paris (1990) explain that AIDS is no ordinary epidemic but more than a passing tragedy that will have long-term, broad-ranging effects on personal relationships, social institutions, and cultural configurations.

The onslaught of AIDS threatens to single handedly undermine economic progress and actually facilitate the expansion of poverty (Jamison, Sachs, & Wang, 2001). Despite such expectations of gloom and death, it seemed that no one, except what appeared to be the predominantly White lesbian and gay communities, wanted to talk openly about this growing epidemic (Cohen, 1999). Of new infections among women in the United States, CDC estimates that approximately 75% of women were infected through heterosexual sexual activity and 25% through injection drug use. According to the National Institute of Allergy and Infectious Diseases (2002), of newly infected women, approximately 64% were Black; 18% were White; 18% were Hispanic; and small percentages were members of other racial/ethnic groups. Of the estimated 15,245 AIDS-related deaths in the United States in 1999, approximately 50% were Black; 30% were White; 18% were Hispanic; and less than 1% were Asian/Pacific Islanders and American Indians/Alaska Natives (National Institute of Allergy and Infectious Diseases). Nonetheless, no matter the gender or racial group of the person infected with the HIV virus and regardless of how someone becomes infected, (e.g., heterosexual, bisexual, homosexual, etc.), the outcome for those infected with the virus in most cases is traumatic and painful. Moreover, no cure exists today.

HIV/AIDS in Florida

The Florida Department of Health (2004) HIV Incidence Surveillance Report reflects that HIV infection occurs in groups of people, not individuals, and the results are meaningful when applied to a population. The report details the number of people in each group who may have been recently infected with HIV. According to the report, of the 40,000 new HIV infections reported in the United States during 2002, 4,000 were in Florida. The report also indicates there was an estimated 100,000 people living with HIV in Florida. In 2003, the latest year for which national data are available, Miami-Dade County had the second-highest rate of AIDS cases per capita in the nation, behind New York City. Florida had the fourth-highest rate among states (LaMendola, 2005). The black-to-white ratio was 23:1. The Hispanic-to-White ratio was 35:1. Also in Florida, women accounted for 24% of reported AIDS cases in 1994. That figure rose steadily to 30% in 2004. Of the 1,741 AIDS cases diagnosed among women in 2004, Whites accounted for 16%; Hispanics 12%, and Blacks 70%. Of the 11,795 HIV (not AIDS) cases diagnosed among women in Florida reported through 2004, Whites accounted for 16%, Hispanics accounted for 11% and Blacks accounted for 72% (Florida Department of Health, 2004). According to a 2003 Escambia County Health Department (ECHD), report, Florida currently ranks first in the United States in pediatric AIDS cases. Fifty-eight percent of these pediatric cases are African American children (ECHD, 2005). Also, Lieb (2004) reports that the Florida's Office of Vital Statistics on death certificates indicate that HIV/AIDS in Florida is the leading cause of death among Black males and Black females between 25 and 44 years of age. According to Lieb in 2002, Florida reported that 14% of its population was Black. Tragically, 64% of all HIV/AIDS deaths in Florida were from the Black population. Blacks accounted for 64% of all HIV/AIDS deaths, but only 14% of the population. According to the Pregnancy Risk Assessment Monitoring System, Florida's percentage of childbearing women who were tested prenatally for HIV ranks the highest in the United States and has probably contributed to the continued increase in pediatric AIDS cases in Florida (Florida Department of Health, 2004).

In rural areas across the United States, HIV/AIDS discrimination often occurs at unacceptably high rates. Unfortunately, in many urban cities and rural areas, the general society has not begun to approach this issue. In the state of Florida, of the 67 counties, 46 are classified as rural (Brown, 2003). Rural areas include counties with a population density of fewer than 99 individuals per square mile or those counties classified as rural by the United States Census (Bushy, 2004). AIDS cases reported from rural counties totaled 6,999 or 9% of Florida's 77,373 cumulative AIDS cases through 2000. Whites living in rural counties make up the majority (83%) of the population living in those areas; however, 47% of the AIDS cases were reported to be African American men. African Americans represent 50% of rural AIDS cases, Whites 37%, Latinos 9% and American Indian/Alaska Natives 2%. African Americans and Latinos are disproportionately affected by HIV in rural areas (CDC, 2007c).

HIV/AIDS and African Americans

Dr. Donald Acheson, as cited in Hancock & Carim (1986), warns that unless effective means of controlling the spread of HIV become available, an exponential increase in the number of infected persons can be expected. According to United States Surgeon General, Dr. David Satcher, the spread of AIDS among Blacks and Latinos is a public health emergency (CDC, 1999). HIV prevention efforts must take into account cultural issues as well as social and economic factors such as poverty, underemployment, and poor (if any at all) access to the health care system that affects many United States minority communities (CDC, 1999).

For many African Americans, being infected with HIV has brought problems surrounded by medical, legal, psychological, and social complexities. Lynch (2000) explains that African American women are at very high risk for disease transmission primarily as a result of IDUs, and secondarily as a result of unprotected sexual activity with infected bisexual partners and with heterosexual IDUs.

As the number of women with HIV/AIDS continues to increase, disparities in the services available for women, particularly those women in minority groups, have become increasingly evident. Because of this gender gap, women are far less likely to be educated about HIV transmission and prevention, to be tested for HIV, or to seek treatment if they indeed are infected. Because of a combination of economic, social, and cultural inequalities, American women are three times more likely to die from AIDS than men (American Association for World Health, 1988). Race and ethnicity are not risk factors for HIV transmission but do reflect social, economic, and cultural disparities that are associated with HIV transmission (CDC, 1994). Minority women are at greater risk for HIV infection because of higher infection rates among racial and ethnic minorities in the United States and greater concentrations of HIV in urban inner-city areas (Dicks, 1994). For minority women in poor or poverty stricken areas, a lack of awareness about HIV/AIDS education and prevention programs and a belief that they are not at risk for HIV are problematic. Because many African American men report multiple risk factors and low rates of condom use (Peterson, Catania, Dolcini, & Faigeles, 1993), heterosexual transmission of HIV to African American women is expected to continue to increase (Hobfoil, Jackson, Lavin, Britton, & Shepherd, 1993).

HIV/AIDS and Women

According to the American Association for World Health (1998), among the reported AIDS cases in 13-19 year-olds in 1997, 49% were female; in the 20-24 year-old age group, 38% were female; and in the 25 and older group, 21% were female. African-American women represent 56% of all reported AIDS cases among women, and AIDS incidence is 18 times higher among African American women than White women. For Latina women, the AIDS rate is eight times higher than for White women. Latina women represent 20% of AIDS cases among women (American Association for World Health).

The impact of AIDS on the African-American community is best reflected by Mario Cooper, a leading Black AIDS advocate. In Cooper's opinion, he explains that except possibly for slavery, nothing in our history will have killed so many Black people in such a short time as AIDS (as cited in Stanley, 2000). According to Logan and Freeman (2000) the Task Force on Black and Minority Health issued a report indicating people of color suffered nearly 60,000 excess deaths annually when compared with Whites. Within this report, the causes of death included cancer, strokes, diabetes, heart disease, and chemical dependency. Following this report, the Minority Health Act was enacted in 1990 (Logan & Freeman). This act was supported and strengthened by Healthy People 2000, a wide-scale prevention project with goals to improve health care for all Americans. With regard to the dramatic increase in the life expectancy for the United States population in general, the 20th century has not been kind to Blacks with respect to health care. Several reports and research addressing health-related issues that affect

African Americans have provided validation that HIV infection is increasingly and disproportionately affecting African Americans and other ethnic groups of color (Logan & Freeman). Overall, African Americans are diagnosed with HIV/AIDS later than Whites, receive worse care, and die faster. A study of people with a diagnosis of HIV infection found that 56% of late testers (that is, those who received an AIDS diagnosis within 1 year after their HIV diagnosis) were African American. Late testing represents missed opportunities for preventing and treating HIV infection (CDC, 2005a).

The HIV/AIDS virus has affected African Americans across the United States from various walks of life. Women, men, mothers, fathers, brothers, sisters, children, and grandparents, with varied lifestyles and economic statuses from the suburbs to the city streets, are affected; virtually no group has gone untouched. And yet the extent to which African Americans as a people talk about and move to action has not paralleled the extent to which they have suffered. The silence has been deafening; the toll is astronomical (Lynch, 2000). Lynch questions commitments to communities of color. He reports that federal funding for AIDS programs has decreased as the disease has hit marginalized communities with increasing, dogged determination.

With regard to tracking the epidemic, the CDC has implemented policies, procedures, and data that monitor the status of HIV/AIDS by race, risk, group, and gender; this information enables communities to base public health strategies on the best possible understanding of the epidemic. Historically, programs and services were developed to serve clients with HIV/AIDS that were White and male. The implementation of policies, procedures, and data that include minorities is critical to African American communities to provide better services for those with HIV/AIDS. Continued monitoring of various trends enables communities to tailor prevention strategies to meet the local need and provide assistance to many communities of color. However, according to Pierce (as cited in Goode, 2003), scientists who study AIDS/HIV and other sexually transmitted diseases say they have been warned by federal health officials that their research may come under unusual scrutiny by the Department of Health and Human Services or by members of Congress because the topics are politically controversial. Scientists indicated that they were advised they could avoid unfavorable attention by keeping certain key words out of their applications for grants from the National Institutes of Health (N.I.H.) or the CDC. Words such as “sex workers,” “men who sleep with men,” “anal sex,” and “needle exchange” are terms that they were advised should be avoided (Pierce, as cited in Goode). Unfortunately, many of these terms mentioned in the scientist research and program funding would involve African Americans and a large percentage of African Americans who live in poverty.

From the CDC’s surveillance data, it became apparent as early as 1983 that AIDS was disproportionately affecting African Americans. At that time, African Americans accounted for 26% of all AIDS cases yet represented only 13% of the United States population (CDC, 1999). Today, more than half (54%) of all new HIV infections occur among African Americans even though this same group represents only about 13% of the United States population (CDC, 2001b). More than half of all women living with AIDS in the United States are African American. Thirty-one percent of all men living with AIDS in the United States are African American. In a Harvard Medical School news article, Essex (1996) predicted that if current trends continued, by the year 2001 more than 50% of people living with AIDS would be African Americans who currently comprise 13% of the United States’ population. It is also important to note that these data represent only reported cases of AIDS. African Americans are 6 (men) to 16 (women) times more likely to be infected as are White people (Lynch, 2000). According to the CDC (2001b), African Americans accounted for 21,000 or 49% of the more than 43,000 new AIDS cases reported among adults. Although much research has been conducted and research continues, as the United States nears the end of the epidemic’s second decade, the disease burden among African Americans continues to grow rapidly. Little research has focused on HIV/AIDS and African American women’s alarming statistics.

It is estimated by current indicators that 240,000-325,000 African Americans are infected with HIV, and more than 106,000 of those individuals are currently living with AIDS (CDC, 1999). Despite declines in AIDS deaths among all racial and ethnic groups between 1995 and 1998, AIDS mortality rates remain nearly 10 times higher among African Americans than among Whites (CDC, 1999). The CDC August 1999 report, “Fighting HIV/AIDS in African American Communities” indicates that within the United States, HIV, which primarily began over a decade ago and at that time was found mostly in Caucasian men, now affects millions throughout the world. However, with the massive number of people dying in African countries and the continued rise in HIV/AIDS infections and deaths across the world, we realize that HIV/AIDS is not a gay plague as many once thought. The HIV/AIDS virus is indeed indifferent to its victims’ sexual orientation. Landau-Stanton and Clements (1993) suggest that American researchers initially missed the signs of the disease in intravenous drug users, in recipients of (blood) transfusions, in hemophiliacs, in babies and children, and in women. The current finding is that the HIV/AIDS disease does not discriminate against race, sex, age, or geographic locations around the world (Shannon, Pyle, & Bashur, 1991).

HIV/AIDS has become a major problem for communities of color. Issues of stigma, fear, rejection, invisibility, classism, sexism, homophobia, and drug phobia all construct just part of the environment in which a response to this disease has developed in Black communities. To discuss AIDS in Black communities is to discuss a multiplicity of identities, definitions of membership, locations of power, and strategies for the political, social, and economic survival of the community because all these factors interact with a disease that divides and threatens ever growing segments of these populations (Cohen, 1999). As African American communities, cities, and communities across the United States and the world remain daily affected by HIV/AIDS, the history of racism and all the other “isms” that have happened to the African American communities must not be used as a mechanism to indicate that in order for the message to be heard and received, one must be a certain race, gender, or economic status. The reality is that people are dying of AIDS, and African Americans are dying quicker.

Although HIV/AIDS is having a horrendous impact within the African American community, HIV/AIDS is something that even today is rarely discussed within the Black communities. AIDS activist, one of the founders of the National Task Force on AIDS, and National Black Lesbian and Gay Leadership founder Phil Wilson (as cited in Cohen, 1999), admits his first reaction to HIV/AIDS was really something he is not proud of today. Wilson explains he first felt thankful to God that AIDS was happening to Whites and not to Blacks. He explained that he believed like everyone else that AIDS was all about White gay men. After realizing that this virus was neither about White gay men, nor about an “us” versus “them” framework, Wilson later admitted that he was not proud of his views, which were based out of anger, fear, and denial. Today, it would appear that prevention messages have failed in the Black community.

Wilson’s stereotype about AIDS was a general belief from the early media reports of the 1980s on the HIV/AIDS virus. It was clear to the African Americans and other communities of color that AIDS was a disease of White gay men, reducing the attention within communities of color to the epidemic. Many African Americans held White, gay men responsible for the epidemic and believed that it was not a problem that affected African Americans. Cohen (1999) had a personal interview with Gil Gerald, the National AIDS Network's former director of minority affairs. In the interview Gerald explained that growing up during his time, there was a dominate heterosexual view that Black communities did not have gays in their communities. The attitude of some Black gay men was that "you only get AIDS if you sleep with White men," and a belief held by some other Black gay men that only Whites who slept with Whites got AIDS. Recognizing the fallacy of this position, minority leaders within the gay and lesbian community began to challenge the denial present within communities of color.

With HIV/AIDS moving rapidly throughout the African American community and other communities of color, Black gay and lesbian activists worked faithfully to set up programs, seek funding, conduct seminars and workshops, and met with Black leaders in attempts to bring awareness and educate the community about the HIV/AIDS virus. However, with the stigma attached to HIV/AIDS, many pastors, political leaders, and community and social organizations refused to step forward and deal openly with the escalation of AIDS in the Black communities. In his welcoming remarks at the National Conference on AIDS in the Black Community, an event organized by African American men, gay and lesbians leaders, and lay people, Gil Gerald (as cited in Cohen, 1998) highlighted the absence and placed a challenge to well established Black organizations such as the National Association of Colored People (NAACP), Urban League, National Association of Black Social Workers (NABSW), and the National Medical Association. His challenge was for these groups and other minority groups to become actively involved in the fight against HIV/AIDS in the communities of color. As many Africans Americans continued to die or become infected with the HIV virus, the community and the leaders remained in denial regarding its presence throughout communities of color and, in particular, African American communities.

With the continued resistance and refusal to take actions by leaders of their communities, Black gay men and lesbians found support and helpful information from the White gay and lesbian community, which had already experienced great losses because of HIV/AIDS. The personal experiences of loss which brought together and raised the consciousness and anger of Black lesbians and gay men were also instrumental in motivating their response. Additionally, the increasing number of openly gay Blacks and lesbians created a pool of potential activists less vulnerable to moral judgments made by traditional institutions in Black communities. Because of their public identity as Black lesbians or gay men, these individuals already stood outside (often voluntarily) the ideologies and institutions which sought to regulate their behavior through a secondary process of marginalization. However, the agenda was not about their sexuality or the debate on the needle exchange program. Rather, it was about the HIV/AIDS epidemic moving throughout the African American community (Cohen, 1999). During their attempts to educate and make the community aware, some held on minimally to their open and visible identity as African American and gay. However, it became evident that the silence and invisibility that had been a part of their conditional membership could no longer be honored if lives were to be saved.

In the United States, the HIV/AIDS virus is no longer associated only with the face of White males; now it is also associated with a face of color -- African American and Hispanic. Black women represented 57% of United States AIDS cases reported in women through 1999. In states with confidential HIV infection reporting, Black women accounted for 68% of HIV cases reported through 1999. Women, Blacks, Hispanics, adolescents, persons exposed to HIV through heterosexual contact, and persons living in the South are the populations with the greatest increase in reported AIDS cases over time (Escambia County Health Department, 2003). Many reports indicate that HIV infected individuals and those with AIDS living in rural parts of the United States are likely to suffer depression and loneliness and have suicidal thoughts. During the 10-year period of 1991 to 2001, the proportion of AIDS cases reported among racial and ethnic minorities (non Hispanic Blacks and Hispanics) differed for both rural and nonrural counties in Florida. Adult Black AIDS cases increased from 36% in 1991 to 47% in 2000 in rural counties and from 39% in 1991 to 56% in 2000 in nonrural counties. Hispanic AIDS cases increased slightly from 10% in 1991 to 13% in 2000; conversely, the percentage of adult White AIDS cases decreased by over 10% from 1991 to 2000 for both rural and nonrural counties.

Effective January 1, 1993, the CDC (1992) expanded the surveillance definition of AIDS to include those HIV seropositive persons with CD4 T-lymphocyte counts below 200 cells or a CD4 percentage of total lymphocytes fewer than 14. In addition, three more diseases were added to the 23 AIDS indicator conditions of the previous definition. Included in the revised definition were pulmonary tuberculosis (TB), recurrent pneumonia, and invasive cervical cancer. This revised definition applies only to adults and adolescents (CDC, 1992). An increasing number of African American women have been diagnosed with AIDS according to the new definition; thus, the incidence of AIDS has increased overall in this population.

Within the United States, the virus has affected individuals across many races, gender, and age levels with African American communities among those most dramatically affected. With specifics to gender, approximately 77% of AIDS cases reported are African American and Hispanic women (Ward & Dunchin, 1998). If compared to White females, Hispanic and African American women have been dramatically affected by the HIV/ AIDS epidemic. For example, in a total of 92,424 AIDS cases reported to the CDC (1997), African American and Hispanic women represented 51,410 and 18,663 cases, respectively. These figures together represent 76% of AIDS cases reported to the CDC as of June 1997 (CDC, 1997). What is suggested by these findings is that health care professionals, mental health professionals, and other professionals who normally provide services in this area should expect a drastic increase in the number of Hispanic and African Americans in their clinical practice.

There is a significant number of HIV positive cases among African American women 50 years of age and older. In African American homes, and in particular those headed by women, poverty, poor education, and access to health care for HIV/AIDS have proven to be a barrier to African Americans seeking health care. The differences of HIV rates among African American women who are older is due to a combination of unique circumstances, such as denial of HIV susceptibility, economic status, and emotional and physiological changes related to age. Statistics from the CDC (1999) indicated that HIV is the leading cause of death in African-American women between the ages of 25 and 40.

Ronald Valdiserri (2001), Deputy Director of the National Center for HIV, STD, and TB Prevention at the CDC, explains that HIV has claimed the lives of more than 21 million people worldwide. In our nation alone, 400,000 people have died, and more than a million have been infected. Now in the twenty first century, HIV poses a fundamental threat to the future well-being, health, and human potentials of many African American men, women, and their communities.

African American Women Living in Poverty and HIV/AIDS

According to CDC (2007c) in 2004 (the most recent year for which data are available), HIV infection was the leading cause of death for black women aged 25–34 years. HIV was the third leading cause of death for black women aged 35–44 years, the fourth leading cause of death for black women aged 45–54 years and among HIV positive women 25 to 29 years of age, 52% are African American. AIDS is the leading cause of death in African American women ages 25 to 34 (CDC, 2007c). HIV/AIDS is the fourth leading cause of death for Black women 15 to 44 years old in two metropolitan areas: New Jersey and New York (Logan and Freeman, 2000). Accounting approximately for 11% of the United States population, health disparities related to HIV/AIDS exist among older adults, especially among minorities. For example, of all older adult AIDS cases in the United States, more than half (55%) are among African Americans and Hispanics (Winningham, 2006). In terms of regions within the United States, a higher number of older adult HIV cases were reported in 2001 in the Southern regions than in any other region of the country (Winningham, 2002). According to a Florida Department of Health (2000), between 1998 and 2000 in rural and non-rural counties, the majority of adult female HIV/AIDS cases were reported among African American females at the rate of 62% and 76% respectively.

According to DeCarlo (1997), the CDC designates communities having residents of 50,000 or fewer as nonmetropolitan areas. Given these definitions, the number of new AIDS cases in southern rural communities is growing at alarming rates, especially among

African American women and those infected with HIV through heterosexual contact (DeCarlo, 1997). As reported by the Escambia County Health Department (2003), in the northwest Florida area, African Americans represent 38% of AIDS and 50% of HIV cases among adults. Among children, African Americans represent 71% of AIDS and 79% of HIV cases. Seventy-eight percent (583 people) of AIDS cases among African Americans in northwest Florida are diagnosed for people of ages 25 to 44 years (indicating they were originally infected in their teens, twenties, and early thirties).

Reported by the Florida Leadership Forum (2007) HIV infections among African Americans in the northwest Florida area (286 people) were most frequently linked to heterosexual contact with an HIV positive person (33% of men, 66% of women). African Americans representing only 14% of the total population of northwest Florida underscores that this group is profoundly overrepresented in the local HIV/AIDS epidemic. African Americans represent only 14% of the total population in Northwest Florida (according to the 2000 census); however, they represent 38% of all AIDS cases and 50% of HIV cases among adults (Florida Leadership Forum). Through 1999, women accounted for 21% of adult cases in Florida (15,954 women) and 16% in northwest Florida (206 women). Florida currently ranks second in the United States (after New York) in the number of adult and adolescent females diagnosed with AIDS. Research in HIV-related health disparities is also evident among older adults; African American women are disproportionately affected by the HIV/AIDS epidemic. Study after study has shown that the most prominent social and health problems fueling this health epidemic in the African American community are poverty and poor access to health care, drug abuse, sexually transmitted diseases, cultural and social stigma and mistrust of the public health system (Florida Leadership Forum, 2007).

In Quincy, Florida, a predominately Black town in the northern region of the Florida Panhandle with a population of approximately 7,500 residents, 130 have been infected with HIV and of the 130, 117 of them, or 90%, are African American; this figure has almost doubled since last year (Zook, 2003). Most people living with HIV and AIDS in Quincy are African American females. In Quincy, although the detrimental affects of the HIV/AIDS virus looms throughout this small town, the average Black woman remains somewhat oblivious to its seriousness and refuses to believe that she can be infected with the virus that causes AIDS. In the South, the majority of women and adolescent girls with AIDS were exposed through heterosexual contact. Approximately four to five times more cases resided in the South than in the Midwest and the West (Zook).

For the HIV/AIDS cases reported in the southern regions, older African American women have the highest number of documented HIV/AIDS cases compared to cases in other regions within the United States. Seniors (people age 50 and older) comprise one of the fastest growing segments of the AIDS population in Florida. In Palm Beach County, for example, people over 50 make up 17% of the AIDS population (Lade, 2002). Multiple sex partners sharing needles, blood transfusions, drug and alcohol addictions, and having risky sexual partners which are mostly the same potential HIV/AIDS risk behaviors associated with young African American female populations, exist for older African American women. However, older women with HIV/AIDS tend to face increasing physical, mental, or emotional health consequences from this epidemic for reasons such as unrecognized risks for infection in new relationships after becoming widowed or divorced, unfamiliar partners, receiving little or no preventive testing and counseling by their health care providers, enduring exhausting financial responsibilities in taking care of children or loved ones who have HIV/AIDS, and as emotional burdens as they face death.

It is important to note that although research and data collecting instruments have been implemented for younger African American females, very little data from surveys or research are available for older African American women. By the end of 1998, of all newly reported AIDS cases nationally among women, proportionally more were in the South (41% of women). Sixty-one percent are black and 38% of these women contracted HIV/AIDS from heterosexual transmission (Hader, Smith, Moore, & Holmberg, 2001). Regardless of race, women suffer from a lack of care and proper diagnosis and often times are unaware of the risk they take when having unprotected sex. With African American women living in poverty, some have never even had a pap smear or a mammogram, or an HIV test. Also combined with the fact that many African American women are politically and economically disenfranchised, these conditions yield fertile ground to breed diseases.

In many high poverty African American communities, the necessary resources to address the HIV/AIDS epidemic properly and the lack of public health resources adds an additional burden. Several reports indicated that HIV positive people in rural areas suffer from more prejudice and isolation than those who live in urban areas. Many expressed feelings of being cut off from services, having limited access to care, and thinking of committing suicide (Logan & Freeman, 2000). Possibly because they are classified as living in rural communities and on the surface may not have the massive number of problems as women living in metropolitan areas, there is a common perception that HIV/AIDS is not a problem for African American women or is not present in rural communities. This misconception increases the problem for those living in these areas who need quality health care, prevention, and education programs and social assistance from the consequences of living with HIV/AIDS. Lack of culturally appropriate interventions for African American families headed by women is a barrier to their seeking health care (Logan & Freeman). bell hooks (1994) discusses that unless the messenger is aware of who the message is for, who they want to hear and receive the message, and what changes are desired to be made through interventions, for example, the message may not be culturally appropriate. To date, no AIDS cure is available, and no vaccine for preventing infection with HIV exists. Currently, education appears to be the most viable weapon against the spread of HIV/AIDS.

During the early years of this epidemic, the media, as a receptor and interpreter of information, largely influenced the social construction of AIDS not only for the general public but also for many elites. Dominant media resources informed policy-makers of the dimensions of this crisis (Gitlin as cited in Cohen, 1999; Hallin as cited in Cohen). Cohen discusses the use of unfair reporting and reviewing by various media of HIV/AIDS as polar and monolithic narratives to define African American women living within the United States who are HIV positive or who have AIDS. One report defined African American women as the transmitters of AIDS. An ABC televised segment reporting the rates of infection among newborns in New York never showed, interviewed, covered, nor even spoke to one infected mother in New York. Reporter George Strait displayed to viewers a room full of Zairian mothers and their children who were dying of AIDS. Although the AIDS/HIV rates continue to increase constantly among African American women, little coverage is devoted to the root causes and issues for this increase. Although millions continue to die and become infected daily (largest percentage being African American women), the urgency exists to understand why the HIV/AIDS rates has become so prevalent for African American women. Little information is known about their stories and their day-to-day life experiences as they face greater possibilities for living with HIV/AIDS.

Policies, laws, institutional rules, regulations and norms that guide media highlight negative portrayals of African American women. Also Black gay and bisexual men are silenced within their own communities of color, and this problem has been a catalyst for men who have sex with men, becoming sexually active with Black women. Some of these men who have sex with other men eventually marry their female partner but continue to have secret sex with their male partners. Although male-to-male sexual transmission remained the number one route of transmission for those classified with AIDS in Black communities and nationally as documented by the CDC (1997), according to Cohen (1999), none of the 13 stories focusing on AIDS among African Americans aired between 1983 and 1993 discussed the experiences or even the numbers of Black gay men with AIDS.

One all too common story that is now present for African American women shared by Cohen (1999) is explained by a Black female AIDS educator who herself was infected by her drug-using husband. The woman explains that many women have become infected by the men they are either married to or are involved in a relationship with. She discusses how these men do not inform the women that they are bisexual. She also adds that a lot of Black men have been in and out of the prison system. As she claims, these men come out of prison and back into the community; they are making love to women who are falling for it because of a lot of voids present in their own lives (Cohen, 1999). The sex-ratio imbalance between African American males and females has caused a shortage of eligible male partners or husbands because of social factors such as drug addictions, incarceration, heart disease, homicide, and HIV/AIDS resulting in the sexual practice of “man sharing” or the willingness of some to tolerate their partners’ having other women. This practice allows limitations for emotional commitment, social and financial resources, and dedication from the man that should be available to each woman. Also, some African American women who are knowingly involved in relationships where man sharing takes place may be less likely to insist that their partner use condoms, fearing that he will stop financial support or leave the relationship. Black women are more likely to become infected with the HIV virus as a result of having sex with a partner who has multiple sex partners than by the other methods of contracting the virus.

In contrast, some Black men may view their sexual options as unlimited and perceive themselves as having greater power in their sexual relationships with fewer behavioral constraints (Medina, 2002). For many women of color, the gender power differential is a predictor of their HIV risk-taking behaviors. These sexual constructions of man sharing perpetuate the traditional view of sex as an impulse for which men are not responsible, yet women are expected to curb their sexual pleasure (Holland, Ramazanoglu, & Scott, 1990).

For women who have sex with women, surveillance tools reveal HIV transmission between women appears to be a rare occurrence. A CDC (2003d) study of more than 1 million female blood donors found no HIV-infected women whose only risk was sex with women. These findings suggest that female-to-female transmission of HIV is uncommon. However, they do not negate the possibility because it could be masked by other behaviors (CDC, 2003d). A case report of female-to-female transmission of HIV according to the CDC (2003d) indicates that women in the United States who have sex with women can increase the risk of female-to-male transmission of HIV. The report suggests that menstrual blood and vaginal secretions may contain the virus and that mucous membrane (e.g., oral, vaginal) exposure to these secretions has the potential to lead to HIV infection (CDC, 2003e). Commonalities of some behaviors that place women who have sex with women at-risk of HIV infection are similar to those mentioned earlier such as injection drug use and unprotected vaginal sex with heterosexual, gay or bisexual men and injection drug users.

Female-to-female sexual contact should be given consideration as a possibility of the HIV virus transmission among women who have sex with women. The CDC (2003e) lists some things that African American women who have sex with other women need to be aware of:

1. Exposure of a mucous membrane, such as the mouth (especially nonintact tissue), to vaginal secretions and menstrual blood is potentially infectious, particularly during early and late-stage HIV infection when the amount of virus in the blood is expected to be the highest.
2. Women using condoms should use them consistently and correctly each and every time for sexual contact with men or when using sex toys. Sex toys should not be shared. No barrier methods for use during oral sex have been evaluated as effective or approved by the Food and Drug Administration. However, natural rubber latex sheets, dental dams, cut-open condoms, or plastic wrap may offer some protection from contact with body fluids during oral sex and possibly reduce the risk of HIV transmission.
3. Women should know their own and their partner’s HIV status. This knowledge can help uninfected women begin and maintain behavioral

> changes that reduce their risk of becoming infected. Women who are found to be infected, need to get early treatment to avoid infecting others.

Lynch (2000) suggests that in the practice of social work, African American couples are rarely discussed. However, the issues, problems, concerns, and special interest groups targeting African American women and their children often discuss issues related to poverty such as funding assistance, child care, and work. A problem that arises when only women and children represent the main focus is that society fails to acknowledge an existence of the African American parental unit. It is as though African American women are not involved with African American men when the reality is African American women are intimately involved with African American men. According to Milloy (2003), in a study by Guy Weston, director of research for the HIV/AIDS Administration, the incidence of AIDS is highest where there are concentrations of low-income, Black, female-headed households that attract a variety of at-risk men including those who engaged in sex with other men before being released from prison, intravenous drug users, and heterosexual males having multiple female sex partners (Milloy).

Influences and Factors That Increase HIV/AIDS Infection Among African American Women

In this section of chapter 2, I address the current trends and research regarding the HIV/AIDS transmission among African Americans. Within any race and culture, secrets and shame exist when referencing sexual activity. In this section, I will focus on this assertion in Black families and the Black culture. Possibly for some African American men, the daily challenge of stepping out into what they perceive as a hostile White world and attempting to fit or closely match society’s definitions of being an African American man presents deeper challenges for acceptance and survival. To further complicate this issue for both African American men and women, many Black men who have sex with men do not consider themselves gay or bisexual but simply on the “down low” or on the DL. Also, some gay Black men have discussed the stereotypes or signs that are used by women as an indication of a man’s sexual orientation, adding that the “down low” has complicated this issue for many Black women.

Lewis (2003) indicates for so long African American men have been told they were not men, and many were not treated as men throughout history. Therefore, according to Lewis, African American men were placed in situations where defending their manhood has been handed down from generation to generation. Given this mindset, many African American men have become accustomed to hiding what they truly feel and have conformed to descriptions of who they think they are supposed to be in order to please someone else. Not all homosexual men are the outrageous characters often portrayed in television and films (Lewis).

Some HIV positive Black women also infected Black men with the virus, but today it is mainly men infecting women. Virginia King, Trident HIV Prevention Collaboration Coordination, says one reason for the rise in HIV cases among Black women is that most women do not talk about sex with men although they are having sex with these men (Minis, 2003). Any research that is done and any meaningful intervention must take into account that when Black men are not acknowledged, no plan is sound or interventions complete (Lynch, 2000).

The American Association for World Health (1998) reports that between 1995 and 1996, there was an 8% decrease in the number of AIDS cases among men, partly because of the increased prevention efforts targeted toward White men who have sex with men. However, the impact of AIDS on different subgroups of African Americans has also been striking. African American men represent 39% of new cases among men and African American women represent 60% of new cases among women (The Henry Kaiser Family Foundation, 1998). David J. Malebranche (2003), MD, MPH, clinical instructor of medicine in the Division of General Medicine at the Emory University School of Medicine, reports that in a study of men between the ages of 23-29 years of age living in one of six cities, the findings showed that 32% of African American men who have sex with men were found to be infected with HIV, compared to 14% of Latinos and 7% of Whites. Findings also showed that 93% of the HIV-infected Black men who have sex with men were not aware that they were HIV positive and describe themselves as being at low risk for the virus. In a report submitted by The American Association for World Health (1998), findings show that of all male adult and adolescent AIDS cases, men who have sex with men accounted for 58% of the total. The percentages for AIDS cases among men who have sex with men of color were significantly higher than the representation of men of color in the overall population. African American males represented 27% of all reported AIDS cases and 35% of all new reported HIV infections among adolescents and adults in 1997. Among the 170,141 cumulative AIDS cases in African-American men, 38% were men having sex with men, and 35% were injection drug users. Among the 93,584 AIDS cases in Latino men, 45% were transmitted through male-to-male sexual activity, and 36% were transmitted through injection drug use. AIDS is among the top three causes of death for African American men ages 25 to 54 (American Association for World Health, 1998).

A 2003 report by the Henry J. Kaiser Foundation reports the following regarding African American men:

1. AIDS cases among African Americans declined by 45% between 1993 and 2001, compared to a 73% decline among whites.
2. African American men account for 43% of HIV cases reported among men in 2001.
3. Thirty-two percent of African American men who have sex with men were found to be infected with HIV in a recent multi-city study of men ages 23 to 29 years, compared to 14% of Latinos and 7% of Whites in the study.
4. Estimated deaths among African Americans with AIDS declined by 49% between 1993 and 2001 compared to an 80% decline for whites.

Malebranche (2003) explains that the term “Black men who have sex with men” is used to include the many Black men who engage in homosexual behavior but do not identify themselves as gay. Unlike their white counterparts who often take the coming out approach to participation in same sex relationships, African American men who have sex with men and also have sex with women must understand the risk they take when having unprotected sex. King et al. (2002) describe this responsibility as brothers taking ownership and responsibility for not only themselves but others, and in particular, “sistuhs” they have sex with. According to King et al., most down low brothers look at themselves as being nothing but a heterosexual man with a twist, every now and then wanting to have sex with another man. King et al. indicate that to a Black man who is on the down low, sex is more about gratification rather than orientation. It is all about getting together to do the sexual thing, then leaving with no ties or responsibilities. This attitude is what makes the behavior so dangerous (King et al.). A Black male speaker at a sorority event sharing his story that he had not told his girlfriend he had also been having sex with men discusses a common example of this problem. Like many other African American men, he felt he had to choose between being Black and being gay. Rather than make that painful choice, he stayed silent; he is HIV positive.

According to Malebranche (2003), research indicates that "coming out" has traditionally been associated with areas such as improved mental health, more responsible sexual behavior, increased awareness of HIV risk, and improved access to HIV prevention services. African American men who have sex with men who disclose their sexual orientation have a higher HIV prevalence (24% versus 14%) and engage in more unprotected anal sex (41% versus 32%) than non disclosers (Malebranche). While not disclosing homosexual behavior is not necessarily associated with safer sexual behavior and decreased HIV risk for Black men who have sex with men, Malebranche asserts that all Black men (including Black men who have sex with men) face institutional and personal racism. Possibly, in the opinions of Black men who live secret lives of having sex with men, coming out of the closet does not guarantee safer sexual behaviors and might be viewed as counterproductive. In response to societal expectations of what it means to be a Black man, some Black men who have sex with men resort to physical and heterosexual prowess, engage in unprotected sex, and get married and father children to prove their manhood. Malebranche notes that these factors may influence sexual behavior and HIV transmission among Black men, particularly Black men who have sex with men. A desperate need exists for more research on this issue. Black communities can assist in the research process by having safe and open discussions that include deeper descriptions of masculinity and gender roles among Black men who have sex with men that effectively address the HIV/AIDS epidemic.

With the tremendous increase in a number of factors including African American men who have sex with men, African American men keeping their sexual activities with other men on the down low, and continued drug use and alcohol abuse, African American females are at greater risk for contracting the virus through these men. The increasing number of African American women living with HIV/AIDS demonstrates the effect of the greater risk. From his recent study on risk behavior, Malebranche (2003) notes that although Black men are getting HIV at disproportionate rates compared to White, Latino and Asian men, he explains that there is not much difference in the amount of reported risk behavior between Black, White, Latino, and Asian men. In his survey of men who have sex with men, Malebranche estimates an HIV incidence rate of 14.7% among Black men who have sex with men in cities across the United States compared with 2.5% and 3.5% among White and Hispanic men, in the same cities, who have sex with men, respectively. Malebranche says the disparity, however, is not explained by higher rates of unprotected anal and oral sex. Rather, four possible explanations include (a) bias in assessment of risk behaviors, (b) increased prevalence of HIV among sexual contacts, (c) increased infectiousness among sexual partners, and (d) increased physiological susceptibility to HIV. Further research is needed to explore the relationship between stress, mental health, and immune markers of susceptibility to HIV so that society begins to understand the current disparity in HIV rates between Black men who have sex with men and other men who have sex with men (Malebranche).

Many African American men who have sex with men and do not identify themselves as gay or bisexual because of cultural, professional, or other connotations attached to gays and bisexuals live on the down low. African American women who are sexually involved with these men, who trust them, and who are married to them are at high risk for HIV/AIDS. One African American woman discussed the fears of the stigmas associated with HIV/AIDS that prevented her from disclosing her positive status. She explained that she was not promiscuous nor a drug user, but contracted HIV through heterosexual sex from an African American man who was on the down low. She explained how in sharing her positive status, she could feel people wondering if she were a prostitute or intravenous drug user; she could see their eyes looking at her arms for tracks.

Education and prevention strategies of HIV/AIDS are important for everyone to decrease risk reduction behaviors towards the continuous spread of this disease. Stigmas surrounding discussions for HIV/AIDS and those infected can only provide justification for silence regarding this epidemic. Those infected with HIV/AIDS face daily struggles, continuous battles from the symptoms of this virus on their bodies, rejections from others, and lengthy other problems and issues. Teaching compassion regarding those infected with the HIV virus and those whose status has progressed to AIDS is imperative for everyone.

Cultural Issues and Social and Economic Factors

In the American Journal of Multicultural Medicine, Dr. Victoria Cargill (2001/2002), Director of Minority Research and Clinical Studies for the Office of AIDS Research National Institutes of Health in Bethesda, MD, discusses how race and ethnicity, particularly in the United States, are often surrogates for other issues including health disparities, racism, and the cultural context in which risk behaviors occur. According to Cargill, not enough attention is being given to the relationship between HIV infection and different cultural norms around sexual and other behaviors. For many of the individuals, particularly minorities, the relationship of various cultures to health care systems and the interactions with these systems usually prove unsatisfactory, tinged with disappointment, fear, contempt, and racial tension. Therefore, not only do racial and ethnic minorities tend to seek care later in the course of HIV infection, but they may also be suspicious of health messages targeted to them. HIV/AIDS continues to be a constant challenge to many health care providers regardless of the demographics of their patient population. Providers who care for racial and ethnic minority patients must be aware of the impact of culture, cultural norms, and contexts on risk as well as on health-seeking behavior (Cargill).

According to Harrison et al. (1991), most people of color do have the facts about HIV/AIDS transmission, but the information does not relate to the cultural and traditional health ideals and beliefs held by the groups. Many reports suggest that counseling and services to people of color living with HIV/AIDS present new challenges for many professionals particularly since the service population is drawn from multiple cultures. Although there are excellent materials and resources available on the clinical and scientific aspects of HIV/AIDS, there is less information and assistance exist regarding counseling persons from diverse cultural backgrounds (Knox & Sparks, 1998). While prevention messages are important, one message does not fit all. Taking an intervention that has been successful among gay, White males and directing it toward other communities without any modifications does not lead to the same outcomes. The cultural context of risk behaviors need to be understood. Very clear differences within African American, Hispanic, Asian Pacific Islander, and American Indian communities exist around high-risk behaviors, such as same-sex contact or injection drug use, all of which must be considered in dealing with HIV/AIDS for people of color (Cargill, 2001/2002).

HIV/AIDS prevention efforts and educational programs must consider cultural and social issues as well as economic factors including poverty, educational levels, employment, and access to good health care facilities.

Minorities who are HIV positive or have AIDS and are in need of assistance bring their power or lack of it to their interactions with providers, and providers bring their values, attitudes, and professional behaviors with them. The term *professional* implies that one has standard beliefs, values, and behaviors. At the most basic level, HIV/AIDS infected individuals can be perceived by others as lacking power to take actions to resist the disease. This culturally driven biological powerlessness is part of a pattern that also manifests itself as social, economic, political, and emotional disempowerment (Knox & Sparks, 1998). Many of the trends for HIV/AIDS in regard to African Americans basically focus on specific behavioral subgroups of “high risk” populations, such as drug users or African American women who have sex with African American men who are bisexual or injection drug users. Without the social context, this approach puts an emphasis on individual behavior. In other cases, entire ethnic or racial groups, such as African Americans or Hispanics, are said to be in high-risk groups, which emphasizes race and ethnicity and obscures the pervasive forms of disempowerment of the group. Gilbert (1998) claims both ignore sociopolitical constructions of HIV/AIDS.

Many African American women who are HIV positive and many who are living with AIDS share similar stories in their attempts to receive assistance, medical treatment, or effective counseling or therapy from professionals who provide services to HIV/AIDS clients. Non-African American professional providers have been unable to adequately adapt to the changing demands of African American women as they experience more possibilities for contracting HIV/AIDS. An effective approach to cross-cultural

HIV/AIDS counseling is one that breaks the pattern of powerlessness by eliciting from the client those values that are deeply held and bases the intervention on those values. Providers can then produce congruent behaviors, attitudes, and practices that enable them to address the concerns of their clients within a shared context (Knox & Sparks, 1998).

For African Americans and particularly African American females, family ties, relationships, and bonds have always held strong kinship patterns in shared flexible roles within a family unit. Of utmost importance to African American women are their families, religion, hard work, and better education for their children. To effectively provide the best services available to these women who are HIV positive or have AIDS, knowledge of their culture, beliefs, values, social economic status, education, and concerns must be made a part of the social and medical assessment for HIV/AIDS care. Professionals must be cognizant of various cultural and psychosocial issues and know how to address them in their practices to meet the various challenges of caring for these women and their families.

Cargill (2001/2002) suggests that there are cultural contexts of behavior that are absolutely essential to understand. Although the issue has been raised, research has not shown that there are race-related differences in HIV/AIDS disease progression. These findings divert the focus from biological explanations for the disproportionately high rates of HIV/AIDS deaths in African Americans and Hispanics to more psychosocial factors (Murrain, 1996).

In the 21st century, many minorities still live in poverty or very close to the poverty index and are not able to afford quality health care. Poverty is considered to be a major underlying factor in HIV/AIDS infection among African American women. For many African American women living in poverty, unemployment, poor education, inadequate housing, lack of access to proper health care, and violence, for example, are only a few factors that directly affect their poverty status. According to Gilbert & Wright, (2003), research indicates that African American women with children are among the poorest women living in the United States. African American populations throughout the United States are more concentrated in poor, urban areas as a result of residential discrimination rooted in the legacies of slavery, segregation, and individual and institutionalized discrimination (Gilbert & Wright, 2003). For African American women who are HIV positive or living with AIDS, this diagnosis can only compound the many problems they already face daily. Demographics of HIV-positive African American women indicate that a disproportionate number are poor and from urban environments. They are usually the sole supporter of themselves and their children (Conners as cited in Gilbert & Wright; Schable et al., as cited in Gilbert & Wright). In some cases, this situation might be the result of the death of their husband or partner because of AIDS. Therefore, in the authors' assessments, psychologists, doctors, HIV/AIDS counselors, and other paraprofessionals should take into consideration the role of socioeconomic factors in this racial disparity.

Murrain (1996) explains that HIV/AIDS efforts need to focus on ways to include the economically disadvantaged minority in responsible, high-quality treatment and research programs. When focusing attention on economic status, women, and HIV prevention behaviors, it is clear that a woman may place more value on securing food and shelter for herself and her children than on practicing safer sex (Airhihenbuwa, DiClemente, Wingwood, & Lowe, 1992). In a study conducted by St. Lawrence et al. (1998), African American women reported that they had never used condoms; 77% of the women had a yearly family income less than $20,000.

Airhihenbuwa et al. (1992) found that, like most Americans, the daily behavioral choices of many African Americans are highly influenced by their economic situation (269). Lee, Ganges, Cross, and Garner (2000) emphasize that because African Americans suffer more from poverty, discrimination, lack of access to health care, and lack of health insurance, they are at an increased risk for HIV and other infectious diseases.

For African Americans living with HIV/AIDS, a sense of abandonment could lead to stress and social conflicts within their families, neighborhoods, churches, or places of employment. It could also lead to social withdrawal, lack of motivation, more stress related attacks, and failure to follow through on regular check-ups and HIV/AIDS testing. According to Schrimshaw, Siegal, and Karus (1999), ethnic minority women living with HIV/AIDS experience social conflict that amplifies the negative effects of HIV/AIDS-related physical symptomatology. Findings such as this indicate that negative social factors can exacerbate physical symptoms of HIV/AIDS.

Fudge (1996) discusses how racial identity is believed to be related to health behaviors. For some African Americans and Latinos, a phenomenon such as the HIV/AIDS capacity to trigger subliminal association (genocide) gives plausibility and validity to rumors. Dalton (1989) explains that many Blacks believed AIDS is directly tied to the genocide of Blacks. He states that genocide reflects the genuine suspicion of many that the HIV/AIDS virus was developed in a government laboratory for the sole purpose of killing off the unwanted. This idea speaks to the pervasive feeling that the perceived hostility of White America toward Black America is so powerful and the disregard so profound, that nothing is unthinkable. He adds that to work with African American people effectively is to understand the fear of genocides is real (Dalton).

Because of historical research studies, such as the sterilization of African American women or the Tuskegee Syphilis study, some African Americans share fears, negative views, and resentment towards traditional health professionals, treatments, research, and anything related to mainstream issues regarding African Americans and health. However, their fears were well grounded in past experiences of federal, state, or local agencies' action or lack of action that suggests conscious conspiracy. In the South, Black fertility had a long history of being controlled by Whites. Under slavery, African American women were encouraged to have children to increase a plantation owner's wealth. After the Civil War, when African Americans were no longer valuable property, the view among white supremacists abruptly shifted. It became desirable to decrease the African American population in the South. Sterilization abuse of African American women by the White medical establishment reached its height in the 1950s and 1960s. Women who went into the hospital to deliver children often came out unable to have more (Public Broadcasting Systems Online, 1999).

Many Blacks and other minorities believe ample evidence exists to show that the Hippocratic Oath sworn by many physicians has often been ignored when patients are people of color. The system fails to support and even control poor women of color living in poverty in the United States, and African American teenage mothers living in low-income housing. Today, many states provide Medicaid funds for voluntary surgical implants of the contraceptive Norplant. According to Roberts (1997) what appeared to be an expensive contraceptive marketed to affluent women through private physicians soon became the focus on government programs for poor women. Lawmakers across the country proposed and implemented schemes not only to make Norplant available to women on welfare but to pressure them to use the device as well. Norplant is now available at no cost to poor Black women and teenagers from several government-sponsored programs. Some people indicate that this temporary, long-term form of sterilization has been used involuntarily in communities of color (Roberts).

During the 1970s, many states adopted a family planning policy of forced sterilization to deal with African American, Latina, and Native American women on welfare (Aurebach, Wypijewska, & Brodie, 1994). According to Gillespie (2003), the Montgomery, Alabama, Community Action Programs (CAP) discovered the Relfs, an African American family living in poverty, directed them to a housing project, and persuaded them to use certain social services, including family planning. Gillespie explains how CAP officials took the Relf girls—Katie, 16, Mary Alice, 14, and Minnie, 12—to a doctor who gave them injections of Depo-Provera before it was approved by the United States Department of Food and Drug Administration (FDA). According to the FDA (2004), Depo-Provera is long-acting progestin (hormone) form of birth control and prolonged use may result in the loss of bone density. When the administration of Depo-Provera was banned pending FDA approval, nurses first took Katie to have an IUD inserted and later sterilized the two Relf daughters, Minnie and Mary Alice. Their mother, told only that the girls would receive “some shots,” signed a consent form (Gillespie). Unfortunately, many incidents such as this took place among African American women as part of the Federal effort to reduce poverty before regulations governing involuntary sterilizations were implemented. Another example of medical experiments performed on Blacks without their knowledge or consent as participants occurred in 1963. The United States Public Health Service, the American Cancer Society, and the Jewish Chronic Disease Hospital of Brooklyn participated in an experiment in which physicians injected live cancer cells into 22 chronically ill and debilitated African

American patients. The patients did not consent nor were they aware that they were being injected with cancer (The Talking Drum, 1998-2003). African American children also have not been exempt. During the 1970s, the government collected blood samples from 7,000 Black youths. Parents were told that their children were being tested for anemia, but instead, the government was looking for signs that the children were genetically predisposed to criminal activity (The Talking Drum).

In the Tuskegee Syphilis Study of 1932, the Public Health Service, now the CDC, promised 400 men-all residents of Macon County, Alabama, all poor, all African American free treatment for bad blood, a euphemism for syphilis which was epidemic in the county. Treatment for syphilis was never given to the men and was in fact withheld (Chadwick, 2002). The men became unwitting subjects for a government sanctioned medical investigation, The Tuskegee Study of Untreated Syphilis in the Negro Male. Therefore, today for some African American women (and men) who are HIV positive or living with AIDS, their immersion into the Black culture and what they have grown to believe about others outside their culture have produced anger and rejection toward any medical finding for the virus. Many African American women are in the immersion stage of racial identity. They know that HIV/AIDS is real; however, they do not trust doctors, researchers, medications, or the explanations regarding the disease’s development. Many are often suspicious of the reports, the statistics, data and research, regarding HIV/AIDS. People of color, specifically African Americans, therefore struggle with seeking health care from traditional doctors. Many in the early stages of the disease do not take the prescribed medications or attend follow-up visits because of a lack of belief in the treatment’s effectiveness.

This example not only describes what a person immersed in Black culture may think, feel or believe, but also reflects some of the social factors pertaining to discrimination, racism, and prejudice that many HIV positive (and those living with AIDS) minorities experience constantly in today's society. African American women who hold beliefs such as these would likely resist opportunities to attend clinics, visit health care facilities, or consult with professionals for HIV/AIDS testing or services. Furthermore, many of these women are more likely to receive late diagnoses of their HIV/AIDS status, thereby jeopardizing their chances for survival.

Myths and Rumors and Conspiracy Theory

Often when important events occur in someone's life and if the news around the event is lacking, the possibility of inaccurate rumors can begin to spread. This transmission is usually done orally but can also be done in print without any proof of evidence. Allport and Postman (1947) and Shibutani (1966) note that when important events occur in the lives of individuals and when factual evidence around these events is lacking, ambiguous and inaccurate, rumors tend to spread. The discourse in the public and scientific community around the origin and spread of HIV/AIDS has been confusing and conflicting. According to Hooper (1999), between 1985 and 1988, reputable scientists Saxinger, Gallo, and Biggar (1985) reported their findings of erroneous results from accidental contaminations in the lab that wrongly claimed there were remarkable levels of HTLV-III or the retrovirus positivity in Africa. He further noted that contaminations and false readings from a scientific perspective are bad enough, but with a sensitive topic such as AIDS, there are further repercussions. African scientists and politicians along with some Western sympathizers accused the Western scientist of deliberately slanting results to further the racist agenda that HIV/AIDS came out of Africa (Medina, 2002). Initially pieces of information on HIV/AIDS trickled down and led to much communal interpretation. Additionally, in the United States, the disease threatened some groups more than others when Reagan's presidential administration avoided acknowledging the epidemic (Medina).

The threat of an HIV/AIDS genocidal plot by the United States government can have the negative effect of promoting condomless sex for some Blacks and Latinos (Sobo, 1995). Decreasing risky sexual behaviors, such as using condoms, could possibly become an act of resistance by communities of color to the hegemonic orders of authority and power. Communities of color may believe the government is trying to curtail not only the sexual pleasures and gratifications of Blacks, Latinos and other minorities but also their very existence.

According to Quinn (1997), as many as 20% of African Americans share the same belief that the United States Government is using AIDS to kill off minority groups. In a study of Black church members, 35% believed that AIDS was a form of genocide against African American people (Winningham, 2002). Quinn reported that African Americans who agreed that HIV/AIDS was a form of genocide were often times more likely to have lower levels of education and lower levels of income. Many African American women and men explain various conspiracies in terms of the origin or spread of the HIV virus, describing how they believe that the United States government, Federal Bureau of Investigation (FBI), Central Intelligence Agency (CIA), or even the CDC have planted HIV into Black or Hispanic communities to eliminate their races. Another rumor shared by some African Americans and Hispanics is that there is a cure for the HIV virus that the government has had for a long time. The rumor posits that government actually created the virus from the beginning and has denied access to the cure for African Americans and Hispanics. For many African American women, all the confusion regarding the origin and spread of HIV/AIDS and their sense of powerlessness over it has aided in the rumors and myths. Consequently, these conspiratorial myths and rumors can become the cultural beliefs and themes that have strong influence in communities of color.

Many African American women bear in mind the scientific explanations of the public health advocates but tend to still operate between the minds as science and traditional tales. Medina (2002) discusses traditional tales made by male study participants, such as withdrawing before ejaculation keeps one safe from the virus, or although condoms can prevent HIV transmission, they always slip or tear.

In 1998, the Congressional Black Caucus declared a state of emergency in the African American community because of the devastating consequences of the AIDS epidemic (Cornelius, Okundaye, & Manning, 2000). Despite that declaration, many African American communities still view HIV/AIDS primarily as a gay issue (Cornelius et al.). Because of the prevalence of this misperception, women within these communities may be unaware of or in denial of their own risk for HIV infection (Peterson, Wingood, DiClemente, DeCarlo, & Quirk, 1999).

Self-Efficacy and HIV/AIDS

The concept of self-efficacy refers to the confidence of an individual to perform a particular behavior within a given situation (Glanz, Lewis, & Rimer, 1997). Self-Efficacy suggests that cognitions, environmental influences, and behaviors themselves interact as determinants of each other in a triadic relationship. Motivation toward an activity is thought to be highest if a person possesses high levels of self-efficacy and feels a sense of dissatisfaction with their present state (Bandura, 1977). According to Bandura’s theory, self-efficacy makes a difference in how people feel, think, and act. In terms of feeling, a low sense of self-efficacy is associated with depression, anxiety, and helplessness. Such individuals also have low self-esteem and harbor pessimistic thoughts about their accomplishments and personal development (Schwarzer & Scholz, 2000). Self-efficacy is assessed frequently in HIV prevention research, but there has been mixed evidence on the relationship between self-efficacy for safer sex and sexual risk behavior (Forsyth, Carey, & Fuqua, 1997).

HIV and poverty among African American women and their families are a lethal combination (Logan & Freeman, 2000). The lack of self-efficacy for African American women living in poverty can contribute to low self-esteem and may contribute to poor compliance with health care, increased self-destructiveness, and inadequate use of coping skills. Statistics indicate an increase in HIV-positive cases among Black women age 50 and older. Suicides and homicides account for the fourth and fifth most common causes of death within this population, respectively (Logan & Freeman). Along with the expanded definition of AIDS, an AIDS diagnosis implies hopelessness and death to many people although they may be asymptomatic at the time. A positive HIV diagnosis for these women may threaten their self-efficacy and self-esteem and also present challenges for their perceptions of control over their economical or health status. Opportunities for enhancing their self-efficacy may occur for African American women if they receive education, interventions, and medical assistance culturally appropriate and sensitive to their cultural needs.

Applying Bandura's self-efficacy theory to HIV/AIDS prevention suggests that when people are given adequate information about the threat of HIV/AIDS, they will take appropriate self-protective actions (Bandura, 1977). Heightened awareness and knowledge of HIV transmission and health risks are important preconditions for self-directed change. However, information alone does not exert the influence to change health behavior (such as increased unsafe sex behaviors motivating high-risk individuals to be tested). As cited in Medina (2002), Bandura said that motivation depends on a strong self-belief in one's efficacy to exercise personal control. African American women, who are knowingly or unknowingly at risk, encounter difficulties in practicing safer sex because self-protection might conflict with interpersonal pressures and conflicts. Violence, racism, incarceration, and lack of economic opportunity reduce the pool of potential African American male partners, increase the value of having a mate, and contribute to male dominance in interpersonal relationships (Dicks, 1994; Quinn, 1993; Shervington, 1993). As a result, many African American women perceive that they have little control or self-efficacy over the sexual behavior of their partners and limited opportunity to introduce condoms into the relationship (Weeks, Schensul, Williams, Singer, & Grier, 1995; Zierler & Kreiger, 2000).

There could also be issues of low self-esteem or self-hatred that directly correlates with high-risk behaviors. According to Southerland's (2003) study of 196 sexually active African American female college students between the ages of 18 and 24, many perceived that the benefits of using male condoms did not outweigh the risks of unprotected sex. For example, introducing a condom may suggest issues of trust and may lead to a less stable relationship. St. Lawrence et al. (1998) also report that African American women tend to view condoms in a very negative light. African American women are found to view condoms as an interference with lover spontaneity, as unromantic, and as distracting from sexual pleasure. They also found African American college women to be particularly receptive to the social stigma associated with condom usage. They associate condom usage with casual (uncommitted) relationships, infidelity, disease, and a rejection of emotional intimacy. All of these attributions occur despite information about the dangers of no condom usage and the effects HIV has on the quality of one's life.

Jemmott and Brown (2003) report the results of their pilot study with 12 sexually active African American women between the ages of 20 and 55 who had previous drug detoxification experiences and all who at some point had traded sex for money, drugs, or alcohol. Jemmott and Brown's study shares commonalities with Southerland's 2003 study of African American female college students. With regards to self-efficacy and their ability or desire to negotiate condom use, these women stated that practicing safer sex was more challenging. The women all agreed that one's confidence in one's ability to use condoms might be an important issue. However, most participants thought that it was easier to negotiate safer sex with a newer partner than with an old sexual partner, particularly if condom use was never an issue. To insist on condoms would imply infidelity. In their words, it would imply that one is messing around. The women reported that for women in one-on-one or steady relationships with partners who take care of them and provide them with material things and the substances they desire to be happy, condom negotiation never occurs. The women reported that they could not insist that their male partner use a condom. Making the request would imply that they did not trust each other. In addition, they reported they worried about being physically abused. One participant in this study stated her awareness of her partner's positive HIV status. The participant explained that the positive status was a low priority in the relationship, and she continued to have unprotected sex with him several times.

Women of color infected with HIV/AIDS are a heterogeneous group whose disenfranchised status binds them to a common and often tragic outcome. They are sicker at the time of diagnosis and die far more rapidly than do White males with HIV/AIDS (Dennenberg, 1992). These women present a shocking picture of what can happen to people disempowered because of gender, race, ethnicity, and poverty. They suffer the stigma of a disease associated with promiscuity, illicit drug use, and death (Land, 1994).

In her report on African American women living in poverty in a rural county in Florida, Zook (2003) tells the story of a 14-year-old African American girl who had dropped out of school, was sexually active, and had a regular practice of taking bleach baths. The girl had been taking what she called bleach-and-bubble baths after letting several men give her “gold showers,” the street name for allowing a sex partner to urinate on the girl’s naked body. Zook reports that neither this teenager nor anyone in her household was aware of what could possibly happen to her as a result of this toxic behavior to her body. Other African American women in this same area, many who were HIV positive, shared similar stories of trading sex (oral, vaginal, anal), mostly unprotected, for money to get their hair or nails done or for food. Zook states that poverty, poor education, despair, hopelessness, and low self-worth and self-esteem are some things that many African American women living in poverty face daily. With self-efficacy referring to the confidence someone has to perform a particular behavior within the realm of HIV prevention, that particular behavior could refer to negotiating condom usage with a partner or being tested for HIV (Glanz et al., 1997; Valdiserri, 1989). With the perceived barriers to self-efficacy against HIV/AIDS, many of these women have given up all hope and belief that their living conditions will change. In their daily survival to exist, these women often simply long for someone, anyone, to make them feel wanted, if only for a little while.

A group of low-income African American women participated in a 1998 HIV/AIDS prevention program in Illinois (Dancy, Norr, Marcantonio, & Smith, 1998). At the end of the study, significant effects across time of the participant’s positive attitudes about the negotiation of condom use, knowledge of condom use, self-efficacy to stick to a decision to use condoms, and increased low-risk HIV/AIDS behavior were revealed. The study also revealed that culturally specific HIV/AIDS prevention interventions based on social learning theory and taught by their peer leaders were helpful in promoting attitudes and behaviors conducive to the reduction of HIV/AIDS (Dancy et al. 1998).

Forsyth and Carey (1998) suggest that research on HIV calls attention to the limited evidence of self-efficacy measures. Traditional psychological assessment, which advances a trait conceptualization of social desirability responding, has been adopted in HIV prevention research. Not surprisingly, this approach has revealed no relationship between socially desirability bias and efficacy beliefs (Forsyth et al., 1997). One limitation of these findings is that investigators attempted to predict dynamic efficacy beliefs from items reflecting stable personality traits, with the latter having no clear relevance to the HIV domain. Failure to find significant correlations among social desirability, self-efficacy, and HIV risk behavior may be attributed to incongruences inherent in the assessment. Participants may present in socially acceptable ways when asked about HIV-risk behaviors but do so in ways that are not detected by trait measures of presentation bias. Just as risky sexual behaviors may be under reported, beliefs like self-efficacy for risk reducing behaviors may be over reported (Forsyth & Carey).

Therefore, with the fight against HIV/AIDS in the African American community, the need to translate health knowledge into effective self-protective behaviors and self-efficacy for HIV/AIDS for African American women must reflect self-regulating and social skills. It must also yield a sense of power that exercises control over the major modes of HIV transmission, sexual and drug activities, and their daily survival. According to Logan and Freeman (2000), the lack of culturally appropriate interventions for African-American families headed by women is a barrier to their seeking health care. To present a culturally sensitive message to African American women living in poverty who are at high-risk for HIV or who are sexually active and not consistently practicing safe sex, the self-efficacy message should help African American women understand the differences among constructs from related social-cognitive theories (e.g., self-efficacy, outcome expectancies, behavioral intentions, behavioral difficulty, self-esteem and optimism). The message should encourage African American women to develop a measure of self-efficacy for any health-related behavior that avoids confounding self-efficacy with these other constructs. Finally, if the health behavior is socially stigmatized (e.g., sexual behavior or illegal drug use) or if social norms suggest that one should engage frequently in a behavior (exercise), the message or interventions should focus on how social desirability response biases might improve their self-efficacy and self-esteem (Forsyth et al., 1997).

Drug Use and HIV/AIDS

African American women are at very high risk for disease transmission primarily as a result of injection drug use and secondarily as a result of unprotected sexual activity with infected bisexual partners and with heterosexual injection drug users (Land, 1994). Karon, Fleming, Steketee, and DeCock (2001) indicate that the proportion of HIV cases acquired through heterosexual contact has increased and almost equals the proportion of cases attributable to injection drug use. According to the CDC (2001b), HIV/AIDS Surveillance Report, the proportion of all AIDS cases reported among women has tripled since the mid-1980s, primarily as a result of heterosexual exposure and secondarily through injection drug use. Minority groups are the most heavily affected by HIV associated with drug injection (CDC). African American women who are heavy users of alcohol and other drugs or those who normally combine alcohol and other drugs with sexual activity place themselves at high risk for HIV and are likely to engage in unsafe sex.

The spread of HIV among injection drug users, their sexual partners, and their children that are HIV positive account for a major percentage of new HIV infections in the United States. As of winter 1997, injection drug use accounted for one third of all AIDS cases reported to the CDC, with women, children, and minorities disproportionately affected. A few key statistics from Stein (1997) to keep in mind follow are as follows:

1. Between 44% and 46% of all women diagnosed with AIDS had injected drugs.
2. Approximately 17% of women with AIDS were sex partners of male injection drug users.

3. Fifty-three percent of babies with AIDS were born to mothers who injected drugs or were sex partners of male injection drug users.
4. Thirty-five percent of all male African Americans with AIDS and 36% of all male Hispanics with AIDS had injected drugs.

For some African American men causes such as unprotected sex, intravenous drug use and sharing of injection equipment has attributed to their high risk factors for contracting HIV. Additionally, some heterosexual African American women have become infected with HIV through unprotected sex with men who are or have been intravenous drug users Gibson (1998). Programs such as the Needle Exchange Program (NEP) have been implemented successfully in a number of communities of color and have proven beneficial in the decrease of HIV/AIDS cases. According to Gibson (1998), injection drug use is a major risk factor for HIV infection in the United States and numerous other countries. In the United States, injecting drug users now account for more than one third of new AIDS cases and for a majority of new HIV infections.

In their study to better understand the types of substance abuse and dependencies found in a detoxification unit that put African American women at high-risk for HIV, Jemmott and Brown (2003) discussed with the participants the various types of substances they used. Participants used drugs such as marijuana, crack cocaine, turbo (a combination of crack and marijuana), reefer, cocaine, weed, LSD, PCP, angel dust, alcohol, and various types of pills. In relation to the difficulty of practicing safer sex and reducing the risk of HIV, they discussed the interaction among the types of substance dependency, the stages of high dependence on the drug, the type of sexual behavior, and the stages of sexual arousal by engaging in touching, rubbing, kissing, and penetration. When the participants were asked if the sex is different or better with different substances and if practicing safer sex is more difficult to practice when using some substances as opposed to others, the group responded “yes” to both questions (Jemmott & Brown). The women mainly agreed that the turbo, a crack cocaine and marijuana combination, is the drug that poses the greatest risk for HIV because this drugs leaves one very high and sexually aroused. According to the participant, the person is interested in sex and sex alone, and they claim safe sex or not (Jemmott & Brown). Another participant in the study explained that the consumption of alcohol makes a person feel romantic, good, free, and uninhibited to the point where sex becomes the number one priority. Therefore, according to the participants in this study, practicing safe sex is invariably difficult when using drugs (Jemmott & Brown).

The African American Church and HIV/AIDS

African Americans are said to be the most religious group in the world. In Logan & Freeman (2000) they cite that Gallup and Castelli (1991) report a national poll found that 81% of African Americans were church members; 78% believed religion was important in their personal lives; and 93% felt that religion would become even more important to them over the next 5 years (Logan & Freeman, 2000). Formed in the midst of slavery and continually shaped by the oppression of Jim Crow segregation, discrimination, and institutional racism, the church provides for African Americans a means for coping and surviving in a hostile world (Morris & Robinson, 1996; Washington, 1994). Wright (1941) described the African American church as a place where tired bodies are dipped in the cool springs of hope, where one retains his or her wholeness and humanity despite the blows of death. Over the years, the African American church has performed various functions other than religious practices. For many, the African American church often served as a place to meet, where members of the community could not only experience fellowship but also pass the news, take care of business, and find strength of purpose. Often when access to the dominant culture, institutions, and services were denied, most African Americans turned to the church.

With the many issues involving African Americans and HIV/AIDS, not only have many leading Black organizations chosen to remain silent, but many African American churches and their leaders remain silent as well. HIV is a disease that is spread primarily through sexual contact, and many churches, not just African American churches, have often been a stumbling block, contributing to the denial, discrimination, and suffering of individuals and their families infected with HIV or dying from AIDS. Many African American churches in dealing with the issues of HIV/AIDS have simply chosen to play it safe and not get involved with any issues surrounding HIV/AIDS.

There are many African American women and men who are desperately in need of healing from the ravages of HIV/AIDS. For many of these individuals, the wall of fear and shame draws them apart from others and the African American church and leaves them fearful to share their stories or to reach out for help. Many would agree that in most African American churches, people are reluctant to address HIV/AIDS beyond a moral standpoint. Although many African Americans spend a great deal of time at church congregating and the church setting could easily be an avenue to disperse HIV/AIDS information to those who attend, the needed discussions and dialogues on HIV/AIDS are not taking place.

Unfortunately, at many African American churches, the problem with conducting HIV/AIDS workshops, seminars, focus groups, or dispersing information is that most people do not want their church to know if they or a family member has been diagnosed

HIV positive or has AIDS because of the stigmatism attached to HIV/AIDS. Ronald Henderson, Florida’s Statewide Minority AIDS Director for the Department of Health, explained to Zook in her 2003 Special Report that many African American communities, experience a plethora of churches with large and small congregations. Because of homosexuality, drugs, and other risk factors involved, many churches continue to feel that people with AIDS have sinned and are getting what they deserve. To some degree, this way of thinking still exists even though lesbians are at a very low risk for AIDS since they do not often engage in high-risk sexual behaviors. In any case, the fact that most lesbians do not contract HIV raises a question regarding the notion of God’s curse on homosexuals (Brannigan & Boss, 2001).

Topics of homosexuality, brothers on the down low, heterosexual sex and HIV, drug use, and other issues with proven direct connections to HIV/AIDS remain taboo at many African American churches although many community members are directly affected. However, in order for there to be a true dialogue between those affected by HIV/AIDS in all communities of color, discussions regarding the political, social, and economical impact the virus has on Black communities need to occur. This discussion should include HIV/AIDS and the political, social, and economical impact the virus has on minority communities. It should be addressed by the communities, churches, schools and leaders, and the programs currently being used for HIV/AIDS. Issues such as HIV/AIDS and drug use in Black communities, as well as the extreme, isolated poverty disproportionately experienced by Black women and issues which disproportionately and directly affect poor, less empowered, and “morally wanting” segments of Black communities unfortunately often fall into political issues. The African American church has been slow to move on HIV/AIDS issues that surround the community. Meanwhile, African Americans continue to fall ill.

Church attendance has been identified as another social influence variable for African Americans and was significantly correlated with HIV risk behaviors. That is, as church attendance increased, the number of HIV risk behaviors decreased. This finding lends support to past research suggesting that religious affiliation and regular church attendance may influence an individual’s health by providing a supportive social network and discouraging lifestyles with health risks (Scandrett, 1996). Most religions took a less harsh approach and viewed the AIDS crisis as an opportunity to express genuine compassion for fellow sufferers. Some priests, pastors and ministers have explained their view of AIDS in that it is not leprosy and how they would like to see individuals infected with AIDS compared with the story of the Good Samaritan who found the dying man by the roadside and took him in, cared for him, and paid for his care. Many also believe that AIDS is not a curse from God’s wrath, but that the curse of AIDS seems to be our refusal to meet AIDS sufferers and their families with simple Christ-like charity and love.

In response to this horrendous HIV/AIDS epidemic, some Black churches are taking an increasingly greater role in HIV/AIDS prevention and education. Some African American pastors, their assistants, staff members, and congregants are actively becoming involved in the political issues and decisions made within their communities and having somewhat more access to funding opportunities. This and the findings aforementioned by Scandrett (1996) yield way for HIV/AIDS prevention programs, training, or discussion groups that could be developed within African American churches. The willingness of church leaders to allow HIV/AIDS programs, workshops, or seminars to take place at their churches sets the stage for HIV/AIDS education and prevention efforts to exist.

The leaders of African American churches must also be willing to discuss how drug use and sexuality, in particular African American men on the down low and gay male sexual identity and behaviors, influence the receptiveness of different segments of Black churches and communities toward owning the issues surrounding African American women and HIV/AIDS. In many Black churches and communities, gay sexual identity and now African American men on the down low have been viewed as mitigating one's racial identity and deflating one's community standing. Black churches must be willing to examine the disease from a Christian standpoint instead of the “not-in-my-congregation” position. The continued denial of homosexuality and African American men on the down low often costs the lives of many African American women who attend their churches and has an enormous impact on their families and communities.

The African American church as a body can make a difference in the fight against HIV/AIDS. The church must realize the need for caring, supporting, nurturing, and helping people heal on spiritual, emotional, and physical levels instead of allowing its congregants to continually confront HIV/AIDS alone, many having lost the support of families, friends, and, in many cases, their spiritual leaders. Some believe that although the Black church does not teach acceptance of homosexuality, there is a need to teach compassion in order to have proper education. A high number of the new HIV/AIDS cases are Black women, and contributing to the rapid spread of AIDS among straight, nondrug using Black women are part-time bisexual men who still desire a long-term companionship with a woman (Anderson, 2002).

Since its beginning, the African American church has been active in providing direct social welfare services as well as leadership for social activism through participation in the Underground Railroad during slavery, providing leadership and guidance to freed slaves after the Emancipation Proclamation during the Montgomery Bus Boycott, and more. Today, some African American churches are beginning to understand their unique strength and force in stopping the spread of AIDS in the Black community. During The Black Church Week of Prayer for the Healing of AIDS, the mission seeks to mobilize churches to become community centers for AIDS education and compassion.

The Black Church Week of Prayer for the Healing of AIDS has grown over the years to become the largest AIDS awareness program targeting African-Americans in the United States. The success of the Black Church Week of Prayer for the Healing of AIDS in mobilizing churches to address HIV/AIDS is rooted in the cultural appropriateness of the program. Many Black churches across the nation are assuming their leadership role in the war against this epidemic and are communicating the importance of HIV testing and treatment in their communities. Churches are developing and are implementing AIDS ministries that include HIV testing clinics, housing programs for people living with HIV, and condom distribution programs (The Black Church Week of Prayer, 2001). Some African American women who are HIV positive or living with AIDS and have affiliations to African American churches now share their stories and remind others that anyone can get AIDS, and church fellowships, meetings, seminars, and discussions, provide opportunities to encourage those who are infected and affected and warn others who are not at risk in today’s world. However, many African American communities of faith have turned their backs on someone in their church family suffering from HIV/AIDS. African American churches have the ability to help provide preventive education to decrease the numbers of African Americans contracting HIV/AIDS. When this occurs, new research can then determine the effect these programs have on reducing AIDS/HIV contractions.

HIV Testing and Access to Health Care

Cases of AIDS must be legally reported in all 50 states. Problems arise when persons who know themselves to be HIV infected continue to engage in sex without informing their sexual partners of their HIV status. HIV testing is required of immigrants, military personnel, and inmates in federal prisons (Brannigan & Boss, 2001). African American communities tend to the healthcare profession. A dire lack of medical coverage contributes to the strong resistance to HIV testing among most African Americans. Also, homophobia and discrimination against people who are HIV positive or have AIDS could be diminished, African Americans may be more likely to voluntarily get tested for HIV. Many reports indicate that more African Americans report being tested for HIV than Whites, but African Americans tend to have less knowledge about the availability of HIV/AIDS treatment and programs. African Americans are more likely to be uninsured than Whites; a disparity that also holds for Blacks and Whites with HIV/AIDS according to the Henry J. Kaiser Family Foundation (2006). According to the Kaiser Foundation (2006) a study by the HIV Cost and Services Utilization found that African Americans with HIV/AIDS were more likely to be publicly insured or uninsured than their White counterparts. More than one half (59%) of African Americans with HIV/AIDS rely on Medicaid compared with 32% of Whites (Henry J. Kaiser Family Foundation, 2006). According to a study of 10 primary HIV care sites in the United States, African Americans seem to have less access to highly active antiretroviral therapy (HAART). Even though the overall prevalence of HAART has increased since the mid 1990s, women, African Americans, and injection drug users are less likely to receive the treatment (Gebo, 2005). The racial gap that seems to exist between patients and their providers might also explain the disparity in HIV/AIDS for Blacks. A study of 1,241 HIV positive adults receiving care from 287 different providers in the United States found that African Americans with White physicians tended to receive HAART later in their illness than did African Americans with African American physicians, and both these groups received HAART later on average than White patients with White physicians (King et al., 2004). Another study found that African Americans also were more likely to postpone medical care because they lacked transportation, were too sick to go to the doctor, or had other competing needs (Cunningham, 1999).

Many countries agreed that HIV screening should not be mandatory since it opens the doors for possible discriminatory practices. In Australia, voluntary screening remains in place although medical professionals advocated the mandatory screening of patients who could place healthcare professionals at risk of contracting HIV infection (National HIV Testing Policy 2006). In the United Kingdom, mandatory testing was strongly recommended by some groups for the purposes of obtaining more accurate statistics regarding the incidence of AIDS. However, there are others that believe the United Kingdom government should support policies that encourage voluntary HIV testing for the purpose of more effective access to treatment and care (Singh, 2003). Great Britain's Department of Health argued that testing should be voluntary since there was a danger of discrimination; as a result, the government adopted a voluntary screening policy (Singh). In Japan, voluntary anonymous HIV antibody testing and counseling services at public health centers in Japan were initiated in 1987 (Shima et al., 2004). However, when AIDS became viewed as a public threat despite the relatively low incidence of cases in Japan, the Ministry of Health and Welfare took steps such as urging anonymous screening, and many Japanese were voluntarily tested for HIV (Shima et al.). Officials are also required by law to report anonymously incidences of HIV infection as well as to penalize HIV infected patients who did not comply with prevention regiments. According to the United Nations (2007) Kodera of Japan explains that although birth control pills do not prevent HIV, the ministry banned birth control pills and urged condom use in their place, believing that condom use was a more effective measure against AIDS. Kodera also explains that the Secretary General's report stressed the importance of a comprehensive and multisectoral approach to HIV/AIDS (United Nations). In Africa, the continent hardest hit by AIDS, officials began taking more control over the testing of imported condoms because of fears that defective condoms were being imported from India to South Africa. Also after many years of weak official response to HIV/AIDS, the government of Kenya took aggressive measures to energize its fight against the disease, including the passage of legislation designed to facilitate the importation of cheaper, generic anti-retroviral drugs and the first steps to removing tariffs on imported condoms (Fox, Nkosi, & Kistner, 2003).

In the United States, all cases of AIDS must be reported in all states. However, only 26 states required the (confidential) report of HIV positive cases and the two states with the largest populations of AIDS patients (New York and California) did not require the reporting of HIV infection (Brannigan & Boss, 2001). Knowing who is infected with the HIV virus or has AIDS could prevent its spread to others. However, in the United States, there is a compounded problem because some states do not classify HIV infection as a sexually transmitted disease (STD). While 12 states view AIDS and HIV infection as an STD, 16 states view them as communicable diseases, and the remaining states view them as a separate category of disease. No clear, uniform classification of AIDS and HIV exist. The separate and often divergent policies and procedures for handling AIDS and HIV have been created (Brannigan & Boss).

Some reports indicate that in 1993, $940 billion was spent on health care in the United States or 2.1% of the gross national product (Moon, 1993). Most chronic diseases cause two thirds of American deaths while 75% of total health expenditures are spent to treat chronic diseases that are largely preventable (CDC, 2005b). Also, billions of dollars are spent every year on prevention and health promotion by the federal government, but the cost of care for preventable conditions is growing (Partnership for Prevention, 2001). Given the long latency period and the development of effective HIV treatments, AIDS has the potential to consume a large portion of United States health care dollars. According to Bloom and Carliner (1988), the cost of AIDS is defined in terms of monetary and nonmonetary costs. Monetary costs normally include both direct and indirect costs. Examples of direct costs are personal medical care costs, such as diagnosis and treatment and nonmedical costs include research and prevention. Examples of indirect costs represent the production lost to society because of the disease's morbidity and mortality (Farnham & Gorsky, 1994). Nonmonetary costs include the value that AIDS patients, their families and friends, and other members of society place on the suffering and death of AIDS patients and on the need to behave differently to avoid contracting AIDS. In the United States AIDS is responsible for over 15,244 cases per year, 1,270 per month, 293 per week, 41 per day, 1 per hour (Wrong Diagnosis, 2007).

Summary

HIV/AIDS has impacted the world and people from all walks of life. The review of this research indicates there are many themes and common threads that exist not only in the practices and beliefs of African American women but among people from various parts of the world, cultures, and races. The influences and factors that increase the chances of HIV/AIDS infection not only for African American women are those that exist for people throughout the State of Florida, the United States, and the world. Although each country has its own problems and struggles with HIV/AIDS, globally many share some commonalities. Also, there are similarities in people's behaviors that place them at risk of contracting HIV/AIDS. Today HIV/AIDS is a pandemic in some countries and an epidemic in others; it is a global problem. To better understand one aspect of this global problem, my research focused on African American women living in poverty.

CHAPTER III

METHOD

Introduction

This study explored the knowledge, beliefs, and fears of African American women who live in Escambia County, Florida, who live in high poverty, high crime areas and who are at risk for contracting Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). The data gathered were used to determine components of a culturally appropriate HIV/AIDS educational prevention program to reduce the risk of HIV/AIDS infection among African American women.

With HIV being the second leading cause of death for Black women between the ages of 24 and 44, HIV risk preventions and interventions are urgently needed to reduce the risk for HIV/AIDS among African American women. Several studies raise the hope that behavioral interventions emphasizing attitudes, knowledge, beliefs, and fears of African American women about contracting HIV/AIDS can reduce HIV sexual risk behaviors and incidence of sexually transmitted diseases (STD). Evidence from other studies demonstrates that well-designed intervention programs can assist in reducing the number of HIV infections occurring in African American women. Education and prevention strategies are crucial for the promotion of HIV/AIDS risk-reduction behaviors among African American women and teenage girls.

A case study approach was used to investigate the research questions of this study. I implemented a cross-case analysis to identify the patterns and themes that cut across African American women’s perceived knowledge, beliefs, and fears about contracting HIV/AIDS. This process helped me gain an in-depth understanding of each case prior to comparing them with each other. In this study, I gathered and analyzed information from 10 African American women in Escambia County, Florida, to answer five research questions:

1. What do African American women know about HIV/AIDS?
2. To what extent do African American women believe they engage in sexual behaviors that place them at risk of contracting HIV/AIDS?
3. Do African American women fear contracting HIV/AIDS?
4. To what extent do knowledge and fear affect African American women’s sexual behavior?
5. What themes and common threads are there in the practices and beliefs of African American women that place them at risk for HIV/AIDS?

Each research question and the instruments were developed using the University of Central Florida (UCF) AIDS/HIV Questionnaire (Appendix A) and the UCF AIDS/HIV Risk Assessment Interview (Appendix B) as a framework. The research questions and instruments were reviewed by a panel of experts in HIV/AIDS and minority populations for content validity.

This chapter includes the following sections: (a) research setting, (b) research participants, (c) case study method, (d) data collection, (e) instrumentation, (f) procedure, (g) data collection procedures, (h) data analysis, and (i) summary. Approval for this study was obtained through The University of West Florida Institutional Review Board (Appendix C).

Research Setting

African American women participating in this study lived in public or subsidized housing units in Escambia County, Florida. Nearly one in five Escambia County, Florida residents live below the poverty level, and the percentage of Escambia County individuals living below the poverty level in 2003 was 16% (Escambia County Planning & Zoning, 2007). More often, the occupants of public or subsidized housing units living at or below the poverty level are African American women and their children. As of 2003, there were 603 public housing units identified by the Area Housing Commission (AHC) in the city of Pensacola (AHC Receptionist, personal communication, April 5, 2005). The housing is owned and managed by the AHC. Public housing located in Escambia County includes Tucks Court and Tucks Court Addition (120/52 apartments), Zalez Court (98 apartments), Ramellia Court (58 apartments), and various other apartments (75 apartments). Two hundred additional public housing units are located outside the county limits. Other assisted or Housing and Urban Development subsidized housing in Escambia County include the following: Cottage Village (200 apartments), Brentwood Terrace 1 (200 apartments), Baywood Terrace II (100 apartments), Argo Village (200 apartments), The Sorings (187 apartments), and Setson Apartments (150 apartments). The majority of the occupants in these units are African American and female.

Among the state’s 16 largest counties throughout the United States, Escambia County, Florida has the highest poverty rate per capita in Florida. Escambia County has the 17th worst poverty rate per capita among larger counties in the United States.

According to United States Department of Health and Human Services (2005), the definition of poverty varies by size of household. For instance, the threshold for a family of four was $18,810 annually while for two people, it was $12,015 annually.

Research Participants

I gathered information from African American women living in poverty to investigate their knowledge, beliefs, and fears about contracting HIV/AIDS. I selected participants to gain an in-depth understanding of how African American women living in poverty experience HIV/AIDS in their communities. Therefore, the 10 African American women were strategically selected to provide rich information that I used to answer my research questions.

The targeted population for this study was African American women considered at high risk for contracting HIV/AIDS living in public or subsidized housing and living in high crime, poverty stricken areas in Escambia County, Florida. For this study, a purposeful sample of study participants were invited to participate who met the selection criteria of race (African American), gender (female), age (between the ages of 18 and 55), location and county (living in public or subsidized housing units in Escambia County, Florida), economic status (living at or below the poverty level), and living in the housing units between the timeframe of August-December 2005. All participants were recruited by word of mouth to participate in the study. The recruitment process continued until the desired number of study participants had been met. The majority of the study participants included single parents. Some had education beyond the high school level, and some had not graduated from high school. If employed, they normally earned low wages.

Case Study Method

A case study provides a way to study the particularity and complexity of a single case within a defined context, coming to understand its activity within important circumstances (Stake, 1995). The empirical inquiry investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Merriam, 1998). Within the study, researchers look for the details of events within a defined context, expecting to catch the complexity of a single case (Stake). The qualitative analysis process typically helps the researcher describe specific cases and similarities and differences across cases (Patton, 2002). For the 10 African American women participants involved in the study as stated in the introduction, individual case study approaches were used to investigate the research questions. I first analyzed the information gathered from each participant. I then used a cross-case analysis to identify the patterns and themes that cut across the individual experiences of the knowledge, beliefs, and fears of African American women who live in an environment that presents risks for contracting HIV/AIDS.

Approval for this study was obtained from The University of West Florida Institutional Review Board (Appendix C). Information fliers were distributed throughout low-incoming housing areas in Escambia County. I extended an invitation to participate to all residents of the housing areas. Residents agreeing to participate in the study signed the appropriate consent forms (Appendixes D and E). All study participants were informed that participation in the study would occur on a volunteer basis. They understood they could at any time choose not to participate or withdraw from the study. All participants were awarded a $25.00 stipend per session. Stipends were dispersed at the end of the study. Participants were given assurance that they would have complete confidentiality if they choose to participate in the study.

I collected data using two approaches: (a) a standardized, open-ended interview and (b) a questionnaire. Sessions for completing both the interviews and the questionnaires were conducted with each individual in an agreed upon private setting. The interview sessions were not restricted to time constraints, and research participants were allowed to speak freely and openly during sessions. To ensure that all information discussed by the participants was captured for the analysis, each study participant agreed to the interview being tape recorded.

Instrumentation

Survey items and scales used within a culture should be reflective of that culture in order to measure the intended study variables effectively. Therefore, criteria for selecting survey items and scales to be used in a standardized interview were appropriateness of language and reading level for the study population and utilization with populations similar to the study population. I used two instruments in the sessions with research participants. The UCF AIDS/HIV Questionnaire (Appendix A), was developed to determine AIDS/HIV-related knowledge, attitudes, and behaviors, used in a standard session with each participant. This instrument has been used extensively in assessing and predicting AIDS-related knowledge, attitudes, and behaviors and was initially developed by selecting items from previous epidemiological studies of adolescents' knowledge, attitudes, and high-risk behaviors regarding AIDS (Lanier, DiClemente, & Horan, 1991; Lanier & McCarthy, 1989). The UCF AIDS/HIV Questionnaire includes 73 items divided into four sections for analysis: (a) knowledge

(19 items); (b) attitude (26 items); (c) behavior (23 items); and (d) sociodemographic (5 items). For the purpose of this study and to align with the research questions, the sections on the questionnaire were modified and included an additional analysis section covering items of fear and common themes and threads. Also, items per section differed from the original instrument as follows: (a) knowledge (37 items); (b) attitude (3 items); (c) behavior (8 items); (d) knowledge and fear (8 items); and (d) common themes and common threads (14 items).

Instrument 2, AIDS/HIV Risk Assessment Interview (Appendix B), consisted of 37 open-ended questions focusing on the research questions. It also covered the majority of issues measured by the questionnaire. For the questionnaire and the interview, a brief description of each construct follows:

1. Knowledge items measured objective knowledge including methods of transmissions and means of preventing or reducing risk for infection.
2. Fear items measured the extent that contracting HIV affects their sexual behaviors.
3. Attitudes measured included self-efficacy, personal risk, friends' risk for becoming infected, and magnitude of HIV/AIDS epidemic.
4. Self-reported high-risk behaviors included unprotected sex, sex with multiple partners, and injecting drug use with needle sharing.
5. Sociodemographics included age, race, ethnicity, gender, and length of time living at present housing location.

Procedure

I contacted local housing area managers to gain permission to conduct the study. For 3 months I visited the housing complexes, occasionally meeting and greeting the housing residents informally. During this time, I also participated and conducted weekly educational, aerobic, and empowerment sessions allowing for more opportunities to become acquainted with the research participants and establish trust. In the housing office, I posted a schedule covering approximately a 6 week time period for the AIDS/HIV Risk Assessment Interview that listed available dates and times. After receiving participants' consent to participate in the study, we agreed upon a location for the interview sessions. Participants met with me 2 times. In the first session I administered Instrument 1, the AIDS/HIV Questionnaire. Instrument 2, the AIDS/HIV Risk Assessment Interview, was administered in the same manner at another session. Throughout the research study and approximately 3 months thereafter, I continued to participate and conduct weekly empowerment sessions. After all research instruments had been administered and if no follow-up sessions were needed, each research participant received her stipend for participating in the study.

Data Collection Procedures

Semistructured interviews allow for questions that are more flexibly worded. Semistructured interviews are guided by a set of questions and issues to be explored, but neither the exact wording nor the orders of questions are predetermined. Usually specific information is desired from all the respondents, in which case there is a highly structured section to the interview (Merriam, 1998). I used a semistructured approach in addition to the standardized interviews to allow fresh insights and new information to emerge from the study participants. An interview guide containing the questions I intended to ask the participants was developed and used to ensure that the same basic lines of inquiry were presented during each interview.

The purpose of each interview with the participants was to gather data aligned to the research questions of this study. The framework of the interview allowed each participant to respond in her own words expressing her individual perspectives. I completed the interviews and questionnaires in a private and quiet setting that was agreed on by the participant. To ensure that all information discussed by the participant was captured for the analysis, each study participant agreed to the questionnaire and the interview sessions being tape recorded. Sessions were held with each individual to complete the standardized questionnaire and the interview.

A copy of the definitions of terms in the study and study instruments were given to each participant along with a large, brown, unidentifiable envelope. The participants were instructed that the envelopes were to be used at the end of the session. Participants were assigned pseudonym names; these pseudonym names were used in the written report of the study. All participants were asked to identify themselves during the face-to-face interviews; however, they were requested to not reveal their real names on the questionnaire. Each research participant agreed to participate in the study. While administering the questionnaire and the interview, I read aloud the purpose of the study, the informed consent form (Appendix D), and definitions of terms in the study needed for the survey instruments. After addressing their questions, I collected the signed consent form provided to each participant. Each study participant kept a copy of the consent form in case questions arose at a later time.

To allow all study participants to participate regardless of their reading levels, I read aloud the questions when administering both the questionnaire and the interview. The AIDS/HIV Risk Questionnaire took approximately 15 to 30 minutes to be administered. Approximately 3 to 4 weeks later, using the same procedures outlined above, all participants completed a 45-60 minute AIDS/HIV Risk Assessment Interview. The interview was administered once over a 6 week time period to each of the 10 African American women participants. At the end of each session, participants were instructed to place their completed information into the envelopes provided and to seal the envelopes.

Data Analysis

I analyzed each interview text from the transcribed tapes for the 10 study participants, identifying the common themes and patterns of the responses. I also analyzed the interviews by research question, identifying the patterns and themes by case for each question and the patterns and themes across cases for each question. Once the patterns, themes, and categories from the interviews and questionnaires were established through the analysis process, I used the analysis from this data to answer my research questions.

Four survey items were included to verify that all study participants met the study’s criteria of race (African American), gender (female), age (between the age of 18 and 55), and residence (currently residing in subsidized housing units in Pensacola, Escambia County, Florida). The completed AIDS/HIV Risk Assessment Interview (consisting of 37 open-ended questions) and the AIDS/HIV Questionnaire (consisting of 70 items) were manually coded to align with the research questions. To minimize data entry errors, the data were double-checked by taking each of the surveys and visually comparing the responses to the questions with the entries in the data set.

Limitations

The participants' perception of what it means to live in poverty became one overarching limitation of this study. Their perceptions did not necessarily align to the definition of the United States poverty index. The Health Belief Model's framework uses this index as a way to define poverty to define self-efficacy or one's confidence in the ability to successfully perform an action. Although the participants in the study lived in low-income housing with household incomes below the national poverty index, many of the participants did not perceive themselves as living in poverty nor was there a desire or effort to move out of their current economic status. My initial survey questions directly addressed questions of poverty. However, during my first interview I realized that my definition of poverty and the United States poverty index differed from many of the participants' definition of poverty. Not wanting anyone to be offended by the use and definition of poverty, I reworded some of the questions by taking out the term poverty. Therefore, the initial way I framed my study using the Health Belief Model had to be modified when making interpretations of the study results.

I witnessed two other limitations or possible barriers when working with the participants. Scheduling meetings with study participants seemed quite challenging. Most of the participants had smaller children, and it was often difficult to conduct meetings and interviews due to constant interruptions. Also, I used instruments that to some degree required the participants to provide written responses, although both instruments were read to each participant. The varying literacy levels of the participants could have influenced the data collected.

Summary

In summary, I administered two data collection instruments individually with 10 African American women living in low-income or subsidized housing in Escambia County, Florida. I analyzed the information each participant provided and then compared this analysis for all participants. Chapter 4 provides a description of the responses of each participant, and analyzes the responses for all 10 participants to address the five research questions.

CHAPTER IV

RESULTS

The purpose of this study was to explore the knowledge, beliefs, and fears of African American women about contracting HIV/AIDS with the aim of identifying any common themes of these variables. I used these findings to create recommendations for education and prevention strategies to reduce HIV/AIDS risk behaviors among African American women and teenage girls. To achieve the research goals, I addressed five research questions:

1. What do African American women know about HIV/AIDS?
2. To what extent do African American women believe they engage in sexual behaviors that place them at risk of contracting HIV/AIDS?
3. Do African American women fear contracting HIV/AIDS?
4. To what extent do knowledge and fear affect African American women’s sexual behavior?
5. What themes and common threads are there in the practices and beliefs of African American women that place them at risk for HIV/AIDS?

Entering the Field

The study was conducted in Escambia County, Florida, where approximately 25 women volunteered to participate. The housing staff assisted me with the intake of the participant pool. Although many volunteered to participate in the study, the staff advised me on the participants that they believed would and would not successfully complete the study. They explained that some of the candidates might complete only the first session, if that much, and might prove to be a waste of my time and efforts. After the housing staff assisted me with screening those volunteering to participate, I randomly selected 10 African American women from a group of 25 to participate in the study.

The targeted population for this study was African American women considered to be at high risk for HIV/AIDS mainly living in public or subsidized housing or living in high crime poverty stricken areas in the City of Pensacola located in Escambia County, Florida. Upon entering the field to administer the survey and the questionnaire, I received requests to participate in the study from not only African American women, but also Caucasian and Hispanic women. However, for this study, a purposeful sample of study participants who met the selection criteria of race (African American), gender (female), age (between the ages of 18 and 55), location and county (living in public and/or subsidized housing units in the city of Pensacola, Escambia County, Florida), economic status (living at or below the poverty level), and living within the housing complex during the time frame (between August-December 2005) were invited to participate.

Some of the women selected to participate in this study did not fit the description of the typical welfare moms or recipients. The women were all African American, and their ages ranged between 22 and 46 years. Their educational levels ranged from having an undergraduate degree to current enrollment in a GED program. Of the 10 women participants, all but 1 indicated they had received a high school diploma. One participant recently graduated from college with her degree in teaching, and another participant is due to receive her bachelor’s degree within a year or so. Four participants indicated attending some college beyond high school but did not receive a degree. One participant indicated she attended vocational school after graduating from high school. Two participants indicated they had no other formal education or training beyond high school. One participant was enrolled in a General Education Program (GED) trying to complete her GED. The occupations of the 10 women ranged from school teacher, law enforcement officer, bank clerk, administrative assistant, secretary, receptionist, telemarketer, and day care worker to unemployed. Six of the women were single mothers; 4 had no children. Five of the women indicated they were involved in a relationship with a significant other, and 5 participants indicated they were not. All participants successfully completed the survey process.

Reice McKinney

Reice McKinney was 29 years old. I observed Reice as being a nicely groomed woman who presented herself well throughout our session. She explained that she was a part-time student at the university majoring in Health Education and hoping to graduate within a year or so. She worked part-time at a local bank as a clerk. When questioned as to why she resided within the low-income housing area, she explained that she currently lived with her mother who is disabled and also raising the children of her older sister. Her sister, by her own choice Reice explained, no longer had contact with her family or her two children because of years of drug use. Because of the mother’s disability and the assistance the mother needs with the children, it was best for Reice to live with her mother for now. The participant quickly explained that this situation was only temporary and that she had only been living with her mother for the last year or so. Her younger sister also lived with her mother and was able to help take care of her mother and the children; however, she moved away to attend college. She explained that when the situation gets better for her family, and she would be comfortable leaving her mother alone, then she would leave. She claimed she would move back into her own place to live in her own space with privacy.

She briefly addressed how living in the housing area for the last year had been a major adjustment for her. Reice shared that she was raised most of her life living in low-income housing areas and once she moved out, she never had a desire to move back. While growing up, she always dreamed of having a better life for herself and her family and of moving away from the projects. She shared a common theme that I've often heard spoken within the African American community by those who were raised in low-income housing. She always wanted something more than the projects, no longer having to receive government assistance and being able to provide for her family. She talked of being able to make enough money to move her mother out of low-income housing, being financially stable to support herself, and having better things in life. Reice's short and long-term goals such as continuous employment, attending college, and one day getting her Ph.D. validated her desire to improve the quality of life for not only herself but also her family. She also talked about getting married, having children of her own, and settling down possibly in a city somewhere other than Escambia County, Florida.

This participant was knowledgeable in many areas about HIV/AIDS. She also happened to have the highest number of sexual partners of the 10 women. When I asked about the number of sexual partners she had had within the last 10 years, she was unsure and said, "I know more than 20 something." Giving more insight to her high number of sexual partners, she shared that while growing up, having sex was no big deal. It was what teenagers did. However, now that she was older and understood the values of being a woman, she did not sleep with any and everyone. She shared that she had also been tested for HIV and tested negative. She indicated that she takes protective measures against becoming infected and pregnant and is proactive in the sexual negotiations process with her partners. She wittily shared her belief that if women are going to “give it up,” then they should be proactive as to whom, how and when they “give it up.”

This participant also shared what I thought was in-depth information about being an African American female, being raised in the projects, working and living in a predominately White male setting and society, and being sexually active. She shared that she believed her White male coworkers viewed her (and other African American women) as being good enough to sleep with but not good enough to be seen with in public or date or marry. She shared that she viewed herself as a fairly attractive Black woman. However, she believed that the White men she worked with probably would perceive her as being too thick and bordering along the lines of fat. I listened carefully, wanting to ask if she had ever been involved with any of her White male coworkers and wondering why her thoughts flowed along this path. As though she read my mind, she immediately explained that although she had never been sexually involved with any of her White male coworkers, she spent a lot of time talking and joking with them at the office. She had on a few occasions given consideration to hooking-up with one of her White coworkers outside the office, but her perceptions about their thoughts of African American women bothered her so much that she never got involved with any of them in a sexual relationship. She then shared that she was currently involved with an African American male who lived out of the city. They had been involved in a long distance relationship for over a year. They saw each other twice a month with either him coming to visit her or her going where he lives. They had protective sex *most* of the time.

During our sessions, Reice asked several questions regarding HIV/AIDS and discussed that she shares with her friends the need to protect themselves against HIV. Before having to move in with her mother, she discussed having hosted a party at her apartment. She went to the Health Department and other places to pick up free male and female condoms which she included in the gift bags she presented to her party attendees. She explained that she was trying to give something fun and serious at the same time. She shared that she had once dated a guy who was in prison for a while. She had real reservations about becoming sexually involved with him once he was released from prison. I asked why. She shared she had watched television specials about Black men on the “down-low,” men having sex with other men while in prison. She had read and heard about the increased rates of HIV/AIDS for African American women becoming infected by Black men who live on the “down-low.” Reice explained that she believes men living on the down-low were an increasing problem for the African American population and one that she did not believe was being addressed. She explained that in most Black churches where HIV/AIDS information could possibly reach a larger number of Black people, it was not being discussed. Reice said, “It is like people are afraid to talk about HIV/AIDS, or they do not want to talk about how HIV/AIDS is killing Black people or about how some Black men are having sex with other men, then having sex with Black women and infecting them with the HIV virus.” Reice and I met twice to complete the survey and the questionnaire, and both sessions were completed successfully.

Suzie Brown

Suzie Brown was 34 years old, a recently divorced mother of two beautiful girls and worked full-time as an administrative assistant. She presented herself as being an outwardly positive person and appeared to be very in-touch with her children and a positive role model and influence for the other young ladies who frequented her home for various reasons during our sessions. She was somewhat tall and appeared quite ambitious, and she and her children were always well groomed during my time with them. Her small apartment where we met to conduct our study was neat and clean.

Suzie indicated that she was born and raised in Escambia County, Florida. She moved away with her husband years ago to another state. After their divorce, she returned back to Escambia County, Florida and had to seek the aid and assistance of government housing while she tried to get back on her feet; she has been in the housing area for almost 2 years. Suzie explained that she had never lived in a government housing complex before and had many reservations upon moving there and bringing her children there to live. Suzie is recently divorced; immediately it became obvious that she was definitely dealing with many issues from the divorce. Suzie became emotional as she talked about her life. She feared raising her children alone in the projects as she tried to recover from her divorce. She feared starting over in a new relationship at some point in her life, and she feared Black men on the down-low and all that she has heard about HIV/AIDS.

During our sessions, her children passionately called her “Mommy” and hugged and kissed her often. Her children appeared to be well-mannered and well-behaved and enjoyed playing and watching TV. Suzie, at her own submission and somewhat early at the beginning of our session, began to share personal information about the dissolution of her marriage and how she had to go through HIV testing because her ex-husband became involved with other women and abandoned their family. She explained that before everything happened (referring to the marriage ending), she really did not know or give much thought to HIV/AIDS; she is not HIV positive. However, many things changed and changed very quickly. She softly shared that her ex-husband was the only man she had ever been involved with sexually. She spoke of getting through what she defined as the healing stage of her life but knew that she was still hurting from many issues surrounding her divorce. She also shared that at the beginning of the separation, she attended marital counseling; unfortunately, she no longer was able to afford the sessions. The divorce process seemed like a death to her. She explained that since the divorce and relocating, she and her girls have had to make major adjustments in their lives, but pointed out they are making it okay. During the interview, the oldest child witnessed her crying and asked "Mommy, why are you crying," offered her a tissue and hugged her. At one point, we were all crying during the first session.

Suzie explained how drastically the goals in her life have shifted within the last year. She explained that her short-term goal for now was simply to get on her feet, become financially stable, and properly provide for her kids and herself. Once she established this goal, her long-term goal was to complete school, get a bachelor's degree in business, and possibly start her own business someday. She explained that early on, her focus was to get out of the housing complex because she did not want to have to raise her girls in the projects or in high-crime areas. However, after adjusting to the environment, which she explained was not as bad as she thought it would be, she and her kids had made friends and acquaintances. She added that most of her fears, doubts, and concerns regarding living in a housing project were from stereotypes of project lifestyles. She explained that since she had been living there, she met many good people trying to make it from day-to-day just like her.

Suzie presented herself as being somewhat knowledgeable regarding many things about HIV/AIDS. She had many fears about becoming involved with someone else in this day and age because of HIV/AIDS and explained that since her divorce, she would not know where to begin in the dating scene. Most of her responses regarding HIV were those that addressed issues with all mankind, education, and protecting children. She held strong beliefs that the more everyone is educated and informed about HIV/AIDS, the more they will choose to protect themselves. She reiterated that until the infidelity issues with her ex-husband and the possibilities of entering the dating scene, she was unaware of most things regarding HIV/AIDS and Black men on the down-low. Suzie believed that first educating oneself and then educating others were key factors to solving the problems with HIV/AIDS in America. Suzie was very cooperative every time we met and thanked me over and over again for the opportunity to learn more about HIV/AIDS and participate in the research. At our last session, a few of Suzie's neighbors dropped by to use the phone for a short pop-in visit. It was interesting to listen to Suzie share what we had discussed in our sessions with the women who came to her home. Most of these young women were single mothers. She made comments to them such as "Do you need any of these condoms or HIV information?" Each participant received an information packet from me at the end of our last session, which included male and female condoms. Susie explained that it was her way of giving back to her community, friends and family and it was the least that she could do to help educate others.

Willamena Williams

Willamena Williams was 22 years old. I observed her as being quite pleasant; she lived in the complex with her grandmother. She explained how she was abandoned as a child by her parents and, therefore, had always lived with her grandmother. Willamena appeared really excited about the opportunity to participate in the study and showed up rather early for the session. Willamena and research participant four, Taneka Blackburn, a 39-year-old slightly overweight young lady, were often conveniently located in the same areas of the complex. They often spent a lot of time together. The three of us agreed to meet in the recreation room of the complex. In my attempt to save us some time, I asked if the participants did not mind if I administered their interviews in the same setting; they both agreed. During the first session, I quickly observed the different educational levels, obvious differences in maturity, and age differences of the two candidates making this approach unworkable. Both participants had a copy of the AIDS/HIV Questionnaire and AIDS/HIV Risk Assessment Interview. I asked them to follow along as I read the instruments aloud to both participants. It was quickly evident to me that Willamena either had difficulty reading and comprehending the interview material or was not able to fully understand all of the basic terminology. Not wanting to offend or embarrass anyone, I explained that I'd never administered the interview to two people at the same time and felt that this method was not the best way to conduct the interview session. With the assistance of Willamena and Taneka, I rescheduled the sessions for specific times and places for each participant.

When I met with Willamena in a one-on-one session, the interview flowed much smoother. It became more obvious that Willamena had difficulties with engaging in a learning situation. Willamena shared that she had been enrolled in a GED program trying to obtain her high school diploma. She shared that she had been in this program for the last 3 years and was in special education courses during her time in public school. I asked her why it had taken her so long to complete the GED program. Willamena explained that her teachers felt she was not ready to take the GED exit exam again. Outside of our scheduled sessions for the study, I offered to meet with Willamena and work with her on her GED preparations. When we met, it appeared to me that Willamena had problems with terminology, reading comprehension, and math. This also somewhat explained to me the comments Willamena shared that her teachers had made regarding her progress toward passing the GED exam and possibly why she had not passed.

Willamena did not drive nor did she know how. She used the public transportation system or depended on her grandmother to go back-and-forth wherever she needed to go. When I met her, she was not employed, and her short-term goal was to get a job at Wal-Mart. It did not matter in what position; she just wanted to work at Wal-Mart. I noticed whenever Willamena spoke of working at Wal-Mart she became really enthusiastic and would often mention some of her friends who also worked at Wal-Mart. To assist her with becoming employed at Wal-Mart, I inquired with several of the local Wal-Mart stores regarding the process for employment. I began to pay more attention to employment signs whenever I saw them at Wal-Mart and shared the information with her. I taught Willamena how to follow-up and follow-through on an application once she submitted it to Wal-Mart; she had never done this before. During the time I spent with Willamena, I observed that she was excellent with children. She shared that she had previously worked at various daycare centers working with children, which she enjoyed. Therefore, I assisted Willamena with gaining temporary employment as a childcare provider on a grant-funded project that I knew was being offered at her church that assisted Hurricane Katrina victims. The job paid Willamena $12.00 an hour, the most money she had ever made in her life. She was ecstatic when she received her first paycheck. Willamena successfully worked for the grant for approximately 12 weeks.

After our interview sessions were over, I continued to keep in touch with Willamena. She shared that although she had not completed the GED program nor gotten on at Wal-Mart, she had a long-term, part-time job working in food service.

During my interview sessions with Willamena, she responded freely to my questions. However, she appeared somewhat shy and unsure of her comments regarding HIV/AIDS. She explained that she really did not know that much about HIV/AIDS and had only heard about it on TV and from others talking about it. Willamena did explain that she was sexually active with her boyfriend, a 46-year-old married Black man. I questioned if she had ever had an HIV test, and she answered that she had. She took the test at the health department where she also gets her birth control and other medicine; the results were negative. Willamena shared that if she was positive, she would not want to know because she would not know what to do. It was obvious to me that Willamena was somewhat vulnerable and could be easily taken advantage of. She wanted to discuss more openly her relationship. Willamena shared that she met her boyfriend at various places; they talked and had sex in his car, hotels, etc., and that she had been seeing him for a while. He occasionally gave her money, bought her things like her cell phone, paid to get her hair and nails done, and sometimes picked her up when she needed a ride. Willamena added that she did not know where he lived nor had she ever met his wife; she did not know whether or not he had children. She explained that she had only had two sexual partners within the last 10 years, including this one she discussed with me.

Willamena was somewhat comical during our interview sessions with her responses, and often she took long deep breaths before she answered. Given her responses, it became obvious to me that Willamena was very limited with her knowledge on HIV/AIDS and often participated in many behaviors that put her at risk for HIV. She shared that she and her boyfriend never used condoms, but she took birth control pills to keep from getting pregnant. When I asked her in the future if she would use a condom if she was unsure of her partner's sexual history, she answered "never" because her boyfriend did not like to use condoms. I found many of her comments to be disturbing and felt it necessary to spend more time with Willamena during the sessions to make sure she understood every question. I also spent a lot of time outside the sessions further discussing HIV/AIDS with her. We also discussed ways to establish trusting relationships and complete the GED and her future long-term plans. She explained that one day she wanted to own her own daycare, get married, and start a family.

I met with Willamena a few times after we completed both sessions because I wanted to share as much information regarding HIV/AIDS as possible with her and continue to follow up with her regarding many of the issues she shared during our sessions. At our last meeting, Willamena was still involved with her married boyfriend and not using the condoms that I had given her in her packet to protect herself against HIV. I asked again why she did not use condoms. Her response was the same that her boyfriend did not want to use condoms because he did not like the way they felt. She was still employed and appeared to be happy with her new job.

Taneka Blackburn

As indicated earlier, Taneka Blackburn was a friend to Willamena. Taneka was a single mother of three: two boys and one girl. During our first session, she discussed with me that her oldest son, a local hometown star athlete, was scheduled to graduate from high school this year. However, Taneka added that she was concerned if he would graduate. He had not passed the state-required exam. It was obvious to me that this was what she wanted to discuss before we began our session. Therefore, we talked about an hour or so discussing avenues to get tutoring for her son.

I observed Taneka as being a pleasant young woman who was very involved with her children and their school activities such as football, basketball, piano practice, etc. In the past, she worked odd jobs such as a childcare provider and receptionist. Just recently, she got the job she had hoped for as a clerk. Taneka, a talented musician and singer, made money on the side singing and playing the piano. She wanted to get her eldest son off to college and continue to provide a strong foundation for her youngest two children. Her goals for herself were to begin taking classes at the local community college to get an associate’s degree and to develop her music career.

Taneka, a divorced single parent, explained that she tried to do all that she could to stay afloat financially and keep her kids out of trouble. She never asked when the $50.00 participation stipend would be given to her but indicated that every little bit of money she got helped her and her kids make it from week-to-week. She also explained that if it were not for the graciousness of other people, she and her kids would have gone hungry many days because money had been so tight. She and her three children had lived in some form of low-income housing for the last 10 years or more. She explained that they did not stay at home enough to really know what was going on in their complex. She indicated normally they were either at church, school, work, or some type of sports events, or they got home late in the evenings when it was time to go to bed.

Taneka and I had to reschedule our sessions several times because of the conflicts in both of our busy schedules. Because we had difficulty with scheduling, I realized it was important to complete both the survey and the questionnaire during our first session. She was very cooperative and agreed to stay the extra time to complete both parts.

Taneka explained that she had never been tested for HIV and did not know if she would test positive or negative. She shared that she would like to be tested. Within the last 10 years, she had only one sexual partner and that was her ex-husband. Nonetheless, she quickly added that to her surprise and discovery, her husband had several sexual partners during their marriage. Therefore, Taneka was more at risk of contracting the HIV virus than she was aware. During my interview with her, she gave much thought to the questions; often she asked questions before or during her responses. I found Taneka’s responses interesting. She often related her answers with her upbringing in church. For example, when questioned, “Would you ever have sex with someone of the same gender?” She excitedly said, “Oh no, I do not believe in that kind of stuff. I was raised in the church. That is not right, and I find behaviors like that simply repulsive.” Many of her responses somewhat followed the same pattern throughout the duration of our interview. However, from a different standpoint, she referred a lot to her teenage son and how she often talked to him about sex, sexually transmitted diseases, getting girls pregnant, and using condoms. At the end of our session, she shared with me that she would give the condoms that were in her information packet to her son and his friends so that they could protect themselves.

Taneka questioned if I would be willing to conduct an HIV/AIDS information session or seminar-type event at her church. She explained that during our interviews, she became aware of the serious consequences of being HIV positive or having full-blown AIDS. She realized that these consequences could affect not only herself but also her family, friends, and her future. She believed that most Black women simply were not aware of how at risk they were when they had unprotected sex, which she believed many of them had. Her eldest son walked in at one point during our interview. She shared that he had passed the requirement for the state exam, was on track to graduate, and was on his way to college. I gave her son a big round of applause. At the end of our session, I gave Taneka her packet which included her $50.00 stipend. With a big smile, she thanked me, commenting she had a bill that was due.

Temple Sooner

Temple Sooner was a 32-year-old single mother of five: three boys and two girls. She had four of her children with her. The oldest child, since the age of 6 months, lived with Temple’s parents. Within the last 5 years, Temple had lived in 5 or 6 different housing complexes both in and outside of Escambia County, Florida, including hotels. She explained that she and her four children had been homeless a few times, forcing them to live in either a shelter or a hotel. I inquired as to the circumstances that led her to moving from complex to complex or becoming homeless. She shared many different situations. In one instance she moved her children from what she defined as one really bad housing complex to a complex that she believed was better managed with well-managed playgrounds. She stayed there for 3 years until she moved out with her boyfriend to a trailer park in another city. She said that after that relationship became physically and emotionally abusive, she relocated back to Escambia County, Florida. She lived with her parents upon her initial return to Escambia County, Florida, and then got her own place. Temple shared that once she had violated some of the rules for low-income housing; at that time she was no longer eligible for low-income housing although she still qualified for food stamps and health benefits. It was during this time that she and her children lived with her grandmother for a while. This arrangement was short-term, and they moved in with Temple’s boyfriend’s father. Finally, they got their own place.

However, this situation did not work for various reasons, so they moved into a hotel. She was able to get recertified for public housing and had been in this complex for a year.

I observed Temple as being a heavy smoker, often not well-groomed, and a somewhat small-framed woman. I observed her with her children on many occasions. Her children were not as well-disciplined as many of the other children I had observed. Her kids were often dirty and left to themselves watching TV. Her children seemed to enjoy entertaining each other. She shared that her oldest son was having trouble at school with his teachers; her kids had switched schools more than five times within the last 2 years. Her smallest child, a little boy somewhat less than a year old, needed medical care because of severe bronchitis. While I was present at Temple’s home, the child’s grandmother, Temple’s mother, stopped by for a short visit. The grandmother threatened to take the child to the doctor if Temple did not take him the next morning. Temple assured her mother that the baby had an appointment with the pediatrician first thing the next morning. The other two children I noticed needed much attention given to their ability to speak properly and form their sentences correctly. I asked Temple if her smaller children were attending school on a regular basis and how were they doing in school. She explained that with the family having moved around so much, it had been difficult getting them on track to do better in school. While I was conducting this study with Temple, I noticed Temple spent little time with her children reviewing their school work, reading, or correcting their sentences when they spoke incorrectly. Temple loved to read and shared with me several books that she had read or was preparing to read. I offered the suggestion to her to turn reading into a family event, possibly allowing her oldest son, who Temple indicated loved to read, to read a short story out loud to everyone or that she read a children’s book to her kids. She thought this was a wonderful idea and said she would give it some thought.

It was difficult to set up our sessions because Temple did not have a house phone, and her cell phone was often out of service. I made several attempts to reach Temple before we actually sat down to complete the study. When we finally set up our second appointment, I realized the importance of completing both the questionnaire and the interview with her during our second session. I was concerned that it would be difficult to get in touch with her to complete the second session. However, during our first session, we had many interruptions with her children, her boyfriend and, her boyfriend’s friends and neighbors. Therefore, a second session was necessary.

During our first session, Temple shared that she was an only child and grew up in a military family. She shared she had lived both in and outside the United States. She explained that she always wanted to have brothers and sisters, and this was why she had five children of her own. Temple explained that she had never been married but hoped to someday get married and settle down. She also shared that the guy she was dating was not someone she would consider marrying. I immediately asked her why she was dating him. Temple stated that he was just somebody to be with for now. During the course of our first session, Temple explained that of her five kids, two of them have the same father, and the other three have different fathers. Two of the fathers were involved with their children. She received a small amount of child support from the two of them. She did not hear from the other fathers, and they had no interactions with their children.

Temple indicated that she had an HIV test, and the results were negative. She indicated she had twelve sexual partners within the last 10 years. She stated that she asked her partners about their sexual histories. However, she did not always practice safe sex with her partners, but this was by her own choice after she had gotten to know the person better. I asked Temple if she contracted HIV and developed full-blown AIDS, who would raise her children. She explained that she had never really thought about it from that standpoint. Temple shared with me that her 63-year-old grandmother, who also lived in low-income housing, was HIV positive and also that she had an uncle who died of AIDS. She stated that their family received the news about her grandmother 3 years ago. Temple did not really think her grandmother understood what it meant to be HIV positive or to have full-blown AIDS. She said her grandmother was often sick for various reasons and that her grandmother was under a doctor’s care.

Temple shared that her goals in life for the moment were to have a continuous place to stay for herself and her kids. I asked her what she meant by that and asked whether her current status as a resident at the complex was in jeopardy. Temple explained that something was always going on with her living at this particular complex. She shared that she and some of the residents did not get along well, and her remaining in the complex was somewhat up in the air. Her other goals in life included taking care of her kids and going back to school. Temple explained that she had attended college before to major in engineering; for now, she would be happy just getting an associate’s degree or certificate.

It was difficult to set-up the second session with Temple because she was never at her apartment, and her cell phone was no longer in service. I actually ran into Temple one day at an event and took advantage of that opportunity to schedule our next session. We met approximately 3 days later at Temple’s mother’s house because she said we would be free of distractions and we could complete the interview without interruptions. This second session went a lot better than the first session. We completed the interview in a timely manner. At the end of our session, I gave Temple her information packet that included condoms, HIV/AIDS information pamphlets, and her check for $50.00. Since the last time I saw or spoke with Temple, I was informed by others who lived in the complex that she no longer lived in the complex and was once again living in a hotel with her boyfriend and four children. I was also informed that Temple was being investigated for possible child neglect and abuse.

Cynthia Whatley

Cynthia Whatley was a 46-year-old single mother of one son. Cynthia also helped take care of her grandchild, her niece, and her brother. They all lived with her, and this arrangement seemed to allow her to be eligible for low-income housing. Cynthia informed me that she was in the process of purchasing her first home through Housing and Urban Development. She was excited about becoming a homeowner. Cynthia appeared to be a confident, no nonsense woman who presented herself very well and appeared to have a strong influence within her family and with others whom I saw interact with her. She had been a security officer for several years, a job she said she loved. Her goals in life were to purchase her first home, continue to help raise her grandchild, and get everyone else out of her house so she could live alone.

Cynthia thanked me for the opportunity to participate in the study and hoped that this type of educational information could continually be made available for the people who live in her complex and other places. She believed that too many people have already died from AIDS and many more were living with HIV/AIDS and probably did not know it. She immediately began to discuss Black men who were having sex with other men and passing the virus on to Black women. She explained that based on what she had read, watched on TV, and heard in conversations with some of her acquaintances, this appeared to be a major way that Black women were becoming infected with the virus. Cynthia shared that she had been through a few HIV/AIDS training and information sessions as part of the training that was given sometimes at her job. She said that she tried to share the information that she received with her teenage son, her adult niece, her brother, and others she came in contact with. During our session, she showed me a few brochures on HIV/AIDS that she received while attending a seminar on sexually transmitted diseases. When I asked Cynthia if she had ever had an HIV test, she remarked, “Yes, and the results were negative.” Cynthia also had a variety of condoms she gave to her son, brother, niece and all of their friends. She shared that when and if she needed to, she would use them herself.

We were able to complete both interviews during our first session. Cynthia was very attentive and focused, and there were no interruptions. She participated throughout my discussion and often shared her own knowledge and information with me. She believed that HIV/AIDS was a very big problem not only in the United States but also in the world and that education and the use of condoms would help keep others from contracting HIV. Cynthia explained that she knew a few people with AIDS. She had attended a few funerals of men and women she knew who died from AIDS. She said that Black women must learn to talk more about sex to the men they are having sex with, ask more questions, carry condoms, and require that their partners use them. Cynthia stated that she had many cares and concerns for the generation of African American men and women being raised in today’s world. More specifically, she was concerned about African American women. She explained it appeared that the new generation of Black women seemed to have lesser morals and values. Some women seemed to prostitute themselves before men. She explained that while she was growing up, females were called young ladies, and now many young females allow themselves to be called “bitches and whores.” Cynthia dropped her head as she claimed, “This is just awful.”

At times, Cynthia was somewhat comical during our session. Cynthia explained that she does not, and advises her friends not to, have sex with anyone not willing to wear a condom. At the end of our session, I gave Cynthia her information packet which she promised to also share with her friends, other women in her complex, and her family.

Tammy Jones

Tammy Jones was a 47-year-old single parent of two children; one adult daughter and one son enrolled in high school. She was unemployed and had been for quite some time. She completed high school and attended some trade school for occupational training. Tammy’s career goal was to take courses and training to become a certified caregiver and secure employment in this field. Her short-term goal for her family was to get her son through high school and hopefully into college where he can make a better life for himself. For a short-term goal, she wanted to complete a program for caregivers and start a small caregiver’s service. I met Tammy’s son during my visit. I observed Tammy’s son being a mild-mannered young man. He presented himself in a friendly and respectful manner. He appeared to have a good relationship with his mother. Tammy explained to me that she really wanted her son to be a part of some type of tutorial program to improve his grades. She shared that she and her son had applied for various programs; however, many of the programs required money for participation, something they simply did not have at this time. After listening to Tammy talk about her son and his academic progress, I referred Tammy and her son to a few programs conducted both at the community college and the university that provide student support services for high school students.

I met Tammy during one of my office visits with the housing staff as we discussed the dynamics of my research at the complex. She overheard our conversation and began to question me and the housing staff about what could be done to educate the younger women in her community. I took a moment to explain the purpose of my study and answer some of her questions regarding HIV/AIDS and African Americans. Tammy asked whether or not anyone could participate in my study. I explained to her that the participants in my study would be randomly selected from the participants who submitted their names and information for selection. During one of my visits to the housing office, Tammy and several other residents were also in the housing office taking care of housing issues. This meeting presented another opportunity for a short discussion regarding the dynamics of my study and how the participants would be selected. In this group of women, a White female inquired about being able to participate in the study. I explained to her that the population of my study was for African American women. However, I informed her that I would check with my committee to see if she would be eligible to participate. After checking with my committee, they confirmed that because of my study’s defined sample, this young lady would not be eligible to participate as a member of this study.

Tammy was pleasant and cooperative and asked many questions throughout our sessions. Often she shared information from her past that seemed relevant to the study. She explained that she learned a lot about HIV/AIDS from friends, reading, and specials on television shows. Tammy also stated that her church held a few health fairs, and HIV/AIDS educators were presenters at the fairs. When I asked had she ever had an HIV test, she responded, “Yes, and the results were negative.” She was unsure as to whether or not there was a cure for HIV/AIDS and believed that HIV/AIDS was a very big problem throughout the United States and the world. When I asked, “Have you ever been incarcerated?” she indicated no, but stated, “My never being incarcerated was only by the grace of God.” I asked her to explain, and she shared that she’d been a daily drug user for many years to the point of being an addict. Tammy then began to discuss her drug use more in-depth, explaining how she had struggled for many years trying to be freed of the desire to get high and use drugs. Her drugs of choice were crack, cocaine, and marijuana. She explained that for years she would get high all day and night. However, Tammy stated that she never abandoned her children and continued to take care of them with the help she received from her family. She shared that had her family not helped her with the children during those years of her life, she probably would have lost her kids. I asked Tammy if her children were aware of her drug addiction. She explained that if they were aware, they never said anything to her about it. After the break-up with her husband, she said that things got worse, and the drugs became her best friends. I asked Tammy when she was getting high day and night who took care of her children. She stated that at that time, she felt like they were big enough to take care of themselves but, now looking back, she realizes how much they really needed her. With much emotion, Tammy explained that she loved her children and would never do anything to hurt them. I then asked Tammy how long had she been drug free and what was her motivation to stop using drugs. Still filled with much emotion, Tammy continued to wipe the tears away from her eyes; she said that she had been drug free for over 5 years. She said that after many years of wanting to be free of drugs, no longer having to depend on her family to take care of her children, and having the desire to be a better mother and person gave her the inner strength to stop using drugs. Her faith and belief in God helped her to become free of drugs and remain free today.

Next, Tammy began to reflect on her years of marriage to her husband and how it affected her and their children. Her husband was a truck driver and was often gone; she and the children spent a lot of time by themselves. According to Tammy, when her husband came home from his road trips, they argued a lot, often in front of the children. She shared that her husband was physically, mentally, and emotionally abusive to her, and leaving was the best thing she could have ever done for herself and her children. She also discussed her husband’s intimate involvement with other women while he was away from home. Although when Tammy confronted her husband about having sex with other women he would always deny it and the arguing and fighting only would begin. She was afraid of possibly testing positive for HIV; however, after being tested she was HIV negative. Tammy explained that she was not happy that her children had to grow up without their father, but the choice not to be a part of the children’s lives was his choice. She stated that she never talked bad about their father to her children because he was still their father regardless of whatever happened between them. Tammy and her son appeared to have a warm, loving mother and son relationship and often spent much time together with various activities. Although Tammy continually talked about her daughter, I never had the opportunity to meet her. I completed both the survey and the questionnaire with Tammy during our first session.

Nichelle Malone

Nichelle Malone was 23-years-old and had no children. She lived at the complex with her family when she came home on the weekends from college. When I met

Nichelle, she was living back in the complex because of being in transition after completing her degree. However, because Nichelle was traveling back and forth from school to live in the complex, we had to make several arrangements to complete the sessions. Nichelle, having recently completed her bachelor’s degree, was a certified elementary education teacher currently looking for a full-time position. She was often quite comical in our interview. Nichelle had a strong connection to her family and spent a lot of quality time with them. She shared that without the support and prayers of her family, she knew she would not have made it through college and be where she is today. She said, “My family means everything to me, and I love them all so very much.” She explained to me that her educational, professional, and personal goals included completing her master’s degree, becoming a principal, getting married, and starting a family.

During our first session, Nichelle shared with me that she learned the most about HIV/AIDS from television, school, and various pamphlets; however, she added that she felt her knowledge about HIV/AIDS was limited. She explained that although she was sexually active, having had four sexual partners within the last 10 years, she had not had an HIV test and only assumed that she was HIV negative. When I asked Nichelle what she would do if she found out that she was HIV positive, she indicated, “I have no idea, and it’s really something to think about.” We discussed her role in the sexual negotiation process at which time she explained that she does protect herself against HIV by using condoms most of the time. I questioned what she meant by most of the time, and she stated, “probably 75% of the time.” She explained to me that she had known all of her sexual partners for quite some time and felt confident that they were not HIV positive. I then asked Nichelle if she had ever actually discussed the HIV status with any of her sexual partners, and she said, “Probably not as in depth as I should have.”

Nichelle explained to me that she had never been a drug user of any type and added that she believed the tremendous increase in drug use added to more people being HIV positive. I asked her to explain. She indicated, “many times when people are using drugs, they often do things that they normally would not do if they were not under the influence of drugs.” However, she explained that sometimes when people were using drugs, they did not remember the next day what they had done. Having recently graduated from college, Nichelle described some of her friends in college who participated in drinking binges and sex parties. According to Nichelle, many of them could not remember what took place during a night of partying. Given this information, I asked her who she thought was at risk for HIV. She shared that “anyone who engages in risky sexual behaviors at any time is at risk.” I asked her to explain what she meant by risky sexual behaviors. She stated, “Those who go around having sex with anyone they know just because they can and those people that do not use condoms.” I asked Nichelle if she believed that she was at risk, and she stated, “Yes, to some degree.” Nichelle shared that while in college, she believed that this took place more often than most people probably realized. She added that for many students college was their first time being away from home. No one watched or monitored their behaviors, and some students would participate in almost anything, including sex parties, just to fit in with their peers. I took this opportunity to have Nichelle reflect on one of the statements she made earlier regarding knowing all of her sexual partners for quite some time and feeling confident that they were not HIV positive. I asked Nichelle if she thought that any of her sexual partners, who were also college students, would ever participate in a sex party and not make her aware that they had participated. How did this differ from her definition of risky, sexual behaviors? I also reminded her that she claimed that most times at sex parties, people did not practice safe sex. Nichelle looked at me with a smile, and said, “Okay, you got me. You’re right. I see your point.”

At our second session, Nichelle was still residing with her family in the complex and had began working with students in her complex to assist them with their academic achievements in school. She was also still in the recruitment process for what she defined as her ideal first teaching position. Nichelle was selective in her acceptance of a full-time position because she wanted to be close to her home and desired to teach at schools where the African American student population was large. She explained her reason in making this decision was her feelings for the need of African American role model teachers. She believed she would make a greater impact on African American students and that there were not enough African American teachers, especially male teachers. Teaching would be her way of making a difference in African American children’s lives. She believed African Americans needed to help other African Americans and care about what was going on within our race. That led us to a discussion about HIV/AIDS within the Black community and what could be done to keep the number of infected African Americans from increasing. Nichelle stated, “Education is the key. Black people must learn to listen more about what is being said about HIV/AIDS and pay attention to the impact that this disease is having not only in our Black communities and urban cities, but in our country and throughout the world.” She shared that she believes “since HIV/AIDS is affecting mainly African American and Hispanic populations, nobody really cares; they are just talking and not much of anything will be done by our government because we’re not the right color. This is just another example of how people of color must learn to help themselves instead of waiting for somebody else or the government to do it for them.” However, Nichelle added that “if the statistics and the reports are true, and now that more White women are dating and having sex with Black men than ever before, it’s probably only a matter of time that White women will probably start getting infected.” Nichelle angrily looked at me and stated, “I wonder will the government give billions of dollars for HIV/AIDS research then?” She immediately added, “I’m not wishing the HIV virus upon anyone, but this epidemic, just like everything else in this country, involves color, and we’re still not the right color.”

She shared with me that since our last session, she gave deep thought to the questions I asked her and our conversation overall. She explained that she really did not realize the risks she was taking by not using a condom every time she had sex. Nichelle said, “No one really thinks they are going to get HIV. Most people believe that HIV will not affect them. They will not get it. I was the same way.” She explained that without any hesitation she would definitely use a condom from now on every time she had sex and would also advise her family and friends to do the same. She also reported that she has begun to talk about using condoms more often with the group of youth she worked with. She advised them all to be more careful to protect themselves against HIV and to educate themselves about HIV/AIDS. She shared that on her predominately Black college campus, the school often held HIV/AIDS workshops and information sessions, distributing free condoms and information packets. Although many students took advantage and participated, given the epidemic of HIV/AIDS with Blacks, Nichelle said, “It should have been a mandatory session on campus.” However, she knew that sex parties continued to happen and as with many other things, sometimes “things got out of hand, students got drunk, their peers influenced them, or they got caught up in the moment." Nichelle also added that on her campus, she knew many Black guys who were suspects for being on the down low. She was sure that some of these men were participants in sex parties at some point.

Nichelle and I then began a lengthy discussion on Black men on the down low, the increase in Black women with HIV and Black women dying from AIDS. She shared with me that many of her friends had been tested for HIV for fear that some of the guys they had slept with earlier in their lives were later identified as being on the down low. She shared that on many Black college campuses she understood that this was becoming a problem. Yet many students were having unprotected sex. We discussed that in many White communities White male students appeared to be somewhat confident and feel safe about making others aware that they were gay. She shared that within our Black communities, if we learned to embrace Black men despite their sexual preference, the need for so many Black men continuing to live a double life or being on the down low would decrease. Nichelle was quite informed in this area, thanked me for the discussion, and at the end indicated our discussion helped her to see this situation from an entirely different perspective. She added that she would really think twice before having unprotected sex again.

Annie Hunter

Annie Hunter was a 40-year-old African American female who had legal custody of her cousin's children; she had no children of her own, but raised these children for over 6 years. Three girls, two of whom Annie said she knew for sure were born crack babies because of the mother's drug use during her pregnancy with the children, appeared to be respectful of Annie. According to Annie, the girls, one in middle school and two in high school, had a difficult life while living with their mother. Annie claimed the mother would often leave the girls unattended while going out in the evenings and all night, searching for and using drugs. Annie explained that after the girls were repeatedly moved from family member to family member, they were about to be placed in the foster care system. At this point, Annie agreed to take them to her house with her and her husband.

During my time with Annie, I observed her as being a soft spoken, well organized, pleasant person. Every time I saw Annie and the girls, they were always well-groomed, appeared to enjoy each other's company, and kept busy schedules. When Annie and I met for our session, she shared a lot of information about the girls and their background. She explained that the girls had been through a lot and were still making many adjustments. Annie claimed that for a long time after she got the girls, they continued to worry about being moved again to another home. According to Annie, two of the girls were having discipline problems in school, which Annie believed was a consequence of the children being born addicted to crack. The youngest girl did okay academically; however, she continued to get into trouble for lying and stealing. She had almost been arrested on one occasion for stealing repeatedly. The oldest girl, who was in high school, maintained good academic records but was often in trouble for disrespecting her teachers and others who had authority over her. Annie explained that the girls often appeared to be unable to understand things being explained to them; often they appeared to be in a daze. The middle girl was an excellent student academically who struggled socially. Annie shared that the girls' mother had been on drugs for many years. The latest report indicated the mother had become a prostitute to support her drug habit. However, she explained that the girls loved their mother and asked of her whereabouts often.

During our session, Annie explained that she had put many things in her life on hold to try to get the girls stable and secure. She reported that things were often difficult and complicated, and many things were tied up legally with the foster care system that involved several issues surrounding the girls. Before she began caring for the girls, Annie shared that she was enrolled in school trying to complete her degree. Although she had not been able to return to school full time, she continued to take one class a semester as she worked toward her bachelor’s degree in counseling. Annie worked as an administrative assistant and had a goal to become a professional counselor someday.

Annie shared that she had been married twice. Both marriages ended in divorce because of the physical abusiveness of one husband and the infidelity of the other husband. According to Annie, one husband fathered a child while being married to Annie and then abandoned her and the girls. It was during this time when she and the girls had to move into the subsidized housing complex. They could not afford to remain where they lived previously. Annie claimed that moving into the complex was a major adjustment for her and the girls because their tiny apartment could barely accommodate all of them. Now that they had gotten a larger apartment within the complex and made some changes in their lives, over the years they had adjusted, and things were going relatively well.

Annie and I were able to complete both the questionnaire and the interview during our first session. She was attentive and continued to ask many questions throughout our session. I asked Annie if she’d been tested for HIV. She said that she had and the results were negative. She shared that she felt she knew very little about HIV/AIDS and now that so many African American women were becoming infected with HIV, she really wanted to know more. Annie believed that the best prevention against HIV/AIDS in addition to condoms included educating anyone who would listen, and hoped that the information they received would be shared with others. She reported that within the last 10 years, she had five sexual partners, two of whom were her ex-husbands. She stated that although she was not involved with anyone at the time of the interviews, she did not have sex without the use of a condom. Annie shared that in addition to the girls' mother being HIV positive and having AIDS, she also knew many other people who had died from complications with AIDS. She recognized the disease was a serious problem throughout the world. Since my initial session with Annie, she contacted me regarding the possibility of conducting an HIV/AIDS information session with a youth group. I explained to Annie that I was still in the midst of conducting my research and would be happy to assist her once it was completed.

Peachtree Woodburn Pokemeat Smith

Peachtree Woodburn Pokemeat Smith was a 30-year-old mother of one. She had been living in the complex for the last 7 years. She was unemployed and hoped to start searching for employment within the next couple of weeks. Since graduating from high school, she had not attended any formal educational or vocational training but desired to get her certification in cosmetology so that she could own a beauty shop someday. Peachtree had one child, a 10-year-old daughter. The events of Peachtree's daughter continually forced us to reschedule our meetings. It appeared that Peachtree's daily activities revolved around her daughter. Her daughter appeared to enjoy spending time with her mother.

Peachtree and I played phone tag for weeks before establishing contact. When we finally met each other in the parking lot of the complex, we had to reschedule our session because of an unexpected appointment Peachtree had to attend with her daughter. We were not able to complete our session during this time. We set our next appointment for the following week at the same time at a local restaurant across town. Peachtree indicated she would be in that area and meeting there would better accommodate her schedule and give us more time. In that session we completed both instruments. Peachtree expressed her apologies for having to reschedule our sessions. Before we began the questionnaire and interview, I asked Peachtree if she had any questions or concerns. She indicated that she did not and was glad to have been selected to participate in the study.

Immediately Peachtree shared that she had been tested for HIV and the results were negative. While administering the questionnaire to Peachtree, I observed her hesitation with many of the responses. Often she responded, “I don’t know” and took long breaths before responding. Peachtree talked and asked questions throughout our session; she appeared to really want to learn more about HIV/AIDS. She shared that she had known a few people who had died from AIDS, mostly men. She also knew some women who were HIV positive. She believed that AIDS was an epidemic that had not only affected African countries, but also appeared to be making its way throughout African American communities everywhere. I asked her to explain what she meant. Peachtree stated, “Every time I turn on the television or the radio, there is something about Black women that are either dying because they have AIDS or becoming infected with HIV, or Black men that are having sex with other men calling it being on the down low.” Peachtree immediately looked up at me and stated “Why can’t they just say I am gay?” Why does it have to be that they are on the down low? Just call it what it is, “I’m gay” or “I just prefer to be with a man and not a woman.” Peachtree began to discuss a television special she recently viewed about African American women and HIV. She said the show was so disturbing and depressing to her. As she watched the show she questioned her understanding of HIV/AIDS. Peachtree stated that she did not understand the difference between HIV and AIDS. Viewing a special on AIDS and African American women helped her understand the difference between the two. She added that even after viewing the show that included stories of Black men on the down low, she still did not understand the difference between being on the down low and being a homosexual. Peachtree stated, “This seems so unfair to Black women that are in relationships with these men, having no clue of their other lifestyles and becoming infected with the virus by these men. Many Black women do not know that these men are having unprotected raw sex with other men and hauling the virus back to them when they come home at night or get with them again.” As I listened to Peachtree, she began to talk about this topic with much energy, almost to the point of anger. It seemed evident that she was disturbed over this issue. In her discussion she posed several questions but continued with her comments not allowing me to respond. I listened carefully as she discussed one of her close friends who recently discovered she was HIV positive. Peachtree stated, “My friend has kids and now she’s HIV positive. What is going to happen to her kids? Who will take care of them when she is dying from AIDS?” She shared that her friend had not told her family for fear of being isolated or rejected by them. She claimed her friend simply did not know what to do. I asked her if her friend was under a doctor’s care. Peachtree commented, “It’s been only a few months now, and apparently she’s still in shock.” According to Peachtree, the friend’s boyfriend who apparently gave her the HIV virus was in denial about her HIV status and would not get tested.

Our conversation then shifted somewhat. I asked her if people in prison should be tested for HIV. Peachtree claimed that if people in prison were tested when they entered the prison system and before they left, Black women's rate of contracting the HIV virus might decrease. I asked her to explain what she meant. She said, "Most prisons are populated with Black men, and many men while in prison engage in sex with other men. However, when they get out of prison, many of them often return to the women they were with before entering prison. Many of them just leave prison and never get an HIV test. They engage in sex with the women they were with before, and if they are positive, they spread the virus to these women." Peachtree said, "Many times women get pregnant from their husbands, boyfriends, etc., when they get out of prison, so now the virus also spreads to the unborn baby."

After talking for a few hours, Peachtree and I stopped to order a bite to eat. This was my treat to Peachtree to thank her for her time and for sharing such stories. After eating, we continued our discussion, basically picking up right where we left off. I asked Peachtree what she would do if she found out she had HIV/AIDS. She stated, "I would pray that God would take it away because He can do all things." Peachtree added, "America should pray for a cure for HIV/AIDS and invest the necessary dollars for more HIV/AIDS research and research with HIV and herbal teas." I questioned why she added research with herbal teas; she explained her strong belief and support of herbal teas and products. She also believed that since so many Black women were dying from AIDS as compared to White women, very little would be done to solve the problem. However, she believed if White women were dying, something would be done very quickly, and there would be no limit to the amount of money that would be spent for a cure. She stated, “Since it’s women of color, it’s really no big deal here in the United States, and that’s why HIV/AIDS within our community is now an epidemic-nobody cares!”

Survey Process

To assure that as many participants were given the same opportunity to participate in the study, I created an information flyer outlining all information for the study. The residence complex managers and assistant managers were helpful in allowing information flyers and sign-up sheets to be placed in the complex offices. All participants were recruited by word of mouth to participate in the study. After 10 women from a pool of 25 were selected to participate, I contacted all participants by telephone to set up the initial interview, answered any of their questions or concerns, and completed the informed consent forms with them.

For most participants I administered the AIDS/HIV Interview using the methods initially outlined and planned. I met with the participant and read aloud the questionnaire and interview. Also, each participant was given a copy of both the AIDS/HIV Questionnaire and AIDS/HIV Risk Assessment Interview so she could follow along as I read them aloud. With some participants, both the questionnaire and interview were completed in the same meeting while with others the survey was completed in one meeting and the questionnaire in an additional setting. Most sessions were completed within a 2 hour time frame. I often stayed longer if needed to address questions and concerns about HIV/AIDS education. However, because of constant time conflicts for two participants, I left the questionnaire with those participants to review until our second session. Our second session was then scheduled at a time convenient for the participants. I observed while administering the questionnaire and the interview that all women were serious, attentive, and some quite inquisitive about the topics. At the end of each session and to ensure confidentiality, participants were instructed to place their completed AIDS/HIV Questionnaire and AIDS/HIV Risk Assessment Interview into the envelopes provided and to seal the envelopes. Both the questionnaire and the interview for all participants were completed over a 6 week timeframe.

Upon entering the field to conduct research, I was able to secure grant funding from a local foundation. The grant funds were placed in an account with a local agency which offers a variety of services to people living with HIV/AIDS or at risk for HIV. The funds were used to thank participants for their time and efforts in the research. At the end of completing both the questionnaire and the interview, each participant received a $50.00 stipend.

In this section, I provided the findings of the AIDS/HIV Questionnaire and AIDS/HIV Risk Assessment Interview. The results using the questionnaire and risk assessment interview are provided.

All 10 research participants completed both the questionnaire and the risk assessment interview. According to Lanier and McCarthy (1989), the UCF AIDS/HIV Questionnaire was developed specifically to determine AIDS-related knowledge, attitudes, and behaviors of adolescents. The original UCF AIDS/HIV Questionnaire included 73 items divided into four sections for analysis: (a) knowledge (19 items); (b) attitude (26 items); (c) behavior (23 items); and (d) sociodemographic (5 items). For the purpose of this study and to align with the research questions, the sections on the questionnaire were modified. I included an additional analysis section, covering items of fear and common themes and threads. My questionnaire included 70 items; items per section differed from the original instrument as follows: (a) knowledge (37 items); (b) attitude (5 items); (c) behavior (8 items); (d) knowledge and fear (6 items); and (e) common themes and common threads (14 items). The original UCF AIDS/HIV Risk Assessment Interview consisted of 37 open-ended questions that covered the majority of issues measured by the AIDS/HIV Questionnaire. Once again for the purpose of this study, the instrument was modified to 43 open-ended questions to facilitate in-depth discussions with the 10 participants.

The AIDS/HIV Questionnaire

The first objective using the questionnaire was to determine the knowledge related to HIV/AIDS reported by the 10 African American women. On the AIDS/HIV Questionnaire, 37 questions were asked that required a direct response using three choices, *Yes*, *No,* or *Don't Know*. Each of these questions assessed the women's knowledge regarding modes of transmission, HIV risk reduction, and overall general knowledge of HIV/AIDS. Overall, the majority of participants reported relatively high levels of knowledge regarding HIV/AIDS, means of transmission, prevention, and high-risk behaviors. The results from the questionnaire revealed some differences between the participants and their responses to the knowledge variables.

Knowledge of HIV Transmission

When reviewing questions concerning the participant's knowledge of HIV transmission reported on the questionnaire, Question 1 revealed 6 of the African American women participants had taken an HIV test, 3 had not, and 1 participant indicated that she did not know whether or not she had an HIV test (Table 1). For the question stating "I tested positive for HIV," 8 participants marked *no* and 2 marked *don't know*. All research participants knew that sharing razor blades was a means of HIV transmission and all knew that babies can be born with HIV. All women were aware that AIDS was transmissible through sharing drug needles. Most participants visibly demonstrated some hesitancy or questioned their knowledge relating to whether or not HIV could be caught from heavy tongue kissing. With this question, 4 of the 10 participants indicated *yes*; five stated *no*; and one selected *don't know*. Another question where participants demonstrated hesitancy, and all but 1 gave the correct response was, "HIV can be caught if a hospital has to give you blood." However, the participants gave a different response to the question, "HIV can be caught from donating blood." For this question, 3 participants said *yes*"; 6 responded *no* and 1 marked *don't know*. A summary of responses are presented in Table 1.

Table 1

Sample of Participant Responses to Subquestions on the AIDS/HIV Questionnaire for Research Question 1

Questionnaire subquestion	Yes	No	Don't know
I have had a test for HIV.	6	3	1
I tested positive for HIV.		8	2
HIV can be caught from heavy tongue kissing.	4	5	1
HIV can be caught from sharing needles.	10		
HIV can be caught from sharing razor blades.	10		
Babies can be born with HIV.	10		
HIV can be caught if a hospital has to give you blood.	9	1	
HIV can be caught from donating blood.	3	6	1

Note. $N = 10$.

Engaging in HIV/AIDS Risk Behaviors

The second objective was to identify the extent that African American women believe they engage in high-risk sexual behaviors that place them at risk of contracting HIV/AIDS. Using the AIDS/HIV Questionnaire, Research Question 2 assessed the African American women’s high-risk behaviors for individual and group intentions (Table 2). With respect to behavioral intentions, some of the HIV-related behavioral risk items included condom use, same-sex relationships, injecting and noninjecting drug use, number of multiple sexual partners, preventive measures against catching HIV, failure to ask sexual partners about their sexual history or relationships over the last 10 years. Some of the African American women participants reported some high-risk behaviors. Of the 10 participants, all were sexually experienced, having engaged in at least one physical relationship at some point. For the question addressing condom use, 8 of the research participants indicated that using a condom would help prevent catching HIV; 2 did not know. When questioned about trusting a sexual partner if she or he said he or she was free from disease or HIV, all participants responded the same, indicating *never*.

Fears of Contracting HIV/AIDS

Research Question 3 assessed the attitudes of the participants with regard to their fears of contacting HIV/AIDS (Table 3). On the AIDS/HIV Questionnaire, Research Question 3 states “Do African American women fear contacting HIV/AIDS?” Responses for this question resulted in many different responses from the participants. For example, when questioned as to whether or not the participants think about their partners having HIV, 4 marked *frequently, 3* marked *sometimes,* and 3 marked *never*. They also responded to whether or not they were fearful of contracting HIV. The responses to this

Table 2

Sample of Participant Responses to Subquestions on the AIDS/HIV Questionnaire for Research Question 2

Questionnaire subquestion	Frequently	Sometimes	Never	Yes	No	Don’t know
In the future, I will use a condom if unsure of my partner’s sexual history.	7	1	2			
In the future, I will demand the use of a condom (rubber) for my own protection.	8	2				
In the future, I will demand the use of a condom (rubber) for my partner's protection.	7	3				
I would trust a sex partner if she/he said they are free from disease/HIV.			10			
Using a condom (rubber) will help prevent catching HIV.				8		2

Note. *N* = 10.

Table 3

Participant Responses to Subquestions on the AIDS/HIV Questionnaire for Research Question 3

Questionnaire subquestion	Frequently	Sometimes	Never
I take special precautions to prevent catching HIV.	7	2	1
I am fearful of contracting HIV.	4	3	1
I ask partners about their sexual history.	7	2	1
I do think about what if I contracted HIV.	6	3	1
I do think about if my partner has HIV.	4	3	3

Note. *N* = 10.

question yielded the same results where 4 marked *frequently,* 3 marked *sometimes,* and 3 marked *never.*

Knowledge and Fears That Affect Behaviors

When questioning the participants regarding Research, Question 4 (Table 4) which addresses the extent that knowledge and fear affect African American women's sexual behaviors, six questions were asked. Item 1 stated, "I would have sex with an attractive partner if no condom was available." When responding to this question, 9 participants responded marking *never,* and 1 participant responded marking *yes*. Item 2 addressed condom use. Participants responded to "I would have sex without a condom if I had a negative HIV test." Three participants indicated *yes,* and 7 indicated *never*. Item four asked "If I caught HIV, I would tell any sex partners." In responding to this question, 5 participants responded *strongly agree, 3* responded *agree,* 1 responded *disagree,* and one responded *I don't know*.

Table 4

Participant Responses to Subquestions on the AIDS/HIV Questionnaire for Research Question 4

Questionnaire subquestion	Frequently	Sometimes	Never		
I would have sex with an attractive partner if no condom was available.		1	9		
I would have sex without a condom if I had a negative HIV test.		3	7		
	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know
If I caught HIV, I would not have sex again.	4	2	2		2
If I caught HIV, I would tell any sex partner(s).	5	3	1		1
I worry a lot about catching HIV.	2	1	6		1
I worry a lot about my friends catching HIV.	3	1	6		

Note. *N* = 10.

Themes and Common Threads

Research Question 5 assessed the themes and common threads that were present in the practices and beliefs of African American women that placed them at risk for HIV/AIDS (Table 5).

Table 5

Participant Responses to Subquestions on the AIDS/HIV Questionnaire for Research Question 5

Questionnaire subquestion	Frequently	Sometimes	Never
In the future I plan to inject drugs.			10
I share injecting drug needles.			10
	Yes	No	Unsure
I have been sexually abused.	3	7	
I have been physically abused.	1		9
Have you injected drugs in the last three (3) months?			10
Have you ever used marijuana?	9	1	
Have you ever “shot-up” drugs?			0
Have you ever exchanged sex for money, food, etc?		10	

(table continues)

	Strongly agree	Agree	Disagree	Strongly disagree	Don’t know
There is nothing you can do to prevent catching HIV.	7		3		
If you catch HIV, it’s your own fault.		1	4	5	
Is it possible for someone to have HIV, not know it and infect others?	6		4		

	None	1	2-5	6-10	Don’t know
With how many partners have you had a same sex relationship?	10				
How many of your friends do you think have had a homosexual relationship?	4	1	1		4

Note: *N* = 10.

All respondents reported that in the future, they do not plan to inject illegal drugs, and none of the participants responded *yes* to the question, “Have you ever “shot up drugs?” When questioning past abuse, 3 indicated that they had been sexually abused; 7 indicated they had not been sexually abused, and 1 indicated that she had been physically abused. When asked whether there was anything they could do to prevent catching HIV/AIDS, 3 disagreed while 7 strongly agreed. In addition, 1 of the participants believed that if someone catches HIV, it’s that person’s own fault; 4 disagreed, and 5 strongly disagreed. Participant responses were also different when questioned if it was possible for someone to have HIV, not know it, and infect others. Six strongly agreed, and 4 disagreed to this question.

The survey also addressed sexual behaviors among friends. When questioned, “How many of your friends do you think have had a homosexual or same sex relationship?” 4 indicated they did not know, 1 indicated possibly three of her friends, 4 indicated they believed none of their friends have had this type of relationship, and 1 indicated at least one of her friends. Finally, all of the participants responded that they have not had a same sex relationship, nor have they ever exchanged sex for money or food. During the interview process many of the participants discussed this subject openly based on personal and religious beliefs and values.

AIDS/HIV Risk Assessment Interview Results

The second instrument used to collect data from the participants was the AIDS/HIV Risk Assessment Interview. This instrument consisted of 43 open-ended questions that allowed for elaboration and in-depth discussion of the information collected from the participants’ social, economic, and educational backgrounds and their knowledge of HIV/AIDS. The sociodemographic data for the assessment interview included race, gender, age, place of birth, and current city of residency. All participants indicated they were African American and female. They also listed their age and indicated they currently live in Escambia County, Florida; most were also born and raised in Escambia County, Florida.

Knowledge of HIV

Using the AIDS/HIV Risk Assessment Interview, I used Research Question 1 on the questionnaire presented in the prior section to explore the knowledge of the 10 participants regarding HIV/AIDS. Many participants indicated they knew little about HIV/AIDS and possibly not as much as they should know or would like to know. Most explained that they learned a lot about HIV/AIDS from watching television specials, reading articles on HIV/AIDS, or personally going through the HIV testing process. When questioned about the relevance of the problem HIV/AIDS presented, all participants reported that they believed “AIDS is a big problem in America.” When questioned what should be done about the HIV/AIDS problems in America, most participants shared that education was a major key to the pandemic.

One part of the interview gave the participants the opportunity to elaborate on their current and future plans. Out of the 10 responses, 1 participant who is currently working towards her bachelor’s degree in Health Education indicated she wanted to get her Ph.D. someday in the Health Education field. One participant, having recently completed her bachelor’s degree, will be entering into a master’s program, seeking to complete her master’s in education. Two participants were enrolled to complete their bachelor’s degree. Four participants are completing or want to complete their certifications in vocational programs and start their own business. One participant was trying to complete her 4th year in a general education program hoping to get her G.E.D. Another participant explained that she was content with her current job and had no plans to return to school.

There were common social themes among the participants regarding their plans for supporting their families, getting financial assistance, and trying to change their economic status. However, the women’s professional and educational goals were different. Many of the participants indicated a similar response on the questionnaire and the interview when questioned, “What would you do if you had HIV?” and asked to respond to the statement, “If I caught HIV, I would not tell anyone.” Most of their responses indicated they would first educate themselves further about HIV/AIDS, and then inform and educate their families, and make others aware of the HIV/AIDS pandemic.

Research Question 2 on the interview asked, “To what extent do African American women believe they engage in sexual behaviors that place them at risk of contracting HIV/AIDS?” Seven sub-questions were presented to the participants on this topic. One interview question asked, “Do you discuss your partner’s sexual history with them?” Of the 10 participants, 7 indicated “*yes,*” 1 stated “*sometimes,*” 1 stated “*no,*” and 1 responded “do not have a partner, but I would if I did.” From this question many of the participants expounded on their fears of contracting the HIV virus, and the importance of protecting themselves. However, some of the participants reported they did not protect themselves against the HIV virus. Comments they shared earlier conflicted with their previous responses. In an effort to make sure they clearly understood the depth of the question and a reminder of their earlier responses, I took the opportunity with the participants whose responses were different to restate the question and give examples. After this, some of the participants changed their response from “yes” to responses such as “we sort of talk about it or we talk around the issue.” In response to perceived norms of past sexual behaviors, the question “How many sexual partners within your lifetime have you had?” led participants to share various responses to this question. Two participants indicated having had only one partner; 3 participants responded between four and seven; 3 other participants stated having had three sexual partners; 1 participant stated more than 20 and another participant indicated she did not know. All participants indicated that they preferred a male partner, and they had not had a sexual encounter with anyone of the same sex. When questioned why or why not, responses included that it was “not something that they believed in” or that “it was a sinful act.” One stated engaging with same sex partners was “morally inappropriate.” One woman indicated that to her, “homosexuality was repulsive.” For many participants, this question also led us back into the discussion of Black men on the down-low, how Black women are becoming infected with the HIV virus, and the overall effects that the virus was having within the African American community. For many participants, the conversations on this topic seemed endless.

Attitudes Regarding HIV/AIDS

Research Question 3, addressed if African American women fear contracting HIV/AIDS. The participants were asked questions about being incarcerated and being sexually involved with anyone who had been incarcerated. They were also asked whether or not people in prison should be tested for HIV. They responded to questions regarding engaging in deviant sexual acts, such as working as a prostitute and having multiple partners. None of the 10 women participating in the study had ever been incarcerated. However, 1 participant claimed she had been a heavy drug user at one point in her life. She feared being arrested for drug use or addiction, but she felt fortunate that she had not encountered the law. She explained that “it was nothing but the Grace of God that protected me during this self-abusive time in my life.” Three of the women indicated that they had been involved at one time with at least one person who had been incarcerated. Nine of the participants agreed HIV testing should occur within the prison system. One indicated that inmates should be tested if they chose to be tested but should not be forced to be tested. None of the women had engaged in deviant sexual activities, such as selling their bodies for money or participating in sex parties.

Another interview question addressed the “extent that knowledge and fear of HIV/AIDS affect African American women’s sexual behavior.” The participants were informed what the research shows regarding African American women and the high HIV rates that exist. They were then asked what could be done to keep this number from increasing. Many participants responded they thought that education was a key factor to controlling the increase of HIV among African American women. Others indicated that the distribution of condoms and more HIV advance testing would decrease HIV rates. All participants indicated that most people are at risk for contracting the HIV virus and more specifically, the risks were higher for those who had more than one sexual partner and chose not to use a condom. Six participants believed that they were possibly at risk for the virus if they did not continually practice safe sex. The responses regarding “whether or not condoms should be available in prisons” reflected a yes response from all participants. However, they felt different about having condoms available in schools. Some believed condoms should be available in schools; some indicated that “condoms should be available in high school and above." However, 1 indicated that "they should not be available in high school or lower because students should not be having sex at that age." Everyone agreed that it was not difficult for anyone to get condoms because they were free in many places.

Common Themes and Threads

Six interview questions addressed the common themes and threads that existed between African American women that placed them at-risk for HIV/AIDS. None of the 10 participants had used intravenous needles for personal drug use, and all responded that they would never share intravenous needles. Most understood the dangers in contracting the HIV virus when sharing intravenous needles. Regarding past sexual behaviors and activities, participants were asked, "If you could do things over what would you do differently?" The responses varied tremendously from using a condom more often, to becoming better educated, to being more selective about sexual partners.

Although less knowledgeable in some areas, overall, the 10 African American women reported high levels of HIV/AIDS knowledge. Relative to their overall general knowledge, the vast majority of the participants were aware that a virus causes HIV. Many of the 10 participants were aware that the disease was not confined to certain segments of the population. For example, they knew that HIV/AIDS was not necessarily harder to catch if a person is young and healthy. When addressing whether or not "all gay men, mainly White homosexuals, have contracted the HIV virus or had full-blown AIDS," all of the participants correctly responded *no*.

Summary of Findings

In this chapter, I have outlined the steps that I took as I conducted my study. I used the AIDS/HIV Risk Assessment Interview and AIDS/HIV Questionnaire in two meetings with 10 African American women to help me answer five research questions. In this chapter, I provided an overview of the meetings with each participant and then provided the information collected when using the two instruments. In chapter 5, I summarize the results of the study and discuss the findings.

CHAPTER V

SUMMARY AND CONCLUSION

I explored the educational needs and assessed the knowledge, beliefs, and fears of African American women about contracting HIV/AIDS. I assessed the behaviors, attitudes, knowledge, and common themes of the women's responses. The AIDS/HIV Questionnaire and AIDS/HIV Risk Assessment Interview were used to gather data. After all 10 participants had completed the two instruments, a cross-case analysis of their responses was conducted. Individual responses and common patterns and themes that cut across the individual experiences of the participants were analyzed.

The participants differed on variables such as age, economic status, formal education, and the number of sexual partners they had within the last 10 years. The findings in this study and their responses to the interview questions provided information that could be used to develop an HIV/AIDS educational program designed specifically for African American women. The health belief model (HBM), which is based on motivating people to take actions such as protecting themselves against the HIV virus and changing their behaviors depending upon their knowledge and attitudes, could be blended with this study's results to explain some of the participants' behavioral components. The components of the model explain why some individuals fail to protect themselves from coming in contact with the HIV virus and their hesitancy to take action to help themselves if they contract the virus. According to the HBM, a person must first perceive or believe that he or she is at risk for contracting the HIV virus. My findings showed that although some of the participants in the study indicated responses of high-risk behaviors for HIV, many of these participants did not view themselves as being at risk. Also, the HBM outlines the perceived benefits for preventive actions against the HIV virus, such as being able to avoid the virus by using condoms. My findings showed that not all the participants used condoms on a consistent basis although many participants often had condoms in their possession at the time of intercourse.

The conceptual framework of the HBM begins to fall apart when addressing poverty and the concept of self-efficacy or one's confidence in the ability to successfully perform an action. My findings showed that there was a difference in the African American women’s perception of poverty and the definition of poverty embedded in the HBM. Although the participants in the study lived in low-income housing and many had household incomes below the national poverty index, the participants did not perceive themselves as living in poverty nor was there a strong desire or effort to move out of their current economic status. My initial survey questions directly addressed questions of poverty. However, during my first interview I realized that my definition of poverty differed from many of the participant’s definition of poverty. I did not want to offend anyone; therefore, I reworded the questions taking out the word poverty.

Summary of the Questionnaire and Interview Results

During our meetings the 10 participants shared various personal stories and testimonies as they completed the questionnaire and the interview form. Most participants indicated they were aware that HIV/AIDS remained a global issue. The findings from both the questionnaire and the interview of the 10 participants reflected differences in their economic status although they all lived in a subsidized housing complex. Some of the participants were employed, owned at least one automobile, were the sole providers for their families, and had an established plan to move from the low-income housing and become a homeowner in the future. Other participants, however, were unemployed and had been for quite some time. Some were not the sole providers for their families and often depended on others for financial contributions. Also, they did not own an automobile and were basically dependent on others or the public transportation system to get around. I sense that some of the participants had no intent of exiting the low-income complex and appeared content with their current lifestyle.

Although the women differed, they shared some common social themes. Some of the social commonalities shared by the participants pertained to their regard and interactions with their family, community, and church. Many of the participants were actively involved in providing care, financial assistance, and necessities for other family members such as their parents, grandchildren, and siblings. Several participants had established extended relationships and bonds within the complex; this theme also appeared to be common within the African American community and church. Through various involvements with community and church affiliations, some of the participants had been exposed to, if not participated in, HIV/AIDS workshops and seminars while other participants had not. Given the history of African Americans' involvement in their spiritual faith, the differences in the participants' responses are noteworthy. Some participants focused their responses on their commitment to their faith and trust in God. However, none of the survey or interview questions mentioned anything about God or spirituality. Their opinions on homosexual relationships and high-risk sexual behaviors, and their comments made during the interviews were different from participants who did not integrate “faith in God” into the conversation.

Economic factors seemed to influence the way the participants answered the questions. Some participants were employed; some were not. Some paid their bills; some did not. All participants marked *no* on the questionnaire for the question, “Have you ever exchanged sex for money, food, etc?” However, a few participants discussed their relationships with their boyfriends or significant others, by eluding to exchanging certain things for sex. The number of children, family responsibilities, educational levels, and other obligations, such as taking care of elderly parents were also factors reflecting differences among the participants. They represented different age levels and life experiences. It appeared that the younger participants were somewhat more materialistic and often responded with replies that were concerned with the moment rather than with long-term goals. Often, the younger participants’ responses reflected buying something, getting their hair and nails done, buying things for themselves and their kids, or quick solutions to the problems in their lives. On the other hand, the older participants’ responses revolved around family and long-term solutions. They talked about ways to improve their overall quality of life including saving more of the money they made instead of spending it as quickly as they received it.

The younger participant’s responses regarding the precautions they took against HIV were not always consistent with their behaviors. However, in comparison to the older participants, their responses were often consistent with their behaviors in protecting themselves against the HIV virus. Almost all of the participants were aware of the many precautions to take against HIV and sexually transmitted diseases. However, the older participants described actual practices, such as consistently using condoms and taking more precautions against the spread of HIV and sexually transmitted diseases. The younger participants indicated behaviors that were considered high risk for HIV and other sexually transmitted diseases, such as not using condoms. The younger participants also indicated higher numbers of sexual partners as compared to the older participants.

The participants were divided on “whether or not there was an actual cure for the HIV virus.” Five believed there was a cure and possibly the government was not telling them a cure existed. Of the 5, 2 believed that the government had developed the HIV virus as a way to specifically infect and ultimately wipe out minorities, more specifically Blacks. Five believed that there was not a cure; of the 5, 2 believed the government had not spent enough money toward research for a cure.

Research question 1 on the questionnaire and the interview asked, “What do African American women know about HIV/AIDS?” More specifically, the question asked, “Where did you learn the most about HIV?” and on the interview form the question asked, “Where did you learn the most about HIV/AIDS?” On both the questionnaire and the interview, participants commonly responded that they learned about HIV/AIDS from TV, radio, magazines, and news reports. Also on the questionnaire, all participants were asked “If they had been tested for HIV.” Nine participants indicated they had been tested for HIV.

Finally, participants responded to questions about their knowledge and fears that could affect their sexual behaviors. There were commonalities as indicated by the responses shared by the 10 participants regarding their fears of HIV/AIDS. Most participants expressed fears and concerns with the current increased rates of African American women with HIV/AIDS. Almost all participants expressed concerns for Black men who have sex with men and also have sex with Black women. They feared and knew the virus spreads quicker to African American women when men live on the down-low. Many of them expressed their fears and concerns of the increased percentages of Black men in the prison system who do not get HIV tested as they enter or exit. The participants were concerned that many of these men leave the prison system not knowing their HIV status. They fear the men often return to the women they left before going to prison (and other women) to reestablish sexual relationships. However, some of the discussions and responses from the older participants in the study were based on their knowledge of previous studies such as the Tuskegee Study where African Americans were wrongfully used in syphilis research by the Public Health Services, now known as the Centers for Disease Control or the CDC (Chadwick, 2002.) A few participants believed that there was a possibility that HIV could have been created by the CDC or any other agency. Some participants reiterated this concern during their comments about Black men in the prison system, their ability to spread HIV to Black women, and the overall ability to reduce the Black population.

All 10 participants indicated moderate to high levels of knowledge regarding HIV/AIDS (modes of transmission for the virus, African American populations, high-risk sexual behaviors, and general knowledge). Given the responses of each participant, a key variable in the differences of their responses appeared to be their age, life experiences, sexual behaviors, and general knowledge.

According to the CDC (2006b), African American men and women are among the hardest hit populations in the United States. For many years African Americans have accounted for a large percentage of all new HIV diagnoses and AIDS deaths in this country. African American men who have sex with men are especially hard hit. Recent data show significant declines in HIV diagnoses in nearly every group of African

Americans except Black men who have sex with men. Black women also remain a particularly vulnerable population, accounting for 29% of all HIV diagnoses in 2004 (CDC, 2006a). Most research shows that many African American men who are infected with the HIV virus are unlikely to be tested for HIV antibodies; therefore, many are often unaware of their HIV serostatus. Although there was no reporting of same sex behaviors by the participants in this study relating to their male partners, the high-risk nature of this type of sexual behavior along with the failure of many African American communities and churches to discuss the behaviors, indicate a need for its inclusion in an HIV/AIDS educational prevention for African Americans. Black women are diagnosed with AIDS at a rate 25 times that of White women. HIV positive African Americans are seven times more likely than Whites to become infected with the virus or die from HIV-related illness (Smiley, 2006). According to Stevenson and Davis (1994), many African Americans do not wish to discuss their sexuality with others for fear that they will be negatively perceived as promiscuous, dirty, and responsible for current sexual disease epidemics.

My Personal Experience

Some years ago, long before the thought of being a doctoral student and gathering research for this dissertation, I received a call from Sally, a close personal friend, requesting that I meet with her “as soon as possible.” I could tell from the short comments and the cold chill in Sally’s voice that this was not a normal social call. Realizing the urgency of my friend’s request, I met with her on a cold, rainy day of the same week. While meeting with her, I felt some sense that Sally did not really know where to begin our conversation or initially, what to say. As we began our discussion, I could see the seriousness in her eyes and listened closely to Sally’s carefully selected words. She started our conversation off by reminding me of her current profession, which was a drug and alcohol/HIV/AIDS counselor at one of the local healthcare agencies. At that time and at this healthcare agency, the protocol for clients testing positive for HIV and not wanting to personally tell their sex or needle sharing partner was to submit the names to a healthcare provider representative and have this representative notify the individuals without divulging the name of the HIV positive client. My name had not been submitted, and therefore, legally, Sally could not provide me with any information regarding her client. However, morally, Sally felt the need to "warn" me. She informed me that the name Paul Raymond Franks, my husband at that time, had been submitted by a client, an African American male who tested positive for HIV. The client indicated that Paul had been one of his sexual partners. To this day and even now as I type this story for my dissertation, the chills and fears that ran through my body and the tears that came to my eyes after receiving this information from Sally remains with me today. I sat at the table for a long period of time with Sally crying and shaking; she held my hand until I came to some form of calm.

Although I had always known to some degree what Sally actually did in her profession, the information that Sally shared with me on that day was all new to me, and I had many fears of the unknown. In retrospect, it was at that time that I realized how little I knew about HIV. Sally patiently and calmly explained many things to me although at that time, I was unable to process much of the information because I was emotionally overwhelmed. I eventually calmed down to some degree, and Sally was able to ask more specific questions of me regarding my health and my marriage with Paul. Paul was a crack cocaine addict during the last few years of our marriage, and I was aware that he had at one time been one of Sally's clients.

On that same day after receiving the devastating news from Sally, I returned home, and fortunately, Paul was not there. Because of the policies regarding confidentially at the agency where Sally worked, I could not discuss with Paul the information that I had received from Sally regarding his name being turned in. At that time, I did not know if Paul was or was not HIV positive. I did know that Sally was required to inform him that his name had been submitted. Because of the many problems surrounding Paul’s drug use, our marriage was already in trouble and had been in trouble for at least a year, and there had been no intimate contact. Our conversations were basically business related or related to maintaining the household. There was also a financial strain placed on our marriage, mostly because of the spending of money by Paul to support his crack cocaine habit.

For at least a year or more, I was not aware of his use of crack cocaine. When we married, I discussed with Paul his habit of smoking marijuana daily and how I thought this was a problem. By the time I became aware that he was smoking crack, Paul had become a daily user. I discovered his crack cocaine habit purely by accident when a semicrushed Coke-Cola can fell out of the passenger side of the car he was driving. When I picked the can up, Paul immediately tried to snatch the can out of my hand. As he tried to get the can away from me, I took a closer look at it and realized that it had actually been used as some type of crack-smoking paraphernalia. I had heard of this method of smoking crack cocaine from conversations with others and through information provided on television and radio but really did not fully understand. Realizing at that moment that Paul was possibly smoking crack and possibly had been for a while, I immediately understood many of the lies he had told me. Paul often lied about money and various items missing out of our home. On two separate occasions while Paul was using drugs, he took all of the money out of our joint bank account and spent it all on drugs. Another time, Paul pawned the title to our car for cash which he used to purchase drugs. The pawn company came to our home to get either the car or their money that they had given Paul; again, I was not aware this had happened. In another incident, Paul purchased drugs from a local drug dealer in our neighborhood. The plan for payment for the drugs included musical equipment that belonged to our church music group and was being kept at our apartment. Paul and I went out for the evening, and when we returned home and found items missing, I thought our apartment had been broken into. I immediately called the police, and Paul and I waited for the police to arrive. Not realizing that Paul and I had returned home and were in the back of the apartment, the drug dealer came back to our apartment, entering through the back door. It appeared that I was the only one upset and in shock over what appeared to have been a home robbery. However, in the presence of Paul, the dealer explained the plan to me that he and Paul had arranged. The plan called for the drug dealer to enter our home, remove the musical equipment, and have it appear as if a break in had occurred to our home so that Paul would not be held accountable for the missing equipment. The dealer explained that he returned only to get the remainder of the equipment that he was unable to fit into his car on his first trip. On another occasion, Paul was badly beaten and had to be hospitalized because of a drug deal that turned bad. I never really got the whole truth behind what actually happened. However, our vehicle was vandalized, audio equipment and other items were stolen out of the vehicle, and money was missing along with Paul being severely beaten.

I come from a close-knit family, and we often spent much time together. As a result of the emotional turmoil of dealing with all of the issues surrounding Paul and having to be tested for HIV, I knew I could not verbally tell my family any of what was going on in my life. Therefore, I wrote them a letter that explained some of the things I was going through and that I needed some time to myself. Over the next 6 months, I experienced deep depression, and I lost weight because I could not eat and worried constantly about the results of my HIV test. I underwent a series of three HIV tests, the first of which I took while still living with Paul. He was never aware of any of them or the results.

At that time, an HIV test was conducted on a small sample of blood that was withdrawn from my forearm. Ironically, the only other time I had blood withdrawn during my entire life was for the required blood testing when Paul and I got married. Sally took me to an agency where HIV testing was done discretely and privately. At the agency, I was advised that I should be tested on three separate occasions for the virus that causes HIV. I was not only humiliated that I had to go through the HIV testing, I was scared to death of the procedure and the outcome. During my first test, I remember crying uncontrollably. Sally and the nurse held my hand and talked to me throughout my entire testing process, attempting to calm me down. The nurse explained to Sally that she was really concerned about my mental state and questioned whether or not I was going to be left alone. Sally assured the nurse that she was going to stay with me. I had to wait three agonizing weeks for test results to come back. To receive my test results, I had to return to the same agency and once again endure what I described as humiliation.

Some time later, I received a call at home from a doctor’s office requesting to speak with Paul; I explained to the nurse that Paul was not in. She left an urgent message for Paul to contact the doctor’s office immediately. After I informed the nurse that I was Paul’s wife, the nurse explained to me that Paul’s test results had come in and the doctor wanted to meet with him as soon as possible to discuss his results. When I inquired as to what type of test, the nurse explained that she would need to speak with Paul and could not give that information to me but indicated he needed to return the call immediately. I gave Paul the message. After his visit to the doctor's office, Paul explained that the doctor wanted him to go in for a few more tests. Paul never mentioned anything about HIV testing to me. Months later, I discovered that Paul had known of his HIV positive status for a while, even before going to this doctor's office, although he never told me. I also discovered that Paul had been sexually involved with several African American men. Some of them were also HIV positive, and some were diagnosed as having AIDS and eventually died.

Paul was indeed an excellent musician and being a local church musician, he was often occupied with some musical events or rehearsals and spent a great deal of time away from home. During those months while waiting for my test results, I often sought a place of solitude at home, not realizing that I was sinking deeper and deeper into depression. It was also during this time that I discovered that Paul had often lied about his whereabouts, spending a lot of his time with his African American male partners. I also found out that many of these men were on the downlow; some were married with families, and some I knew personally. They had often frequented our home, and some were acquaintances from church. In the years to come and as more things began to be revealed, a few of these men died from AIDS.

A few months later, I gave Paul notice that I was filing for divorce, and either he would leave the home where we resided or I would leave. By this time, it did not matter to me. The choice was his, but I could no longer live in the same house with him and continue through with the HIV testing and all his lies. Paul continued to spend all of his money on drugs and established a pattern of being in and out of the legal system. I still cared for Paul as a person but felt that he would probably have a difficult time getting on his feet and adjusting on his own. However, I informed Paul that he could take whatever furniture and other material items he needed to get himself reestablished. We had two cars at that time, and I told him to select which car he wanted. I simply wanted him out of my life and gave him a 2 week notice. My reason for separating from Paul at that time was not solely because of his having contracted HIV. His drug problem had increased, and the lies continued. At times, dealing with Paul and his drug use caused me to feel as if my life was in danger, and the distance between us grew daily.

Years after my divorce from Paul, I learned that his drug use continued, and subsequently, he lost his apartment and had to move in with his brothers. I also learned that Paul was eventually diagnosed as having full blown AIDS, did not have health insurance, and could not afford proper medical care. It is important to note that during my marriage to Paul, I discussed with him on a few occasions the need for him to get health insurance which he did not have. At that time, in order to get private health insurance, a complete physical exam including blood work was required. Reflecting back, I remember how Paul often made excuses and came up with reasons not to go to the doctor and, therefore, never acquired any health insurance. I learned that Paul died from complications of AIDS. In the obituary section of the local newspaper, it stated that Paul died of cancer.

For my own peace of mind, I continued to get tested for HIV for several years, and all tests were negative. I eventually sought professional and spiritual counseling. I was blessed to be able to move on with my life. I remarried and moved to another state. Yet to this day, the mental trauma and anguish that I endured during the later years of my marriage with Paul still often haunt me.

Discussion

My reasons for conducting this study were both personal and professional. An article written by Zook (2003) in *Essence Magazine* entitled “Headache, Hardwork and Hope: Saving a Southern Town in the Grip of AIDS” was my main motivation. The article was shared with me by my professor; at that time, neither she nor I had any idea how close to my own life story the article would parallel. The article concentrated on the rapid spread of HIV/AIDS and African American women living in a rural Florida town where many were dying from AIDS, and many others were infected with the HIV virus. Being a resident of Florida, I was disturbed when I learned that Florida has the highest number of AIDS cases behind New York and California. Within the United States, the fastest growing number of new HIV cases is African Americans, more specifically women between the ages of 25 and 34.

I also had some concerns regarding the death and positive HIV status of a few close friends, both men and women. Many of the women were intimately involved with African American men who at one time had been through the prison system. Much of today’s research suggests that there appears to be a positive relationship between the transmission of the HIV virus and African American women who have been sexually involved with African American men who have gone through the prison system. Other research suggests a relationship of the spreading of the HIV virus to African American women from African American men who are identified as being on the downlow. The downlow is a slang phrase used mainly by Black men who secretly have sex with men, often explaining it as a matter of “just kicking with their boys,” but who also have sex with women and do not make the women aware of the sexual history. These men do not identify themselves as either homosexual or bisexual. Other studies, including studies conducted by the CDC, estimate that thousands are getting infected annually with the virus that causes HIV. Consistently, the largest increases in the HIV virus have been within the African American and minority populations.

Even within wealthy countries of the world such as the United States, AIDS is a disease that is strikingly patterned along lines of social and gender inequality (Mayer & Pizer, 2005). According to Zierler and Kreiger (2000), more and more women and people of color are the most at risk for becoming newly infected with HIV. The AIDS/HIV Questionnaire and AIDS/HIV Risk Assessment Interview results revealed that African American women are at the highest risk for exposure to and infection with the HIV virus. One of the main implications of these findings is that while African American women appear to be knowledgeable about HIV/AIDS to a certain degree, some continue to engage in high-risk sexual behaviors. Also, my findings and other research studies suggest that African American women are becoming infected with the HIV virus and dying of AIDS at epidemic rates. Unfortunately, many African American women are not aware of their high risk sexual behaviors and the downlow status of some Black men. My research suggests that the behaviors of African American men who are on the downlow have a direct relationship with the increase in HIV/AIDS for these women.

My findings also reveal that many HIV/AIDS educational intervention programs that are currently being used are not culturally appropriate or sensitive for the targeted population, (i.e. African American women). Many of the programs that are currently being used do not properly address the personal, social, spiritual, educational, and often financial needs or levels of these women. To assess HIV/AIDS programs for these women and minorities of both genders properly, cultural barriers that properly address their needs and the devastation that HIV/AIDS is having on minority communities needs to be explained more thoroughly.

On any given gathering of African American congregants, the population is mostly female. African American leaders and congregations have many opportunities to address the HIV/AIDS epidemic within their community. However, this is not happening. My findings indicate that settings such as the Black church that would provide great opportunities to reach many minorities regarding HIV/AIDS are often the most difficult settings to penetrate because of the “sinful” perception of the epidemic. Faith-based leaders should increase their involvement in the fight against HIV/AIDS by taking opportunities to discuss the disproportionate impact it has within the African American community and to harness the power of faith communities to educate people about the epidemic. Within Black communities, Black churches and their leaders must realize that HIV is a disease, not a sin, and that God still loves the person who is infected with the HIV virus or who is dying of AIDS. There must be a change of attitude within the Black church about the disease, how it is contracted, and how to continually embrace those affected by HIV/AIDS.

Many United States prisons are largely populated with African American males and minorities. With regard to preventing the spread of HIV among the inmates, many prison systems concentrate their efforts on preventing sexual relations between inmates while in prison, although sexual behaviors continue. Therefore, some of these men as they exit the prison system do so possibly unknowingly HIV positive. Many then return to African American women and reestablish their sexual relationships. Therefore, the spread of HIV continues to affect African American women. My research findings also suggest that the United States prison system, unknowingly or without care, plays a role in the spread of HIV for minority populations, more specifically Black communities.

Implications of the Study

The implications of my findings are somewhat consistent with similar findings in other studies involving African American women and the CDC findings. According to the CDC (2006a), women benefit from programs aimed at increasing their awareness of their own risk, assertiveness in sexual situations, and coping skills. The CDC (2006a) also found that the following interventions were effective in reducing high-risk sexual behaviors:

1. Teaching young heterosexual Black women about assertiveness, negotiation, and condom use.
2. Teaching male and female low-income clients at high risk about expectations of outcome, skills, and the belief that their words and actions will be effective at preventing HIV transmission.
3. Showing videos on assertiveness, negotiation, and planning skills to promote abstinence and safer behaviors among single, pregnant women.

Ainsworth, Beyrer, and Sourat (2003) indicate that prevention activities need to be designed with the local epidemiology of the disease in mind. In settings in which HIV is largely a sexually transmitted disease, information and education campaigns can save lives. Again, from my findings, an example of this type of campaign would be condom distribution within the prison system.

African American women must learn to become proactive about protecting themselves against the virus that causes HIV. They must continually avoid at risk behaviors for HIV/AIDS, regularly use condoms, and become proactive in their sexual negotiations. Additionally, they should also get tested for HIV early and become more educated to the seriousness of HIV/AIDS and the effect it has on African American women, men, and children, and minority communities.

Health care educators, professionals, and providers involved with HIV/AIDS prevention among African American women and minority communities must acknowledge that knowledge alone does not necessarily translate into positive behavior changes. My study findings support this idea. In the development of HIV/AIDS prevention programs for African American women and minorities, the programs must do the following:

1. Provide adequate and correct information that addresses the real issues and concerns for minorities and HIV/AIDS.
2. Provide opportunities and resources for African American women and minorities to develop the behavioral skills required to decrease their participation in high-risk behaviors and increase their participation in risk-reduction activities.

Because of the lack of access to health care for many Blacks, AIDS is now the leading cause of death for African American women between the ages of 25 and 34 in the United States, according to CDC (2007b). Given the legacy of the Black church and the civil rights movements, HIV/AIDS intersected with crack cocaine, heroin, and poverty, and in some cases, the crumbling of some Black communities presents new and complicated issues the Black communities now face. Often the conversation of HIV/AIDS leaves our communities speechless and uncomfortable. Also, there appears to be some form of denial or resistance within the African American communities regarding

HIV/AIDS and the nation regarding the HIV/AIDS epidemic among minorities. The African American communities must stand firm to combat and address HIV/AIDS and its effect on minority populations.

The bulk of the educational prevention programs in the short term must consist of improved and integrated HIV/AIDS prevention and care. Physicians, psychologist, social workers, public health officials, civic and faith leaders, and others who service those with HIV/AIDS should play a role not only in supporting HIV/AIDS patients, but also in assessing as honestly as possible the strengths and weaknesses of the tools currently at our disposal for HIV/AIDS prevention (Mayer & Pizer, 2005).

Past and current research appears to indicate that AIDS is out of control within the African American communities. Although there is now more organized activism within some Black communities for the fight against the virus that causes HIV for African American women, men, and gay Black men, the need is still great for more programs and services. African-Americans have emerged as the second wave of the AIDS epidemic; gay White men were considered the first wave. Epidemiologic evidence indicates that African American adults as well as adolescents have a disproportionately higher risk of AIDS and HIV virus infection. In today’s society, we continue to find programs that are designed to increase self-protective behaviors. Although these programs are urgently needed to avert a further increase in HIV infection among this population, there is little understanding of African American sociocultural factors that may influence the acceptance of HIV information and the adoption of HIV-preventive behaviors (Airhihenbuwa et al., 1992). If the HIV/AIDS programs are not culturally and appropriately designed to meet the needs of this targeted population, they will not be effective.

In today’s society, we are observing a myriad of educational, social, economic, and cultural factors including racism, poverty, sexism, and a negative history with government sponsored public-health prevention programs that are operated for poor, heterosexual African-American women attempting to manage their sexual risk for HIV infection (Airhihenbuwa et al., 1992; Lewis, 2003; Mays & Cochran, 1988). Even in today’s society where we have more advanced forms of health care and more health care providers, it is unfortunate that often because of past medical historic studies with African Americans and their lack of trust with these systems, many will opt to manage their own care, including those infected with the HIV virus. However, as African Americans in the United States continue to die of AIDS and more become infected with the HIV virus, the nature of the silence of the HIV/AIDS epidemic continues to hang over the Black AIDS epidemic like a shroud. The silence within the media, the government, the medical establishment and the Black community itself has allowed the disease to fester among Blacks even as gay America has to some extent, managed to contain it (Levenson, 2004).

More Black women are becoming infected with the HIV virus as sexual behaviors increase, such as the downlow with Black men, high-risk sexual behaviors by Black women, and drug usage by both. Although some progress is being made, social stigmas behind HIV/AIDS within the Black community continue to prevent productive discussions, training, and educational forums for African American populations. Black churches that took on the civil rights movements appear not as willing to be the leaders and advocates to reduce HIV/AIDS rates in the Black community. The Black churches, community leaders, and the United States Health Administration have not done enough for the HIV/AIDS in Black America; there is a great deal of work ahead.

Many have begun to give notice that HIV/AIDS is reaching beyond the gay and Black communities; it is just a matter-of-time before other populations within the United States are affected. However, while people are dying and government health officials are aware that they are dying from AIDS and more people are becoming infected with HIV at epidemic proportions, the issues that intersect with the epidemic should affect us all. The stories of those who become infected and those who are vulnerable to the disease should be the concern of our society as a whole. Socially and economically, HIV/AIDS will affect us all. Whatever negatively impacts our population will eventually and ultimately impact us all unless something is done to decrease the rising numbers of HIV/AIDS patients in our minority communities. The lives of the women in my study present a picture that shows that African American women living in subsidized housing remain vulnerable to HIV/AIDS; often the consequence is death.

Recommendations for Future Research

My study focused on a group of African American women at high risk for exposure to HIV. The findings indicate a need for future HIV/AIDS research to assess accurately and effectively the behavioral and educational needs of African American women who are at high risk for HIV/AIDS. Also, more HIV/AIDS research is needed for African American women who participate in high risk behaviors, such as having unprotected sex, having multiple sexual partners, and using drugs. Also, just as important, if not more, research is needed to understand how and to what extent the HIV/AIDS virus is transferred to African American women from African American men who were once a part of the prison system and Black men on the downlow.

My study suggests that a direct relationship exists between African American men, women, HIV, and the prison populations. Most prisons focus their HIV prevention efforts on preventing sex in the prison system. Current research and the increased HIV/AIDS statistics among Black men and women, indicate that this method is ineffective. Therefore, further research is needed to prevent HIV/AIDS transmission between African American women who are involved with African American male partners that have current or past ties to the prison system. Additionally, more research is needed for Black men who secretly have sex with other men identifying themselves as on the down-low and then have sex with Black women. Currently, research indicates that this pattern appears to have an enormous impact on the number of African American women who are becoming HIV positive. For these men, some of whom have come out of the prison system, the possibility of passing the virus to African American women increases. Often some of these men are not aware of their HIV status.

Despite 2 decades of experience in using information and education as the primary tools in HIV prevention, there have been, until very recently, no careful studies on the efficacy of HIV interventions. One meta-analysis of information and education campaign concludes that somewhat surprisingly, toward the end of the second decade of the AIDS pandemic, there is still no good evidence that primary prevention works (Mayaud, Hawkes, & Mabey, 1998). HIV surveillance and diagnostic testing for HIV infection share elements yet differ notably in context. Clinical testing provides vital information for individual medical and behavioral decisions whereas surveillance, which focuses on populations, provides information to develop policy, direct resources, and plan services. HIV/AIDS surveillance has evolved over the course of the epidemic, reflecting changes in scientific knowledge, populations affected, and information needs. Likewise, the benefits of early diagnosis of HIV have become increasingly apparent with advances in HIV treatment (Valdiserri et al., 2000).

More research is needed to understand the patterns and behaviors of those living in high-risk situations. As the HIV virus passes from African American men to African American women who may become pregnant, the chances are great that the virus will pass to their unborn child. Therefore, it is imperative that the development of appropriate HIV/AIDS preventions, educational programs, and planning be implemented for minority men and women in and outside the prison system. Health care professionals, politicians, clergymen, people of all races and genders, and other involved parties must begin to realize that the HIV/AIDS epidemic is one that must be articulated in a way that goes beyond race, gender, social, religious, and political issues.

Within the United States and globally, we must realize and understand the failure to communicate the seriousness of HIV/AIDS properly. This epidemic must be discussed in areas that allow meaningful discussions which goes beyond racism, beyond the bureaucracies of hidden political agendas and correctness and focuses on cultural relativism for all those needed services. Research must address the most sensitive issues facing Black America and HIV/AIDS.

The continued pressing need for effective HIV control activities has forced traditional sexually transmitted disease control programs to incorporate primary and secondary HIV prevention activities like HIV counseling and testing, postexposure prophylaxis, HIV early care services, and working with community groups most at risk not only for STDs but also for HIV (Mayer & Pizer, 2005). Further research is needed to address these areas of HIV/AIDS within African American and minority communities. This research should address how state and local health care professional policies and procedures regard HIV/AIDS services to Black and other minority communities. African American and minority leaders, churches, organizations, and agencies should also address the HIV/AIDS pandemic. The research should also explore possibilities of administering HIV/AIDS prevention programs, counseling, testing and referral procedures, prevention for high risk populations, and partner notification.

There is a desperate need to review past and present HIV/AIDS educational preventions for minority communities and more specifically for African Americans. Additionally, because there appears to be a relationship between the spread of HIV and African American men who have been in the prison system, with the virus being passed on to many African American women, interventions and educational programs used within the prison system should also be evaluated. Evaluation and assessment instruments used for African American women and minorities regarding HIV/AIDS must effectively and properly assess their cultural, social, and educational needs.

Summary

In conclusion, as stated earlier, I chose the topic of my dissertation for educational, professional, and personal reasons. Now that this task is completed, I believe that studies such as this are needed and necessary. Whatever negatively impacts African Americans living in poverty or in challenging positions, will eventually and ultimately impact everyone unless something is done to prevent increases in the number of people who contract HIV/AIDS. The information from the 10 African American women participants in my study reinforces the seriousness for understanding how African American women are becoming one of the most affected groups for contracting HIV/AIDS. Today, for many African American women, sexual encounters and relationships with men who are drug users, living in and out of prison systems or living on the down low, continue to increase the number of Black women affected by HIV/AIDS.

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APPENDIXES

Appendix A

AIDS/HIV Questionnaire:

Instrument 1

AIDS/HIV Questionnaire
Instrument I

You have been selected to participate in a study of HIV and AIDS. Your thoughts concerning HIV/AIDS and how it is spread are important to us. We are trying to slow the spread of HIV/AIDS among African American women. You are free to withdraw from this study at any time. There are no harmful effects and in no way can your responses hurt you. We strongly encourage you to take 15 minutes and fill out this questionnaire. By completing this questionnaire you voluntarily indicate your willingness to participate in the study. NO ONE WILL KNOW WHO YOU ARE OR HOW YOU ANSWERED. ALL SUBJECTS HAVE COMPLETE ANONYMITY AND CONFIDENTIALITY. Read each question, and after you decide which answer is best, fill in your response.

Question #1
What do African America women know about HIV/AIDS.

1. I have had a test for HIV. (a) Yes (b) No (c) don't know

2. I have tested positive for HIV. (a) Yes (b) No (c) don't know

3. I would like to be tested for HIV. (a) Yes (b) No (c) don't know

4. I would like for my friends to be blood tested for HIV.
   (a) Yes (b) No (c) don't know

5. In the future I will share injecting drug needles.
   (a) Frequently (b) Sometimes (c) Never

6. In the future I will not share injecting drug needles.
   (a) Frequently (b) Sometimes (c) Never

7. HIV can be caught from sharing a glass of water with an infected person.
   (a) Yes (b) No (c) don't know

8. HIV can be caught from toilet seats.
   (a) Yes (b) No (c) don't know

9. HIV can be caught from kissing on the cheek.
   (a) Yes (b) No (c) don't know

10. HIV can be caught from heavy (tongue) kissing.
    (a) Yes (b) No (c) don’t know

11. HIV can be caught from sharing marijuana pipes or cigarettes.
    (a) Yes (b) No (c) don’t know

12. HIV can be caught from sharing needles.
    (a) Yes (b) No (c) don’t know

13. HIV can be caught from donating blood.
    (a) Yes (b) No (c) don’t know

14. HIV can be caught from sharing tattoo needles.
    (a) Yes (b) No (c) don’t know

15. HIV can be caught from sharing cigarettes.
    (a) Yes (b) No (c) don’t know

16. HIV can be caught if a person who has HIV sneezes on you.
    (a) Yes (b) No (c) don’t know

17. HIV can be caught if a hospital has to give you blood.
    (a) Yes (b) No (c) don’t know

18. HIV is harder to catch if you are young and healthy.
    (a) Yes (b) No (c) don’t know

19. If a restaurant cook has HIV, you will catch HIV if you eat food the cook prepared.
    (a) Yes (b) No (c) don’t know

20. All gay men (homosexuals) have HIV.
    (a) Yes (b) No (c) don’t know

21. Babies can be born with HIV.
    (a) Yes (b) No (c) don’t know

22. HIV is caused by a virus.
    (a) Yes (b) No (c) don’t know

23. You can catch HIV by shaking hands with a person who has HIV.
    (a) Yes (b) No (c) don’t know

24. HIV can be caught from sharing razor blades.
    (a) Yes (b) No (c) don’t know

25. My friends have a high chance of catching HIV.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

26. White people have less of a chance of catching HIV than other non-Whites.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

27. There is a cure for HIV but it is too expensive for most people.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

28. My chances of catching HIV are great.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

29. If I caught HIV, I would not tell anyone.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

30. If I caught HIV, I would tell close friends.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

31. Only homosexuals catch HIV.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

32. HIV is a made up problem by the government to decrease sexual activity and drug use.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

33. You can have HIV and not know it.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

34. If you catch HIV, you will die within ten years.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

35. Compared to most people I feel that I know a lot about HIV.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

36. Where did you learn the most about HIV?
    (a) Relatives (b) books, magazines (c) television, radio (d) public school/college

37. Where have you heard the most talk about HIV?
    (a) Relatives (b) books, magazines (c) television, radio (d) public school/college

Question #2
To what extent do African American women believe they engage in sexual behaviors that place them at risk of contracting HIV/AIDS?

1. In the future, I will use a condom if unsure of my partner's sexual history.
   (a) Frequently (b) sometimes (c) never

2. I would trust a sex partner if she/he said they are free from disease.
   (a) Frequently (b) sometimes (c) never

3. In the future, I will demand the use of a condom (rubber) for my protection.
   (a) Frequently (b) sometimes (c) never

4. In the future, I will demand the use of a condom (rubber) for my partner's protection.
   (a) Frequently (b) sometimes (c) never

5. Using a condom (rubber) will help prevent catching HIV.
   (a) Yes (b) no (c) don't know

6. In the last five (5) times you had sex, how many times did you use a condom?
   (a) 0 (b) 1 (c) 2 (d) 3 (e) 4 (f) 5

7. With how many partners have you had sexual intercourse?
   (a) None (b) 1 (c) 2-5 (d) 6-10 (e) Over 10

8. How many sexual partners have you had in the last three (3) months?
   (a) None (b) 1 (c) 2-5 (d) 6-10 (e) Over 10

Question #3
Do African American women fear contacting HIV/AIDS?

1. I take special precautions to prevent catching HIV.
   (a) Frequently (b) Sometimes (c) Never

2. I am fearful on contacting HIV.
   (a) Frequently (b) Sometimes (c) Never

3. I ask partners about their sexual history.
   (a) Frequently (b) Sometimes (c) Never

4. I do think about what if I contracted HIV.
   (a) Frequently (b) Sometimes (c) Never

5. I do think about if my partner has HIV.
   (a) Frequently (b) Sometimes (c) Never

Question #4

To what extent do knowledge and fear affect African American women's sexual behavior?

1. I would have sex with an attractive partner if no condom was available.
   (a) Frequently (b) Sometimes (c) Never

2. I would have sex without a condom if I had a negative HIV test.
   (a) Frequently (b) Sometimes (c) Never

3. If I caught HIV, I would not have sex again.
   (a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

4. If I caught HIV, I would tell any sex partner(s).
   (a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

5. I worry a lot about catching HIV.
   (a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

6. I worry a lot about my friends catching HIV.
   (a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

Question #5

What themes and common threads are there in the practices and beliefs of African American women that place them at risk for HIV/AIDS women?

1. In the future I plan to inject drugs.
   (a) Frequently (b) Sometimes (c) Never

2. I have been sexually abused.
   (a) Yes (b) No (c) Unsure

3. I have been physically abused.
(a) Yes (b) No (c) Unsure

4. I share injecting drug needles.
(a) Frequently (b) Sometimes (c) Never

5. There is nothing you can do to prevent catching HIV.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

6. If you catch HIV, it's your own fault.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

7. It is possible for someone to have HIV, not know it and infect others.
(a) Strongly agree (b) Agree (c) Disagree (d) Strongly disagree (e) Don't know

8. Have you injected drugs in the last three (3) months?
(a) Yes (b) No

9. Have you ever used marijuana?
(a) Yes (b) No

10. Have you ever "shot-up" drugs?
(a) Yes (b) No

11. How many sex partners do you think most of your friends have had?
(a) None (b) 1 (c) 2-5 (d) 6-10 (e) don't know

12. With how many partners have you had a same sex relationship?
(a) None (b) 1 (c) 2-5 (d) 6-10 (e) Over 10

13. How many of your friends do you think have had a homosexual relationship?
(a) None (b) 1 (c) 2-5 (d) 6-10 (e) don't know

14. Have you ever exchanged sex for money, food, etc.?
(a) Yes (b) No

Appendix B

AIDS/HIV Risk Assessment Interview

Instrument 2

AIDS/HIV Risk Assessment Interview; Instrument 2

Interviewee's Name__________________________________

Date_____________________________

Location______________________________

AIDS/HIV Risk Assessment Interview Generic Data

a. What is your race?
b. What is your gender?
c. In what year were you born?
d. In what city and county do you live in?

Research Question #1

What do African America women know about HIV/AIDS?

1. How much formal education have you had?
2. What type of educational ambitions do you have? (e.g., get a GED, high school diploma, attending college, vocational/technical school).
3. How much do you know about HIV/AIDS?
4. Where did you learn the most about HIV/AIDS? (List in order)
5. What would you do if you had HIV/AIDS?
6. How big of a problem do you think HIV/AIDS is?
7. Is there a cure?
8. What should be done about the HIV/AIDS problems in America?
9. Have you had an HIV test?
10. If yes, what was the result?

11. If no, would you like to be re-tested?

Research Question #2

To what extent do African American women believe they engage in sexual behaviors that place them at risk of contracting HIV/AIDS?

1. What are your future plans (school, work, children, party, etc.)?
2. What type of work ambitions do you have? (e.g., to work at a day care, become a teacher, nurse, work @ a factory)
3. How many sexual partners have you had?
4. Do you discuss your partner's sexual history with them?
5. For sex, would you prefer a male partner or a female partner?
6. Would you ever have sex with someone of the same gender?
7. Why or why not?

Research Question #3

Do African American women fear contacting HIV/AIDS?

Have you ever been incarcerated?

1. Have you or are you sexually involved with anyone that has been incarcerated?
2. If so, how many partners?
3. What offenses were he/she/they charged with?
4. Should people in prison be tested for HIV?
5. Why or why not?

6. Have you ever engaged in deviant sex acts? Use or work as prostitute multiple partners, etc.) Give examples.

Research Question #4

To what extent do knowledge and fear affect African American women's sexual behavior?

1. Many young African American women have HIV. What could be done to keep this number from increasing?
2. Who is at-risk for HIV?
3. Are you at-risk for HIV?
4. Are your friends, family members?
5. Should condoms be available in prison?
6. Should condoms be available in schools?
7. Is it hard to get condoms when you are not in custody?
8. Why or why not?

Research Question #5

What themes and common threads are there in the practices and beliefs of African American women that place them at risk for HIV/AIDS women?

1. Have you ever shared needles for any of the following: (1) tattooing? (2) drugs? (3) body piercing? (4) for any other reason?
2. Would you ever share needles?

3. Why or why not?

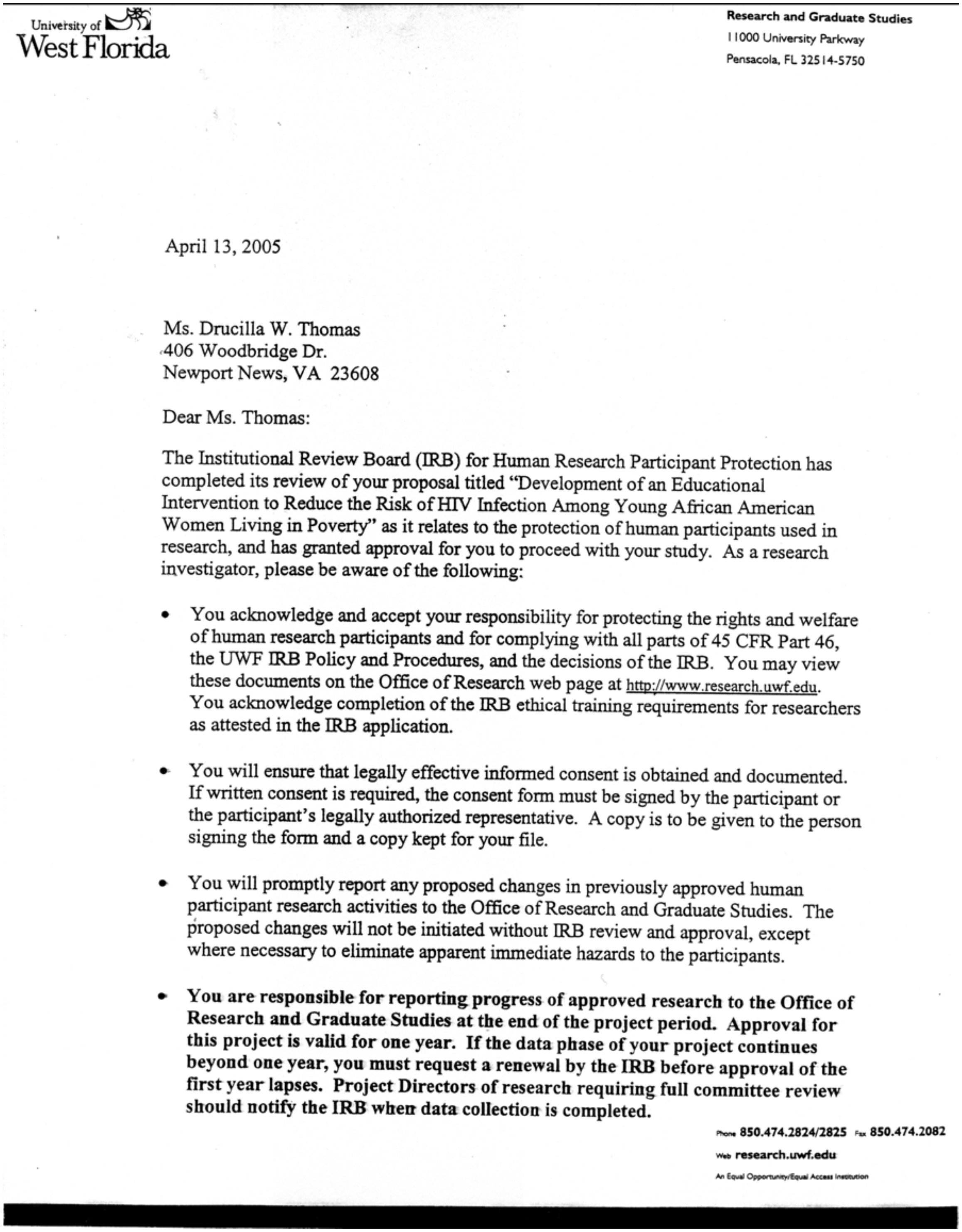
4. If you could do things over, what would you do different?

5. Why or why not?

6. Are there any issues or problems that we have not discussed?

Appendix C

Institutional Review Board Approval Letter



University of West Florida

Research and Graduate Studies
11000 University Parkway
Pensacola, FL 32514-5750

April 13, 2005

Ms. Drucilla W. Thomas
406 Woodbridge Dr.
Newport News, VA 23608

Dear Ms. Thomas:

The Institutional Review Board (IRB) for Human Research Participant Protection has completed its review of your proposal titled "Development of an Educational Intervention to Reduce the Risk of HIV Infection Among Young African American Women Living in Poverty" as it relates to the protection of human participants used in research, and has granted approval for you to proceed with your study. As a research investigator, please be aware of the following:

- You acknowledge and accept your responsibility for protecting the rights and welfare of human research participants and for complying with all parts of 45 CFR Part 46, the UWF IRB Policy and Procedures, and the decisions of the IRB. You may view these documents on the Office of Research web page at http://www.research.uwf.edu. You acknowledge completion of the IRB ethical training requirements for researchers as attested in the IRB application.

- You will ensure that legally effective informed consent is obtained and documented. If written consent is required, the consent form must be signed by the participant or the participant's legally authorized representative. A copy is to be given to the person signing the form and a copy kept for your file.

- You will promptly report any proposed changes in previously approved human participant research activities to the Office of Research and Graduate Studies. The proposed changes will not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the participants.

- **You are responsible for reporting progress of approved research to the Office of Research and Graduate Studies at the end of the project period. Approval for this project is valid for one year. If the data phase of your project continues beyond one year, you must request a renewal by the IRB before approval of the first year lapses. Project Directors of research requiring full committee review should notify the IRB when data collection is completed.**

Appendix D

Informed Consent Form

Informed Consent Form

Title of Research: Development of an Educational Intervention to Reduce the Risk of HIV Infection among African American Women Living in Poverty

I. Federal and university regulations require us to obtain a signed consent for participation in research involving human participants. After reading the statements in sections II through IV below, please indicate your consent by signing and dating this form.

II. **Statement of Procedure:** Thank you for your interest in this research project being conducted by Drucilla W. Thomas, a Distance Learning Site Director for Old Dominion University and a doctoral student at the University of West Florida. Hopefully, this consent form will explain the nature of this research project. Basically, this phase of the research involves the administration of this survey and/or a semi-structured interview for the purpose of gathering data. The major aspects of the study are described in the statements below, including the risks and benefits of your participation. Your participation in this study is confidential and you are requested to not place your name anywhere on this survey; pseudonym names (fictitious names) will be assigned.

III.

I understand that:

(1) I will be asked to disclose certain information about my knowledge, practices, ideas, beliefs, habits, commonalities, and differences regarding HIV/AIDS, and sexual behaviors that place one at risk for contracting HIV.

(2) I will participate in semi-instructed interview(s) and complete a survey/questionnaire for the purpose of collecting information related to African American women living in poverty, HIV/AIDS education, risky sexual behaviors and condom use.

(3) I may discontinue participation in this study at any time and for any reason. I also understand that there will be no coercion, threats, or other illegal methods used to force participation.

IV. **Potential Risks of the study:**

(1) There are no foreseeable risks involved with the study.

V. **Potential Benefits of the study:**

(1) Data obtained from this study may provide HIV/AIDS educators, African American women and others information for instructional components of HIV/AIDS education intervention programs and HIV/AIDS intervention strategies.

(2) Information obtained from this study will help to support and increase HIV/AIDS education intervention programs and strengthen self-efficacy

(3) Information obtained from this study will help outline the direct connections between HIV/AIDS and African American women.

VI. **Statement of Consent:** I certify that I have read and fully understand that statement of procedure given about and agree to participate as a subject in the research described therein. Permission is given voluntarily and without coercion or undue influence. It is understood that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I will be provided a copy of this consent form.

Participant's Signature Date

If you have questions or concerns, please call or write, Drucilla W. Thomas, the researcher at (757) 897-3073, or e-mail: dwthomas@cox.net.

Appendix E

Participation Form

Participant Form

Drucilla W. Thomas
3880 San Gabriel Drive, Pensacola, FL 32504

December 2, 2005

Hello:

Thank you for consenting to participate in my study; please know that your participation means a great deal to me and further research to be conducted in this area. At this time I am presenting to you two documents (1) **Informed Consent Form** (2) **Survey I**. Please carefully read the directions on the Informed Consent Form. After reading the directions and using a fictitious name, complete the form and the survey. After you have completed survey one, I will then present to you survey II. **<u>After they are both completed</u>,** place both in the envelope. After you have completed both surveys and no other sessions are needed, I will request that a $50.00 research participation check in your name.

Thank you again, Prayers & Blessings,

Drucilla W. Thomas
Doctoral Student and Candidate
College of Professional Studies
University of West Florida