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Not on My Street: Exploration of Culture, Meaning and Perceptions of HIV Risk among Middle Class African American Women

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Exploration of Culture, Meaning and Perceptions of HIV Risk among

Middle Class African American Women

by

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A dissertation submitted in partial fulfillment
of the requirement for the degree of
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DEDICATION

To my parents, Catherine S. Heath and Willie F. Heath, for supporting me through this process; you may not necessarily understand what I do or why I make some of the decisions that I do, but nevertheless you still encourage me to follow my dreams. I thank God for your love, your prayers, and your patience.

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ABSTRACT

Black women remain at a higher risk for HIV infection than women of any other ethnic group. Of all new infections reported among U.S. women in 2010, 64% occurred in African Americans compared to 18% Whites and 15% Hispanic/Latina women (CDC 2013a; CDC 2014b). While the literature on HIV risk among African American women is extensive, it mostly focuses on low income, low education subgroups of women or those involved in high risk behaviors such as drug use. Very little has been done to understand the risk for HIV among college educated, middle class women who do not fit into traditional "risk categories."

Based on extensive fieldwork in Atlanta, GA, this study illustrates how middle class African American women's attitudes, beliefs, perceptions, and behaviors related to HIV risk are influenced by their social and cultural norms. This research employed a womanist framework to examine the intersection of race, gender, and class and the way these factors interact to shape HIV risk in middle class African American women. Whereas some middle class African American women perceive their HIV risk as low based on social class, structural factors associated with experiences of being an African American woman in Atlanta, GA (e.g., gender imbalance, geographic location, sexual networks) weaken the protective influence of class and put them at risk for HIV. Thus, findings from this study will help inform prevention strategies to focus on African American women who fall outside of "traditional risk groups."

CHAPTER ONE:

INTRODUCTION

With over 15 years of public health research experience and having most recently worked in the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia, I am comfortable discussing the impact of HIV on Black women from a public health perspective. However, in writing this dissertation, my goal is not to merely report overwhelming statistics or talk about the epidemiology (the study of patterns) of HIV and AIDS. Instead, I wish to highlight a segment of the population that is often overlooked in social science and anthropological HIV-related work.

A large body of literature exists on HIV and Black women, which includes data and statistics relating to Black women's risks, infection rates, new cases, and mortality compared to women of other ethnic groups. Likewise, various studies show factors that are associated with Black women's HIV risk. But as a middle class college educated African American woman, I often questioned how that information applies to me. Like many African American women I would like to think that I am not at risk for HIV infection. I am not promiscuous, I don't so drugs, and I am very well-educated. Thus according to what is mostly read in the literature, one would say that I am safe. It was not until I began to meet women who did not fit the stereotypical image of HIV (e.g. low-income, sex workers, low education, and drug users) that I started consciously assessing Black women's risk for HIV. In saying that, I mean I was meeting college-

educated, middle class, professional, middle-aged, Black women who were HIV-positive or living with AIDS. Thus putting a face on the disease and data allowed me to re-examine the labels constructed by society and groups of people identified as being at risk for HIV.

This chapter provides a brief summary of the problem of HIV and AIDS in African Americans. It begins by offering current data on HIV prevalence and trends in African Americans in general and women specifically in the United States and in the state of Georgia. Additionally, the chapter presents the study's purpose, research questions, and definition of terms, and concludes by summarizing the content of subsequent chapters.

BACKGROUND AND CONTEXT

For the past three decades, HIV and AIDS has been a major contributor to mortality and morbidity in the United States, where Blacks/African Americans are disproportionately affected by the epidemic. Thus, an issue once thought exclusive to gay White men is now a major concern in the African American community. In 2010 Blacks/African Americans accounted for approximately 44% of all new infections among people aged 13 and up, despite only representing an estimated 12% of the U.S. population (CDC 2014a). In the same year, the rate of new infections for Black/African American adolescents and adults, in the United States, was approximately eight times that of new infections among Whites and nearly three times the rate of new infections among Hispanic/Latinos (Kaiser 2013; CDC 2012b). For some subpopulations, like African American women, the rate of new HIV infections has increased substantially

since the early years of the epidemic (Mays et al 2012; Hodder et al 2010; Mays and Cochran 1998). In 2010, HIV was among the ten leading causes of death for Black/African American women ages 15 to 64 (CDC 2013a). Specifically, in 2009 it was the fourth leading cause of death for Black[1] women ages 25 to 44 (Kaiser 2013; CDC 2013e). Of all new infections reported among women in the United States in 2010, 64% occurred in African Americans compared to 18% in Whites and 15% in Hispanic/Latina women (CDC 2013a; CDC 2014b). Herein, approximately 1 in 32 Black women will be diagnosed with HIV at some point in their lifetime compared to 1 in 106 Hispanic/Latina women and 1 and 526 White women (CDC 2013a). While new HIV infections continue to disproportionately impact Black women, recent data show a 21% decrease in the number of new infections among Black/African American women between 2008 and 2010 (CDC 2013a; Kaiser 2013). However, data do not provide reasons for the decline and additional data are needed to confirm that the decrease in new infections represents the beginning of a trend (personal conversations from CDC researchers). Therefore, HIV disparities in African American women remain of great concern.

Georgia has been greatly impacted by the HIV and AIDS epidemic and was noted as the nation's sixth highest state for total number of adults and adolescents living with HIV in 2010 (GDPH 2013a; CDC 2011b). In 2011, Georgia was ranked fifth among the 50 states for total number of new HIV infection diagnoses (CDC 2014d). While Blacks only make up 30% of Georgia's population, in 2012 they represented 55% of new HIV infections, 70% of new AIDS diagnoses, 64% of adults living with HIV, and 75% of women with HIV (GDPH 2013b). Further, it was reported that almost two-thirds

[1] Throughout this dissertation the terms black and African American are used interchangeably.

of the people living with HIV in Georgia in 2012 resided in the Atlanta Metropolitan Statistical Area (MSA) (GPDH 2013a) which includes Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton counties (GDPH 2013a).

Lower social status (Hodder et al 2010; Fleming 2006), poverty, drug use, high risk sex, STIs, and inadequate access to healthcare (Mays et al 2012; Sharpe et al 2012; Hixson, et al 2011; Hodder et al 2010; Tillerson 2008; McCree and Rompalo 2007) have been identified as factors contributing to African American women's risk for HIV infection, particularly in the South (Mays et al 2012; Hixson et al 2011). Likewise other factors associated with sexual decision making or HIV risk include environment in which females are socialized (e.g., unsupervised settings, excessive peer pressure) and self-esteem (how the woman feels about herself or her body) (Stevens et al 2014; Brown et al 2014). This will be discussed in further detail in Chapter Two – Research on HIV and Women. Similarly, recent research suggests that HIV rates among African American women in Atlanta and other U.S. cities are higher than previously thought. Yet, as with past HIV research, the aforementioned study centered on poverty or financial insecurity as a major social determinant of HIV risk (Woodruff 2012; Columbia SPH 2012). Most research and media concerning African Americans and HIV tend to highlight the experiences of the poor. Similarly, images of African American women mostly seen in health statistics are those of low-educated, low-income, and sometimes drug using women (Jackson and Cummings 2011; Barbee and Little1993). Consequently, such depictions contribute to society's view and perceptions of African

American women's risk for HIV. Few studies consider the experiences and perspectives of HIV from African American women identifying as middle class (Tolman 1996; Barnes and Bynum 2010). Given that, evidence shows that many middle class African Americans distance themselves from what Reid (2000) refers to as the "plight of low-income individuals" (714) that are deemed at risk for HIV.

Ethnographic Studies on the Black Middle Class

In recent years, many scholars have published informative ethnographic research centering on the Black middle class. Ethnographers such as Mary Pattillo-McCoy, Monique Taylor, and John Jackson have conducted research examining the complex ways the Black middle class manage their lives in Black neighborhoods (Lacy 2007). The primary purpose of these ethnographic studies, which also included samples of the Black poor and working classes most often in Northern and Midwestern communities, was to show how middle class Blacks define their identities in relation to Black lower classes (Lacy 2007).

However, there is a dearth of recent studies concentrating on just Black middle class populations and even fewer focusing on southern communities, especially relating to African American women and HIV. The research study presented in this dissertation focuses solely on middle class African American women living in metropolitan Atlanta, Georgia. Given the study's attention to the impact of a southern Black city's social and cultural context on middle class African American women's identity and perception of HIV risk, the study contributes to the growing dialogue of HIV/AIDS disparities in African American women in the South and fills an important gap by focusing on a demographic group that has received limited attention in the HIV/AIDS literature.

RESEARCH PUROSE AND RESEARCH QUESTIONS

Studies exploring perceptions of HIV risk are a major topic of interest, particularly as scholars try to understand the association between risk perceptions and sexual behaviors. This research uses a womanist anthropological approach to explore the construction of perceived HIV risk among middle class African American women living in Atlanta, GA. The study will illustrate how middle class African American women's attitudes and beliefs about HIV and perceptions of HIV risk are influenced by their social and cultural norms. Moreover, this study will richly describe the self-reported sexual behaviors and sexual experiences of the participants and how they associate those behaviors to risk. The research questions guiding this study are:

1. ***How do middle class African American women perceive their risk for HIV?*** Despite the high incidence of HIV among African American women, research suggests that perceptions of risk are often lower among women of a higher social status (Gilbert 2003). Although middle class African American women may have more economic resources or access to healthcare compared to women of lower status, the realities of ethnicity, gender, and class have the potential to impact middle class African American women's health outcomes all the same. Given that, it is important to obtain information on how social class and position influence how middle class African American women understand their risk for HIV.

2. ***How are middle class African American women's HIV risk perceptions constructed in relation to their social and cultural norms?*** Family values and upbringing about sexuality and partner selection as well as relationships with peers, intimate partners and other social networks are believed to shape African American women's attitudes towards sexuality and HIV (Jarama, Belgave, Bradford, Young, and Honnold 2007; Stephen et al 2009). Hence, assessing how HIV is perceived as a disease and whether or not middle class African American women's attitudes and perceptions are influenced by family, peers, relationships, upbringing, religion, or other cultural/social factors is essential in understanding how the women construct their perception of risk.

3. ***What are the self-reported behaviors and sexual experiences of middle class African American women and how do they contribute to HIV risk?***
   It is important to understand how middle class African American women's knowledge of HIV and cognitive awareness of HIV prevention strategies correlate with their actual behaviors and whether or not the women associate potential sexual risk behaviors with actual HIV risk.

The broader impact of this study lies in its concern with a population that has been underrepresented in previous social science and anthropological HIV related research. Few studies have been published to date on middle class African American women and HIV risk. Therefore, findings from this study will help provide a better understanding of how middle class African American women understand and perceive their risk for HIV in relation to their actual sexual behaviors as shaped by the social and cultural context of their lived experiences.

DEFINITION OF KEY TERMS

Throughout this dissertation, the following terms will be used relating to HIV risk and African American women.

Race

As defined by Omi and Winant (1986), "race is a social-historical-political construct' (61) embedded in a system of power relations. According to Anderson and Collins (1995), race shapes everyday social relations, creates systems of privilege, and reflects an individual's or group's beliefs or practices. Hence, race is a part of our daily society. The term 'race' generally has no validity for anthropologists, because they find no scientific basis for racial classifications (Guest 2014). However, race is used in this research because its conceptualization is relevant to our discussion of womanist theory;

identifying structural factors of HIV risk; and exploring inequalities of HIV among African American women.

As Elizabeth Higginbotham states:

> "Like gender and class, race must be seen as a social construction predicated upon the recognition of difference and signifying the simultaneous distinguishing and positioning of groups vis-á-vis one another. More than this, race is a highly contested representation of relations of power between social categories by which individuals are identified and identify themselves" (1992:253).

Race was historically created to be used as a tool for Black oppression in the social context of slavery (Higginbotham 1992; Fields 1990). Over time, studies of Black women have come to make poignantly clear the role of race in shaping class relations. Additionally, Black women's studies illuminate the role of race in understanding the relationship of gender to power and the distribution of resources (Higginbotham 1992; Bolles 2001; Mullings 1997). Hence as asserted by Lynn Bolles (2001), the thread that connects womanist theorizing both inside and outside of anthropology is the idea of simultaneous oppression. Here race, gender, and class are conceptualized as intersecting in a variety of ways that govern Black women's historical and political contexts (34; Brewer 1999). Therefore, in this research, race is used in a historical, social, and political context relating to Black women's oppression and experiences. When possible, ethnicity is used interchangeably with race.

Black/African American

In this research, Black or African American is defined in accordance with the Centers for Disease Control and Prevention (2014c), United States Census Bureau (2011; Rastogi et al 2011), and the Office of Budget and Management (OMB) (2000) definition and guidelines. Herein, Black or African American refers to anyone having origins in any of the Black racial groups of Africa (U.S. Census 2011; Rastogi et al 2011:2). Black or African American populations include people who when asked, self-identify their race as Black, African American, or Negro. Additionally, it includes those who identify as Sub-Saharan African, such as Kenyan and Nigerian; and Afro-Caribbean, such as Haitian and Jamaican (CDC 2014c; U.S Census 2011; Rastogi et al 2011).

Middle Class

In this research, middle class is defined as a combination of the following: *education* (having at least a college degree), *income*, which is generally based on a single annual income of at least $35,000; *occupation*, which consists of white collar positions such as doctors, lawyers, teachers, business owners; and *social networks*, which includes organization memberships and affiliations

OVERVIEW OF CHAPTERS

Chapter Two, *Research on HIV and African American Women,* presents an overview of literature from various fields focusing on HIV and African American women's risk for infection. The chapter highlights epidemiological, social, and behavioral work and identifies gaps in the literature where additional research is needed

(e.g., examining social class). Additionally, the chapter addresses the concept of risk perception, construction of risk, and cultural factors that are not always considered in HIV risk research (e.g., religion).

Chapter Three, *Theoretical Perspectives in HIV Research,* situates HIV research among African American women in a broader theoretical context. This chapter looks at theories currently and previously used in social science HIV research and their strengths and limitations. It discusses the anthropology of HIV and describes the construct of social class and its use in anthropology. Additionally, the chapter introduces the use of womanist theory and its engagement in anthropological research, providing a brief discussion of its contribution to HIV studies and the discipline of anthropology.

Chapter Four, *Research Setting*, provides a history of Atlanta, Georgia and a snapshot of its political-economic and socio-cultural context. It gives a geographic overview of the metropolitan area by ethnic make-up. Moreover, it offers an in-depth exploration of the emergence of the Black middle class in Atlanta, with specific emphasis on the role of education, religion, business, and politics.

Chapter Five, *Methods* discusses the goals of the research project, the overall research design, the methods employed to answer the primary research questions, and general demographics of the research sample which includes African American HIV-positive and African American HIV-negative middle class women as well as Black female HIV service providers and community experts. This chapter also includes a description of the analysis procedures and concludes with an explanation of the study's ethical issues, challenges, and limitations.

Chapter Six, *Knowledge, Beliefs, and Perceptions of HIV Risk*, is the first of two chapters that present study results. This chapter discusses the knowledge, attitudes, and beliefs of HIV and AIDS among the HIV-negative and HIV-positive participants. It reports findings of how middle class African American women construct their perceptions of risk for HIV and offers HIV providers and community experts' perspective of African American women's HIV risk perceptions, based on their professional experience.

Chapter Seven, *Sexual Decisions, Sexual Behaviors, and HIV Risk Assessment*, is the second chapter of study results. This chapter discusses results from the sexual history timeline of HIV-negative participants' sexual relationships. These findings describe the participants' sexual behaviors, sexual experiences, decision making, and assessment of HIV risk. The main question in this section is: how do HIV-negative middle class African American women's self-reported sexual behaviors and decisions contribute to HIV risk.

Chapter Eight, *Discussion, Recommendations, and Conclusion*, is the final chapter. It presents a detailed synthesis and discussion of findings from the semi-structured interviews and sexual history timelines. This chapter also links findings to existing literature and the study's research questions, while identifying gaps that will expand our knowledge in HIV research on African American women. The chapter concludes by offering recommendations for prevention strategies based on literature and participants' responses.

CHAPTER TWO:

RESEARCH ON HIV AND AFRICAN AMERICAN WOMEN

RESEARCH TRENDS

In the United States, women have historically been underrepresented in medical research (Cohan and Atwood 1994; Fox-Tierney et al 1999; Lawless, Kippax, and Crawford 1996; Strebel 1995). In the early 1980's, early on in the epidemic, AIDS was mostly defined and addressed as a gay man's disease (Corea 1992). Thus, much of the information published during that time regarding HIV, was based on data collected from predominately male cohorts (Ginzburg, Fleming, and Miller 1988; Phair et al 1990; Silvestre 1993; Ojikutu, Stone, and Bardeguez 2009). In the mid 1980's, cases among women began to appear and subsequently increased over time. As demographics of the epidemic changed, so did the need for research investigating the impact on women. However, initially women's perspectives were scantily included in prevention research. Moreover, the research that included women largely highlighted them as reservoirs for infection or vectors of the disease (Amaro, Raj, and Reed 2001). For example, female sex workers were initially blamed for spreading HIV to their male clients who in turn passed the disease on to their wives and children or women were stigmatized as HIV positive mothers infecting their children (Amaro 1995; Cohan and Atwood 1994; Corea 1992; Sacks 1996; Strebel 1995; Welch Cline and McKenzie 1996). In the late 1980's and 1990's, women were primarily infected with HIV through injection drug use (IDU) (Ojikutu et al 2009: Hader et al 2001; Amaro et al 2001). Additionally, injection drug use

(IDU) contributed to the high incidence of HIV among sex workers (Anastos and Marte 1991; Campbell 1991). Similarly, evidence shows that heterosexual sex which includes having sex with IDU partners and having sex in exchange for non-injection drugs such as “crack” cocaine was linked to women’s HIV infection (Amaro et al 2001; Zierler and Krieger 1997; Holmberg 1996; Chiasson et al 1991; Gilbert 2003; El-Bassel et al 2010). Nonetheless, infected women were labeled and stigmatized as prostitutes, drug users, and unfit mothers (Cohan and Attwood 1994; Amaro et al 2001).

Until the 1990’s, there was a significant void in women’s voices and participation in HIV discourse and research. Consequently, this silence allowed for the spread of infection among women, as many were being misdiagnosed which lead to the delay in or lack of adequate treatment for those who were infected (Cohan and Atwood 1994, Amaro et al 2001; El-Bayoumi 1993: Fox-Tierney et al 1999; Bova 2000). Since the early 1990’s, studies have included more women (Barkan et al 1998; Smith et al 1997; Cook et al 2004). The emergence of new HIV research with a more gendered approach has helped researchers gain an improved understanding of women’s risk for HIV infection (Amaro and Raj 2000; Ojikutu et al 2009). Prospective and longitudinal studies have helped provide a better understanding of environmental factors that impact women’s disease progression (Ojikutu et al 2009). Additionally, clinical trials and other studies with pregnant women have shown unprecedented success in creating prevention programs and developing strategies to ensure that undiagnosed infected women are identified and provided prophylaxis to prevent mother to child transmission as well as treatment, for their own health (Koenig and McCree 2011). Yet, our

knowledge regarding the unique impact HIV has on women of color; particularly Black/African American women must continue to expand.

African American women remain at a higher risk for HIV than women of any other racial/ethnic group. In 2010, the estimated rates of new infections for African American women were 20 times higher than White women and nearly five times higher than Hispanic/Latino women (CDC 2014a). Yet in some instances the impact of the HIV epidemic among U.S. women often remains hidden from effective dialogue. For example, after more than 30 years of the epidemic in the United States, conversations and societal notions still focus heavily on the high prevalence of HIV among men who have sex with men (MSM).

While risk factors for HIV among women have been well defined (e.g. unprotected sex, drug use, other STIs) (CDC 2014b; Ojikutu et al 2009); the context for women's sexuality, sexual relationships, protective behaviors, and rational for sexual risk taking is in some aspects still poorly understood and less widely appreciated (Hodder et al 2010; Amaro et al 2001). Additionally there is limited research targeting populations like college-educated middle class African American women (Reid 2000) and older African American women, age 50 years and older (Mallory, Harris, and Stampley 2009). While HIV in older populations is often under recognized; the Centers for Disease Control and Prevention (CDC) reports (2013c) that a growing number of people in the United States, aged 50 and older, are living with HIV. In 2010, individuals aged 55 and older accounted for 19% of the people living with HIV in the United States (CDC 2013c.) In the same year, the estimated rate of HIV diagnoses for older Blacks was approximately 11 times the rate of diagnoses for older Whites and nearly three

times the rate of diagnoses for older Hispanic/Latinos. Moreover, data shows that Black women accounted for 15% of new infections among Americans aged 55 and older, compared to four percent of new infections among both White and Hispanic/Latino women respectively (CDC 2013c; Brooks et al 2012; Linley et al 2012).

Research studies often treat Black women in the United States as a monolithic whole, ignoring factors that contribute to differences in beliefs and behavior such as age, educational attainment, marital status, and socioeconomic status or class (Beatty, Wheeler, and Gaiter 2004). Hence, despite the recent decline in new infections and the remarkable advances in the introduction of rapid HIV testing and the various once a day antiretroviral therapies, more research recognizing the importance of contextual factors in women's sexual health is needed to help understand the HIV disparities evident among Black women.

RESEARCH ON AFRICAN AMERICAN WOMEN AND HIV RISK

A large amount of data and literature show HIV prevalence among women in general and Black women specifically (CDC 2013a; CDC 2013b; CDC 2013d; Stone 2012; Ojikutu et al 2009). For example, the CDC (2014b) reports that at the end of 2010, one in four people living with HIV in the United States were women, Additionally in 2010, women aged 25 to 44 represented the majority of women diagnosed with new HIV infections (CDC 2013a; Kaiser 2013). In 2011, women aged 13 and up accounted for 21% of individuals who received a HIV diagnoses in the United States (CDC 2014b). Also like Black women, in 2009 HIV was the fourth leading cause of death for Black men aged 25 to 44 in the United States; which ranks higher among causes of death

than men and women in other ethnic groups (Kaiser 2013; CDC 2013e). Furthermore, in 2010 Black women accounted for 29% of new infections among all Blacks compared to White women accounting for 11% of new infections among Whites and Hispanic/Latino women accounting for 14% of new infections among all Hispanic/Latinos (Kaiser 2013; CDC 2012b).

Risk factors for HIV transmission in African American women (e.g., lack of sexual behavior disclosure among male sexual partners, lack of available men due to incarceration, and geographic location) have also been thoroughly defined (Brawner 2014; Mays et al 2012; Sharpe et al 2012; McCree and Rompalo 2007; Tillerson 2008; Gilbert 2003). Largely epidemiological and prevention studies provide needed data about the spread of the HIV epidemic in women, including statistics, prevention challenges, and challenges to accessing care (CDC 2011a; Wingood et al 2009; Quinn 1993). In this research, the groups identified as being at the highest risk for infection are drug users, women with low educational attainment, those living in poverty, and women involved in risky heterosexual sex (Zierler and Krieger 1997; Sharpe et al 2012; Sobo 1995). Other groups of interest include adolescents and college students (DiClemente et al 2004; Jemmott, Jemmott, and Fong 1998; Alleyne 2008; Lewis et al 2000; Ybarra 1996). Additionally, geographic areas in the United States, such as the Northeast and the South, are an important focus of HIV research because these are locations where infection is more concentrated (Mays et al 2012; CDC 2011b; CDC 2013d; Stone 2012). This subject will be discussed in more detail below in the section on sociocultural factors of HIV risk.

Exclusion of Sub-populations of African American Women

As stated in the previous section, because of their exclusion of middle class African American women, HIV studies are often limited in their applicability to the prevention needs of this segment of the population. Hence, very little is known about these women's sexual health, behaviors, or their perceptions about HIV and being at risk for HIV. A systematic review of studies relating to HIV prevention, sexual risk, or risk perceptions among middle class Black women yielded approximately ten reports pertaining to the topic of interest. Eight of the articles found were studies focusing on Black female college students (Alleyne 2008; Alleyne and Wodarski 2009; Barnes and Bynum 2010; Ferguson et al 2006; Lewis et al 2000; Kanekar et al 2010; Braithwaite and Thomas 2001). The remaining articles included studies where Black women identifying as middle class were a small number of a larger study population (Higgins and Brown 2008; Grant and Ragsdale 2008) or the research focusing on middle class Blacks specifically was carried out in an African context (Green et al 2009). Likewise an assessment of studies targeting older African American women, age 50 and older, yielded less than ten studies. Hence, there is a dearth of data on sexual behaviors, knowledge, and attitudes of HIV among middle class African American women beyond the college years and in the U.S. context.

Poverty and lower educational attainment are correlates of HIV risk among African American women. Thus historically research has often targeted the inclusion of these populations to assess and monitor HIV prevalence (Aral et al 2008; CDC 2011a). For example, in CDC's study assessing characteristics related to HIV infection among heterosexuals in selected urban cities from 2006 to 2007, recruitment efforts targeted

individuals with high poverty rates (CDC 2011a). However, some researchers argue that African American women are likely to be at risk for HIV infection while in college due to risky sexual behaviors, which include multiple sexual partners and inconsistent condom use (Kanekar et al 2010; Alleyene and Wodarski 2009; Adefuye et al 2009; Ferguson et al 2006; Lewis et al 2000). For example, a study assessing factors related to STI infection and condom use in African American female college students showed that in a sample of 140 sexually active African American female college students, only 24% of the women reported consistent condom use. Additionally, 38% of the sample reported a history of having a STI (Lewis et al 2000).

Similarly, results from a qualitative study assessing the relationship between gender imbalance and HIV risk among African American female students on Black college campuses revealed inconsistent condom use as a common practice among students (Ferguson et al 2006). Hence the above findings lead one to question the level of risk that may exist among college-educated middle class African American women. For by virtue of the power structures of race and gender that exists among Black women, college-educated middle class African American women face multiple risks of HIV infection. First, they are members of the ethnic group at highest risk for infection (CDC 2013b; CDC 2014a). Secondly, heterosexual contact is the main mode of HIV transmission among women, where in 2010, 84% of all new infections among women were a result of heterosexual sex (CDC 2014b; CDC 2013a; Kaiser 2013).

A study by Painter and colleagues (2012) examining the relationship between African American women's educational attainment and laboratory-confirmed STIs suggest that African American women having a college degree or higher have a

decreased risk for STIs or HIV than women with less education. Specifically, findings revealed that the odds of an STI diagnosis was 73% lower in women with a college degree or higher compared to the odds being 45% lower among women who completed some college, and only 15% lower for women who completed high school (Painter et al 2012). While these results are important, this study is limited in that it only looks at STI infection at one point in time as opposed to the women's history of STI infections. Additionally, the study compares STI and HIV risk in African American women by educational level; whereas few studies consider the behavior of only college-educated middle class African American women or provide detailed information regarding their sexual histories (Barnes and Bynum 2010). Therefore, we must broaden the focus of populations deemed at risk for HIV in order to advance the body of knowledge needed to develop interventions for different groups (e.g., older adults, middle class, college educated).

Because of social status, education, and income; middle class African American women are frequently perceived as being less susceptible to HIV infection than women of lower social economic status (Green et al 2009; Alleyne and Wodarski 2009; Ferguson et al 2006). Herein Schneider and Ingram (1993), Hammonds (1995), and Jordan-Zachery (2009) argue that the social construction of certain target populations (e.g., drug users, women with low educational attainment, and those living in poverty) is the result of race and gender stereotypes created by politics, culture, society, media, and history. For example, discussions of HIV in the context of African American women often relegate them to negative stereotypes or individuals who engage in reckless behaviors, such as drug users, partners of drug users, or women who have multiple sex

partners (Hammonds 1995, 1997). Thus Black women of lower status are often over-represented in many of the above identified social ills. Moreover, such characterizations expose African American women's inequitable positions of race, gender, and class and also contribute to society's view of women's risk for HIV or the lack thereof (Jordan-Zachery 2009). For instance, Lubiano (1992) suggests that Black women of lower economic status are categorized into social taxonomies that construct and manipulate the public's view of HIV narratives. Herein classifications or stereotypes like the "welfare queen" and "baby mama" are used to depict Black women as those who exhibit irresponsible behavior or those who are unable to accept their risk for HIV (Lubiano 1992; Hammonds 1997; Jordan-Zachery 2009). Consequently, these negative representations of HIV have caused many to inaccurately see African American women's risk for HIV.

Social Inequalities and African American Women's HIV risk

African American women are disproportionately affected by HIV and bear the brunt of the disease among women (Williams and Prather 2010; Ojikutu et al 2009). The prevalence and incidence of HIV infections in African American women has progressed since the epidemic's early years (Mays et al 2012). Between 1992 and 1995 African American women accounted for approximately 53% of women diagnosed with AIDS – stage three HIV infection (CDC 2013d). Most recently, data shows that from 2005 to 2008, African American women accounted for 64% of new HIV infections among women (Mays et al 2012; CDC 2014b). Issues impacting African American women's risk for HIV, such as poverty and low educational attainment, are often

discussed in public health and social science literature (Mays et al 2012; Sharpe et al 2012; Williams and Prather 2010; Lane et al 2004; Gilbert 2003). Hence it is necessary to clearly understand the social, economic, and political realities African American women face in order to effectively address the epidemic.

According to Williams and colleagues (1997) African American women are at increased risk for living in poverty and experiencing economic deprivation as they often have fewer financial resources and receive less pay than men and women of other ethnic groups (Williams and Prather 2010). Similarly, data from the United States Census Bureau American Community Survey (2008) show that Black women working full-time year round have lower annual median incomes ($31,035) compared to those of Asian women ($40, 664) and non-Hispanic White women ($36,398). Low educational attainment also contributes to poverty. In general, level of education is a predictor of potential earning. Hence, the more education a woman has, the greater her earning potential (Mays et al 2012; Bishaw and Semega 2008). For example, according to the United States Census Bureau American Community Survey (Bishaw and Semega 2008), women who did not complete high school reported median earnings of $14, 202. Women who completed high school reported median earnings of $21, 219. Women who completed some college or obtained an associate's degree reported median earning of $27,046. Those who obtained a bachelor's degree reported median earnings of $38,638. Moreover, for women with education higher than a bachelor's degree, the reported median earnings were $50,937 (Bishaw and Semega 2008).

Here it is important to note how race and ethnicity impact economic indicators such as education, income, employment and potentially increase African American's

women risk for HIV. While African American women have made remarkable educational and income gains in the past 30 years (Pettit and Ewert 2009; Bishaw and Semega 2008), a disproportionate number still live in poverty (Bishaw and Semega 2008). Regardless of educational attainment, at every level of education, African American women earn less money than non-African African women and men (Bradbury 2002). Due to these circumstances, African American women sometimes rely on men for financial assistance (Forna et al 2006), which results in them using sex as a survival mechanism (Dunkle et al 2010). Similarly Hearn and Jackson (2002) and McNair and Prather (2004) argue that when African American women are faced with issues related to meeting their basic needs (e.g. finances, food, or housing), then practicing safe sex may become less of a priority. For example, in a sample of 20 to 45 year old unmarried African American and White women, Dunkle and colleagues (2010) examined the women's prevalence of starting relationships, staying in relationships, and/or having casual sex for financial reasons. Results showed that 22% of the African American women reported starting a relationship for financial reasons compared to 11% White women. Thirteen percent African American women compared to three percent White women had casual sex with a non-regular partner for financial reasons. Additionally, one-third of the women reported staying in a relationship for financial reasons; however there was no difference by race (Dunkle et al 2010). Hence, such conditions also make it difficult for women to negotiate condom use or other safer sex practices with their partners (e.g., insisting their partner be tested for HIV or being monogamous) (Sharpe et al 2012; Williams and Prather 2010). Herein, Forna and colleagues (2006) found in data from a series of focus groups with African American women, that their dependence

on male partners for financial assistance hampered their ability to negotiate condom use, to ask their partners to be tested for HIV, and to insist that their partners be faithful in their relationship (Williams and Prather 2010).

Although men in general have higher college completion rates than women, such is not always the case for American Americans (Bradbury 2002). Hence many middle class or college-educated African American women encounter African American men with lower levels of education, lower occupations, and sometimes lower incomes than themselves (Jackson and Williams 2006). Similarly, race and ethnicity are linked to the disproportionate number of incarcerated African American men in the United States penal system (Carson and Sabol 2012; Bowleg and Raj 2012). According to the United States Department of Justice, in 2011 Blacks were imprisoned at higher rates than Whites in all age groups. Specifically Black males age 18 to 19 were imprisoned nine times the rate of White males and Black males ages 20 to 24 were imprisoned seven times the rate of White males (Carson and Sabol 2012). Scholars suggest that combined structural factors such as low educational attainment, poverty, unemployment, underemployment, and high rates of incarceration decrease the pool of available African American male partners for African American women (Adimora and Schoenbach 2002; Williams and Prather 2010; Sharpe et al 2012; Mays et al 2012). This results in gender imbalance between men and women in the African American community, wherein such conditions are believed to lead to African American women's increased engagement in high risk sexual behaviors (e.g., concurrent sexual partnerships, sexual partnership formation between low-risk and high-risk individuals)

(Adimora, Schoenbach, and Doherty 2006; Sharpe et al 2012). Gender imbalance, sexual networks and HIV risk will be discussed in further detail in later sections below.

Individual Level Risk Factors for HIV Infection

The nature, pattern, and distribution of HIV disparities in African American women are complex and cannot be assessed solely by individual risk behaviors (Aral et al 2008). Research shows that disease epidemics and disparities in infection rates are the results of complex systems of population dynamics. Hence, risk of infection is best approached by investigating the individuals in the population, the interaction and interdependency between individuals (i.e., relationships), the relationship between population-level and individual-level factors, and the effect of population-level factors on individual health outcomes (Aral et al 2008).

Research examining African American women's HIV risk often primarily emphasized individual risk (e.g., perceived risk, HIV knowledge, and HIV risk behaviors) (Lane et al 2004; Amaro et al 2001; Jones 2006; Zierler and Krieger 1997; Sanders-Phillips 2002). Yet over time, some researchers have expanded their focus to not only assess individuals' risk of disease exposure but to also examine the social conditions in which individual factors and disease exposure are related (e.g., how is risky sexual behavior and HIV risk related to geographic location) (Lane et al 2004; Poundstone, Strathdee, and Celentano 2004). For example, Lane and colleagues (2004) used structural violence as a conceptual framework to assess ecological factors contributing to HIV risk among African American and Hispanics/Latino women living in Syracuse, New York. They argued that factors such as disproportionate incarceration rates, gender imbalance, sexual networks, and limited STD services increased HIV risk for

African American women. Likewise the authors suggested that service providers and policy analysts/makers address such factors in order to decrease HIV transmission in underserved communities (Lane et al 2004). While this study extends beyond individual-level risk to explain ethnic differences in HIV risk, like other studies that use a structural framework, a shortcoming is that it focused on low income populations and underserved communities.

Recent studies with U.S. participants revealed that reported sexual behaviors such as number of sexual partners and condom use do not solely account for observed ethnic HIV disparities (Hallfors et al 2007, Adimora and Schoenbach 2005; Adimora and Schoenbach 2002; Kraut-Becher et al 2008; Lane et al 2004). Similarly, previous community-based studies show non-Hispanic White women reporting higher incidences of sexual risk behaviors that include more sexual partners, higher proportion of anal, oral, and group sex, and lower condom use than African American women (Lindberg, Jones, and Santelli 2008; Mosher, Chandra, and Jones 2005; Laumann et al 1994; Michael et al 1994). Additionally, data from the 2006-2008 National Survey of Family Growth indicated Black women ages 15 to 44 reported having fewer sexual partners in the previous year compared to White women (Chandra, Mosher, and Copen 2011). Yet Black women still experience more adverse health outcomes than White women and a higher incidence of HIV infection (Williams and Williams-Morris 2000; Giscombe′ and Lobel 2005; CDC 2013a). These unexplained differences in HIV rates among ethnic groups speak to why it is important to understand more than just the impact of individual behavioral factors in HIV risk. Hence, it is essential to examine and discuss African

American women's individual risk factors for HIV with regard to the sociocultural factors influencing their sexual behaviors (McCree and Rompalo 2007).

There are a number of circumstances that affect African American women's health, and survival. Therefore, considering the sociocultural context of African American women's HIV risk also helps define the unique realities of African American women's lives and aids in understanding how such factors (e.g., geographic location, sexual networks, relationship dynamics, stigma, religious beliefs) impact the women's vulnerability to HIV, risk-taking behaviors, and effectiveness of health prevention efforts (Mays et al 2012; Sharpe et al 2012; Adimora, Schoenbach, and Doherty 2006; Gilbert 2003; Sobo 1993).

SOCIOCULTUAL FACTORS OF HIV RISK

Geographic Location

In recent years, the assessment of "place" and where people live has become a significant factor in terms of identifying determinants of health (Acevedo-Garcia et al 2003; Acevedo-Garcia and Osypuk 2008). According to Mays and colleagues (2012), place refers to "an organizing structure that reflects the social, cultural, and economic capital locally available to individuals as well as the contextual forces that help shape their options and experiences of health" (774). Similarly, researchers argue that social and individual determinants coupled with physical location create an environment that threatens the health of Black women living in a particular area and places them at risk for HIV (Quian et al 2006; Whetten and Reif 2006; Mays et al 2012). This is especially important when addressing the HIV epidemic, as some geographic locations, such as

the South, are found to have higher HIV prevalence rates than other locations. Geographic locations are designated by area of residence at the time of HIV or AIDS diagnosis. There are four regions of residence defined by the United States Census Bureau and used by the Centers for Disease Control and Prevention (CDC) for reporting diagnosis. They include the Northeast, Midwest, South, and West. According to the CDC (2011c), the South is comprised of Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

In the early years of the HIV epidemic, diagnosed cases among women were heavily concentrated in the Northeast. But most recently, within the past five to seven years, an increasing number of new HIV cases in women have risen in the South (CDC 2011b; CDC 2013d; Stone 2012). This has significantly impacted Black women in the South, where the overall rate of diagnosed HIV infections among Black women age 13 and up is 43.1 per 100,000 (CDC 2013d). This rate is second to that of the Northeast (51.6 per 100,000), but nearly twice that of both the Midwest (25.9 per 100,000) and the West (25.7 per 100,000) (CDC 2013d; Stone 2012). Although the Northeast has the highest incidence of HIV among women, data show that at the end of 2010, the South accounted for the most new estimated AIDS cases (45% of 33,015) and the highest number of deaths due to AIDS (48% of 17,774) in 2009 (CDC 2012a). Additionally, there are nine states not including the District of Columbia with HIV diagnoses rates among women in the 10 per 100,000 range or higher. All but three of those states (NY, NJ, and MA) are located in the South (CDC 2013d).

In areas like the South, conditions such as poverty, low educational attainment, and high rates of incarceration also exist. This is important as all these factors facilitate the spread of, or increase African American women's vulnerability to HIV infection (Sharpe et al 2012; Williams and Prather 2010; Bowleg and Raj 2012: Mays et al 2012). Likewise, it is argued that socially and geographically isolated individuals with constrained social-sexual networks often choose partners from within their social network and are thus likely to transmit infections among others in their sexual networks (Friedman and Aral 2001; Rosenberg et al 1999; Youm and Laumann 2002; Lane et al 2004). This speaks to the notion of racial residential segregation, where the majority of African Americans reside in a concentrated area of the city regardless of income or social status. Herein, scholars suggest that residential segregation not only limits African American's access to educational and economic opportunities; but also increases their risk for HIV because of limited partner selection or isolated "pockets of sexual networks" (Williams and Prather 2010:36; Zierler and Krieger 1997; Lane et al 2004). This information about geographic location provides an important context for this dissertation research as the data was collected in metropolitan Atlanta, Georgia, which is located in the South. Atlanta is the largest metropolitan statistical area (MSA) in the South and experienced a 39% increase of African Americans between 2000 and 2010 (Atlanta Regional Commission 2010). With a combined population of approximately 771,420 Blacks, Fulton and Dekalb counties encompass a majority of the African Americans (51.8%) living in the Atlanta metropolitan area (ARC 2010; U.S. Census Bureau 2010). Herein, at the end of 2012, Fulton and Dekalb counties had the highest number cases of persons living with HIV and stage three AIDS (GDPH 2013a).

However, public health professionals and service providers contend that gaps in HIV knowledge, education, care, prevention, and intervention services still exist, despite increased funding for prevention and care (Hixson et al 2011; Mayes et al 2012; GDPH GDPH 2008; Dean and Fenton 2010).

Relationship Dynamics

While ethnicity and gender by themselves are not risk factors for HIV infection (Sharpe et al 2102; Quinn 1993); they both contribute to the risk of infection in African American women who are relatively more vulnerable because of gender inequality in their personal and sexual relationships (Quinn 1993; Gilbert 2003). Research shows that African American women engage in less risky sexual behaviors than women of other ethnic groups (Mosher et al 2005), yet they still have higher rates of HIV infection. Hence, it is necessary to situate HIV risk among African American women and their experiences within broader social, cultural, and relational contexts (Hearn and Jackson 2002). Heterosexual contact is the primary mode of HIV transmission for African American women, in which factors such as gender imbalance, sexual networks, and the risky behavior of male partners (e.g., multiple partners; lack of disclosure about other relationships) affect their risk for infection (O'Leary 2000; Pequegnat and Stover 1999; McCree and Rompalo 2007; Millett et al 2005).

Gender Imbalance

Gender imbalance, where there are substantially more African American women than available African American men, plays a significant role in relationship dynamics for African American women (Guttentag and Secord 1983; Ferguson et al 2006; Sharpe

et al 2012; Mays et al 2012). In Ferguson and colleagues' (2006) study on gender imbalance and the association of HIV risk among African American female college student, it was found that female college students reported male students having multiple female sex partners, which limited their dating options. Herein some women reported that having to decide whether to share a man with another female was a campus norm. Moreover, the women reported that their ability to talk about condom use or use condoms during sex with their partners was often compromised because of these limited dating options or gender imbalance (Ferguson et al 2006). Hence, this unbalanced male-female ratio in Black communities creates a competitive market for African American women when seeking eligible partners (Sharpe et al 2012). Gender imbalance is partly a result of high rates of imprisonment, the male homosexual population, and migration, depending on geographic location (Guttentag and Secord 1983; Lane et al 2004; CDC 2013d; Sharpe et al 2012; Mays et al 2012). Yet, this phenomenon is compounded when specifically looking at college educated middle class African American women. Data from the American Enterprise Institute for Public Policy Research shows that college educated African American women have lower fertility rates than college educated White women (Wattenberg 1997). Furthermore, research by Nitsche and Brueckner (2009) suggest that highly educated African American women, those with postgraduate training, are twice as likely as White women to never marry or have children. Similarly, for those highly educated African American women who do marry, their spouses are likely to be less educated than they are (Nitsche and Brueckner 2009; Sharpe et al 2012).

Guttentag and Secord's (1983) "social exchange theory predicts that when one gender is in short supply" (e.g., African American men), "the result is relatively less power for the larger group" (e.g., African American women) (Gilbert 2003:18). Guttentag and Secord (1983) as well as other scholars (Adimora et al 2001; Albrecht et al 1997; Logan, Cole, and Leukefeld 2002) suggest that African American women's interpersonal power is diminished in relationships because of African American men having more available dating options than African American women. As a result, African American men demonstrate less commitment in relationships and have a greater number of female partners (McNair and Prather 2004; Gilbert 2003). Hence, the diminished pool of available African American men due to gender imbalance creates an environment for African American women's exposure to HIV in several ways. The culturally perceived surplus of Black women contributes to the women's lack of negotiating safe sex practices with male partners (e.g., condom use) (Sharpe et al 2012). For example, Sharpe et al (2012) asserts that the unbalanced male-female ratio in African American communities often makes it difficult for African American women to demand condom use with their partner. Likewise Hearn and Jackson (2002) contend that when there is a lack of eligible heterosexual African American males, some African American women may perceive themselves as having less power in their sexual relationships. As a result, the women may not use condoms for the fear of losing their partner (Hearn and Jackson 2002; Sharpe et al 2012). Additionally, African American women's tolerance in less than desirable relationships (Gilbert 2003; Alleyne and Wodarski 2009; Sharpe et al 2012), which include men having multiple sexual partners, women sharing men, and women engaging in concurrent partnerships (Mays et al 2012;

Adimora, Schoenbach, and Doherty 2006; Lane et al 2004) also puts African American women at risk for HIV. This will be discussed further below, in the section below on sexual networks.

Since there are more single African American women than available single African American men, there is the tendency for men to maintain more than one sexual relationship (Lane et al 2004; Gilbert 2003). Similarly, research among Black female college students, shows that gender inequity creates a complex dating environment where some African American women are faced with the decision of whether or not to participate in "man-sharing" (Alleyene and Gaston 2010:136). To do so means to knowingly engage in a sexual relationship with a man who is also having a sexual relationship with another woman (Ferguson et al 2006). This occurs even with women who are not financially dependent upon their partner (e.g., middle class African American women). Hence, there is sometimes the perceived need for a woman to have a man in her life because of societal standards (e.g. marriage) or to fill a personal void of self-esteem (Gilbert 2003; Sobo 1993). While research shows that many African American women will never marry, they will however engage in several serial relationships and incur an increased number of lifetime partners (Pattillo-McCoy 1999; Marsh et al 2007; Mays et al 2012; Sharpe et al 2012). Herein Mays and Cochran (1988) argue that, "the scarcity of eligible African American men polarizes the status of being single and puts more pressure on some African American women to give in to sexual pressures from men for unsafe sex" (953). Moreover, Sobo (1995) contends that emotional and social dependence on men explains why some women participate in

unsafe sex, go from one relationship to another, or accept less than desirable relationships (e.g., infidelity, man-sharing).

E.J. Sobo (1993) provides explanations of why women engage in unsafe sexual behavior in relation to their social and emotional dependence on men. The main reason is based on what is called “the wisdom narrative” (Sobo 1993:468). This is where a woman may convince herself that she has the ability to judge a man or identify whether or not he is clean or disease-free based on a set of standards she uses for choosing a mate, Additionally Sobo (1993) contends that a woman subscribing to “the wisdom narrative” believes that requiring her partner to use condoms sends a message that he is diseased or not of good quality (468). The second reason is referred to as the “the monogamy narrative”. This is where a woman idealizes the existence of a monogamous relationship between her and her partner. According to Worth (1990), this type of relationship is believed to bring women the most status and esteem (125). Likewise, it is believed that a woman subscribing to “the monogamy narrative often refuses to acknowledge that her partner may have other sexual partners (Sobo 1993).

Sexual Networks

Sexual networks are key factors in the spread of sexually transmitted infections (STIs) and the transmission of HIV (Adimora and Schoenbach 2005; Adimora, Schoenbach, and Doherty 2006; Aral et al 2008). Sexual network patterns focuses on more than just individual level behaviors to also include a broader perspective of population level parameters (Adimora, Schoenbach, and Doherty 2006; Aral 1999). Adimora and Schoenbach (2005) define “sexual network” as “a set of people who are linked directly or indirectly through sexual contact” (S115). More specifically, sexual

networks encompass concurrent sexual partnerships, multiple simultaneous sexual relationships, or sexual relationships that overlap in time (Adimora, Schoenbach, and Doherty 2006; Morris and Kretzschmar 1995; Aral et al 2008). Here such patterns of behavior can dramatically impact African American women's HIV risk (Adimora and Schoenbach 2005; McCree and Rompalo 2007).

Multiple and concurrent partnerships and high levels of sexual mixing create an environment of risk for HIV infection among African American women (Aral et al 2008; McCree and Rompalo 2007; Adimora and Schoenbach 2005). For example, findings from a study examining sexual networks and HIV risk among a sample of African Americans living in North Carolina (Adimora, Schoenbach, and Doherty 2006) revealed that nearly 25% of the women reported having multiple partnerships in the previous year and 26% of the women reported that their partnerships were often concurrent within the past one to five years. Additionally, most of the women (68%) reported knowing that at least one of their last three partners had sex with others partners while in a relationship with them (Adimora, Schoenbach, and Doherty 2006). Differences in patterns of sexual networks have been used to explain marked ethnic disparities in HIV among women (McCree and Rompalo 2007; Youm and Laumann 2002; Adimora and Schoenbach 2005). Herein Adimora and Schoenbach (2005) asserts that differences in number of sex partners have not been able to adequately explain racial disparities in STI rates; however evidence does suggest that differences in patterns of sexual networks exist among Black and White populations which create a greater infection risk for Blacks than for Whites. For example, Blacks were found to more likely partner with other Blacks, which created more racially segregated sexual networks among Blacks than those of

other ethnic groups (Adimora and Schoenbach 2005; Laumann and Youm 1999). In addition, Adimora and colleagues (2011) found in data from the 2003-2003 National Survey of Family Growth, that among U.S. women ages 15 to 44, 10% Black women reported concurrent partnerships in the past twelve months compared to 5.3% White women and 4.3% of Hispanic women. Although concurrent partnerships appear to occur more frequently among African American women; it is suggested that this difference is mostly due to lower marriage rates among African American women (Adimora, Schoenbach, and Doherty 2006; Adimora and Schoenbach 2005; Sharpe et al 2012). The formation of sexual networks for African American women is very similar to the formation of social networks. Relationships are usually formed between people with similar characteristics such as race, ethnicity, age, educational background or social status (Adimora and Schoenbach 2005). Aral and colleagues (2008) also refer to this as assortative sexual mixing. Here it is argued that African American men and women are most likely to partner assortatively by ethnicity (e.g., African American female to African American male); however dissortative partner choice (a low risk person forming a sexual relationship with a high risk person) is most prevalent in African American communities, which has resulted in highly connected sexual networks (Aral et al 2008; Sharpe et al 2012; Adimora, Schoenbach, and Doherty 2006). For example, partner preferences and residential segregation result in many African American women choosing sexual partners from within their own race or communities. Specifically, African American women are more likely to choose sexual partners who are African American. Therefore, their sexual network is more racially segregated than other ethnic groups (Adimora and Schoenbach 2005; Laumann and Youm 1999). Similarly,

exclusion within sexual networks can influence the risk of HIV exposure among African American women. Sexually exclusive individuals tend to choose partners from within their own social network, social class, and ethnic background. Herein, African American women are least likely to marry or date outside their race, in comparison to women of other ethnic groups (Lane et al 2004; Adimora et al 2004; Cornwell and Cunningham 2006; Mays et al 2012). Conversely, dissortative sexual mixing occurs when African American women with low risk behaviors choose partners with high risk sexual behaviors (e.g. multiple sexual partners). Hence, this segregation or partner preference among African American women coupled with behaviors such as multiple and concurrent partnerships, whether among men or women, underscores the propensity of sexual networks in African American communities and the likelihood of increasing the risk of HIV infection (Adimora et al 2003; Adimora et al 2006; Sharpe et al 2012).

Sexual Networks and Men Who Have Sex with Men (MSM)

Sexual networks (Aral et al 2008) also include lack of disclosure regarding sexuality among African American men (Lane et al 2004). This too is an important factor to consider when assessing African American women's relationships and infection risk. In talking about multiple and concurrent sexual partnerships and HIV risk among African American women, the topic of men on the "down low" often emerges. Thus it is important to discuss the issue of women, who have sexual relationships with men who have sex with men (MSM), where the men self-identify as heterosexual and do not disclose their sexual orientation or sexual practices. This behavior is characterized as being on the "down low" or "DL" and is most commonly associated with African American men (Lane et al 2004; CDC 2006; Robinson 2008). The term "down

low" or "DL" originated in the African American community signifying one's desire for secrecy or discretion (Boykin 2005; Saleh and Operario 2009). Subsequently, heterosexual identified African American men who had sex with men adopted the term as a means of describing secret same-sex behavior while avoiding self-identifying terms like gay, bisexual, or homosexual (Saleh and Operario 2009).

"Down low" behavior is not specific to African American men; however the high HIV incidence among both African American men who have sex with men (MSM) and African American women having sex with men (i.e., heterosexual contact), suggest that these covert sexual behaviors may contribute to African American women's increased risk for HIV infection (Robinson 2008; Millett et al 2005). Research shows that 75% of African American MSM kept their same-sex behavior hidden from their female partners compared to 36% of White MSM (Millett et al 2005; Stokes, et al 1996). Similarly, studies show that African American men who have sex with both men and women (MSM/W) report low rates of HIV testing compared to those who disclose their status (Doll et al 1992; McKirnan et al 1995; Kalichman et al 1998; Stokes et al 1996). Additionally, African American MSM/W report higher rates of unprotected sex with their female partners compared to White MSM/W (CDC 2003; Stokes et al 1996; Millett et al 2005).

Research shows that fewer African American women reported having a bisexual sex partner than did White women (Montgomery et al 2003; Michigan Department of Community Health 2000; CDC 1999; Stokes and Peterson 1998. For example in assessing the association between bisexual Black men's HIV risk and heterosexual transmission, Millett and colleagues (2005) reported that when African American

women were asked about currently or ever having a bisexual partner, 20% reported being aware of their partner's bisexual activity compared to 80% of White women reporting knowledge of their partner's bisexual practices. Herein, there is no evidence showing that the high prevalence of HIV among African American women is mainly due to them having sex with African American men who have sex with men (MSM). However, there is an association between African American men's non-disclosure about their sexual behavior and the increase in HIV and other sexually transmitted infections among African American women (Doll et al 1992; Montgomery et al 1992; Dodge, Jeffries, and Sandfort 2008). For example, in examining the implications of heterosexual transmission among HIV infected bisexual men, Montgomery et al (2003) found that among a sample of HIV-infected MSM, African American men reported also having sex with women (34%) more than White men (13%) or Hispanic men (26%). Yet, consistent with findings from previous studies (Kalichman et al 1998; Stokes and Peterson 1998; Millett et al 2005), African American did not disclose their bisexual activity to their female partner (Montgomery et al 2003). While the results from this study did not measure the prevalence of HIV transmission between bisexual HIV-infected men and their female partners, it suggests that women's risk may be higher because of their partner's sexual behaviors. Hence Messner (2004) argues that the increased prevalence of HIV among African American women confirms that African American men's sexual practices must be challenged, given the fact that their behavior enhances African American women's risk for HIV infection. Similarly, Bowleg, Lucas, and Tschann (2004) argues that there is a need for more effective communication and

open discussion about African American men's risk-taking behaviors and disclosure of HIV status.

Risk Perceptions, Denial, and Stigma

A key element in some health behavior models is the relationship between prevention behaviors and risk perception. Herein the prevention behaviors are based upon the heightened perception of risk (Mehorotra et al 2009). Such health behaviors paradigms include the health belief model (Janz and Becker 1984), Weinstein's five-stage precaution adoption process model (Weinstein and Sandman 2002), and the extended parallel process model (Witte 1992), which have all been used in studying HIV. In using these models, researchers find that risk perception is based upon one's belief of personal threat by a health condition, which in this case is HIV infection. According to Mehrotra and colleagues (2009), risk perception also encompasses what is referred to as a "cost benefit analysis of one's behavior with regard to specific behavioral outcomes" (40). This helps individuals determine their level of risk and in return motivates them to take precautions as deemed needed (e.g., safer sex practices, denial of seriousness of risk, or ignoring the threat of risk due to thinking it irrelevant) (Witte 1992; Mehorotra et al 2009). There is much debate as to whether perception of risk actually motivates one to engage in safer sex behaviors or if risk perception itself reflects one's "current and recent sexual behaviors" (Mehortra 2009:40; Gerrard, Gibbons, and Bushman 1996). Herein Reisen and Poppen (1999) and Kowaleski and colleagues (1997) all contend that both views possess valid arguments; however it is more important to accurately define risk perception and determine how individuals

construct their risk for disease or infection rather than using global definitions and measurements.

Perceived risk is considered a primary motivation for engaging in preventive behavior. Hence, understanding one's perception of risk is important because HIV prevention strategies are often based upon presumed relationships between risk and behavior (Mehrotra et al 2009). Here Cochran (1989) proposes that if a woman has an inaccurate perception of her risk, change in behavior will be ineffective. For example, perception of risk will be inaccurate for African American women who diminish their risk because of social status (e.g., middle class) or age (e.g., mature women age 50 and over). Likewise African American women who have general knowledge of HIV risks to women, yet underestimate their own personal risk, may also fall in the category of having risk perceptions that are less than accurate (Quinn 1993).

Research shows that many African American women tend to underestimate their personal risk for HIV infection compared to women of other ethnic groups (Johnson 1993; Kalichman, Hunter, and Kelley 1992; Quinn 1993; Neff and Crawford 1998; Gilbert 2003). Similarly, studies indicate that a number of African American college females make unsafe sexual health decisions, such as having multiple sex partners as well as low and inconsistent condom use because of lower perceived risk of HIV infection (Adefuye et al 2009; Chng, Carlon, and Toynes 2006; Alleyne and Wodarski 2009). A study by Adefuye and colleagues (2009) assessing HIV risk behaviors and perceptions of risk among college students on a predominately African American urban Midwest university campus found that most students (less than 20 years old – 57.9%; 30 years and older – 48.1%) perceived their HIV risk as generally low. However when

examining students' HIV risk behaviors, results showed that 77.4 % African American women reported inconsistent condom use in the previous 30 days compared to 50% White women. Additionally, 61.7% African American women reported not using a condom during their last sexual encounter compared to 45.5% White women (Adefuye et al 2009). Often, the belief is that HIV is something that happens to someone else. Having the sentiment of what Sobo (1995) calls HIV risk denial, in spite of risky sexual behaviors, some African American women report not being concerned about HIV exposure because they do not "consider themselves the kind of person to get AIDS" (Gilbert 2003:15). This may be influenced by the lack of culturally, gendered relevant HIV prevention messages or programs targeting subgroups such as middle class or mature (ages 50 and up) African American women (Quinn 1993; Freeman 2010; Mallory et al 2009). For that reason and because of the stigma associated with HIV, some women may create their own hierarchy of values to explain or justify their sexual behaviors (Gilbert 2003). Moreover Sobo (1993) contends that with some African American women, perception of risk "is constructed in relation to idealized cultural constructions of gender and heterosexual relationships" (463) that serves as a strategy of self-protection to preserve one's self-esteem and social position. Hence, this thinking allows middle class African American women to escape the fear associated with the thought of susceptibility to HIV and the social marginality related to infection (Sobo 1995).

Although it is not completely clear how risk perceptions are formed and developed, nor is it entirely understood to what extent culture influences risk perceptions (Hawkes and Rowe 2008), research shows that the construction of

perceived risk is based upon a combination of both internal and external factors (Younge, Salem, and Bybee 2010; Sobo 1995). Demographic variables such as race and gender (Klein, Elifson, and Sterk 2003; Theall et al 2003), sexual context variables (Hou 2004), and safer sex or preventive behaviors (Prohaska et al 1990) are all considered essential aspects of assessing perceptions of risk (Mehrotra et al 2009). It is also argued that relationship dynamics (Younge et al 2010; Mehrotra, et al 2009) and beliefs such as family values (Jarama et al 2007) and stigma (Muturi and An 2010) influence African American women's perception of HIV risk. Given the high prevalence of HIV among African American women in general, it is important to understand some of the reasons for low perceptions of HIV risk. Research indicates that knowledge of HIV does not readily translate to safer sex practices and behavior for preventing HIV infection (Braithewaite et al 1998; Katz 2003; Jarama et al 2007). Therefore gaining knowledge of perceptions of risk is important for understanding an individual's potential risk for HIV infection (Sobo 1993). Additionally, more research is needed to understand African American women's, particularly middle class women's, self-perceptions of HIV risk.

HIV/AIDS is one of the most stigmatized diseases in U.S. history (Parker and Aggleton 2003). Such stigma, coupled with low risk perception and denial, brings about resistance from individuals who believe HIV and AIDS is not representative of their culture or socioeconomic status (Weeks et al 1995; Katz 2003). Research shows that fear and stigma associated with HIV and AIDS play a significant role in controlling the epidemic in certain populations (e.g., ethnic, religious) (Mays et al 2012; Herek 2007; Mahajan et al 2008). For example, in some Southern Black Cultures individuals

engaging in same sex relationships, sexual infidelities, or having children outside of their marriage, are often pressured not to bring shame or embarrassment to the race (Pitt 2010; Gilbert, Harvey, and Belgrave 2009; Glick and Golden 2010). Similarly, conservative Black church congregations typically frown upon homosexuality or sex outside of marriage (Pitt 2010; Muturi and An 2010); therefore such social conditions can make it difficult to address HIV-related or sexual issues (Akers et al 2010; Mays et al 2012). Additionally studies suggest that HIV risk and infection are perpetuated by variations of communal and cultural stigma that impede efforts to encourage HIV testing and disclosure (Johnny and Mitchell 2006; Miller and Rubin 2007). For example, HIV and AIDS related stigma in African American religious communities often interferes with prevention strategies. For some, HIV and AIDS are often viewed as the result of willful acts or punishment for immoral behaviors (Beatty et al 2004). Hence this mode of thinking often creates an atmosphere of fear and shame that deter individuals from obtaining adequate education, getting tested, or disclosing their status (Beatty et al 2004; Mahajan et al 2008).

Stigma has been examined from psychological, sociological, and anthropological perspectives and is found linked to both individual and societal characteristics (Muturi and An 2010). Stigma is viewed as a social or cultural process as well as a moral issue in which the stigmatized condition (e.g., risk for HIV) threatens that which is at stake for the sufferers (e.g., middle class status or position in one's community) (Yang et al 2007). Additionally, stigma crosses physical, emotional, social, and cultural domains (Muturi and An 2010). Hence religious stigma is believed to be deeply-rooted in the beliefs and teachings of a set of social rules that offer support for obeying God (e.g.

God's protection) as well as judgment and sanctions for behaviors of immorality (e.g. God's punishment) (Franklin et al 2007; Younge et al 2010; Mays et al 2012). Within African American communities, religion is an important aspect of one's everyday life, especially for women (Levin, Taylor, and Chatters 1994; Muturi and An 2010). Research indicates that religion and spirituality are central to African American's health-seeking behaviors (Dessio et al 2004), in making sense of illness, and coping with sickness and disease (Mattis 2004; McNair and Prather 2004). At the same time, some churches and spiritual leaders have used religious messages and teachings to justify religious stigmatization, where HIV is associated with sin and immoral behaviors (Mays et al 2012; Harris 2010). Thus in some instances the church and potentially other social institutions in the African American community (e.g., hair salons, social organizations) play significant roles in African American women's lives and have the ability to influence their socialization process relating to behaviors and HIV risk perceptions (Muturi and An 2010; Jarama et al 2007). In a qualitative study exploring socio-cultural factors that influence sexual behavior and perceptions of HIV risk among African American women, Jarama and colleague's (2007) analysis revealed that the women's religious beliefs influenced their views on homosexuality and bisexuality. For example several women made statements like, "God made man and woman, not man and man or woman and woman" (Jarama et al 2007:313). In another study exploring how religion and faith-based messages play a role in shaping attitudes about HIV-infected people, Muturi and An (2010) found in a sample of African American women that 11% of the women indicated a negative effect of religion on their attitude towards people with HIV. This means that the more religious the women were; the more stigma shown towards HIV-

infected people. Conversely, most of the women (53%) indicated religion having limited or no effect on their attitudes towards those infected with HIV, despite religious messages (Muturi and An 2010).

Sexual Scripts - Gender, Race, Sexuality, and HIV risk

Most research relating to HIV and sexuality in the African American community has focused on men who have sex with men (MSM) (Hodder et al 2010; Hammonds 1995). Yet, there is little examination or discussion of how African American women's emotions, thoughts, values and beliefs, and social and cultural norms regarding sexuality influence their sexual behavior or shapes their perception and attitudes about HIV risk (Jones 2006; Amaro et al 2001; Stephens and Phillips 2005). According to Amaro and colleagues (2001), "sexuality is a social phenomenon based on prescribed arrangements and sexual scripts that provide guidelines for gender-appropriate behavior" for relationships and sexual behavior (325; Bowleg et al 2004). Such guidelines vary culturally and historically (Schneider and Gould 1987; Simon and Gagnon 1986; Amaro et al 2001). Herein socially approved sexual scripts give individuals meaning and direction for behaving sexually (Amaro et al 2001; Wiederman 2005).

Sexual scripts are defined as "organized knowledge structures (schemas) that are instrumental in helping individuals organize ideas of appropriate sexual experiences" (Stephens and Phillips 2005:38; Simon and Gagnon 1984, 1987; Jones 2006). They are culturally shared norms that influence individuals' behaviors regarding relationships, such as what is appropriate in terms of partner choice, sex, and emotions (Stephens and Phillips 2005; Jones 2006; Bowleg et al 2004; Simon and Gagnon 1986).

Additionally sexual scripts can guide one's expectations about appropriate sexual activities and direct a person's interpretation of whether or not a sexual relationship is safe (Jones 2006). Some researchers have used sexual scripts as a framework to explore the relationship between sexual behavior and relationship dynamics (McLellan-Lemal et al 2013; Bowleg et al 2004), sexual risk (Jones 2006), and HIV prevention (Ortiz-Torres, Williams, and Ehrhardt 2003; Maticka-Tyndale 1991). Hence, sexual scripts provide a different perspective for considering the sociocultural context of African American women's lives in relation to HIV risk as opposed to solely focusing on individual-level predictors (Zierler and Krieger 1997; Amaro 1995). Sexual scripts do not occur in a vacuum; but rather they are shaped by cultural scenarios related to gender, race, and class (Bowleg et al 2004). Thus it is important to identify the contexts that influence African American women's sexual socialization processes and script development (Stephens and Phillips 2005).

Stereotypes of women's sexuality generally vary by race (Reid and Bing 2000), where historically Black women's sexuality has been linked to exotic, immoral, hypersexual images such as the jezebel, a seductive woman lacking chastity and the inability to exercise sexual control (Dickerson and Rousseau 2010; Jordan-Zachery 2009). Herein Collins (2000a) argues that the controlling image of jezebel lies at the heart of several systems of Black women's oppression (e.g., race, gender and class), which have been often used to "justify sexual assaults against Black women"; to uplift and make possible notions of "pure White womanhood"; and to "foster the sexual exploitation of Black women's bodies" (2000a:132). The jezebel image, in some cases, remains an influential framework of African American female sexuality. This is

exemplified by television and film, which often portrays African American women as sex objects, baby mamas, mistresses, or whores (Gilbert 2003; Stephens and Phillips 2005; Gray 1995). Hence, mass media provides a number of damaging and demeaning sex scripts for African American women, which are promoted widely through television (Gray 1995), film (Manatu 2003), and music videos (Ward, Hansbrough, and Walker 2005). For instance, results from qualitative studies exploring the development of sexual scripts in African American female adolescents showed Black music videos as main sources for emphasizing stereotypical images of Black women as hypersexual, materialistic, and amoral (Ward et al 2005; Stephens and Phillips 2003). Furthermore stereotypes of African American women are reinforced in primetime televisions shows like *Scandal*, *Being Mary Jane*, and *How to Get Away with Murder*, where the main characters are college-educated professional middle class Black women. However in each case, the women are shown engaging in extra-marital affairs, having multiple sexual partners and concurrent sexual partnerships in each episode. Hence, such stereotypes shape the everyday usage of scripts that impact African American women's attitudes and beliefs about their self-identify, their sexual behaviors and experiences in relationships, their understanding of power and sex, as well as their sexual decision making processes (Stephens and Phillips 2003; Emerson 2002; Ward et al 2005).

Family and friends are also key sources of script development for African American women (Stephens and Phillips 2005; Jones 2006). These sources along with mass media provide African American women different meanings about gender and sexuality. For example, some African American women may see negative stereotypes of women expressed in the media; however they know or feel that their family or friends

may provide countering standards for sexual behavior (Wyatt 1997). Thus, it is argued that such sources (e.g., family, friends, and mass media) interact to influence sexual script negotiation for African American women on decision making regarding sexual behavior (Stephens and Phillips 2005). This occurs through observations of actions and approval linked to sexual behaviors expressed by family, friends, and other valued social units with which African American women interact, such as the church (Stephens and Phillips 2005). Thus, it is believed that good girls or women are those who do not initiate sex and engage in serial monogamous relationship (if sexually active and not married). Conversely, bad girls or women are those who are sexually aggressive, have multiple partners, or exchange sex for money, drugs, or other commodities (Fullilove et al 1990; Maticka-Tyndale 1991). Therefore in regard to this research it is important to understand the sexual experiences of the women and the relationship of their sexual scripts to their perception of HIV risk. Moreover, sexual scripts are important to this study because of their cultural influences.

CONCLUSION

African American women represent a disproportionate number of women with HIV and AIDS. Several economic, social, and cultural factors related to the realities of African American women's lives impact their increased risk for HIV infection compared to women of other ethnic groups. Such factors include STIs, high risk sex, engaging in sex with high risk partners, multiple and concurrent partnership, and geographic location (Tillerson 2008; Adimora et al 2006, 2011; Sharpe et al 2012; Mays et al 2012). Research pertaining to African American women and HIV risk often focuses on

individuals who are low-income, have low educational attainment, or are drug users (Barnes and Bynum 2010; Alleyne and Gaston 2010; Alleyne 2008; Ferguson et al 2006). Hence, there is a dearth of information concentrating on subpopulations of African American women such as the middle class and college-educated. While poverty and lack of education are considered direct links to HIV risk among African American women, research often targets or is biased towards populations to support these claims (Aral et al 2008; CDC 2011a). However, studies show that many African American women are likely to become infected while in college (Alleyene and Wodarski 2009; Ferguson et al 2006). Therefore in examining HIV risk among African American women, it is not enough to assess how income and education may or may not affect one's risk for HIV. We need to also gain an understanding of how the experience of economic security, access to healthcare, education, social position, and status also shapes the sexual behaviors and attitudes of HIV and risk for African American women. This means moving beyond research that concentrates on poor African American women to also include the voices of African American women who are college educated and financially secure.

There has been a substantial amount of research examining factors associated with African American women's risk of HIV acquisition, in which early studies mainly emphasized individual level risk factors. Yet when studying factors of HIV risk, it is also important to identify and critically analyze the sociocultural factors the influence the African American women's sexual behaviors (McCree and Rompalo 2007). Such determinants play a significant role in shaping perceptions of HIV risk and forming attitudes and responses to HIV. Similarly few studies have used sexual scripts to

explain or understand HIV risk. Yet it is important to note that existing sexual scripts that stereotype African American women as promiscuous or sexually aggressive have fundamentally shaped HIV research, which have largely focused on sex workers, low-income, or loose women (Amaro et al 2001; Stephen and Phillips 2005). Thus, the inclusion of middle class African American in HIV research counters the stereotypes that have historically depicted them as baby mamas and jezebels (Skylar 1995; Marshall 1996; Mullings 1994), while confronting racially gendered and classist attitudes that contribute to stigma and HIV risk denial (Jackson and Williams 2006). Moreover, it challenges the concept of individual risk, emphasizing that social and cultural contexts create environments in which risk behaviors occur and are influenced by structural factors that put all Black women at risk for HIV.

CHAPTER THREE:

THEORETICAL PERSPECTIVES IN HIV RESEARCH

PREVIOUS HIV RESEARCH - INDIVIDUAL-BASED THEORETICAL ORIENTATION

Various theoretical approaches have been used to explain risk and occurrences of HIV in women. Herein previous research has included theoretical frameworks such as the Health Belief Model (HBM); one of the most influential models that was developed in the 1950's to understand people's reluctance to participate in screening tests or to adopt disease prevention strategies (Carey et al 2004; Rosenstock 1974; Rosenstock, Strecher, and Becker 1994, 1988). In looking at HIV, the Health Belief Model suggests six variables that influence individuals' health behaviors. They are: (1) *Perceived threat* which refers to one's subjective perception of risk for becoming infected. (2) *Perceived severity* which refers to how one interprets the seriousness of contracting the disease. (3) *Perceived benefits* refer to one's beliefs regarding the effectiveness of HIV risk reduction strategies in relation to decreased threats of infection (e.g. women believing that asking their sex partner to use a condom will lower risk of contracting HIV). (4) *Perceived barriers* are the negative consequences believed to result from one engaging in recommended HIV prevention strategies (e.g., a woman asking her male partner to use condoms may fear rejection, abandonment, or in some cases abuse). (5) *Cue to action* is the awareness of bodily symptoms (e.g., contracting an STI) or other stimulus (e.g., media, doctor's advice, illness of someone close) needed to engage in prevention strategies. (6) *Self-efficacy* refers to one's confidence

or belief that he or she has the ability to successfully perform a specific health-related behavior (Carey et al 2004; Boston University SPH 2013). This last concept was added to the Health Belief Model in the mid 1980's. It is used in many behavioral theories and relates to whether or not an individual can perform a desired behavior.

HIV interventions based on the Health Belief Model have tried to increase individuals' perceived risk for HIV, convince them of the benefits and effectiveness of engaging in prevention strategies, as well as assist persons in finding realistic ways to overcome barriers that hamper risk reduction skills. However, this model has several limitations in that it does not take into account the beliefs, attitudes, and other individual factors that influence a person's behavior. It does not consider how economic and environmental factors influence (e.g. prohibit or promote) the adoption of prevention strategies. Similarly, the model assumes that everyone has equal access to resources and information relating to health, illness and disease (Boston University SPH 2013).

Social Cognitive Theory is another theory used where health behavior is mainly influenced by a person's social environment. This theory takes into account a person's past experiences to assess whether behavioral change occurs and to evaluate a person's reasons for engaging in specific behaviors (Bandura 1977, 1990; Zierler and Krieger 1997). This model is based upon six constructs that include; (1) *Reciprocal Determinism* - the reciprocal interaction between the individual (learned experiences, the environment (social context), and behavior (response to incentives to change behavior). (2) *Behavior Capability* which refers to one's ability to carry out a behavior (e.g. effectively using condoms during sex) based on knowledge and skills. (3) *Observational Learning* which contends that a person can learn and execute a

behavior by watching the behavior being conducting by others. (4) *Reinforcements* are the internal and external responses that affect whether or not a person is likely to continue engaging in a behavior. (5) *Expectations* refer to the anticipated outcomes related to a person engaging in a health-related behavior (e.g. engaging in safer sex practices leads to the expectation of lowering one's risk for HIV infection). *Self-efficacy* refers to one's confidence or belief that he or she has the ability to successfully perform a specific health-related behavior (Boston University SPH 2013).

The Social Cognitive Theory also reflects many aspects of the social ecological model in addressing individual behavior change and has been widely used in health promotion given its emphasis on individual behavior and the environment. However, major limitations of the theory are that it assumes changes in environment lead to automatic behavior changes. Additionally, this theory is considered very broad in scope and is thus difficult to use in its entirety (Boston University SPH 2013).

The Theory of Reason Action, where one's intentions influence health behaviors, social norms, attitudes, and perceived control (Ajzen and Fishbein 1980; Fishbein and Ajzen 1975; Zierler and Krieger 1997) is another theory previously used in studying women's HIV risk. This theory was used to predict why people engage in certain behaviors at a particular place and time (Amaro et al 2001). When applied to HIV research, the model includes the following three key components: (1) *Defining specific behaviors of interest* – this is done to minimize ambiguity in research and intervention design. (2) Assessing the strength of a person's intention where one of the strongest indicators of an individual performing a behavior is considered the strength of the person's *previous intention to do the behavior*. (3) Strength of intention is believed to

be influenced by (a) one's *individual attitudes*, both positive and negative beliefs regarding outcomes and consequences of performing a certain behavior and (b) one's *perceived norms*, which are based on other's opinions regarding a specific behavior and the willingness to conform to popular views (e.g. HIV testing every year is good). (Carey et al 2004). Herein the main element of this theory is behavioral intent. Yet it is limited in that the model assumes a person has the resources and opportunities to succeed in carrying out their desired behavior, regardless of their intentions. Thus, it does not take into account the economic and environmental factors that may influence a person's intention to carry out a desired behavior (Boston University SPH 2013).

Researchers have also employed the Transtheoretical Model of Behavior, also called Stages of Change, which is an integrative, biopsychosocial model that conceptualizes the process of intentional behavioral change. The model was developed by Prochaska and DiClemente in the 1970's and initially used to examine the different experiences between smokers who try to quit smoking on their own and those who require treatment in quitting (Prochaska and DiClemente 1983). Since that time, the model has evolved to be used in examining behavior change in HIV research. Hence this model mainly centers on individual's decision making and intention of altering behavior through a series of incremental steps that include: (1) *precontemplation* – the time when one has not realized he or she has a problem or is not interested in changing his or her behavior; (2) *contemplation* – when one is aware that he or she has a problem and is thinking about behavior change; (3) *preparation for action* – when a person has decided to change their behavior, but has been practicing the behavior inconsistently or for less than a month; and (4) *maintenance* – when a

person has been actively doing a new behavior consistently for more than six months (Boston University SPH 2013; Carey et al 2004; Prochaska and DiClemente 1983). The Transtheoretical Model is not a theory like those previously mentioned. Instead it is a model that seeks to incorporate key constructs from other theories into a comprehensive theory of change to apply to a variety of behaviors, populations, and settings (Prochaska and DiClemente 1983; Prochaska et al 1994).

The above frameworks are commonly used in public health HIV-related research and have been effective in explaining aspects of people's behavior associated with HIV risk and assessing factors that predict behavioral intent. As each individual model's limitations have been discussed, it is also important to note that these models fall short in understanding women's risk for HIV in that they all center around individual-based risk behaviors and only explain a part or fraction of the behavior in question (Pool and Geissler 2005; Amaro et al 2001; Boston University SPH 2013).

Anthropology, Medical Anthropology and HIV

The increase of HIV cases among African American women over the past three decades has shown a need for researchers to take a social and cultural perspective in understanding women's risk and designing programs and interventions for decreasing infection rates. HIV affects people from different backgrounds, social locations, and across various life cycles. Herein, anthropology offers a holistic approach to examining HIV disparities, particularly among women. Specifically, it offers alternative bio-cultural and socio-cultural models to examine structural factors that impact HIV inequalities. Anthropologists seek to understand how social, economic, and political aspects and the interaction of behaviors, beliefs, values, and customs impact HIV risk (Chapman and

Berggren 2005; Whelehan 2009). Thus, anthropology's holistic, relativistic, and comparative perspectives aid in understanding the cultural complexities of the disease (Whelehan 2009). Moreover, anthropology has the unique ability to identify and integrate contextual factors that increase individuals and communities' vulnerability to HIV infection (American Anthropological Association 1997; Whelehan 2009).

Since the 1980's, anthropologists have encouraged and supported an ethnographic, culturally-sensitive and specific approach to doing HIV research that reflects community values and norms (Herrell 1991; American Anthropological Association 1997; Parker and Ehrhardt 2001; Parker, Barbarosa, and Aggleton 2000a; Whelehan 2009). Anthropologists have historically engaged in both qualitative and quantitative research, which enables them to discern a multiplicity of factors that influence people's behaviors (Carrie and Bolton 1991). Thus ethnography is employed to generate new knowledge on HIV inequalities and disparities. As stated by Arthur Kleinman (1999), anthropologists are "called into the stories and lives of others by the moral process of engaged listening and by the commitment to witnessing", through the use of ethnography (89). Here they have the ability to map the direction of research that moves from merely examining risk behaviors to facilitating action that addresses structural barriers related to fundamental causes of illness and disease (Chapman and Berggren 2005). More specifically the use of ethnography in HIV research allows anthropologists to better understand how prevention messages are perceived in certain populations. For example, heterosexual Black men being encouraged to get tested is sometimes assumed that they have engaged in homosexual activity. Likewise, it aids in revealing rationales people us for and against performing safer sex practices (e.g., why

women use condoms with some partners and not with others). It helps provide understanding of behaviors that hamper HIV-risk prevention and HIV-related care, such as stigma, fear and provider bias. Furthermore, ethnography allows researchers to examine contextual factors (e.g. economic, environmental, social, and political) that affect HIV risk (Carey et al 2004)

Medical anthropology, a subfield of cultural anthropology has a tradition of examining patterns of disease among human populations and investigating how disease responses reflect the sociocultural systems in which they occur. On a whole, it is an applied field, in which researchers seek to understand why certain situations exist and how they can be improved (Pelto 1998; Singer 1995). Specifically, it offers an integrated approach to responding to the impact of HIV and AIDS on specific groups. Here anthropologists take active roles in prevention and intervention efforts by investigating how political, cultural, and socioeconomic factors influence disease risk of individuals and groups at local, national, and international levels (Parker and Ehrhardt 2001; Parker 2001; Whelehan 2009). In addition, the analysis of belief and value systems, social and economic relations, and other expressions of group interactions and cultural meanings (e.g., HIV and the black church) helps in constructing programs that respond to the disease in its social and cultural context (Weeks, Singer, and Schensul 1993). Much of the research done in medical anthropology is applied. Hence anthropological perspectives are based on research and theory operating in real-life situations and as tools used in practical problem solving (Whelehan 2009; Leap and O'Connor 1993).

ANTHROPOLOGY OF HIV

Theoretical Approaches to Anthropological HIV Research

Anthropologists conducting descriptive and analytic ethnographic research contribute immensely to the growing body of knowledge on HIV risk and the development of culturally sensitive and appropriate prevention programs by providing insight on how HIV risk is shaped by communities' economic, social, and cultural context (Chapman and Berggren 2005; Parker 2001). Seeking to move beyond merely identifying statistical correlates of HIV risk behaviors, researchers wanted to give faces to the statistics and voices to the unheard, by examining and explaining the meaning behind the sexual behaviors and risk of those involved, the context in which the risk occurs, the social scripting of the sexual encounters, and the diverse sexual cultures and subcultures with the communities of interest (Parker 2001; Bolton and Singer 1992; Brummelhuis and Herdt 1995; Herdt and Lindenbaum 1992; Parker 1994; Parker 1996; Chapman and Berggren 2005). Thus over the years, various theories in medical anthropological research have been used for explaining and understanding the global nature of HIV and AIDS (Whelehan 2009).

One theory most commonly used by medical anthropologists is critical medical anthropology. According to Merrill Singer (1995), critical medical anthropology is described as a theoretical and practical way of understanding and responding to issues and problems related to health, illness, and treatment in terms of the *interaction* between "the macrolevel of political economy (such as economics, housing, and education), the national level of political and class structure, the institutional level of health care systems, the community level of popular folk beliefs and activities, the

microlevel process of being ill, behavior, and meaning, as well as environmental factors" (81; Baer, Singer, and Johnsen 1986; Singer 1986, 1990). Critical medical anthropology is holistic, historical, and is concerned with "on the ground" (e.g. a place where practical work is done) features of social life and relationships as well as with culturally constituted systems of meaning (Singer 1995:81). In simple terms, critical medical anthropology underscores the significance of political and economic forces and the use of power in shaping health, illness experience, disease, and health care (Singer and Baer 1995).

Critical medical anthropology consists of several key tenets. First Singer (1986) contends that expressions of development and expansion of capitalism are the most significant transcending social processes. Hence critical medical anthropology espouses the concerns of political economy of health, which understands "health-related issues within the context of the class and imperialist relations inherent in the capitalist world-system" (Baer 1982:1; Singer 1986). Second, within this framework, health is defined as having access to and control over the basic resources that promote and sustain a high quality and satisfaction of life. Hence, health is considered a flexible concept to be evaluated in a larger socio-cultural context, rather than as an absolute state of being.

Third, from the critical medical anthropology perspective, disease is not a direct consequence of a pathogen or physiological disturbance. Instead, disease susceptibility includes a variety of social problems such as economic insecurity, occupational risks, malnutrition, industrial pollution, and substandard housing (Singer 2004; Baer, Singer, and Johnsen 1986). Thus, critical medical anthropology is

concerned with understanding the relationship between what McNeil (1976) terms as the macroparasitsm (the social relations of exploitation that ultimately cause many diseases) and microparasitism (the individual behaviors that are immediate causes of sickness) and their impact on illness and disease. Fourth, critical medical anthropology considers the concept of medicalization which is “the absorption of ever-widening social arenas and behaviors into the jurisdiction of biomedical treatment through a constant extension of pathological” naming of new conditions, disorders, and behaviors (Singer 2004:28). Examples include clinics or health care organizations providing classes on stress management, alcoholism, drug addiction, or living with HIV. Hence medicalization contributes to health organizations and physicians having increased control over behavior and assisting in depoliticizing the social origins of one’s personal distress (Singer 2004).

Fifth, all health care systems are generally based on a patient-provider interaction, which may also be called a hegemonic interaction (Singer 2004). Herein hegemony comes through the diffusion and constant reinforcement of certain attitudes, values, beliefs, social norms, and legal precepts of key societal institutions. Examples of such interactions are a patient’s attention being focused toward immediate causes of an illness and away from structural factors or a provider stressing the need for a patient to comply with an expert’s or social superior’ decision. Lastly, regardless of how complex a health care system is, as previously stated, they are all based upon a dyadic core which consists of the healer-patient (provider-patient) interaction. Therefore, critical medical anthropology recognizes the importance of power relations in the medical system and calls attention to the various existing levels of industrialized capitalist and peripheral

nations in the health care system (Baer, Singer, and Johnsen 1986). Herein, critical medical anthropology seeks to understand the nature of articulation, which means mediating structures or platforms for dialogue or negotiation, between such levels (Singer 1986). Furthermore this concern for health care systems extends to knowledge of medical pluralism, which thrives in all class-divided societies and tends to mirror aspects of a broader scope of unequal social relationships (Singer 2004, 1986).

In using critical medical anthropology, anthropologists frequently focus on the impact of structural and political economic forces, such as race, gender, and class inequalities, on the spread of HIV (Doyal et al 1994; Schoepf 1992; Farmer, Connors, and Simmons 1996; Farmer 1999, Farmer et al 2004; Lane et al 2004; Singer 1994, 1998, Singer et al 2006). Herein, evidence shows that social, political, and economic factors impact individuals' sexual experience, vulnerability to infection, and may constrain options for sexual behavior change (Singer et al 1990; Farmer 1992; Schoepf 1991; Parker 2001). As researchers, anthropologists have used critical medical anthropology in contextualized HIV studies to document ways in which gender, social, and economic hierarchies affect communities and groups. For example, Romero-Daza and colleagues (2003) use critical medical anthropology to study the lives of women engaged in street level prostitution and their exposure to violence, drugs, and risk for HIV. Farmer (1998) examines how poverty and gender inequality impact risk for AIDS transmission among women living in rural Haiti. Schoepf (1992), applying critical medical anthropology, uses vignettes of stories from women living in Kinghasha, Zaire to illustrate their daily responses to dealing with economic hardship and life's uncertainty as a result of HIV transmission. Moreover, Singer (1994) examines HIV in

terms of social class and ethnicity and calls attention to issues of gender and economic inequalities and their intersection with power dynamics (Singer 1994). In such cases, power is defined as a function of an individual's available resources, their access to resources, and how the two impact the realities of HIV risk and prevention measures (Singer 1998; Altman 1999).

Studies employing critical medical anthropology have been responsive to assessing inequalities of race, gender, and class. Using critical medical anthropology proves helpful in calling attention to structural forces that impact African American women's HIV risk and situating the disease in context. Additionally it aids in providing suggested solutions for creating prevention strategies. However, this model is not without flaw.

One critique of critical medical anthropology is that it stresses the political economy of health perspectives, where biomedicine is broadly understood in terms of its relationship with the global capitalist economic system (Singer and Baer 1995) and medicine is viewed as what Barbara and John Ehrenreich call "a desirable but poorly distributed commodity" (Ehrenreich 1978:4; Morgan 1987). Herein, critical medical anthropology is concerned with exploring how material or wealth impacts access to care as opposed to studying patient-health system experiences. Another important critique from the interpretive perspective is that critical medical anthropology depersonalizes medical anthropology's content and subject matter by solely concentrating on an analysis of health structures or social systems and not focusing on the social and cultural realities of individual patients and their lived experiences (Scheper-Hughes and Lock 1986; Singer and Baer 1995). Hence, the critical medical anthropology's heavy

focus on poverty, lack of healthcare access, and low education attainment as determinants for HIV risk causes researchers to frequently overlook populations such as college educated and middle class Black women.

CONCEPTIONS OF CLASS

Social class or simply class is used in a number of social science disciplines for studying social and economic relationships within and between groups. In health research, class is often used interchangeably with socioeconomic status (SES), where it is generally considered a key determinant in health outcomes and inequalities (Krieger, Williams, and Moss 1997; Jackson and Williams 2006). In general, class refers to a system of power based on income, wealth, and status, where society's resources are unequally distributed (Guest 2014). Accordingly, there are different approaches to the concept of class, which are represented by theorists, Karl Marx, Max Weber, and Pierre Bourdieu.

Karl Marx

Marx, one of the most widely read theorist of class emphasized the determining role of economic relationships and increasing inequalities in a capitalist society. His approach begins with production relationships, specifically characterized by patterns of labor and capital. Thus class relationships were determined by one's association to the means of production, which includes relations of economic exploitation, reinforced by relations of social and political dominance-subordination. According to Marx, there are two main classes defined by their relation to the means of production, the bourgeoisie or capitalist class - those who own the land, factories, and banks and the proletariat or

working class - those who are forced to sell their labor power to the owners of the means of production (Saunders 1990; Patnaik 2012; Guest 2014).

For Marx, labor is important for obtaining value and profit in the market (Guest 2014). Similarly, the character of class relations and specific mode of production are defined by the specific forms in which labor is performed by the actual workers engaged in production and the forms of appropriation of economic surplus produced by the class with control, ownership, assets property rights (Patnaik 2012:47). Hence, the capitalist mode of production and ensuing relations are mediated by markets. Patnaik (2012) further asserts that Marxist capitalist mode of production "dispenses with such direct legally unequal and hierarchical relations between classes" (49). In this conflict between classes, working class and capitalist, the working class seeks to reach a point through continued struggle where the capitalist class is compelled to "institutionalize" political and legal equality (Patnaik 2012). Recognizing the difference between these two fundamentally different classes, within the economy, was essential for Marx understanding power relations in a society.

Moreover, Marx recognized that this two-class model was far too simplistic for modern capitalist societies. He acknowledged the complexity of class relationships and identities by conceiving of "class fractions" to acknowledge the power and privilege of middle classes who could accumulate money and other commodities and who often saw their interests tied to those of the capitalists rather than to those of the proletariat. Hence the middle class also referred to as the "petite bourgeoisie" is characterized as those who are not owners of means of production, who sell their labor power on a labor market, yet are not a part of the working class (Wright 1998:146). According to

American class scholar Wright, Marx's more complex class structure (capitalist, middle class, and proletariat) is delineated based on three forms of control over economic production authority and ownership location within capitalist property relations (Wright 1978, 1979, 1998; Veenstra 2006). The three forms of control are: 1) economic ownership – control over economic surplus; 2) command of production physical apparatus – supervisory control over factories, machines, etc.; and 3) command of labor power – supervisory control over other workers. In this three-tier class schema, the capitalists possess all forms of control, the middle class possess some of the first and second forms of control, and the proletariat have no control at all (Veenstra 2006).

Max Weber

Weber's view of class was characterized by a focus on multiple determinations and the achievement of social status as part of class formation. He was concerned with presenting a multi-dimensional perspective on class, where economic relationships were given their due; while acknowledging other forms of status. Thus, for Weber, classes and status groups are a "phenomena of the distribution of power within a community" (Levine 2006:50), in which there are three dimensions of social stratification: economic status or wealth, power, and prestige (Crompton 1998). Here prestige refers to influence, reputation, and deference given to certain people because of their association with certain groups (Weber 1963, 1946; Guest 2014).

Weber saw class divisions as a collective of people for whom similar backgrounds determine their life chances (Levine 2006). By life chances, Weber means the opportunities individuals have of sharing in the economic, social, and cultural goods of society, obtaining their goals, and improving their quality of life (Levine 1998).

Life chances are determined by access to social resources such as education, food, healthcare, and shelter, in addition to economic resources. Hence according to Weber, class status as it relates to wealth, prestige, and power determines access to economic and social resources.

Pierre Bourdieu

The body of work attributed to Marx and Weber is immense; however it is also important to understand Bourdieu's approach to conceptualizing class. Bourdieu's view of class is based on his studies of the French educational system (Calhoun 2000). Herein he understands the relationship between class, culture, and power and criteria for defining social groups not to be primarily based on the economic labor market (Veenstra 2007; Guest 2014). In addition to economic wealth, Bourdieu identified habitus and four forms of capital: economic, cultural, social, and symbolic as key factors for determining social position (Guest 2014; Crompton 1998; Yelvington 1995)

Habitus are the beliefs and self-perceptions that develop as part of an individual's social identity. They influence how one understands the world and where the individual fits into it. This concept is learned at an early age and is emphasized culturally through education, family, friends, and media. Hence, in a class of people, habitus emerges as a set of common beliefs that influence one's expectations and goals and aids the individual in assessing his or her life's chances and potential social mobility (Guest 2014; Calhoun 2000). An example of this would be one making a choice about going to college or choosing a career based on their family's habitus.

Bourdieu's four forms of capital: *economic* (money and material objects), *cultural* (lifestyle, tastes, skills, educational qualifications), *social* (positions and group affiliation,

social networks), and *symbolic* (symbols to legitimate ownership of the different levels of economic, cultural, and social), "together empower agents in their struggle for position within social space' (Crompton 1998:148) and are thus considered a class-relevant capital for distinguishing among groups. Overall, this concept embodies the totality of capital owned by various groups (Yelvington 1995). Likewise, LiPuma and Meltzoff (1989) recommend focusing on the "intersection of forms of capital" when analyzing class to determine the nature of class and class structure in a particular setting (Yelvington 1995:32). They argue that "class statues are the product of the way in which a community objectifies patterns of correspondence between economic, social, and cultural capital…from this standpoint, what we call class status is the objectification of these capital forms within the objective structure simultaneously determined by the capitalist production processes and cultural traditions" (1989:323, 322; Yelvington 1995:32). However economic capital and cultural capital, which is more specifically comprised of knowledge (e.g., education), social background (e.g., habits, customs, norms) and tastes learned from personal experiences and parental interaction are thought to be the more prominent forms of capital for gaining access to societal resources (Veenstra 2007; Guest 2014). With enough money (economic capital), one can afford opportunities like traveling abroad, attending cultural events, and joining social clubs. Having the aforementioned opportunities helps build networks, which is important for developing class identity and position (Veenstra 2007; Guest 2014).

The above theorists have made considerable contributions to the study of class in anthropology. However, for some scholars, class became a universal mode of social organization in the late eighteenth century (Williams 1976; Smith 1984) and evolved as

a major concept for exploring contemporary systems of stratification in the twentieth century (Crompton 1998). The study of class and social stratification was absent from classic anthropology before the 1970's. Topics such as kinship, religion, family, and culture were at the forefront of debates and research (Smith 1984). Yet, in the 1970's anthropologists became influenced by individuals such as Marx and his theory of class conflict. Likewise, other scholars such as Eric Wolf (1982) have made use of Marxism in their research to make sense of "new working classes" in a modern industrial capitalist society (381; Smith 1984).

INTERSECTIONALITY FRAMEWORK: ANALYSIS OF RACE, GENDER, AND CLASS

In recent years, anthropologists and other social scientists have been led to re-examine class relationships and inequalities by analyzing the deep connections between race, class, and gender. Building on anthropology's long history of holistic ethnographic research, scholars like Leith Mullings and Diane K. Lewis use an intersectional approach, wherein they contend that class cannot be studied in isolation, but, instead must be considered collectively with gender and race as interconnecting systems of power (Mullings 2005; Lewis 1993). Intersectionality offers a framework for examining how the effects of race and gender determine how class is experienced in one's life and how all three systems of power interact with one another to produce certain outcomes (Mullings 2005).

Black women scholars insist that contemporary capitalism must be analyzed with respect to the role of racism in class formation. Specifically, bell hooks (1995) contends that class relationships can only be understood through an analysis of racism and its

function in capitalist society. Similarly, Rita Mae Brown (1974) urges women to fully analyze the link between race and class in American society when she asserts:

> "Class is much more than Marx's definition of relationship to the means of production. Class involves your behavior, your basic assumptions about life. Your experience (determined by your class) validates those assumptions, how you are taught to behave, what you expect from yourself and from others, your concept of a future, how you understand problems and solve them, how you think, feel, act" (13).

Similarly, Mullings (1997) contends that although class (e.g., the relationship to the distribution of power and resources) is important for predicting a range of possibilities; it is essential to also understand how historically created relationships of distribution of resources, power and privilege, have manifested to influence meanings and experience of race and gender. For example, in the United States, class relationships created under slavery influenced the meaning of race for the next three hundred years. Hence race is the lens through which relationships of domination and power are perceived and understood. However, class structure (i.e. the distribution of power and resources) is what gives race its meaning (Mullings 1997). Thus an analysis of race is as equally important as our analysis of class, as bell hooks points out, "class struggles are inextricably bound to the struggle to of race" (hooks 1995:272).

History of Intersectionality

One of the earliest expressions of intersectionality grew out of Black women's critique of mainstream White feminism. However, the actual term 'intersectionality' was introduced by Kimbele' Crenshaw (1989) in her work looking at Black women's employment issues in the United States. In this she used Black feminism to critique

feminist theory, calling it “a single-axis framework that erases Black women in the conceptionalization, identification, and remediation of race and sex discrimination” by restricting experiences to those who are members of the privileged group (140). The term became more popular with her work examining issues of race and gender and violence against women of color (Crenshaw 1991).

Whereas feminist perspectives and theories addressed issues of sexism, they did not account for the intersecting oppressions of race and class in Black women’s lives. Thus, during the second wave of feminism (1963-1980’s), Black women began to highlight the distinctions between their social situations and those of the dominant feminist group. Black women were not only affected by patriarchy, but also by what they argued as a racist capitalist society (Turner 2007). Also during this time a group of Black feminist wrote The Combahee River Collective (the black feminist statement, 1977), which has been cited as one of the earliest expressions of intersectionality. This manifesto declares:

> “The most general statement of our politics at the present time would be that we are actively committed to struggling against racial, sexual, heterosexual, and class oppression and see as our particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking. The synthesis of these oppressions creates the conditions of our lives. As Black women, we see Black feminism as the logical political movement to combat the manifold and simultaneous oppressions that all women of color face” (Smith 1982:13).

It is argued that some members of subordinate groups (e.g. African American women) also hold privileged identities such as being middle class. However, we must understand that because of African American women’s membership in two subordinate

groups (e.g. race and gender) they stand in structural opposition with a dominant gender and dominant racial group. Thus, regardless of social class, African American women still lack access to certain resources and power (Lewis 1977). African American women who attain middle class status have a distinct cultural experience of class, rooted in their own specific experiences of race and gender interactions. Therefore the experience of gender is also influenced by the intersecting systems of race and class. For example, African American women have high college completion rates; hold professional positions; and their economic contributions are often essential to their families. At the same time, they earn less income than White men and women at every educational level (Bradbury 2002) and their upward mobility sometimes puts them at odds with their Black male counterparts (Chisholm 1996; Brown 2003). Herein African American women occupy a structural position where race and gender weakens their status of power.

With respect to this study, the intersectional approach interrogates institutional structural power relations and social inequalities of health. Herein the interactions between the two are uniquely positioned to counter traditional research assumptions relating to education, income and HIV risk. African American women in the United States have a higher prevalence of HIV than women of any other ethnic group (CDC 2013a). Research findings also contend that Black female college students have a higher HIV risk than women of other ethnic groups (Kanekar et al 2010; Alleyene and Wodarski 2009; Adefuye et al 2009). Hence, this observation suggests that factors other than education and social class are at work relating to African American women's HIV risk. Therefore, the intersectional lens helps focus this research perspective on

middle class African American women and HIV risk in several ways. It aids in understanding race, gender, and class as relational concepts and not just attributes among women of color. Likewise, it emphasizes the importance of considering how the interrelated concepts operate in the lives of African American women and how they interact to influence HIV risk (Mullings 2005).

Womanist Theory

This dissertation used womanist theory to examine middle class African American women's sexual behaviors, attitudes, and HIV risk perceptions. Historically, symbols and images used in anthropological and social science research to represent Black women have often depicted them as exotic, hypersexual, dysfunctional, deviant, or invisible (Rodriquez 1996; Jordan-Zachary 2009). Hence, employing a womanist framework helped counter what sometimes results in anthropology and other social sciences' distorted, minimized, or concealed information regarding African American women.

Womanism is a term coined by Alice Walker meaning "a Black feminist or feminist of color committed to the survival and wholeness of entire people, male and female. Not a separatist, except periodically for health" (Walker 1983: xi). The term reflects Walker's view that the experiences of Black women are unique and significantly divergent from those of White women. In general, Walker's definition of womanism is synonymous to Black feminism. Both are interrelated concepts that challenge and disrupt racism within the White feminist movement. However, some Black women are attracted to the womanist concept because it provides a way to address feminist issues, such as empowering women and creating equity within Black families, Black

communities, and social institutions, while providing an avenue for building stronger relationships between Black men and women (Collins 1996; Houston and Davis 2002).

Walker's definition of womanism not only reflects the uniqueness of African American women's experiences in society, but also addresses the importance of relationships between African American women and men (Banks-Wallace 2000). This is important to this study as male-female relationship dynamics are significant to how African American women perceive their risk for HIV. While womanism focuses on African American women's experiences with racism, sexism, and classism and the eradication of these intersecting oppressions; it is also concerned with the larger struggle of and survival of the whole community (Rodriguez 1996; Banks-Wallace 2000; Collins 2000a; Townes 1996).

Womanist Theory and Feminist Theory in Anthropology and Other Social Science Research

Womanist theorists and other women of color argue that feminist analysis is predominately based on experiences of White privileged women (Taylor 1998). Similarly, Rodriguez (1996) contends that Black women generally associate feminist identity with the politics of White women who, along with White men, support systematic racism, those who are characterized as liberal, bourgeois, or reformist (McIntosh 1995; Johnson-Odim 1991). Historically, feminist theory was born out of White women's self-conscious struggles to combat patriarchal views of women; to situate women's issues at the center of analysis; to acknowledge the importance of women's ideas and actions; while critiquing male dominance (Banks-Wallace 2000; Schaef 1992; Fonow and Cook 1991). Yet, in their endeavors to challenge hegemonic notions of White male

dominance, White feminists have also contributed to the silence or erasure of Black women's voices and ideas (hooks 1995; Banks-Wallace 2000; Rodriquez 1996).

Feminist anthropologists sought to address political, social, and economic issues using theories based on universal sexual asymmetry (Rosaldo 1974), with the goal to expose sexism and to change male-biased beliefs about women's role in academic and popular culture. For example, scholars such as Ortner (1974), Rosaldo and Lamphere (1974), Sanday (1981), and Rogers (1975) extensively explored topics relating to male dominance, power structures, and gender inequality and the application of anthropological theories relating to domination and women's oppression (Knauft 1996). Similarly, other important contributors include Moore (1988) who has been very influential to the area of feminism and anthropology, Sacks (1989) who impacted the way researchers approach the theorization of race, gender, and class, and Stack (1974) who through her compelling ethnography about women living in The Flats, the poorest section of Jackson Harbor, "brought understanding to the plight of poor Black women struggling to survive in a hostile urban environment" (McClaurin 2001:9).

Herein, womanist and Black feminist anthropologists gratefully acknowledge the above scholars' contributions upon whom they draw for their own work. However, in most feminist anthropologists' quest to assert themselves in this male-dominated discipline, the feminists' universal theories of patriarchy were too general and their claims of inclusiveness often negated the experiences of African American women and other women of color (Rodriguez 1996). Consequently, womanist anthropologists deemed feminism disempowering of the voicing and representation of Black women's perspectives.

It is argued that feminism should not be viewed as a White women's concept, but rather as a framework that is also inclusive of African American women's experiences, since it addresses issues that contribute to the well-being of all women (Bolles 2001; Cole 1994). Yet, while the goal of enhancing women's lives may be the same for both womanism and feminism; the approaches taken to illuminate the varying social, cultural, and historical realities of women's lives differ between the two theories (Bolles 2001). Williams (2006) asserts that womanism is not only female-centered (about women), but is also concerned with conditions, events, meaning, and values in the Black community that influence or shape African American women's thoughts, behaviors, or belief systems. Likewise the theory encourages the creation of new identities and self-definitions that validate African American women's perspectives and experiences (Collins 2000a). For example, Black women having the ability to deconstruct negative societal images and self-identify with positive images. This is important as Collins (2000b) argues that self-definition allows African American women to question assumptions made by those in positions of authority and to interpret their own realities.

Contribution of Womanist Theory to Anthropology and HIV Research

Womanist theory is important to HIV research and anthropology in general because it recognizes African American women as possessors of knowledge, and acknowledges their experiences as valid sources of information (Shambley-Ebron and Boyle 2004). It is an interpretive framework that provides a holistic understanding of the multiplicity of factors that lead to African American women having a higher morbidity and mortality than women of other ethnic groups (Mullings 2005). Moreover, womanist theory provides a critical reflection of African American women's social, cultural, and

historical place in society and acknowledges the significance of their life experiences with racism, sexism, and classism.

The use of womanist theory in this study adds a unique and very necessary aspect to doing anthropological research in various ways. First, while critiquing traditional theories and anthropology's colonialist history, womanist theory allows the African American female researcher to "transform anthropology" by advancing research on HIV and African American women. Herein by using womanist theory in anthropological qualitative HIV research, African American women are allowed direct involvement in the research process through the open and candid discussions of their experiences (Few, Stephens, and Rouse-Arnett 2003). Likewise, Few and colleagues (2003) contend that using womanist theory enables African American women to move from being research subjects who are "simply being talked to" to becoming informants and participants who actually talk for themselves (207). Thus employing a theory in the discipline that is not widely used underscores the necessity of African American women being empowered to speak from and about their own experiences while refusing to be placed along the peripheral in the discipline (Phillips and McCaskill 1995; Rodriguez 1996).

Secondly, womanist theory allows the African American female researcher to explore and chronicle African American women's cultural interactions with the African American community, which counters claims by scholars like John Aguilar in "Insider Research: An Ethnography of a Debate" and Donald Messerschmidt in "Introduction" both in *Anthropologists at Home in North America* (McClaurin 2001), that one is unable to effectively study her own people (Rodriguez 1996). In some cases the

methodological thoroughness, objectivity, and effectiveness of anthropological research have been called into question because African American female researchers choose to stay home and study topics like Black women in communal living or issues related to HIV and AIDS as opposed to engaging in traditional “exotic or adventurous anthropology” (Messerschmidt 1981; Rodriguez 2001:244). However, Rodriguez (2001) contends that African American women conducting research in their own communities require a more centralized focus on the everyday realities that are taken for granted. Hence, womanist researchers are challenged to deconstruct and critique ideas of familiarity. Additionally, it is important to note that womanist researchers engage in native anthropology often with a goal of conducting research that will give voice to understudied populations, represent African American communities in empowering ways, give a new perspective to ongoing issues, and impact the discipline with innovative findings (Rodriguez 2001; McClaurin 2001).

Thirdly, a womanist approach challenges the image of Black womanhood, politically and economically in anthropological HIV research by “studying up” and asserting African American women as legitimate research participants; identifiable by multiple social backgrounds and worthy of space for representation as active partakers in the creation of knowledge and power (Rodriguez 1996). This speaks to the inclusion of college educated, middle class African American women as participants in this present study. Varying dimensions of culture and society, such as work, church, family life, and other relationships influence African American women’s social construction of Black womanhood (Thomas 1998). Hence, womanist theory provides a space for women to interrogate the social construction of Black womanhood in relation to the

African American community and the larger society with the purpose of reconstructing knowledge that enables African American women to declare their own authority (Thomas 1998).

In considering the creation of knowledge and power, Andersen and Collins (1995) suggest asking how we might see the world differently if we acknowledge and value the thoughts and experiences of those women who have been excluded or underrepresented in research, literature, or policy decision-making (Thomas 1998; Jordon-Zachery 2009). Hence, the use of womanist theory as a primary construct in this research validates the life experiences of middle class African American women as crucial to our understanding of HIV and AIDS in this country. It aids in negating the silence of middle class African American women's experiences in HIV research as an excluded or "so-called" privileged group. Moreover, the womanist framework promotes an emancipatory research with brings awareness to the hidden or distorted understandings of African American women's everyday lives (Taylor 1998; Allen 2002). Herein, emancipation is defined as expanding one's perceptions, enhancing the achievement of realizing alternative possibilities from the options that society has imposed (Henderson 1995; Lather 1991; Allen 2002).

Defining Class

When talking about class in the American system, most Americans consider themselves members of the middle class (Weir 2007). As characterized by the *Class in America: An Encyclopedia* (Weir 2007), those who identify with the middle class are situated between members of the upper class and members of the working class. However, because the middle class does not possess the wealth of the upper class,

they associate with the working class in the need for regular employment (Weir 2007). There is a general consensus that, in the United States, obtaining a college degree is a primary indicator of middle class status and largely determines a person‘s capability in terms of occupation and earning potential (Kronus 1971; Patillo-McCoy 1999; Warner, Meeker, and Eells 1998; Bowser 2007) Thus, white collar positions also separate the middle class from the working class or those whose occupation require engaging in manual labor (Kronus 1971; Weir 2007). Historically, examples of middle class occupations included professional jobs such as school teachers, doctors, corporate executives, insurance agents, bank tellers, and secretaries. Conversely, examples of working class occupations were those related to industrialization and included manufacturing, mining and utilities, and transportation workers (Gilbert and Kahl 1982).

Class and Race

Using middle class as an all-inclusive term masks the clear differences of racial inequality between the Black middle class and the White middle class. Therefore in discussing class, it is important to obtain an understanding of the particularities of being Black or African American in the middle class system. Studies show that successful Blacks possess fewer returns on education and acquire less wealth than their White counterparts (Oliver and Shapiro 1995, Jenck and Phillips 1998; Lacy 2007). Thus, while middle class Blacks and Whites may obtain the same level of education and work in the same occupation, significant differences exist in terms of academic achievement and accumulation of income and wealth (Bowser 2007). Specifically, White middle class children have higher test scores and higher academic achievement than Black middle class students (Fraser 1995; Jenck and Phillips 1998; Patillo-McCoy 1999;

Boswer 2007). Likewise, White middle class families have a net worth of approximately $74,922 compared to middle class Black families, which only have a net worth of about $17,437 (Oliver and Shapiro 1995; Bowser 2007). Although the income gap between Black and Whites has decreased, the Black-White wealth gap has not. Income is earned and often tied to education, training, and achievement; however wealth is passed down from one generation to the next (Oliver and Shapiro 1995; Bowser 2007; Conley 1999; Lacy 2007).

Middle class African Americans often maintain social relationships with poor and working class African Americans through various organizations such as churches, social clubs, and businesses (Jackson and Cummings 2011:402). Yet evidence shows that Black middle class social networks may not always be profitable in attaining status and generating sufficient social capital (Jackson and Cummings 2011). Moreover, Patillo-McCoy (1999) argues that although upwardly mobile African Americans leave their low-income communities for what are considered “better neighborhoods”, those new neighborhoods are still racially homogeneous. Thus, disparities between Blacks and Whites exist partly due to racial residential segregation. This causes middle class African Americans living in all Black communities to face problems such as crime, violence, drugs, lower property values, the lack of quality schools, and less access to other services, compared to those living in White middle class areas (Bullard, Johnson, and Torres 2007; Adelman 2004; Cashin 2001; Patillo-McCoy 2000; Emling 1996). As a result, middle class African Americans limit educational opportunities for their children, reduce the returns associated with homeownership, and experience health disparities (Oliver and Shapiro 1995; Jackson and Williams 2006).

In terms of health, middle class status or class relationship does not readily translate into better health outcomes for African American women when compared to White women of lower socioeconomic status (Jackson and Cummings 2011). Data shows that middle class African American women report higher rates of hypertension, obesity, and low birth weight compared to the lowest socioeconomic group of White women (Pamuk 1998; Jackson and Cummings 2011; Jackson and Williams 2006). For example, Black female college graduates have higher mortality rates compared to White women who did not graduate from high school (Pamuk 1998). Black women with college degrees report substantially lower perceived health scores compared to health scores reported by White women who only graduated from high school (Cummings and Jackson 2008). This trend is referred to as the intersectionality paradox because it acknowledges the reoccurring dilemma of health disparities among African American women, and specifically takes into account how the intersection of race or ethnicity, gender, and class at times undermines the benefits of being a member of the Black middle class (Jackson and Williams 2006).

THE BLACK MIDDLE CLASS IDENITY

Overall, class is a system that differently structures group access to economic, political, social, and material resources. Similarly, it is considered both a position of material advantage and power (i.e., the ability to influence and control others) (Andersen and Collins 1995:65). In relating this to and examining the Black middle class, having the right job and possessing financial security are not always enough when assessing one's class status. The cultural dynamics relating to the Black

experience of producing and sustaining a Black middle class are also an important factor in determining one's position in this social class hierarchy in the United States (Bowser 2007).

While class is a function of production relationships and the distribution of resources, it also encompasses one's culture, upbringing, ideas, behaviors, attitudes, values, manners, and language (Langston 1995; Anderson and Collins 1995; Bourdieu 1984). Thus, class affects how individuals or groups understand the world and where they fit in. Likewise, it shapes their perceptions of choices and their life chances (Andersen and Collins 1995 and Veenstra 2007). The above perspective is important in examining the Black middle class in the United States as well as investigating middle class African American women for this research. This viewpoint shows the intricacies of the Black middle class by incorporating the different kinds of capital into the formation of this particular class structure. The anatomy of the Black middle class has consistently been comprised of the economic factors of the larger society as well as the cultural components that one identifies with social status. There are some individuals who were born and raised in Black middle class environments. Then there are individuals who were raised in poor or working class environments, but through educational attainment or social mobility were able to achieve middle class status (Langston 1995). Thus, educational, occupational, and economic attainments are considered middle class values and standards of behavior in which the material basis of class is linked with the social and cultural practice of class (Cole and Omari 2003).

Class Theory and the Black Middle Class

The Black middle class is a system that neither Marx nor Weber anticipated; however there are some aspects of the Black class structure that show similarities to both theorists' ideas of class. For example, Bowser's (2007) reference to the diversity within the Black middle class, where those in the working class are conscious of the status and the position of those of the lower class and members of both groups understand each other's class struggle. This satisfies Weber's belief about social class in that members of similar class or exposure share common life experiences (109; Guest 2014). Likewise, the association of identity in the Black community, which refers to one's inclusion in or exclusion from the Black middle class, mirrors Weber's social psychological aspect of class (i.e., the significance of self-identity and life chances).

In reference to Marx, the Black middle class structure speaks to his concept of middle class. Herein the Black middle class are a group that consists of doctor, lawyers, teachers, business owners, etc., those who are not a part of the working class. At the same time this middle class group or petit bourgeoisie are people who do not own their own means of production. Hence they must sell their labor power on a market like the working class, although they are not a part of the working class. This shows the class conflict of the Black middle class that Marx makes reference too (Wright 1998). Moreover, while the Black middle class has access to resources, such as education and healthcare, and capital, such as nice salaries, jobs, and homes; race often weakens their class security.

Definition of Black Middle Class

Although there has been little consensus on the overall criteria for defining the Black middle class, most scholars use education, occupation, and income as a minimum criteria and add other determinants, such as home ownership and organizational membership (Patillo-McCoy 1999; Lacy 2007; Marsh et al 2007) as they see fit. Likewise researchers like Karyn Lacy (2007) find it necessary to establish and identify levels or socioeconomic divisions within the Black middle class. She contends that doing so will help distinguish between Black lower middle class and the stable middle class (Lacy 2007). Hence, Lacy (2007) divides the Black middle class into three distinct groups based on the following income brackets: lower middle class (those earning less than $50,000 a year), middle class (those earning more than $50,000 but less than $100,000 a year), and upper middle class (those earning more than $100,000 a year). For the purpose of this study, I combined indicators most commonly used to characterize the Black middle class (e.g., college education, income, occupation) with those variables representing forms of social (e.g., community positions, organization membership, resources and prestige (Jenkins 1992; Bourdieu 1984). Additionally, I used Lacy's income brackets to identify the different levels within the Black middle class.

Black middle class is operationalized using five categories which reflect economic, social and cultural capital: (1) *level of education* (having obtained at least a bachelor's degree); (2) *occupation or profession* (having a white collar position), including current work status, taking in account that some respondents may be, currently in school, or unemployed because of the economy; (3) *current financial status*,

which includes annual household income (income for Black middle class is generally based upon a single annual income of at least $35,000 (Marsh et al 2007), number of people living in household; (4) *social networks*, including organization memberships and affiliations and community positions, and leadership roles, and (5) *social class of origin*, including parent's education and occupation. My definition of middle class is a combination of the following: *education* (having at least a college degree), *income*, which is generally based on a single annual income of at least $35,000; *occupation*, which consists of white collar positions such as doctors, lawyers, teachers, business owners; and *social networks*, which includes organization memberships and affiliations.

CONCLUSION

Class represents the distribution of power among individuals and groups, which results from patterns of capitalist relationships. Likewise class is widely used in examining variations between social groups and in explaining the intricacies of historical, social, and cultural practices, relating to material resources, living conditions, life chances, and power and privilege (Williams and Collins 2002; Andersen and Collins 1995). However in analyzing class it is important to understand that it is a concept that cannot be studied in isolation. Instead it has to be assessed in connection to gender and race as intersecting concepts.

Intersectionality provides a framework to examine how race, gender, and class interconnect and impact health outcomes in African American women. Additionally it focuses on the experiences of individuals of multiple subordinate groups, such as African American women. Womanist theory was used as an intersectional theoretical

framework in this research. This theory provides a critical reflection of African American women's social, cultural, and historical place in society and acknowledges the significance of their life experiences with racism, sexism, and classism. Likewise this approach aids in negating the silence imposed on what some would consider a privileged group or a group less likely than others (e.g., low income, uneducated, drug users) to be at risk for HIV. However, when assessing the intersection of race, gender and class, being a Black woman influences the insecurity of class status. This lack of attention to issues associated with risk of HIV among middle class African American women may prove detrimental as research shows that middle class status or class relationship does not readily translate to better health outcomes among African American women when compared to women of lower socioeconomic status (Jackson and Cummings 2011).

CHAPTER FOUR:

RESEARCH SETTING – ATLANTA, GEORGIA

The metropolitan Atlanta area is an important site for expanding research on HIV risk perceptions in African American women. The significance of this site encompasses several factors that include: the high prevalence of HIV infection among African Americans in a southern community; the disproportionate number of African American men compared to African American women, which may increase the likelihood of dissortative mixing (formation of sexual partnerships between high risk and low risk individuals); and the highly concentrated population of middle class Blacks, despite the plight of the underclass – this may contribute to stigma and risk denial of HIV relating to class identity and may influence perceptions of HIV risk.

This chapter will focus primarily on describing the specificities of the Black middle class in the metropolitan Atlanta community. It will first present an overview of the formation of the Black middle class in the United States. Secondly it will provide a brief history of Atlanta, Georgia, which includes the development of Black Atlanta, and then give a more detailed account of Atlanta's Black middle class.

FORMATION AND HISTORY OF THE BLACK MIDDLE CLASS

The Black class structure in American society began within the institution of slavery. The system emerged from the economic necessities of plantation life and generated three social categories: (1) field hands, the lowest on the social ladder; (2)

craftsmen and artisans, which consisted of blacksmiths, carpenters, and masons; and (3) household servants, the highest on the social ladder (Kronus 1971; Bowser 2007). Sexual exploitation of Black women by White men resulted in what was termed "mulatto" (mixed-race or bi-racial) offspring. Subsequently, skin color became a determining factor in social and occupational status among Blacks (Kronus 1971; Bowser 2007; Holt 1977). After the Civil War, those who were mixed race saw themselves as having a higher status in the Black community. In some instances Whites treated light-skinned Blacks better than dark-skinned Blacks. Similarly, working close to Whites helped light-skinned Blacks establish a social standing in society, where they began to internalize a sense of superiority over dark-skinned Blacks. These factors constituted what became known as the "old black elite" (Landry 1987; Keith and Herring 1991; Patillo-McCoy 1999; Kronus 1971). Thus, the first Black middle class was birthed in the South and characterized by how close Blacks were to the White upper class in terms of their skin color, cultural values, and social life (Patillo-McCoy 1999; Frazier and Glazer 1966; Kronus 1971).

Following World War I, a time known as the Great Migration, many southern Blacks moved to northern cities. During this time, the emergent Black middle class consisted of three entities: (1) small businessmen, (2) professionals, and (3) sales and clerical workers (Landry 1987; Lacy 2007). Factors such as income and occupation also became important markers of status. According to Lacy (2007), the early twentieth century marked the time when "the definition of the Black elite began to change from a group composed primarily of those with White ancestry to a more heterogeneous class" (25). However, some individuals still based Black elite membership on skin color and

family background (particularly White ancestry) as opposed to allowing dark-skinned Blacks entry based on economics or occupation (Landry 1987; Bowser 2007; Lacy 2007). Emulating the lifestyle and values of former White masters, bi-racial Blacks continued to place high emphasis on proper speech and dress, and tried to distance themselves from what they considered illiterate or unskilled dark-skinned Blacks. Similarly, Landry (1987) argued that income or wealth was not the priority of status for bi-racial Blacks. As a group, bi-racial Black elites stressed image, values, and morals modeled after middle and upper class Whites (Landry 1987; Bowser 2007). Overall, the goal of this Black elite social structure was to secure its place in society (Kronus 1971; Bowser 2007). Conversely, educational attainment was a primary focus of what became known as the emergent Black middle class and that set them apart from the bi-racial Black elite (Lacy 2007).

Black college enrollment increased dramatically between 1915 and 1940, and by the 1960s over 105,000 students were enrolled in black colleges (Lacy 2007; McAdam 1982). Education was important in the north as well as in the south. As college attendance increased, college-educated Blacks continued to enter the Black middle class (Lacy 2007). Yet, again it is noted that position in the Black middle class was not based on income, because despite being college educated, Blacks earned substantially less money than their White counterparts (Lacy 2007; Wilson 1980). Nevertheless, as time passed and the importance of education increased, ancestry and skin color became less significant in determining Black middle class membership (Lacy 2007).

Jim Crow impacted the Black middle class by restricting individuals to only living and working in Black communities. As a result of segregation, the emergent Black

middle class flourished by providing essential services (e.g., grocery stores, restaurants, barbers, dressmaking, funeral services) to a growing segregated Black community (Lacy 2007; Landry 1987) (see section titled “Businesses” below). The occupations of this new Black middle class consisted of doctors, lawyers, ministers, teachers, funeral directors, insurance agents, bankers, realtors, and other white collar professionals, who provided services that Whites refused to render to Black clientele (Lacy 2007; Landry 1987; Frazier and Glazer 1966). The new Black middle class created a world where status became a dominant value leading to lifestyles filled with what Landry (1987) refers to a “conspicuous” or clearly noticeable “consumption”, particularly in houses, clothes, and cars. This was viewed as the Black middle class’s way of exhibiting their symbols of success in a society that allowed few opportunities for Blacks, due to the harsh social realities associated with the hostile environment of racial discrimination. Yet, while owning homes and cars was important, research shows that family-centered activities and church and civic involvement were also key elements of the new Black middle class identity (Patillo-McCoy 1999; Barnes 1985; Bell 1983; Kronus 1971). This new Black middle class also had access to more occupational opportunities, a wider range of residential neighborhoods, and more purchasing power of goods and services than the old Black elite (Cole and Omari 2003).

Historically, scholars equated the Black middle class to married couples or family households with children (Marsh et al 2007). This description was part of DuBois’s (1967) original definition, where the husband had a professional job and the wife was a homemaker. Later, it was believed that dual incomes were needed for Blacks to maintain middle class status (Besharov 2005; McAdoo 1978). However, the decline in

Black marriage rates, due to the low availability of marriageable Black men (e.g. high incarceration rates, high mortality rates, homosexuality among Black men) (Attewell et al 2004; Mays et al 2012; Sharpe et al 2012), requires us to reconsider the types of households comprising today's Black middle class and to acknowledge that the modern Black middle class extends beyond married families to also include single parents and single individuals with no children (Cole and Omari 2003; Attewell et al 2004; Marsh et al 2007). Marsh and colleagues (2007) argues that today's middle class Blacks encompass a growing body of single adults with professional jobs. Thus researchers who only equate the Black middle class to married couples overlook the rise of unmarried households among Blacks (Besharov 2005; McAdoo 1997, 1978). In doing so, unmarried Blacks may not obtain significant representation as being a part of the Black middle class (Marsh et al 2007). Hence, the Black middle class is a diverse group of educated black professionals which consists of married couples both with and without children and single adults, many of who have never been married, living alone or living with children (Marsh et al 2007; Dickerson and Marsh 2008).

BRIEF HISTORY OF ATLANTA

Atlanta was founded in 1837 as a small southern town and emerged in the aftermath of the Civil War to become Georgia's premier center for business, transportation, and politics (Ambrose 2003). By the turn of the century, Atlanta had become the largest city in the state and the fourth largest city in the Southeast behind New Orleans, Nashville, and Richmond, VA (Ambrose 2003). During this time, the city's population was approximately 90,000 people, of which forty percent were Black (Kuhn,

Joye, and West 1990). Since the 1900s, Atlanta has grown into a burgeoning metropolitan area which encompasses ten counties (Cherokee, Clayton, Cobb, Dekalb, Douglas, Fayette, Fulton, Gwinnett, Henry, and Rockdale, as well as the city of Atlanta - ***see figure 1***) (ARC 2012; Bullard et al 2007).

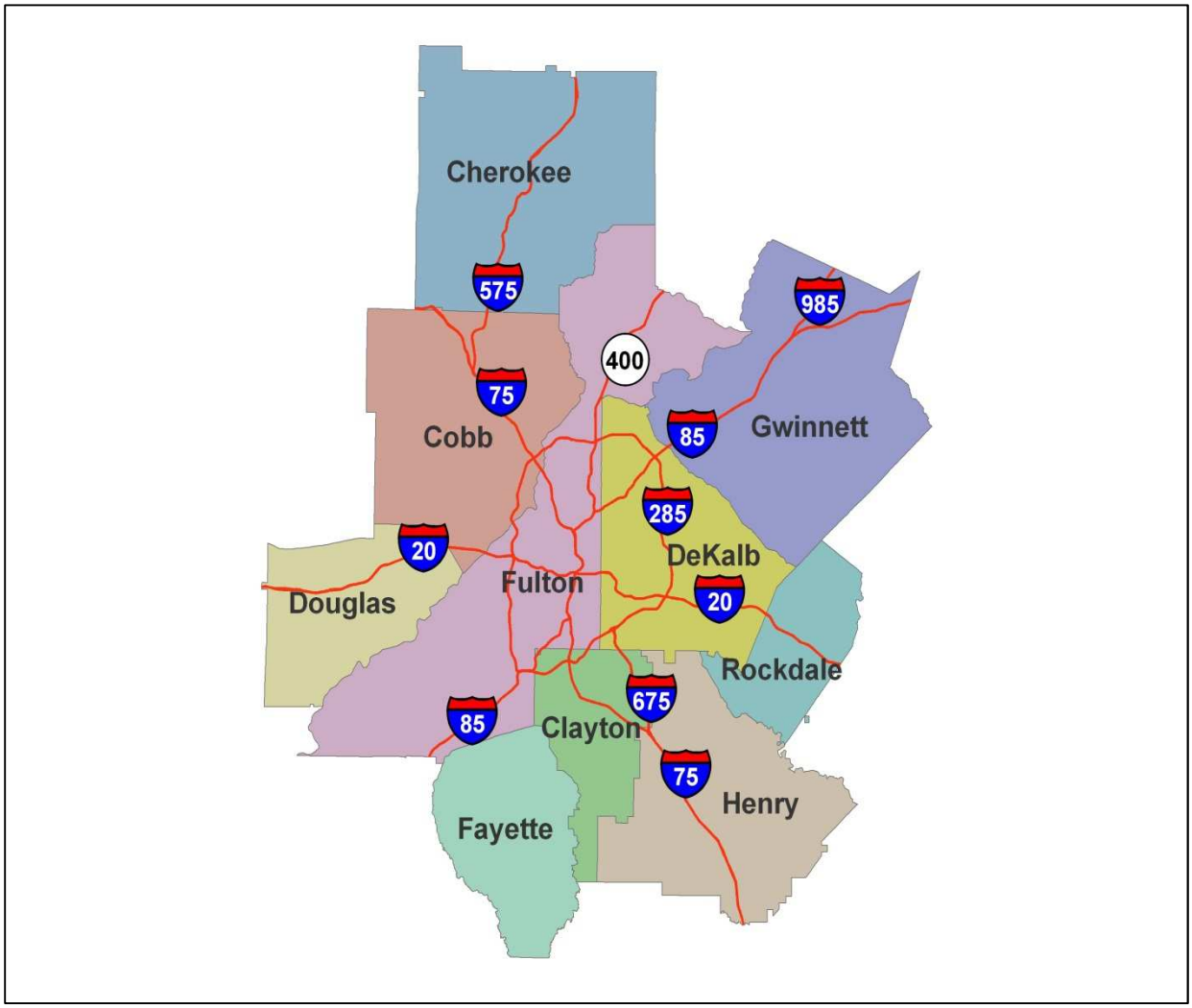

Figure 1 - 10 County Regional Commission of Metropolitan Atlanta
Source: Atlanta Regional Commission 2012

According to the Atlanta Regional Commission's (ARC) Regional Snapshot Report (2012), in 2000 the ten county metropolitan area had a population of over 3.4 million

people. In 2010, the metropolitan area's population increased to approximately 4.1 million people (ARC 2010), making Atlanta the ninth largest city in the United States (Couret 2013; U.S. Census Bureau 2013; ARC 2012 – ***see table 1***). The highlighted counties and the City of Atlanta in Table 1 represent the areas where study participants reside in the metropolitan Atlanta area.

Strategic location, railroad connections, aggressive opportunistic pursuit for business, and the development of regional relationships have all contributed to Atlanta's tremendous growth (Ambrose 2003). From 1990 to 2004, Atlanta went from having the seventh largest Black population to having the third largest Black population among metropolitan cities in the country (Frey 2006). Similarly between 2000 and 2004, the number of new African Americans reported moving to the metropolitan Atlanta area nearly doubled the number of African Americans who moved to the Miami-Ft Lauderdale area, the next fastest growing metropolitan area for African Americans. Overall, 183,000 African Americans were reported relocating to the Atlanta metropolitan area from 2000 to 2004 (Bullard et al 2007; Frey 2006).

In 2000, Whites represented 55.7 % of Atlanta's population (ARC 2010). The remaining 44.3% of the area's population was comprised of Blacks (32%), Hispanics (7.3%), Asians (3.9%) and other ethnic groups (1.2%). By 2010, the White population decreased to represent approximately 44.1% of the city's residents. In comparison, the

Table 1 – Atlanta Region Population 1970 - 2012									
	1970	1980	1990	2000	2010	2011	2012	Average Annual Change 2010-2012	Average Annual Change 1990-2010
Atlanta Region	1,500,823	1,896,182	2,557,800	3,429,379	4,107,750	4,142,300	4,179,500	35,875	77,498
Cherokee	31,059	51,699	91,00	141,903	214,346	218,500	220,800	3,227	6,167
Clayton	98,126	150,357	184,100	236,517	259,424	260,000	262,300	1,438	3,766
Cobb	196,793	297,718	453,400	607,751	688,078	693,600	699,500	5,711	11,734
Dekalb	415,387	483,024	553,800	665,865	691,893	694,400	700,700	4,404	6,905
Douglas	28,659	54,573	71,700	92,174	132,403	133,00	133,900	749	3,035
Fayette	11,364	29,043	62,800	91,263	106,567	107,100	107,500	467	2,188
Fulton	605,210	589,904	670,800	816,006	920,581	928,200	936,100	7,760	12,489
Gwinnett	72,349	166,808	356,500	588,448	805,321	814,100	823,100	8,890	22,441
Henry	23,724	36,309	59,200	119,341	203,922	207,800	209,500	2,789	7,236
Rockdale	18,152	36,747	54,500	70,111	85,215	85,600	86,100	443	1,536
City of Atlanta	49,039	424,922	415,200	416,474	420,003	420,700	421,600	799	240

Source: Atlanta Regional Commission 2012

Black population slightly rose to 36.3%. Also during this time, the Hispanic representation increased to 11.7% of the population. The Asian population increased to 5.6%, and other ethnic groups represented 2.3% of people living in Atlanta (ARC 2010 – ***see Table 2*** for total number of population by ethnicity). Thus, Whites still remain the largest group making up metropolitan Atlanta's population. Black populations are declining in the City of Atlanta, from 61 percent in 2000 to 54 percent in 2004, as well as in areas supported by public transportation (Bullard et al 2007). However, as seen in Table 2, African American's numbers have increased in more suburban areas like Cobb, Douglas, Fayette, Gwinnett, Henry, Rockdale and Clayton counties (ARC 2010; Bullard et al 2007).

DEVELOPMENT OF BLACK ATLANTA

Atlanta's diverse and growing economy, its numerous Black-owned businesses, its housing of one of the largest conglomerates of historically Black colleges and universities in the country, and its large concentration of Black middle class make a unique appeal and serve as a draw for Blacks to come to the metropolitan area from across the United States (Bullard et al 2007; Ambrose 2003). As early as the late 1800s, Black southerners were migrating to Atlanta in large numbers, in search of employment and educational opportunities (Ambrose 2003; Kuhn et al 1990). During this time, many regarded Atlanta as "a symbol of New South progress" (Jewell 2007:65). Hence, Black skilled and semi-skilled freedmen and former planters came

Table 2 – Atlanta Region Population by Ethnicity 2000 and 2012

	White		Black		Asian		Hispanic		Other	
	2000	**2010**	**2000**	**2010**	**2000**	**2010**	**2000**	**2010**	**2000**	**2010**
Atlanta Region	2,039,075	1,963,415	1,352,820	1,714,120	141,051	244,475	267,938	502,344	44,969	103,399
Cherokee	127,929	174,243	3,519	11,633	1,157	3,484	7,695	20,566	1,603	4,420
Clayton	83,078	36,610	121,440	169,020	10,830	12,839	17,728	35,447	3,441	5,508
Cobb	420,424	387,438	114,127	168,053	18,923	30,432	46,964	84,330	7,313	17,825
Dekalb	216,747	203,395	361,690	370,963	27,152	35,173	52,542	67,824	7,734	14,538
Douglas	70,109	64,911	17,047	51,387	1,110	1,876	2,640	11,125	1,268	3,104
Fayette	74,991	72,202	10,446	21,117	2,228	4,106	2,582	6,670	1,016	2,382
Fulton	372,438	376,014	362,550	400,457	25,122	51,304	48,056	72,566	7,840	20,240
Gwinnett	396,301	354,316	77,703	184,122	43,096	84,736	64,137	162,035	7,211	20,085
Henry	95,731	107,083	17,506	74,056	2,117	5,902	2,692	11,813	1,295	5,068
Rockdale	51,105	34,826	12,730	38,996	1,367	1,498	4,182	8,063	727	1,832
City of Atlanta	130,222	152,377	254,062	224,316	7,949	13,098	18,720	21,815	5,521	8,397

Source: U.S. Census Bureau 2010 Data

from surrounding fields and plantations seeking work with the hopes of making a new start and a chance for social mobility within a changing economy (Jewell 2007; Ambrose 2003). By the close of the nineteenth century, Blacks had a notable presence in Atlanta. They established their own thriving businesses, schools and universities, churches, and organizations to help meet the economic, educational, religious, and social needs of Blacks in their communities (Ambrose 2003; Jewel 2007; Meier and Lewis 1989).

Educational Institutions and Black Churches

Atlanta University and Clark University (Clark College) were both established during the post-Civil War era by northern missionaries who wanted to educate freed slaves. Clark University awarded its first baccalaureate degree in 1883. Atlanta University was known for being the oldest graduate institution in the country serving a predominately Black student body. The two institutions merged in 1988 to become Clark Atlanta University (Ambrose 2003; Clark Atlanta University 2008). In 1879, Morehouse College for men moved to Atlanta. It originated as the Augusta Theological Institute (in Augusta, GA) and was renamed the Atlanta Baptist Seminary upon first moving to Atlanta. The school's name was changed to Morehouse College in 1913 in honor of Henry L. Morehouse, the corresponding secretary of the Northern Baptist Home Mission Society (Ambrose 2003; Morehouse College 2012).

Other Black colleges' arrival soon followed Atlanta and Clark Universities and Morehouse. In 1881, two New England women (Sophia B. Packard and Harriet E. Giles) received funding from John D. Rockefeller to start an all-Black female institution

and called it the Atlanta Baptist Female Seminary. The school was later renamed Spelman Seminary (Spelman College) in honor of Rockefeller's mother, Mrs. Laura Spelman Rockefeller (Ambrose 2003; Spelman 2012). In 1885, Morris Brown College began holding classes in the basement of Big Bethel AME Church, located on Atlanta's east side near Auburn Ave. The school later moved to the west side of Atlanta in 1932, near the other institutions (Ambrose 2003; Morris Brown College 2012).

Overall, Atlanta has been a center for Black education for over 130 years (Ambrose 2003). The city is home to the Atlanta University Center (AUC), a unique infrastructure among centers of higher education for Blacks/African Americans, where the six institutions of the center include three undergraduate colleges (Morehouse, Spelman, and Morris Brown), an institution that grants both undergraduate and graduate degrees (Clark Atlanta University), a medical school (Morehouse School of Medicine), and an interdenominational seminary (Interdenominational Theological Center –ITC). Together these institutions have produced many local and national Black leaders and scholars such as Alice Walker (Spelman College), Dr. Martin Luther King, Jr. (Morehouse College), Marva Collins (Clark College), Pearl Cleage (Spelman College), and Dr. David Satcher (Morehouse College) to name a few (Ambrose 2003; Hartshorn 1976). I, the researcher for this dissertation project, also graduated from Clark Atlanta University.

Religious institutions in Atlanta also have a long history of political involvement and influence in the Black community and in the city at large. Leadership from Black churches like Friendship Baptist (1862), Big Bethel AME (1865), First Congregational

(1867), Wheat Street Baptist (1870), and Ebenezer Baptist (1886) served on Black college boards, led efforts to improve Black neighborhood living conditions, and used their position in the community to meet regularly with elected public officials (Ambrose 2003; Penosen 2011). They organized programs such as an employment bureau and the first National Medical Association. Additionally, Black churches in Atlanta played a critical role in the civil rights movement and more recently have influenced decisions made by City of Atlanta and other local government officials (Newman 1994; Penosen 2011). Hence, for some in Atlanta, the Black church is not only a place for spiritual growth, but also a place to promote social justice and change.

Businesses

By the turn of the twentieth century, significant social and economic changes were taking place in Atlanta's Black community. Black college and universities and churches were not the only institutions training Atlanta's African Americans, providing services, and influencing Black communities (Meier and Lewis 1989; Ambrose 2003; Bayor 1996). The increasing Black urbanization in Atlanta created a business base for banking, real estate, morticians, insurances agents, barbers, grocers, and other retail, which all catered to Blacks (Meier and Lewis 1989; Jewel 2007). As in other southern cities, racial policies restricted some aspects of Black employment and occupational advancement in Atlanta (Bayor 1996). However several Blacks built successful businesses based on skills and training developed in personal service to Whites (e.g., barbering, tailoring, and dressmaking). In turn, their businesses thrived in the city's economy, where they accumulated modest levels of wealth catering to Whites and/or Blacks (Ambrose 2003; Bayor 1996; Jewell 2007). For example, Alonzo F. Herndon, a

poor laborer from Social Circle, GA migrated to Atlanta and after some time established himself as the most prominent barber in the city. Later he ventured in the field of selling insurance to Blacks and in 1905 founded the Atlanta Life Insurance Company, one of the leading Black-owned companies in the country today (Jewell 2007; Merritt 2002; Hornsby 1989; Meier and Lewis 1989; Baker 1964).

Likewise, individuals such as Moses W. Calhoun, Willis Murphy, and Telveston Murdock were noted as being very successful in the grocery trade. Each of these men left their former occupation or trade of house servant, carpenter, and shoemaker, respectively (Jewell 2007). Accordingly, all three men ran profitable grocery businesses. Calhoun eventually expanded his store to also include a boarding house and restaurant, where he and the others provided services to Blacks and employed Blacks (Thornberry 1977; Jewell 2007). During the late nineteenth and early twentieth century, restaurants were also a very popular and lucrative business for Blacks in Atlanta. According to the 1886 Atlanta City Directory, 61 percent of the total restaurants listed were Black owned (Hanleiter 1886; Jewell 2007).

Political and Economic Power

Like in any other southern city, race was an issue in Atlanta and segregation existed. However, Atlanta's move towards urbanization, economic growth, and the increase of upwardly mobile Blacks produced fundamental changes in the city's residential patterns and power structures (Jewell 2007; Kuhn et al 1990; Meier and Lewis 1989; Hartshorn 1976). Although Blacks were "assigned their place" by Whites and policies such as Jim Crow laws were enacted to codify White dominance and impose racial segregation, a sub-community evolved among Blacks which took their

place in American society and formed a Black middle class that has over time given direction to the Black community (Hartshorn 1976; Lacy 2007).

Blacks gained more affluence and power in Atlanta than in any other city in the southern region (Hartshorn 1976). With the city being a center for Black education, it also served as a training ground for Black leaders in political and economic power positions (e.g., Hosea Williams, Marvin Arrington, Marian Wright Elderman, James A. Hefner) (Lacy 2007; Ambrose 2003; Hartshorn 1976). Moreover, Atlanta was the first major southern city to elect an African American mayor, Maynard H. Jackson, Jr., in 1973. In the same year, Black representation increased in the legislature, on the city council, and on the school board (Ambrose 2003; Lacy 2007; Hartshorn 1976). Prior to Jackson being elected mayor (1972), Andrew Young (friend of Dr. Martin Luther King, Jr and fellow civil rights activist) was elected to serve Georgia's fifth congressional district. He later served as the city's second Black mayor from 1982 to 1990 (Ambrose 2003; DeRoche 2003; Hartshorn 1976). In the years following Jackson's administration, the legacy of political and economic power continued, in which the succeeding mayors sustained the momentum that generated a thriving business and professional class (Wilson 2007; Bullard et al 2007).

Black Middle Class in Atlanta

Atlanta has an old, influential Black middle class that has uniquely contributed to the city's urban affairs and the shaping of New South politics (Hartshorn 1976; Hobson 2010). Herein Andrew Young, former Atlanta mayor stated:

> "There's a black middle class in lots of towns, but the Atlanta middle class is third and fourth generation middle class. That's the generation that comes into its own and is comfortable with middle class American

> values, secure enough in its middle-class-ness to be really service-oriented, with a sense of dedication and commitment" (Hartshorn 1976:43).

By the 1990's Atlanta had a Black middle class population that consisted of 19% of all African American families in Atlanta, and was constantly growing. Within this Black middle class population, almost a third of the people earned incomes greater than the typical American White family, 40% lived in the suburbs, and a third lived in areas that have historically been categorized as all-White neighborhoods in Atlanta (e.g., Ponce de Leon, Buckhead) (Garreau 1991). Dubbed the "Black Mecca" (Bullard et al 2007; Wilson 2007; Dameron and Murphy 1997), Atlanta is home to numerous Black millionaires and has more local Black owned businesses per capita than any other city, except Washington, D.C. (Wilson 2007; Bullard et al 2007).

Between 2000 and 2004, Atlanta experienced a significant housing boom, which mainly occurred in the suburbs of Cobb, Fulton, and Gwinnett counties (Bullard et al 2007; ARC 2005). However, Cobb and Gwinnett counties refused to allow MARTA, Atlanta's public transportation system, in their jurisdiction. Race was a major factor in shaping this decision as MARTA is often perceived as a Black transit system (Bullard et al 2007; Garreau 1991). For instance MARTA's then board chairman, Bill Moseley stated, "People in the suburbs think MARTA is a Black, transit-dependent system" (Bullard et al 2007: 156). Moreover, it was argued that according to many White suburbanites, MARTA alternatively stood for "Moving Africans Rapidly through Atlanta" (Bullard et al 2000). Thus, Fulton and Dekalb have been the only two counties serviced by the transportation system.

Black suburban enclaves were also expanding rapidly in Atlanta, as in most metropolitan areas where middle class Blacks are concentrated (Bullard et al 2007; Lacy 2007). Within these all Black suburban communities, middle class Blacks isolate themselves from the Black poor, where they live in nice homes, in safe neighborhoods with access to better public schools and quality retail stores. Living in Black suburban enclaves also stems from some middle class Blacks' desire to reside in a community with people "who look like them" in order to protect themselves from racism that may occur from living in comparable White, middle class suburban communities (Lacy 2007; Cashin 2000; Dent 1992).

Behind the Washington, D.C. metropolitan area, Atlanta is the second largest market for Black suburbs (U.S. Census Bureau 2010). Cascade Heights, which seems disembodied from the city of Atlanta, is nestled in the southwest part of town and is home to many middle class Blacks. This neighborhood has been the home to people like former mayors Maynard Jackson, Andrew Young, and Shirley Franklin, the Rev. Joseph E. Lowery, notable civil rights activist, and baseball legend Hank Aaron (Thompson and Isbell 1994). Likewise, on the southeast end of the city, South Dekalb County is considered one of the most affluent African American communities in the U.S. (Bullard et al 2007; Lacy 2007; Cashin 2001). This area is the home to people like Greg and Juanita Baranco, co-founders and owners of Baranco Automotive Group – one of the first African American owned car dealerships in the metropolitan Atlanta area and Gwen Torrence, Olympic gold medalist (The History Makers 2014; New Georgia Encyclopedia 2013; Long 2012). However, these suburban enclaves, where middle class or affluent Blacks settle in an attempt to escape poor neighborhoods or to shield

themselves from racism in suburban White areas still present problems that negatively impact their lives that come as a result of racial segregation (Bullard et al 2007; Lacy 2007; Adelman 2004; Patillo-McCoy 2000). Herein, researchers contend that neither increasing economics, nor affluence, nor middle class status can fully protect Blacks from the level of segregation experienced (Adelman 2004; Massey and Denton 1993).

As discussed in the Theory Chapter (section on *Class and Race*), the Black middle class and White middle class are structured differently, in that Blacks do not have the same social, economic, educational, and political advantages as Whites do (Bowser 2007; Adelman 2004; Oliver and Shapiro 1995). Additionally, many Black middle class neighborhoods are located in close proximity to lower class or poor Black neighborhoods. Hence, segregation causes middle class Blacks living in all Black areas to incur problems associated with poverty, such as crime, violence, drugs, worse schools, higher home insurance premiums, lower property values, food deserts and less access to other services, compared to those living in White middle class areas (Bullard et al 2007; Adelman 2004; Cashin 2001; Patillo-McCoy 2000; Emling 1996). More importantly, residential racial segregation contributes to the structure of sexual networks (Adimora and Schoenbach 2005) (see Chapter Two – section on *Sexual Networks*) which may be especially critical to the networks of African American women living in the metropolitan Atlanta area as residential segregation shapes the context in which Black women potentially choose sexual partners as well as influence their behaviors and decision making within sexual relationships (Mays et al 2012; Adimora and Schoenbach 2005; Lane et al 2004). For instance, people tend to choose sexual partners from within their social and geographic networks (Zenilman et al 1999; Lane et al 2004).

Specifically, African American women are more likely to choose sexual partners, in which their sexual networks are more racially segregated (Adimora and Schoenbach 2005; Laumann and Youm 1999). Therefore, the degree of connectivity across sexual networks impacts the sexual behaviors (e.g. concurrent partnerships, multiple partners) that increase African American women's HIV risk.

The above information sets the stage for the presentation and analysis of results from this study, which uses data collected from middle class African American women living in metropolitan Atlanta, Georgia. Specifically, women who participated in this study resided in Clayton, Cobb, Dekalb, Fulton, and Gwinnett counties and the City of Atlanta.

CHAPTER FIVE:

METHODS AND DEMOGRAPHICS

This research explores HIV awareness, sexual behaviors, and HIV risk perceptions among middle class African American women living in metropolitan Atlanta, Georgia. Specifically, it examines issues of sexuality, decision-making, and the construction of risk perception in the context of upbringing, interpersonal relationships, social and cultural norms, and media influences in the African American community. Within the framework of a womanist perspective, various methods were employed to explore, describe, and analyze, middle class African American women's perceived risk for HIV. These methods included unstructured interviews, semi-structured in-depth interviews, self-administered sexual history timelines, and participant and non-obtrusive observation conducted in various settings throughout the metropolitan Atlanta area. Unlike many other studies that look at African American women's HIV risk as being directly influenced by biological, behavioral, social, or environmental factors (Sharpe et al 2012; Mays et al 2012; McCree and Rompalo 2007; Lane et al 2004; McNair and Prather 2004; Ickovics et al 2002), this research examines the association of sexual scripts (see Chapter Two - section on sexual scripts), interpersonal relationships, and sociocultural context with African American women's decision making and HIV risk perception (Bowleg et al 2004; Amaro et al 2001). This chapter provides a description of the research design, data collection methods, and analysis techniques, and concludes with a discussion of the study's ethical issues, challenges, and limitations.

RESEARCH DESIGN

This study utilized a qualitative, exploratory within-group design, in which college-educated, middle class, African American women were the population of interest. Rubin and Babbie (1993) contend that when researching an area that is not well understood, an exploratory approach is empirically appropriate. In light of the paucity of literature and of theoretical perspectives on middle class African American women and HIV risk, the use of an exploratory qualitative research design which places the participants' experiences at the center of knowledge development and validation, is most fitting for this study (Borum 2007; Marshall and Rossman 2006; Kershaw 1998). Likewise, the within-group design was chosen because of a desire to focus on the views and experiences that were culturally relevant to middle class African American women rather than to compare this group with women from other ethnic groups or socioeconomic backgrounds. The focus on middle class individuals is important given that the majority of studies examining HIV and AIDS among African American women have centered on samples of lower-socioeconomic status women belonging to "high risk" groups (e.g., sex workers, injection drug users), thus reinforcing racial and sexual stereotypes by characterizing Black women as sexually promiscuous and immoral (Few et al 2003; Murray 1995; Wyatt 1991, 1997). This study furthers the body of knowledge relating to African American women and HIV by providing an in-depth exploration of middle class African American women's understanding, knowledge, attitudes, behaviors, and perceptions relating to HIV risk.

Epistemological Approach

This study is mainly drawn from an interpretive or phenomenological paradigm which asserts that reality is socially constructed and defined by the individual or collective context (Firestone 1987). As described by LeCompte and Schensul (1999), the interpretive framework defines concepts of meaning that are located in or influenced by the contextual characteristics of those who espouse them. Hence, social, cultural, and economic factors along with gender and ethnicity all shape how individuals think, perceive and interpret their reality, and present themselves. Specifically, this research is informed by a womanist epistemology (see Chapter Three) which centers on Black women's everyday experiences as a context for investigating knowledge and truth construction. This approach aids in identifying the impact of power relations in shaping African American women's beliefs about HIV risk.

Collins (2000a) outlines three dimensions of womanist epistemology often used in research with Black women: (1) experience as a criterion of meaning, (2) use of dialogue in assessing knowledge claims, and (3) an ethic of personal responsibility. The first concept (experience as criteria of meaning) begins with validating the women's experience as an authoritative standpoint (hooks 1984). For example the research participants acknowledging their risky sexual behaviors, specifically naming or telling what those behaviors were, and then recognizing that the behaviors did occur, all relate to this dimension. The second dimension (dialogue) provides a means for participants to reflect upon their experiences and share information with the researcher. Dialogue helps build a connection between the researcher and the participants. The choice of words or phrases used in a dialogue provides a context for the researcher when

analyzing data. Additionally, this dimension generates viewpoints, images, stories, and other ideas that become a symbolic representation of the women's whole experience relating to HIV risk (Banks-Wallace 2000; Few et al 2003). The third dimension of the womanist epistemology assesses the participants' personal core beliefs about HIV risk and emphasizes empowerment within the women's lives. The ethic of personal responsibility also engages participants in contributing to the development and implementation of HIV prevention strategies. In the case of this study, participants were asked to provide their input on the design of HIV communication campaigns or interventions targeting college-educated middle class African American women.

Overall, womanism provides an interpretive framework for examining how race, gender, and class interact to influence thoughts, behaviors and beliefs pertaining to HIV risk among middle class African American women in this study (Mullings 2005). Moreover, focusing on the experiences of women holding intersecting disadvantaged statuses such as race and gender, while being considered members of a privileged group (e.g. middle class), helps provide new knowledge and a broader understanding of how college-educated middle class African American women in Atlanta, Georgia acknowledge, comprehend, and perceive the impact and risk of HIV among Black women (see Chapter Three for a full discussion of Intersectionality).

Methodological Approach

As a framework, womanist thought supports the use of qualitative methods of analysis. According to Patton (1990), qualitative research best addresses questions that focus on exploration, discovery, and inductive logic. Hence, interviews and the collection of narratives are most helpful in exploring cultural dynamics relating to

ethnicity, gender, class and sexuality in Black women's lives (Few et al 2003). This research study primarily uses an ethnographic approach, which allows me, as the researcher, to function as an agent who collects and disseminates knowledge that centers on African American women's intellectual tradition and articulates their unique social and cultural perspectives (Taylor 1998; Williams 1989; Houston and Davis 2002). Herein womanist methodology aids in guiding the African American female researcher to explore historical, social, and cultural contexts of African American women's lives apart from women's issues previously defined by white feminist researchers (Williams 1989).

This study also uses autoethnography as a secondary approach. Ellis and Bochner (2000) define autoethnography as "an autobiographical genre′ of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural" (739). In autoethnography, self is central to the research process and is also called self-ethnography, autobiography, and reflexive ethnography. Herein the researcher uses herself as a source for generating, collecting, and analyzing data for the exploration of sensitive social and cultural issues (Ellis and Bochner 2000; Taylor, Mackin, and Oldenburn 2008). With autoethnography, the researcher is a member of the social world or culture under study. Herein, the researcher represents what Robert Merton (1988) calls "the ultimate participant in a dual participant-observer role" (18; Anderson 2006). Autoethnogrpahy also allows the researcher to explore aspects of her life in a deeper and more sustained manner (Anderson 2006). For example, in this study, as the researcher, I draw on my own perceptions, beliefs, and personal experiences to inform my broader understanding of HIV risk and to enrich my self-

understanding (i.e., awareness of and ability to understand my own actions and reactions) of HIV. Limitations to using autoethnography include the following: 1) Given that the researcher is an essential part of the study process, it is important to make sure that she is not heavily drawn into participating in field activities at the expense of collecting data and writing field notes (Anderson 2006). Secondly, while, autoethnography gives the researcher an opportunity to give an insider perspective, it is also important to honor and value the beliefs of other members in the community being studied. Hence autoethnographers must ensure that they engage and include other insiders' attitudes, perceptions, and interpretations in their research in addition to their own (Anderson 2006).

Autoethnography is often used in anthropological, sociological, educational, and womanist research, where personal accounts are used to broaden the researcher's self-awareness and understanding of various social issues and challenges (Taylor et al 2008) such as racism, relationship dynamics, and decision making. Both ethnography and autoethnogrpahy were employed to examine racial and gender power imbalances, assess sociocultural assumptions about HIV, and uncover and explore information that may be hidden or unchallenged by Black women and in Black communities because of, fear, stigma, or other related factors (Jordan-Zachery 2009; Few et al 2003; Collins 2000a; Collins 1998; Hull, Bell-Scott, and Smith 1982).

A grounded theory approach (Glaser and Strauss 1967; Strauss and Corbin 1990; Bernard 2006) was used for analysis. Examining perceptions of HIV risk through the lens of middle class African American women allowed me, as a researcher, to see how the participants' behaviors and attitudes were influenced by their simultaneous

advantage of class and disadvantage of race and gender. Additionally the participants' opinions, beliefs, and ideas about HIV prevention strategies and campaigns, and their thoughts about music, books, and other forms of media were valuable examples of information that reflected the women's knowledge. To this end, womanism was used to inductively identify and organize themes that emerged from transcribed interviews and text of sexual history timelines. Particularly, interviews and sexual history timelines were used to provide information about the various dynamics that shape race, gender, and sexuality interactions.

DATA COLLECTION METHODS

Data collection was carried out in metropolitan Atlanta, Georgia from March 2013 to August 2013 through several methods. Semi-structured in-depth interviews were conducted with 30 women of three different groups: twenty-one HIV-negative middle class African American women, three HIV-positive middle class African American women, and six African American female HIV prevention/intervention service providers and community experts. Self-administered sexual history timelines (described below) were used to collect data to complement information gathered through in-depth interviews with HIV-negative women. Sexual history timelines were only used with HIV-negative participants because the purpose of the instrument was to explore the participants' sexual decision making processes, sexual behaviors, and to assess their potential risk for HIV. Because HIV-positive participants were already infected, the sexual history timeline was not used with their interview, instead questions were asked about their past HIV risk perceptions (prior to infection), and attitudes, behaviors, and

experiences that lead to their HIV infection. Additionally, unobtrusive and participant observations were conducted in various settings throughout the metropolitan Atlanta area, which included church sponsored events and worship services, social events and gatherings, health-related events, panel discussions, and other community functions.

Informal Conversation and Meetings with Key Informants

Informal conversations and meetings were held with two African American female informants: a middle class pastor who does HIV prevention work through her local congregation and in the community she serves, and a community expert in the area of HIV and AIDS prevention, training, and education. Both women were valuable resources and were instrumental in providing basic information about HIV-related activities in the Atlanta area, generally and about activities or events targeting the African American community, specifically. They shared their insights on specific issues relating to HIV and stigma in the Black church, provider communication and HIV testing, trends of testing in the metropolitan Atlanta area, social status and information dissemination, and ongoing problems with overall HIV prevention efforts in the African American community. Additionally, they provided resources such as articles, links to websites, books, and data sources, suggested additional contacts, and connected me with other people working in the field. The information obtained from these meetings and conversations was critical in formulating some of the questions for the semi-structured interview and also gave direction to the background research on HIV, sexuality, the Black church, and factors associated with HIV testing.

These two women were identified as key informants because of their professional background and expertise as well as their strong ties and active engagement in the

African American community. Additionally being college educated, middle class African American women, both informants personally identified with the research population of interest.

SEMI-STRUCTURED IN-DEPTH INTERVIEWS: HIV-NEGATIVE WOMEN, HIV-POSITIVE WOMEN, PROVIDERS AND COMMUNITY EXPERTS

A total of 30 semi-structured in-depth interviews were conducted with three distinct groups: HIV-negative middle class African American women (N=21), HIV-positive middle class African American women (N=3), and African American female HIV prevention/intervention providers and community experts (N=6). These interviews sought to gain detailed insight on personal knowledge, sexual behaviors, attitudes towards HIV, and perceptions of HIV risk from the perspective of middle class African American women. They also explored the significance of race, class, and gender interactions with HIV risk among African American women in Atlanta's context.

Interview Procedures

All interviews were conducted using open ended questions guided by research objectives, preliminary review of literature, past HIV research experience, and input from key informants. Questions were used to identify and explore the social, cultural, and political factors influencing middle class African American women's construction of HIV risk; to assess women's HIV knowledge and awareness of prevention strategies in relation to actual sexual risk behaviors; and to explore attitudes about HIV and perceptions of risk from the perspective of middle class African American women. Interview guides were developed and tailored for each of the three groups of respondents (*see Appendix A-C*).

Face-to-face interviews allowed for close interaction with the participants, which included observing their non-verbal communication and engaging in natural dialogue, an important element of womanist epistemological research. Hooks (1989) asserts that dialogue suggests conversation between two subjects as opposed to mere talk or a question and answer session between a subject and object of research. More specifically, dialogue aids in building connections and trust between the researcher and participants. This was accomplished through the selection of topics such as family, relationships, church, work, community, or organization affiliations that are appropriate for obtaining information (Goss and Goss 1995; Banks-Wallace 2000). Additionally the dialogue format allowed for a self-reflexive process in which the participants and I examine and interrogate the systems (e.g., church, family, friends, intimate relationships, society) that shape and perpetuate attitudes and perceptions about HIV (Few et al 2003; Cannon 1995). Moreover, the interviews allowed the women to freely discuss their beliefs and personal experiences relating to their relationships with men, their upbringing, alcohol or drug use, safer sex practices, as well as societal influences and how their thoughts about HIV and perceptions of risk were influenced by these different aspects of their lives.

Sampling, Participant Selection, and Recruitment

The goal of qualitative research is to collect rich data from a sample deemed most qualified to provide meaningful information for the topic of interest. Hence, individuals who have personal knowledge and everyday experiences relating to research topics are considered experts (Gall, Gall, and Borg 2007; Patton 2002). Participants for this study were identified using non-probability sampling techniques,

which included quota, purposive, and snowball sampling. Purposive and quota sampling were used to decide on specific populations or subpopulations of interest. Likewise, with quota sampling, a predetermined number of participants or proportions of the designated subpopulations were selected to make up the final sample. Bernard (2006) suggests that quota sampling is appropriate when studying cultural domains, a "set of items, behaviors, beliefs or events defined by a cultural group as belonging to the same category of things – a basic unit of meaning that shapes how people conceptually organize their worlds" (Schensul, Schensul, and LeCompte 1999:6).

The specific subpopulations included: middle class, college educated African American HIV-negative women (N=21), middle class college educated African American HIV-positive women (N=3), and African American women who are providers and/or community experts in the area of HIV (N=6). Quota sampling was initially used to delineate the number of participants for each subpopulation. However, the final sample encompassed data from respondents who were willing to participate in the study. Finding middle class African American HIV-positive women who were willing to participate in the study, proved to be a difficult task. HIV providers and other HIV-positive participants assisted with recruitment efforts. However, this population was hard to reach because many of the women do not readily disclose their status due to fear of status loss (e.g., position in society, job) or stigma. Therefore, fewer interviews with HIV-positive middle class African American women were completed than proposed. The difference was made up by obtaining additional interviews among HIV-negative middle class African American women and HIV prevention providers/community

experts. The actual study population compared to the proposed study population is detailed in Table 3.

Table 3 - Study Population (Proposed Sample vs. Actual Sample)

Proposed Study Population	Proposed Number	Actual Number
African American Middle Class HIV-negative Women	20	21
African American Middle Class HIV-positive Women	5	3
African American Female Providers and Community Experts	5	6
TOTAL	**30**	**30**

Snowball sampling, a network sampling method, was also used to recruit study participants. This method is appropriate when investigating what Bernard (2006) refers to as hard-to-find or hard-to-study populations. As a group, middle class African American women are understudied in HIV research and some members of this population do not think the issue of HIV risk applies to them and therefore do not feel the need to take part in such research. Additionally, as previously stated, middle class HIV-positive African American women are often hard to identify and are least likely to participate in such a study for fear of social stigma associated with HIV status disclosure.

Key informants and community connections in the metropolitan Atlanta area were used to locate potential study participants. Recruitment flyers and study information were disseminated to a wide audience through HIV and AIDS service providers and other community experts who distributed the materials to individuals they thought would

meet the study criteria. Individuals contacted me via email or phone if they were interested in the study. Recruitment flyers were also posted in venues, such as churches, hair salons, counseling agencies servicing women, sorority meetings, and other social organizations for African American women. HIV providers and community experts were referred by key informants or identified through my past experience of working in the area of HIV in Atlanta. Once identified, potential provider participants were contacted via email or phone, told about the study and its purpose, and asked if they would be willing to participate. Interested HIV-negative and HIV-positive women who called or emailed inquiring about the study were contacted and informed about the purpose of the project. These women were asked a series of questions from an eligibility checklist (*see Appendix D*) to determine their suitability for study inclusion. HIV status was determined by self-report of the potential participants at the time of screening. If eligible, the women were provided additional information regarding details of participation, asked if they were willing to meet for a face-to-face interview, and if in agreement, a time was scheduled to meet.

Meetings with participants were conducted at times and locations that were convenient for and agreed upon by both the participants and myself. This was either in the participants' home, their workplace, or some other common meeting place that provided a private area for talking, such as a university graduate office, conference room, or park. However, the majority of interviews took place in participants' homes. Conducting the interviews and allowing the respondents to share such personal information within a safe, participant-defined space was both empowering and beneficial for the women in processing their experiences and assessing their risk for HIV in a

systematic manner. Specifically, it afforded the women opportunities to revisit and discuss events at their own pace and in their own words (Few et al 2003).

During the scheduled meeting, Participants were again asked the questions from the eligibility checklist to confirm that they were suitable for inclusion in the study. This was done before beginning the actual interview and the signing of the participant consent. All interviews were audiotaped and extensive notes were taken as a backup. The length of the interviews ranged from 50 minutes to two hours.

Inclusion Criteria

Eligibility criteria for participation in the study included: a) being female; b) self-identifying as Black or African American; c) living in the metropolitan Atlanta area; d) having a least a bachelor's degree; e) being at least 30 years old; f) being able to speak and understand English fluently; g) having had a least one male sexual partner in the 12 months prior to the study; and h) being willing to self-report HIV status.

Eligibility criteria for HIV service providers and community experts included: a) being a key staff member, such as the CEO, Program Director or Outreach Coordinator; b) providing services in the metropolitan Atlanta area; c) having worked in the position a minimum of six months; and d) being preferably black or African American and female.

Exclusion Justification

In the state of Georgia, the highest number of newly diagnosed HIV/AIDS cases in women is among those 30 to 49 years of age (GPDH 2013a). Additionally, HIV is a growing problem among older adults in the United States, particularly African American

women over the age of 50 (Jacobs and Kane 2009). For this reason, the age criterion of 30 and above was selected for participation. Thus, women who were younger than 30 years of age were excluded from the study. The main purpose of the study was to explore the perceptions, behaviors, and attitudes of HIV risk among college educated middle class African American women, a population that is quite understudied. In this research project, core elements that construct the black middle class definition include education, income, and occupation, where income and occupation is most often contingent upon educational attainment (see Chapter One for definition of middle class and Chapter Three for definition of Black middle class). This study sought to recruit women with a least a bachelor's degree as many HIV studies focus on women of low education levels or those currently in college. Therefore women not meeting that criterion were excluded. Information about the participant's annual income, occupation, and social networks, which are also relative to the configuration of middle class status, were also obtained during the interview. Additionally those women who did not self-identify as Black or African American were not considered for study participation. The research was conducted in the metropolitan Atlanta area and women who lived outside of the defined geographic area were not eligible for participation. Because all materials were written in English, interviews were conducted in English, and the researcher was English speaking; non-English speaking individuals or those unable to read or understand English proficiently were not included. This study seeks to obtain insight about sexual behaviors, attitudes concerning HIV, and experiences pertaining to HIV risk. Hence, women who reported never having sex were deemed not at risk for HIV through heterosexual contact, the main mode of transmission for Black women (CDC

2013b) and were excluded from the study. Similarly, women who reported no sexual partners in the year prior to the study and who did not know their HIV status or was unwilling to disclose their status were excluded because of the researcher's inability to determine the group to which they belonged (i.e., positive or negative). Women who reported a negative HIV status and no sexual partners in the previous 12 months were considered less at risk for HIV through heterosexual contact than someone who was currently sexually active or sexually active in the past 12 months and thus, were also excluded from the study.

The research was conducted in the metropolitan Atlanta area. Therefore providers who did not offer services in the defined geographic area were not eligible for participation. The provider and community expert interviews focused on their professional perspective from working in the field. Staff members or providers should have knowledge of services and programs offered as well as familiarity with the dynamics and politics of the populations served; hence the reasoning for not including individuals who did have at least six months of experience in the field.

HIV Providers and Community Experts

Interviews were conducted with six HIV providers and community experts from HIV prevention and intervention programs and service agencies in the metropolitan Atlanta area. The interviews sought to gain information about middle class African American women and risk perceptions from the providers and community experts' perspective based on both their personal experiences as African American women and on their professional experiences of working in the HIV field and interacting with middle class African American women.

HIV-Positive Middle Class Women

Interviews with three HIV-positive middle class women were conducted in part to gain an understanding of their HIV risk perceptions in retrospect. Questions were structured to investigate the respondents' individual experiences, social and cultural meanings of HIV risk, structures that influenced their past risk perceptions, and potential behaviors that contributed to HIV infection. Additionally the interviews sought to gain information on how being infected changed the women's attitudes and views about HIV, particularly in relation to middle class African American women.

HIV-Negative Middle Class Women

Interviews were conducted with twenty-one HIV-negative middle class African American women who were interested in discussing their views and experiences relating to HIV risk in African American women. The interviews covered aspects of the participants' HIV awareness, sexual behaviors, and beliefs about sexuality and HIV risk. Questions were structured to examine the women's individual experiences, social and cultural meanings of HIV risk, and structures that influenced their risk perceptions.

Sexual History Timelines

Sexual history timelines were used to complement data collected through in-depth interviews with the HIV-negative middle class African American women. The sexual history timeline is a component of the revised sexual genogram by Belous and colleagues (2012). Hof and Berman (1986) first wrote about the sexual genogram, which is a comprehensive instrument that helps organize, display, and examine intergenerational data related to sexuality (Belous et al 2012; Hof and Berman 1986).

The original sexual genogram was used to explore sexual issues between couples related to experiences of sexuality, intimacy, and other behaviors in the family, both within and between generations (Belous et al 2012). Unlike the original sexual genogram, Belous and colleagues' revised sexual genogram's focus extends beyond its traditional use of just working with couples and their sexual issues to also include work with individuals. The revised tool also includes a sexual history timeline which consists of a variety of comprehensive assessment questions relating to contemporary sexual issues and behaviors, such as history of sexual assault and abuse, history of sexually transmitted infections, number of sexual partners, pregnancies, etc. (Belous et al 2012). The sexual history timeline questions were modified as appropriate for the purpose of this research study and used for participants to depict their life experiences related to sexual relationships over the time from first sexual encounter to the time of the interview. The instrument was self-administered and was completed at the end of the in-depth interview. Participants were provided detailed instructions about the information to include for each sexual relationship such as type of relationship, how they met their partners, relationship dynamics, any significant life events (e.g., pregnancy, abuse, or STI), and reason the relationship ended. A completed, hypothetical sample timeline was provided to the respondents as an example (*see Appendix E*).

The sexual history timeline offered information about the experiences of participants that might have been missed in the in-depth interview. After the timelines were completed and thoroughly assessed, follow-up questions were asked for the participants to reflect upon and discuss their sexual histories. Allowing the women to recount their sexual histories on the timeline enabled both them and me, the researcher,

to explore individual decision making processes and patterns of social interaction, and to assess sexual behaviors and potential HIV risk over time (Few et al 2003; Belous et al 2012). It also showed how participants' past experiences, behaviors, and feelings (e.g., self-esteem) were associated with positive or negative feelings towards their own sexuality and their perceptions and beliefs about HIV risk. This nontraditional source of data collection also aided in empowering women who may struggle finding their voice and telling their sexual story (Bell-Scott 1994; Bell-Scott and Johnson-Bailey 1998). All twenty-one HIV-negative middle class African American women completed the sexual history timeline.

Demographics of Participants

Demographic information including age, marital status, education, income, occupation, current work status, number of children, and information regarding social status was collected from the HIV-positive and HIV-negative participants. This information is covered in complete detail below. For the HIV providers and community experts, demographic information pertaining to age, marital status, education, occupation and current work status was collected.

HIV-Negative Women

Twenty-one women who self-identified as Black/African American and HIV-negative completed both interviews and sexual history timelines. Nine of the women were single, seven were married, three were divorced and two were widowed. The ages of the women ranged from 30 to 55 years, with a mean age of 38.5 years. The women came from diverse family backgrounds. Seven of the 21 respondents' parents were

working class. Three were lower middle class. Ten respondents grew up in middle class households and one respondent reported her family background as upper middle class. Of the 21 respondents, 14 reported having a least a Master's degree, with six of them having a doctorate or professional degree (i.e., JD or Specialist). When asked, nine respondents reported current annual household incomes ranging from $80,000 to above $110,000, and the average number of reported people in a household was roughly two. All women reported being either employed or self-employed. Occupations were diverse and included professions such as attorney, accountant, teacher, banker, professor, consultant, and health scientist to name a few. Additionally, most of the women were members of a sorority (N=16) held memberships in professional organizations (N= 11), and considered their current social status as middle class (N=18). Of the three remaining women, one described her social status as upper middle class. The other two women considered their social status to be lower middle class. A detailed explanation outlining the distinct status groups within the black middle class (i.e., lower middle class, middle class, and upper middle class) is provided in Chapter Three under the section - Conceiving Black Middle Class Identity. Table 4 (below) presents the complete demographics for the sample of HIV-negative women.

Table 4 – Demographics of HIV-Negative Middle Class African American Women

Demographic Variables	HIV-Negative Middle Class African American Women (N=21)	
Age at Interview	30-34	7 (33.3%)
	35-39	6 (28.6%)
	40-44	3 (14.3%)
	45-49	3 (14.3%)
	50-54	1 (4.8%)
	55-59	1 (4.8%)

Table 4 (continued)

Age	Mean Median Range	38.5 years 38 years 30-55 years
Marital Status	Single Married Widowed Divorced	9 (42.9%) 7 (33.3%) 2 (9.5%) 3 (14.3%)
Have Children	Yes No	8 (38.1%) 13 (61.9%)
Number of Children	Mean Median Range	.76 0 0-3
Number of people in household	Mean Median Range	2.29 2 1-6
Education Level	Bachelor's Master's Doctorate Professional (JD) Other professional degree	7 (33.3%) 8 (38.1%) 3 (14.3%) 2 (9.5%) 1 (4.8%)
Work status	Employed/Full-time Employed/Part-time Self-employed	19 (90.5%) 1 (4.8%) 1 (4.8%)
Member – Sorority	Yes No	16 (76.2%) 5 (23.8%)
Member - Professional Org	Yes No	11 (52.4%) 10 (47.6%)
Member - Other Civic/Community org	Yes No	6 (28.6%) 15 (71.4%)

Table 4 (continued)

Annual household income	<$35K	2 (9.5%)
	$35-49,999	3 (14.3%)
	$50-64,999	3 (14.3%)
	$65-79,999	4 (19.0%)
	$80-94,999	2 (9.5%)
	$95-109,999	2 (9.5%)
	$110K+	5 (23.8%)
Family background	Working class	7 (33.3%)
	Lower middle class	3 (14.3%)
	Middle class	10 (47.6%)
	Upper middle class	1 (4.8%)
Current social status as identified by participant	Lower middle class	2 (9.5%)
	Middle class	18 (85.7%)
	Upper middle class	1 (4.8%)
Occupations	Business/Financial Operations	6 (28.6%)
	Legal	3 (14.3%)
	Consulting	4 (19.0%)
	Education/Academia	4 (19.0%)
	Life, Physical & Social Science	2 (9.5%)
	Community/Social Services	1 (4.8%)
	Office/Administrative Support	1 (4.8%)

HIV-Positive Women

Three women who self-identified as HIV-positive Black/African American completed interviews and talked about their experiences of being HIV infected. One woman was single, one was married, and the other reported being legally separated for over 10 years. All the women were over the age of 50, with the mean age being 58 years. In terms of family background, two of the women reported growing up with middle class parents and the other participant reported growing up poor. Two of the women

had a bachelor's degree and one reported having a master's degree. One participant was retired, while the other two reported either full-time or part-time employment in community/social service related occupations. When asked, only one participant reported a current annual household income of $35K or above. The average reported number of people living in a household was approximately two. One participant reported being a member of a sorority and a professional organization and one reported active involvement in other civic, social and community organizations. In general, all of the women described their current social status as lower middle class. Participants were asked the length of time they have known of their positive status. One women reported being positive less than five years. The remaining two women reported being positive for more than 15 years. Table 5 presents the complete demographic data for the three HIV-positive women.

Table 5 – Demographics of HIV-Positive Middle Class African American Women

Demographic Variables	HIV-Positive Middle Class African American Women (N=3)	
Age at Interview	50-54	1 (33.3%)
	55-59	1 (33.3%)
	60+	1 (33.3%)
Age	Mean	58 years
	Median	57 years
	Range	52-65 years
Marital Status	Single	1 (33.3%)
	Married	1 (33.3%)
	Legally Separated	1 (33.3%)
Have Children	Yes	3 (100%)
Number of Children	Mean	2.67
	Median	3
	Range	1-4

Table 5 (continued)

Number of people in household	Mean Median Range	1.67 2 1-2
Education Level	Bachelor's Master's	2 (66.7%) 1 (33.3%)
Work status	Employed/Full-time Employed/Part-time Retired	1 (33.3%) 1 (33.3%) 1 (33.3%)
Member - Sorority	Yes No	1 (33.3%) 2 (66.7%)
Member - Professional Org	Yes No	1 (33.3%) 2 (66.7%)
Member - Other Civic/Community org	Yes No	1 (33.3%) 2 (66.7%)
Annual household income	<$35K $35-49,999	2 (66.7%) 1 (33.3%)
Family Background	Poor Middle class	1 (33.3%) 2 (66.7%)
Current social status as identified by participant	Lower middle class	3 (100%)
Occupations	Community/Social Services Life, Physical, Social Science	2 (66.7%) 1 (33.3%)
Years Known Infected	Less than 5 15 years or more	1 (33.3%) 2 (66.7%)

HIV Providers/Community Experts

The providers and community experts were comprised of six women who self-identified as Black/African American. The ages of the women ranged from 36 to 54 with a mean age of 45.8 years. All of the women worked in the area of HIV and AIDS serving in various capacities that included non-profit executives, public health

educators, and outreach coordinators. All of the women possessed a wealth of knowledge and experience in which the minimum length of time reported was six years in their current position. Four of the respondents reported 10 or more years of experience in their current position or working for their current organization. The same number of respondents (N=4) reported their highest level of educational attainment being a master's degree. See table 6 for complete details of demographic data for HIV Providers/Community Experts.

Table 6 – Demographics of HIV Providers/Community Experts

Demographic Variables	HIV Providers/Community Experts (N=6)	
Age at Interview	35-39	2 (33.3%)
	40-44	1 (16.7%)
	45-49	1 (16.7%)
	50-54	2 (33.3%)
Age	Mean	45.8 years
	Median	46 years
	Range	36-54 years
Marital Status	Single	3 (50.0%)
	Married	2 (33.3%)
	Divorced	1 (16.7%)
Have Children	Yes	3 (50.0%)
	No	3 (50.0%)
Number of Children	Mean	1.17
	Median	0.50
	Range	0-4
Number of people in household	Mean	2.5
	Median	2
	Range	2-4
Education Level	High School Graduate	1 (16.7%)
	Bachelor's	1 (16.7%)
	Master's	4 (66.7%)

Table 6 (continued)

Number years of experience	6 yrs. in current position	1 (16.7%)
	7 yrs. in current position	1 (16.7%)
	10 yrs. In current position	1 (16.7%)
	12 yrs.	1 (16.7%)
	Over 20 yrs.	2 (33,3%)

Participant Observation and Community Engagement

I was born and raised in Atlanta, and have lived there for most of my life. However the scope of my knowledge and exposure of many communities in the Atlanta area has been limited to my traveling to and from work, school, church, organizational meetings, or social events. Therefore, while conducting this research, I drove daily through new communities and surveyed what are specifically noted as Black middle class communities in the Atlanta area, such as South Fulton, Cascade Heights, Camp Creek, and parts of South Dekalb. In these areas, I observed some homes tucked away behind gated estates, where the starting prices are just under a million dollars. Other homes, although not in gated communities, still comprise several distinct neighborhoods. Some homes were located in newer developments, situated in close proximity of recently built shopping centers. Others were in older neighborhoods, surrounded by matured wooded areas. The homes in any of these neighborhoods observed generally had well-manicured lawns and were located near or accessible to parks and recreation centers. However in some areas, such as Southwest Atlanta and South Dekalb, the middle class or upscale communities are also in close proximity to lower class Black neighborhoods.

Most of the interviews were conducted in the participants' homes; therefore I was able to observe the women's homes and the communities and neighborhoods in which

they live. This interaction also provided insight as to why some of the women chose to live in the part of town that they do. As previously stated, because of residential racial segregation, some Black middle class neighborhoods do not readily reflect the status or the residents. For example, those living close to lower income Black communities often experience the problems of crime, drugs, less access to quality stores, and less quality of education in schools (Lacy 2007; Bullard et al 2007; Cashin 2001; Patillo-McCoy 2000). As a result, some middle class Blacks move to White middle class neighborhoods for access to better schools, better quality of stores and government services, and in some cases to get away from the Black poor.

In some cases, study participants lived in far out areas such as Duluth and Loganville. The homes were still within the defined metropolitan Atlanta boundaries, in which the participants lived in either racially mixed neighborhood's (e.g., white, Indian, Asian) where there were very few Blacks or they lived in predominately White middle class communities. This information was obtained through conversation with participants and observations of residents in their yards and other people moving throughout the subdivisions (e.g., children playing or neighbors coming and going). The conversation allowed me to ask the participants why they chose to live in these areas. While this dialogue was not directly related to HIV risk perceptions, it was a way to build a rapport with the participants and allow the women to share experiential knowledge relating to their residential location. The most common response for living in those areas was because of better school systems. Additionally, the researcher-participant exchange regarding this topic was important for contextualizing the research and my gaining insider status. For example, I was self-reflexive as a middle class African

American female researcher living in a Black middle class community of South Dekalb compared to participants residing in White middle class suburbs of Gwinnett or Black middle class neighborhoods of South Fulton and Cascade Heights.

I actively participated in an HIV testing fair held in downtown Atlanta on National HIV testing day. Here I went through the process of being tested for HIV and observed how individuals were treated during the intake process, the questions asked, and some of the assumptions made about individuals being tested. In addition, I noted what took place while individuals waited for their results and went through the counseling process when receiving my test results. I attended a Sunday women's day service promoting community involvement and empowerment, and an HIV education and testing event held at a local church. Additionally, observation and participation entailed my attending social events where college educated middle class African American men and women were the predominant population. This included my going to alumni chapter Black Greek sorority and fraternity functions such as cookouts and step shows, which are artistic and musical entertainment that includes creative and unique forms of step and dance expression as a means to promote and enhance the image of the respective fraternal organizations and to showcase the talent of their membership (Delta Sigma Theta Sorority, Inc. Step Show Participant Guidelines 2012).

One of the cookouts I attended was hosted by one of the local Black fraternity alumni chapters. The event was held at a park in Cascade Heights, one of the affluent Black middle class neighborhoods in Atlanta. This was evident by the subdivisions I passed with homes starting at $400,000 located in close proximity of the park. As I drove around the park looking for a parking space, I observed that most of the cars in

the parking lot were luxury vehicles (e.g. BMW, Lexus, Mercedes, and Cadillac SUVs to name a few). This speaks to Patillo-McCoy's (1999) assertion that African Americans sometimes use material goods such as prestigious or expensive cars as symbolic expressions of status (Lacy 2007) to give others (i.e., Black and Whites) the impression they can afford such things. While at the cookout, I took notice of those in attendance and who they were with, such as groups of women, one or two men, couples, or families with children. Likewise, I observed some of the interactions between the men and women. For example, I watched as one or two couples (male-female) sat off to themselves talking as if they were trying to get to know one another. I say this because the atmosphere at the cookout was one that if these individuals were already a couple (i.e., dating or married), they would have probably been more engaged with other people in attendance at the cookout (e.g., sitting under the pavilion, in lawn chairs, talking to other people, playing games) as opposed to being off in a corner per se having private or (intimate) conversations.

While at a step show sponsored annually by one of the local Black sorority alumnae chapters, where I went with friends as a night of fun, I could not help but notice an African American woman's shirt about HIV testing. She was a few rows in front of me, standing up in the middle of the crowd. Hence I could only see the back of her shirt, which said, "Get tested, know your status." I was never able to see what was written on the front of her shirt. Yet, the reason I found this observation so interesting is because when most people go to step shows, they wear Greek paraphernalia or dress up. But, this woman chose to wear a shirt advertising the importance of getting tested and knowing your HIV status.

I attended events called *Conversations and Cocktails*, which are networking and social events for professional men and women that incorporate thought provoking conversation focusing on topics such as dating and relationships in the Black community and career and life challenges as a Black female. I mainly went to observe and hear what others had to say about relationships and Black women particularly when talking about education, standards, and choosing a mate, Black men on the down low in Atlanta, and the stresses of being a Black female. Yet, there were times when the conversation became really intense and I did engage by asking questions and providing comments. Although HIV as a primary subject was not discussed at any of the forums I attended, a common theme among the forums was how many African Americans in Atlanta live their lives hiding behind their "stuff" (e.g., education, jobs, organization affiliation, cars, etc.). Thus, when meeting someone and in dating, it is hard to know if one is dealing with the real person or their "representative" (i.e. the one he or she wants people to believe they are). This indirectly becomes very important in term of sexual relationships and HIV risk as well as class representation.

Additionally, I often went to church and noted language used by clergy in sermons or bible study lessons, relating to sexuality, stigma, STIs or HIV. For example, one Sunday while attending a Black Baptist church with a middle class congregation, the pastor preacher a sermon entitled "Will the Real Jesus Please Stand". In his message, the pastor talked about how Christians should be accepting of people infected with HIV. Another time while attending bible study at the same church, one of the associate ministers was teaching on the subject of "The Sin of the Saints". During his lesson, the minister talked about the mercies of God and made reference to HIV/AIDS,

saying “some of us lay down with people who we did not know their last name; but when we went to get tested the results still came back negative and that was the mercy of God.” Hence these examples illustrate how clergy communicate messages about HIV and AIDS and the potential impact it has on the perceptions and attitudes of the church congregation. Notes from these worship experiences were recorded in my field notes. Likewise, I attended and obtained information from various church and community activities focusing on HIV awareness and education.

Autoethnographic Field Texts

While doing this research, autoethnographic field texts were composed, which are notes, records, and stories of some aspect of my daily experiences in the research field or other life experiences. Autoethnographic field texts are usually written in first person and are equivalent to empirical qualitative data (see full definition of autoethnography above in section on Methodological Approach) (Connelly, Clandinin, and He 1997; Ellis and Bochner 2000). For this study, the field texts used included conversation, family stories, journal entries, and personal correspondence.

- *Conversations:* Dialogue and ongoing discussion with friends, colleagues, or other individuals on topics of interest. This also included interviews that spilled over into conversations once the formal meeting was complete.

- *Family stories:* These were stories about family members, interaction with family members, and family events. The narratives helped in understanding how one creates a personal identity. Likewise they served as observations and commentaries on the social and cultural development of one’s sexuality, beliefs, and perceptions of HIV and risk.

- *Journal entries:* These are records of self-observation and reflection, where I observed my own behaviors and documented my thoughts about various experiences related to dating and relationships, and religion/spirituality. This method was used as a form of self-introspection for me to reflect upon and evaluate my actions, thoughts, and behaviors as a middle class African American woman living in Atlanta.

- *Personal correspondence:* Emails and text messages written between individuals, other than research participants, and myself, which give account of my interpersonal relationships relating to dating as a middle class African American woman in Atlanta.

DATA ANALYSIS

Interviews were transcribed verbatim. Field notes and autoethnographic field texts were typed after each event or interaction to have the most accurate portrayal of the experience. Interview transcripts and notes were entered into Atlas.ti, a qualitative analysis software program. This software was used to facilitate data management, coding, and overall analysis. A preliminary codebook was created based on knowledge of research literature that contained a list of codes pertaining to HIV knowledge, attitudes, risk perceptions, and influences. It also included accompanying code definitions and explanations of the codes used. Using grounded theory (Glaser and Strauss 1967; Strauss and Corbin 1990; Bernard 2006), additional codes were generated inductively by thoroughly reading interview transcripts and examining sexual history timelines. These codes were added to the previously developed codebook. The constant comparative method was used to code and analyze interview transcripts, field texts, notes, and timeline data. Through

this process general themes were identified and compared across all data. Particular emphasis was placed on identifying relationships between different themes and linking that information to the use of appropriate theoretical frameworks. All data were analyzed using the same codebook.

Demographic data was entered into Excel for data management and converted to an SPSS file and analyzed using the statistical software package *SPSS Statistics 21*. Descriptive statistics were used to summarize and report findings of interview data. Data reported include age, education level, occupation, marital status, community or civic involvement, church involvement, income, social status, family social status, number of lifetime sex partners, history of sexually transmitted infection, and history of HIV test.

Provided in the results section are quotes from participants to support conclusions drawn. All quotations provided are verbatim. However, some minor edits were made to improve clarity. Pseudonyms were used to protect the confidentiality of the research participants.

Data Validity and Reliability

Triangulation

Validity and reliability in qualitative research refer to whether or not the findings of a study accurately reflect the circumstances described and whether evidence exists to support the findings (Guion, Diehl, and McDonald 2011). Using multiple data sources to confirm or corroborate each other, using different methods to establish and check data validity, or examining questions from different perspectives are several ways to increase

the reliability and validity of a research study (LeCompte and Schensul 1999). This process is called triangulation.

Multiple data collection strategies were used in this research to increase the study's reliability and also to aid participants in revealing information about intimate details relating to their sexual behaviors, risk perceptions, and HIV knowledge. Specifically, two techniques were used to increase data reliability: 1) asking the same question in multiple ways and 2) using non-traditional data sources. Approaching questions in multiple ways allowed participants to think about their experiences in different manners and reflect upon different events throughout the course of the interview. This does not mean that I asked the same question three times verbatim per se. Instead, I asked questions that were similar in nature and about the same topic or rephrased questions in a way that enabled me to tap into sensitive topics without leading the participants. This process allowed participants to systematically consider experiences and issues pertaining to sexuality and HIV from multiple angles. For example when asked, some participants readily said they did not perceive themselves at risk for HIV. However those same women could provide different responses about their potential HIV risk and go into great detail about their actual sexual behaviors, when probes were used or questions were rephrased asking about HIV risk (e.g., Do you use condoms? How often do you use them? Do you have multiple sexual partners?) When doing interviews, the participant was considered the gatekeeper of her story. She controlled access to the most sensitive and personal areas of her life. Thus, using a non-traditional source like the sexual history timeline proved beneficial and meaningful in collecting data. Allowing participants to recount their sexual histories helped indicate

how they understood self, their relationships to others, and their decision making process at certain times in their life. Additionally, it aided in examining how social and cultural meanings of HIV have influenced the participants' actual sexual behaviors. This method as well as asking questions in multiple ways was quite useful for triangulating data and increasing data reliability and validity.

ETHICAL ISSUES

An application for this research study was submitted to the University of South Florida Institutional Review Board and was approved on March 8, 2013. A Continuing Review was submitted and approved for completing the writing of the dissertation. Standard procedures were followed to obtain informed consent from participants prior to beginning data collection.

Research focusing on sensitive or stigmatizing topics such as HIV and AIDS warrants special precautions. All information collected throughout the course of the study was kept strictly confidential. Data collected was stored on a password protected computer. Signed consent forms and audio files were kept in a locked file cabinet, to which only I, the PI, had access. Completed study data was coded so that it was not linked to anyone's name. Moreover, no names or other identifying information was used in the analysis or write up. All eligible participants were asked to provide an alias for the interview and only those pseudonyms were recorded. Anonymity was ensured throughout the course of the study.

The interviews with the participants were a one-time occurrence. Once the participants completed the interview and sexual history timeline (if applicable), there

were no other requirements or scheduled meetings. All participants (HIV-negative, HIV-positive, and providers) received a $25 gift card as a token of appreciation for their time and participation.

Psychological Risks Related to Sensitive Questions

Recounting a personal history of HIV or answering questions about sexual history and past relationships can be an emotional experience or make some participants uncomfortable. While this did not occur in the field, it was still necessary to have a plan in place to mitigate such potential risk. Interviewer sensitivity to distress is essential and includes paying attention to both non-verbal and verbal cues. This comes from experience in interviewing and familiarity with the research topic (Corbin and Morse 2003; Kavanaugh and Ayers 1998). If a participant had experienced distress during an interview, there would have been a small break and consent to continue would have been affirmed if possible; however the interview would have stopped if necessary. Mental health resources and other hotline information would have been provided so as not to leave the participant in a state of distress. Additionally, follow up would have occurred to ensure that the participant was feeling better.

Positionality as a Researcher

Identity as a Middle Class African American Female/Inside Researcher

My identity and experiences as a middle class African American female, who has lived in metropolitan Atlanta for the majority of my life, are an important place of departure for my theorization and a critical point of entry for my research. Incorporating

words and voices of middle class African American women in this research began with a process of what Jackson (2009) calls deep structure sensitivity. This means having an intimate knowledge of the participants' social and cultural context relating to their behaviors, experiences, attitudes, and perceptions as impacted by the combined effects of race, gender, and class as African American women. My understanding of how the women navigate situations or make sense of different aspects of their lives, their relationships with men, their views on sexuality, their decision making processes, their attitudes towards HIV, and their perceptions about risk are established through intimate knowledge of the culture and "inner workings" of middle class African American communities, particularly in Atlanta. This was especially important when defining the interactive boundaries between the participant and myself. As participants often viewed the interview as "girl talk" and felt comfortable making comments like, "Girl, you from Atlanta so you know how it is" or "I'm just going to be straight with you because I feel I can talk to you". Hence, the deep structure sensitivity also aided in establishing my identity and credibility as a researcher in the community.

It is often assumed the more a researcher has in common with the participants, such as gender, culture, race, or class; the more access will be granted, information will be shared, and validity of data assured. However, I did not assume unproblematic commonality on the basis of my shared identity with the participants; nor did I expect to be granted pure insider status based on the fact that I was a middle class African American woman from Atlanta studying other middle class African American women living in that city (Merriam et al 2001; Henry 2001; Few et al 2003). Nonetheless, I was

fortunate that my connection to the metropolitan Atlanta community helped facilitate my entry into the lives of the participants.

Because of the sensitive nature of the research topic, I understood that despite my shared identity as a middle class African American woman, as a researcher I was a differently positioned subject with a biography of different lived experiences than some of the participants. Although, the sensitive nature of the research inherently made the research relationship hierarchical (England 1994), participants found ease in having discussions on topics such as HIV, sex, and alcohol and drug use. Hence, the shared identity required me to be reflexive when in the field and analyzing data. This meant me taking note of my thoughts, behaviors, and experiences that arose while in the field, as a result of self-critical introspective and self-conscious scrutiny of me, as a researcher and a middle class African American woman and critically thinking about how such information is used to extend my self-awareness and understanding of HIV risk among middle class African American women.

RESEARCH LIMITATIONS

The main limitation of the study was the challenge of recruiting middle class African American HIV-positive women. This was evident from the difference in the number of proposed interviews for this group compared to the number of interviews actually attained. Middle class African American HIV-positive women were very difficult to recruit, not because they did not exist in the metropolitan Atlanta area, but because many of the women were not willing to come forward or participate in the study. Several recruitment strategies were implemented to enlist participants in this population, but the

efforts were to no avail. This resistance appears to reflect what Sobo (1993) describes as a strategy of self-protection on the part of HIV-positive women, by which they limit to whom they disclose their HIV status in an effort to preserve their social status. Likewise, Quimby (1992) explains that the risk of embarrassment, fear of cultural disenfranchisement among other Blacks, and being vulnerable to social marginality are also major deterrents to middle class African American women "owning" HIV and AIDS (179; Sobo 1993) and consequently participating in this study.

The above limitation reflects a challenge researchers often face when studying stigmatized conditions. While it is unfortunate I was not able to recruit more HIV-positive middle class African American women, the data obtained from the three positive participants provides important findings about HIV and risk among middle class African American women. It helped in dispelling myths about HIV, one being that risk only dwells among poor and uneducated African American women. Moreover, the findings point to areas for future research.

CONCLUSION

Using a variety of ethnographic methods, this exploratory research generated formative data that richly describes attitudes, behaviors, and other factors that influence attitudes about HIV, sexuality, and perceptions of HIV risk among middle class African American women living in Atlanta, Georgia. As viewed through a womanist lens, the focus on middle class African American women provides understanding of the significance of social class on HIV risk among African American women, when intersected with race and gender. Employing a within group research design, this study

challenges the image of Black womanhood, politically and economically by exploring the ideas and thoughts specific to middle class African American women rather than comparing them to women of other ethnic or socioeconomic backgrounds. Moreover, the use of non-traditional data collection methods such as the sexual history timeline helped uncover how middle class African American women understand and make sense of their decisions about sex, perceive their risk for HIV in relation to their actual self-reported sexual behaviors, and assess how ideas of risk and sexuality are shaped by the women's social and cultural context, upbringing, and relationship to others.

CHAPTER SIX:

KNOWLEDGE, BELIEFS, AND PERCEPTIONS OF HIV AND RISK: INTERVIEW RESULTS

This chapter presents themes that emerged from data related to perceptions of HIV risk among middle class African American women. It first provides a broad overview of the HIV-negative and HIV-positive participants' knowledge and beliefs on HIV and AIDS, particularly in the African American community. It then gives the providers and community experts' perspective on HIV education and awareness among African Americans and African American women. Next, the chapter discusses the socio-cultural context of risk construction and all participants' responses about images associated with HIV that have been used and promoted in the African American community. This section looks at factors such as media, religion, sexual networks, and social status that may impact African Americans' view of HIV risk. Further, the chapter reports HIV-negative and HIV-positive participants' personal and cultural attitudes about HIV risk. The main question in this section is how middle class African American women construct and interpret their personal risk for HIV.

KNOWLEDGE AND BELIEFS ABOUT HIV/AIDS

Middle Class Women's HIV Knowledge

A total of 21 middle class African American HIV-negative and three middle class African American HIV-positive women answered questions about their personal knowledge relating to HIV. As expected, most of the women (23 of the 24) possessed a

general knowledge of HIV. Some were more knowledgeable than others because of classes taken in college, their occupation (e.g., public health or health care professions), or personal experiences (e.g., HIV-infected, knows someone who is infected, HIV volunteer work). Monifa, a 30-year old college administrator, April, a 38-year old consultant, and Barbara, a 49- year old marketing professional, all HIV-negative, were quite well-versed in HIV information and statistics. They each spoke in depth about HIV's impact among African Americans and African American women in the United States. Likewise they showed their knowledge by providing answers about the global impact HIV has on Blacks in African countries. On the other hand, Celeste, a 40-year old school teacher, admitted to not knowing a lot about the HIV epidemic. Moreover, she expressed how gaining knowledge about the epidemic has not particularly been at the top of her priority list. She states:

> "Having known several people who have passed from AIDS, I'm a little disappointed in myself for not being more abreast of current statistics. But I think when life happens and things begin to occur in your life you tend to focus on things that are relevant to you at the time and I just didn't have a reason to, I don't want to say care, you know because I do care what happens to my community. But it just hasn't been a priority for me to do my research on HIV, which is one of the reasons why I was interested in doing the study because I was like, ooh I might learn something".

Similarly, Lana, a 65-year old HIV-positive evangelist, stated that until three years ago, she knew nothing about HIV. She one day randomly decided to get tested. Upon receiving her results, she found out she had the virus and that is how she obtained information about HIV and AIDS. Here she states:

> "I didn't even know I had it. It was a complete shock to me. I thought I would just come home and die. That's how I felt at the time because I

> knew nothing about it. I knew it existed. I knew it was out there, but I didn't know the ramifications of having it and how it affected people. Nor did I know any explanations or how it was passed on. I was green."

Most of the women were aware of HIV's disproportionate effects among African Americans. Specifically, 13 of the 24 women talked about the impact of HIV in Black/African American women. For example, Phyliis, a 42-year old consultant stated that "infections are more dominant among African American women". Colleen, a 47 year-old school teacher said, "African American women are affected in large numbers". Additionally, Celeste, a school teacher, said that she believed African Americans, in general, contract the virus more than any other ethnic group. A few of the women even provided statistics on HIV in African American women to support their claims. Other subpopulations of risk in the African American community mentioned were the elderly or seniors and youth, which included young gay Black males. Herein Barbara, a 49 year-old marketing professional said that HIV was most prevalent in African American women ages 25 to 44. Also Erica, a 30 year-old counselor stated:

> "In general I know that young Black men are at high risk. When I say young Black men, I mean African American gay men under the age of 25. Then you have young Black women, so it's kind of a no slowing down to the new infections. ."

Fourteen women indicated what some would consider as obvious factors of risk contributing to the spread of HIV among African American women. They included drug use and risky sexual behaviors, such as the lack of condom use, having multiple sexual partners, and the willingness to man-share. As defined in Chapter Two, man-sharing is when a woman knowingly engages in a sexual relationship with a man who is having a

sexual relationship with one or more other women at the same time. This topic and multiple sexual partners will be discussed in more detail below, in the section on relationship dynamics and perceptions of HIV risk.

Twenty women believed factors such as the lack of open communication about HIV in general and also between sexual partners, ignorance or the lack of knowledge about HIV, not knowing one's HIV status, attitudes of invincibility or risk denial (e.g., it could never happen to me), all have an impact on the rise of HIV in the African American community. For example, Melanie, a 30 year old financial service officer stated,

> "A lot of Black people don't go to doctor, so half the time we don't know what we have. Then on the other hand, we think we're invincible".

Likewise, Jackie, a 57-year old HIV-positive minister and HIV advocate said:

> "I think because we have not been open enough in our conversations about it [HIV], at lot of things are happening in relationships that should not be."

When further questioned, she stated, "some women are so desperate, they are not willing to ask about a person's status or ask them to use condoms. Not knowing is causing more devastation than it should". All these factors will be discussed in more detail in sections relating to risk perceptions and interpretations and risk construction.

Ten women also reported beliefs about HIV-related stigma, relationship dynamics, and sexual networks specifically in Atlanta (e.g., MSMW – men who have sex with men and women and the lack of disclosure about sexual practices) influencing HIV transmission risk. Herein Demetra, a 50-year old college professor stated:

> "I think just being in Atlanta, honestly, there are a lot of men, Black men, who have sex with men. And I think often times African American

> women want to believe their male partners are being monogamous and that they are telling the truth, but often that is not the case. I have been in environments where I have seen people's husbands with other people other than their spouse, so I know they are not being honest with their partners."

In regards to stigma, two women both in their 30s talked about sex as a taboo subject among some African Americans. For example, Kimberly, a 30 year-old corporate event planner said, "Sex was absolutely taboo growing up. Conversations about sex with my mom were basically non-existent". Similarly, Erica, 30 years old stated:

> "There is stigma about sex in general, in some cases a lack of information about HIV, and then discomfort in talking about these taboo subjects. And I think this is because there are not a lot of safe spaces to talk about them or to get information. Therefore we have the blind leading the blind and people are becoming infected because of the lack of knowledge and access to things that can protect us, such as information, condoms, and testing."

Hence as stated above, many do not talk about sex or HIV due to stigma or the lack of safe spaces to have open and honest discussions or to obtain information on related topics (e.g.., HIV testing , STIs, and condom use) (See more about stigma below under HIV risk perceptions and interpretations).

HIV Providers/Community Experts' Perspective on African Americans and Women's HIV Knowledge

Six HIV providers and community experts (all African American women) answered questions about HIV knowledge and attitudes among African American women, based on their professional and community experiences. Collectively, the providers and community experts have over 30 years of experience in HIV prevention research, programming, training, community outreach and mobilization, and counseling;

particularly among African Americans. Four of the six providers/community experts thought some or most African Americans have some level of knowledge about HIV and AIDS. The other two providers/community experts believed that one's level of HIV knowledge was based on age. Here one of the community experts, Anita, a 36-year old HIV non-profit organization manager stated:

> "I would say it depends on the age. It depends on age because young people I think know way more than adults do and have more accurate information".

Another provider, Denise, a 54-year old HIV nurse, said the following after talking about an encounter at a conference in Atlanta with a middle-aged African American professional woman:

> "So I am kind of stunned that people still don't understand that African Americans are at such great risk for HIV; that we still have to talk about basic transmission of risk. But if you talk to kids that are in high school, somebody's doing a really good job because they have all the answers and they know more about HIV than the parents".

All providers and community experts expressed that regardless of age, income, or level of education, there is a large disconnect between individuals' awareness and the application of prevention practices among African Americans. Anita, an HIV non-profit manager added that even with the level of knowledge among young people, "The issue of knowing about HIV is always in the application of that knowledge and also the issue of feeling invincible to what can happen".

When the providers/community experts were asked their thoughts about factors contributing to the spread of HIV among African American women, an array of responses were provided. Among those given included: African American women

putting others including men before themselves; African American women engaging in concurrent relationships; man-sharing; risk-denial; lack of HIV knowledge, which includes not knowing where to get tested; having unprotected sex; lack of communication between sexual partners about HIV status and sexual history; dishonesty in heterosexual relationships; and the sexual behaviors of Black women's sexual partners (e.g., multiple sexual partners, lack of condom use). Sharon, a 48-year old HIV non-profit executive asserts:

> "So there are behaviors at an individual level that we know drive the epidemic, and that is we have a large number of concurrent relationships. We are less likely as a population and race of women in the United States to be in marriages or lifelong monogamous commitments or we might be committed but our heterosexual partners are not committed to us. Thus we have a whole host of risk factors that have nothing to do with our own behaviors, but are directly connected to the risk behaviors of our partners."

In talking about HIV knowledge, relationship dynamics, and sexual behaviors of Black women's sexual partners, Renee, a 39-year old public health educator stated:

> "As Black women we got the education, we got the knowledge, but we are going back to partners who are convincing us that we should trust them or convincing us that everything is ok and then we are coming up with STD's. So we know that they [the men] have been with somebody else. So if we are partnering with men who are not in monogamous relationships, then that's how we are getting infected."

Janice, a 44-year old HIV Outreach Program Coordinator contends that women are sometimes too trusting in relationships. Here she argued:

> "When a man tells us something, we tend to believe it because all we want to know is that he loves me or that he wants to be with me. We do not ask questions regardless of how many red flags we see or despite the writing on the wall. Not thinking that he may not be telling us the truth or

> that we are putting ourselves at risk by not asking questions or just taking him at his word."

Sharon, the non-profit executive further highlighted the issue of lack of healthy attitudes towards sex among African American women. She stated:

> "As African Americans, in general we do not embrace a healthy attitude or sense of respect and sense of engagement in sex and sexuality, sexual communication, and sexual health practices. Because of this, we [African American women] are not able to talk about sex or have the power to address our own sexual safety in a lot of these situations, nor can we even address our partner's risk.

HIV RISK PERCEPTIONS AND INTERPRETATION

Attitudes and Perceived Risk of HIV Infection: *HIV-Negative Women's Perspective*

When talking to the HIV-negative women about how they perceive their overall risk for HIV, the responses ranged from no risk at all to high risk. Ten of the women interviewed, perceived their risk for HIV as minimal or low. Four women believed they had no risk for HIV transmission. Most of the latter women's reasoning was based on them being in committed and monogamous relationships, in which three of the four women were married. The one woman who was not married, nor currently in a serious relationship contended that she was not at risk for HIV because she never had unprotected sex and was "just way too cautious about everything". Three women believed they had a medium risk for HIV transmission. Additionally, four women perceived their risk for HIV transmission as high. All of the women's reasons for their perception of being at high risk for transmission centered on them being single, not in a monogamous relationship, or currently dating. Nechelle, a 42-year old planning analyst, stated:

> "I would consider myself in a high risk category being that I'm single and I'm actively dating. I don't believe my chances have decreased. There is the risk of exposure every time I introduce myself or meet someone with the fact that it may go down the path of being a more intimate relationship."

Melanie, 30-years and single, stated:

> "I think [my risk] is high because I know I've done some risky behaviors in the past. I've dated some men that I just shouldn't have gone near. So I think it's high. Plus I mean you never know what you're getting half the time. You know everything that glitters isn't gold. He could be perfect on the outside and have all kinds of stuff floating through those veins. I think it's the fact that I just don't know that makes the risk higher.

In talking to HIV-negative women about perceptions and attitudes towards HIV, their responses centered on topics of fear or concern of HIV risk, stigma surrounding sexuality, stereotypes, and risk denial. Three women expressed sentiments associated with the fear or concern of possibly contracting HIV. Colleen, a 47-year old school teacher, talked about how nervous she is about HIV and that she needs to learn more about the disease to calm her fears. Demetra, an HIV-negative single woman, also communicated her concern about contracting HIV. She stated:

> "I'm concerned about it. That's one of the things that actually prevent me from enjoying sex as often as I would as a single woman. There are times when you meet somebody and you're like, oh my God, all I need is just an experience. I just need a hook up, but I don't do it anymore because I don't even trust always the fact that a condom is going to protect me. So it's caused me to be very apprehensive in my sexual relationships. It can also cause me to be very apprehensive in actually developing a relationship. It makes me ask off the top, do you have sex with men. And it's frustrating because it makes you feel a little bit trapped."

Likewise, Sonya, a 37-year old victim's advocate executive, viewed HIV as a death sentence, adding that she is grateful to be married and "would not want to be in the single realm now".

HIV/AIDS is possibly one of the most stigmatizing diseases in U.S. history. Thus how individuals perceive their risk for infection is often the result of stereotypes created based on income, social status, and sexuality. Two women indicated that HIV was thought of as a homosexual or Black, gay male disease. Another woman referred to HIV as the "scarlet letter type disease". Phyllis, a 42-year old consultant said, "HIV is still a taboo. It's a hush hush subject, something that is looked down upon, shameful, embarrassing". Similarly, Lisa, a 31-year old accountant said:

> "In the African American community there is a taboo around being homosexual and a man. Many gay black men feel as though they have to keep it a secret and live a lifestyle that they are expected to live, like trying to maintain the appearances of dating women or being married to a woman."

Three women expressed dissociation from HIV or not knowing anyone with the virus. For example, Monique, a 35-year old health scientist stated:

> "To be honest I don't think about HIV/AIDS a lot. Personally, I've never had any close friends or family members impacted by the disease, so it doesn't necessarily ring home as some sort of disease that gets talked about in my circle of family and friends".

Similarly Sonya, a 37 year-old victim's advocate executive explained:

> "If I don't see anyone who looks like me or who has my story that's been affected then it [HIV] can't touch me. It makes sense that the crack heads get HIV or that the prostitutes get HIV, but I don't see anyone like me, [middle class and college educated] with HIV, so it won't touch me. It's just not real right now."

Additionally, Jessica, a 32-year old banker believed HIV to be a disease of poverty or status. She states:

> "I don't know anybody in my age or in my social circle who has been affected by it or any one that they know. So I guess I perceive it to be more of a lower income disease. It makes me think it's not a disease that people I know are really affected by. It's kind of someone else's problem."

Likewise, Toni, a 38-year old paralegal said, she is selective about the company she keeps and does not run in circles where HIV runs rampant. Here she stated:

> "I separate myself from certain types of people to keep from becoming a victim of HIV and if people that I associate with are infected or at high risk of being infected, I don't know anything about it because it's not spoken of."

Conspiracy theories also contributed to the formation of perceptions and attitudes about HIV and potential risk among some study participants. When talking to the HIV-negative women about HIV risk perceptions, one participant emphatically stated, "It's just like another conspiracy". Another woman, a 30 year-old corporate event planner, said she feels like HIV was created to "control different races, similar to birth control and population control". Similarly, three other women questioned the accuracy of HIV and AIDS statistics. They asked can they really trust everything they read or hear about the virus or is some of the information being disseminated "just a bunch of hype". Specifically, a 47 year-old school teacher said,

> "I don't know if I can believe everything I hear or read. I feel like it seems African Americans are the only ones that have HIV. I mean I don't know people's statuses, but I have never run into anyone that says they have HIV".

Perceived Risk of HIV-Infection: *HIV-Positive Women's Reflection*

The three HIV-positive women were asked questions about how they perceived their risk for HIV prior to being infected and their attitudes about HIV since being infected. None of the women thought they were ever at risk for infection. Jackie, a 57-year old minister and HIV advocate, has been living with the virus for over 20 years. In her mind, "HIV was a disease associated with gays or drug users". Hence, "it had nothing to do with her". In speaking about her risk, she states that she was engaged to be married and therefore did not think there was a need to use "protection" with her partner, who ultimately infected her. Jackie learned of her status after giving blood at the Red Cross. Speaking about her experience she states:

> "I received a letter from the Red Cross saying that they needed to communicate with me, so I set up an appointment to find out what they wanted to talk with me about. I didn't think it would be anything more than my anemia because that had been a factor a couple of times when I had previously given blood. I didn't think it was anything more than that."

After finding out it was more than just anemia that the Red Cross wanted to talk about, Jackie informed her fiancé of the news and stated:

> "He said he did not know he was infected and I believed him. He said he was going to get tested. I didn't go with him, but he came back and told me that he was also infected. But like I said, I wasn't with him to know without a shadow of a doubt if he really went to get tested or just said he went. Because I trusted his love, I trusted him and I accepted his every word."

Jackie and her fiancé still married after learning of their diagnoses; however they kept their status a secret for several years. Jackie's husband later died from AIDS and she has since remarried.

Ronnie, a 52-year old medical case manager, had a CD4 count of 131 when she was diagnosed with AIDS in 1998. In speaking with her, she stated that she honestly did not think about HIV and as with most African American women did not think it would happen to her. She went on to explain:

> "I never dreamed my situation would have been what it was because I [was] working; taking care of my daughter and thought I had it going on. I wasn't really sexually involved with a lot of guys and just didn't think it would happen to me. You know I heard about it [HIV] back then in the 90's but never thought I would be one of them that would have to walk that walk. Nor did I think I would get it the way that I did. I was raped. So those two things you know; it's just something I never even took the time to think about, even though people were dying left and right. You know if it don't relate to you, you don't talk about it."

Of all the HIV-positive participants, Ronnie was the only one to report experiences of sexual assault or victimization. In telling about her experience, she described how she was attacked and raped at knifepoint one night while on her way home from work. This occurred in 1996 and the participant was living up north at the time. Ronnie was very open about her experience and the effects of the attack. She said:

> "I had a lot of anger issues. I was angry at the person who raped me and I was mad at men in general. After that I thought they were all the same. Mentally and physically, I didn't want any man after that. I was mentally and emotionally messed up."

Ronnie moved to Atlanta to start a new life. In 1998, during a doctor's visit she learned that she had AIDS. Herein she explained that she had not been in relationship with anyone since before being raped and definitely not sexually active. Therefore, she knew her infection was a result of her attack. After being diagnosed, Ronnie began counseling (e.g., rape, mental health, AIDS). Now she counsels and helps others who are living with HIV and AIDS.

Lana learned of her HIV status at the age of 62. She is now 65. In terms of her risk, she stated that she was not having sex with a lot of people and at the time of her diagnosis was in a monogamous relationship; however she was not using condoms. Lana's thoughts resonated some of the HIV-negative participants' comments about HIV being a disease of poverty. Because of her middle class status, Lana stated:

> "I was in a higher bracket and ran in a better crowd; therefore I had the notion that HIV couldn't happen to me. Likewise, I thought you know I was going out with a good class of men. At least I thought they were a better class, an educated class of people. I wasn't running around with riff raff. They were all working and you know I didn't have anybody that didn't work."

Since becoming infected she believes that "anybody can get HIV". Here she states:

> "The President can get it if he's out there and messing around. The Kennedy's, I'm pretty sure it's one in their family too. It's getting to the point where there's one in every family, you just may not know about it. That's how prevalent it has become. HIV has no color, no race, no religion, nor class. It can affect anyone and being ignorant only makes the disease spread faster."

In talking about ignorance surrounding HIV, Ronnie, the medical case manager, argues that African Americans do not readily to talk about issues of HIV. As a result she states that "there is lot of ignorance as well as a lack of education about HIV among African Americans and throughout the Black community."

Provider and Community Experts' Perspectives on African American Women's Perceptions of HIV Risk

From the providers and community experts' perspectives, African American women generally think they have a minimal or low risk for HIV infection. Specifically, they all agree that middle class African American women's risk perception for HIV is

often diminished due to notions surrounding educational attainment, income, social status and overall risk denial, as one participant stated, “Some women believe they are protected and shielded from HIV”. Some of the attitudes encountered by providers/community experts over the years, from middle class, college educated African American women regarding HIV risk, can be exemplified by the comments they claim their clients have made, including:

> “I don’t hang out with those types of people or in that part of town”.
>
> “That don’t apply to me because I’m not a gay White man and I don’t use drugs”.
>
> “It’s not considered being promiscuous as long as I’m not sleeping with more than one person at the same time.”

The last comment speaks to the idea of women engaging in serial monogamous relationships compared to concurrent sexual partnerships. Here Denise, an HIV nurse explains how some women believe that serial monogamy (having one sexual partner at a time, where the relationship may or may not be serious or committed) is not considered promiscuous behavior. However, serial monogamists often have multiple sexual partners that are separated by gaps in time. This behavior differs from concurrent sexual partnerships because there is no reported overlap in sexual partners. Likewise, Anita, an HIV agency manager stated, “I’ve been doing this [HIV prevention and intervention] for years and a lot of my friends say that they wouldn’t even think about HIV, had it not been for knowing me”

In response to some of the above beliefs, Janice, a HIV Outreach Program Coordinator asserts:

> "Many middle class African American women are married and think it can't happen to me. I'm a professional. I'm in a committed relationship. You know thinking that it can't happen to me. But there are those in the middle class being infected just like those of the lower class. You have some lower class women that are in committed relationships. You have some lower class women that are married; so middle class African American women are no different from lower class African American women. We all put ourselves at risk when we don't ask those questions, when we don't use protection. What middle class African American women are not realizing is that a bachelor's or master's degree does not prevent you from getting HIV. A ring on your finger does not prevent HIV. Sororities do not prevent you from getting HIV. Once you get in that bed and have unprotected sex, you put yourself at risk."

Janice is HIV-positive and was infected by her partner with whom she was in a monogamous committed relationship. She also gave other examples of African American women who were infected by their spouses and emphasized the fact that heterosexual contact is the primary mode of transmission for African American women, "even if the partner is their husband or committed boyfriend".

HIV RISK CONSTRUCTION

Questions were asked about HIV risk perceptions relating to social and cultural norms in the African American community. Through the responses from HIV-negative and HIV-positive women and HIV providers and community experts, it is possible to gain a better understanding of how some middle class African American women form ideas about HIV risk and assess factors that influence their beliefs about HIV and risk.

Education, Income, and Perceptions of HIV Risk

All HIV-negative and HIV-positive women (N=24) were asked how education and income have shaped their perceptions of being at risk for HIV. HIV providers and

community experts were asked their perspectives about middle class African American women's perceptions of the same topics based on their professional and community experiences.

HIV-Negative Women

Twenty-one HIV-negative women responded, with 12 women stating that being college-educated influenced their HIV risk perceptions. Ten of the 12 women, who indicated education shaped their HIV risk perceptions, explained how their educational attainment provided access to resources and organizations whose focus was HIV prevention. For example, Monifa, who is 30 years old and single, told how her undergraduate institution provided many opportunities to learn about HIV, which included free HIV testing on campus and workshops on HIV and STI prevention. Likewise, Alexis, a 32-year old grants compliance officer, talked about her exposure to different programs about HIV while in college, which encompassed testimonials from people living with HIV. Education also allowed some of the women to become more knowledgeable about the risk and impact of HIV through their coursework, degree programs, and special research projects. Here Demetra, a professor in public health stated:

> "The only reason I know so much about HIV is because of being in public health, seeing it, and hearing things about HIV in the community. If I didn't have a public health degree, I don't know that I would have the same perception."

The remaining two of the twelve women believed having a college education, sets one apart from people who are likely to be at risk for HIV. Hence, being college educated

"means having a particular lifestyle, where the risk for HIV is lower", as stated by Erica, a 30-year old social service counselor.

Nine women indicated that education had no impact on their attitude towards HIV, how they approach HIV prevention, or perceive their risk for HIV. Lisa, an accountant said:

> "I don't think education has shaped my perception. I think being college-educated and having access to education pertaining to HIV has given me more information about the disease and about how prevalent it is. But I don't think it has decreased my risk."

Similarly, April added:

> "I don't really think education has shaped my perceptions of risk because it really has nothing to do with HIV when it comes to who you want to be with. I was aware of the literature and statistics, even in school I was a part of a trained peer group that talked about HIV, STDs and condom use and that made me more aware of the reality. But I would throw all of that away when I was with someone that I cared about or I thought I cared about. Yes, the education gives you the knowledge, but we are now talking about emotions, which is much stronger."

Moreover, Colleen explained how two teachers who worked in the same school as her were infected with AIDS and both were college educated. Therefore, she did not believe education had anything to do with HIV risk. Most (N=13) of the women expressed that income did not play a role in shaping their perceptions about HIV and risk. Those women who indicated (N=8) income as being influential to their attitudes about HIV and risk, primarily believed that individuals with higher incomes had better options or could "afford" to make better choices relating to one's risk for HIV. Herein five of the women explained how their income enables them to protect themselves by getting tested and also choosing better sexual partners (e.g., men who are educated,

employed, and have high values). For example Alexis, a grants compliance officer stated, “With my income, I can afford to protect myself [from HIV]”. Kimberly, a corporate event planner said:

> “I think my income reduces my risk because I am very blessed and fortunate to be in a position to get tested every three to four months and not just get swabbed, but have a full-blown blood test, although I know the swabs work just fine. However, I don’t think that level of testing is accessible to women with less income because they would not be able to afford it.”

Moreover, Toni, a paralegal asserts:

> “I think my income and lifestyle makes my standards a bit higher when choosing sexual partners. I don’t feel desperate because I think my income gives me better choices in finding someone who is compatible in terms of education and disease risk”.

HIV-Positive Women

When asked about the influence of education and income on HIV risk perceptions among the HIV-positive women (N=3) before becoming infected; two of the women (Ronnie and Jackie) indicated that they did not have a college degree at the time they were infected. The other woman (Lana), who had a bachelor’s degree at the time she was diagnosed with HIV, stated that she “felt her education and income protected her from HIV.” She went on to say, “But obviously it didn’t”. Ronnie and Jackie affirmed that prior to infection; income was not a factor in shaping their perceptions of HIV risk. Jackie further noted that the person who infected her had money, was well educated, and was from the upper middle class.

HIV Providers/Community Experts

In speaking with the HIV providers and community experts about the thoughts of education, income, and middle class African American women's construction of HIV risk; most of them (N=5) told how among middle class African American women, education and income is often perceived as a "shield of protection from getting HIV". Likewise it was re-emphasized that educational attainment, careers, and in some cases higher incomes causes some middle class African American women to think that it cannot happen to them. Here Renee, a public health educator explains:

> "I think it comes back to the notion of the 'other'. That's it's them, not me. That it can't happen to me. I'm safe because I'm educated, I have insurance and can afford certain things, but not realizing that you're doing the same behaviors as any other woman and that it's not about a, 'them',' they', 'us', or 'we' nor is it about your education or income."

Family, Social Networks and Perceptions of HIV Risk

One's upbringing, family connectedness, peer groups, and social networks are often critical in influencing the development of attitudes about HIV and perceptions of risk (Jarama et al 2007; Stephens and Phillips 2005; Whitaker et al 1999; Miller et al 1998a, 1998b). HIV-negative and HIV-positive participants were asked questions about family and social influences associated with attitudes about HIV and notions of personal HIV risk. This discussion centered on the women's upbringing, including family values, beliefs, thoughts, and parental messages about sexuality and HIV. Likewise it focused on the women's friendships and other social networks, in which they actively participate and their influence in the way the women think about HIV and risk.

In discussing family upbringing, nine women expressed how they "lived sheltered lives" in which their parents kept a close watch on them. As a result, some of the women did not date, have boyfriends, engage in sexual activity (before going to college), nor did conversations about sex, sexually transmitted diseases, or HIV occur in their households. For example, Demetra, 50 years old said:

> We didn't talk about sex much in my family. My father and I didn't talk about it at all and my mother and I really didn't talk about it. We talked about biology, but not sex. My mother didn't talk to me about sex until I was going off to college".

Similarly, Ronnie, 52 years old said:

> "In my family we didn't talk about sex. You know, with my mom, we barely talked about when you got your period. So it was having no little boyfriends or stuff like that. I wasn't involved in that."

Additionally, Barbara, 49, years old, stated,

> "Growing up my parents kept a close eye on me, what I did, where I went, who I was with. I was probably one of the few people who graduated from high school as a virgin."

Five women told how they were raised on teachings of abstinence, no sex before marriage. Here Alexis, 32 years old stated, "Being a PK (preacher's kid), I grew up in the church, so you know I was definitely taught it's no sex before marriage, abstinence" Another five women explained how as part of their upbringing, the overall message received from their parents was "sex is bad and if you are having sex then you can expect bad consequences", which included HIV infection. Colleen, 47-years old told how she was scared to have sex because of her mom always stressing the negative consequences. The remaining five women discussed how they were raised to be

responsible (e.g., to ask questions and to protect themselves) and to value themselves and their bodies as it relates to their sexuality and HIV. For example, Kimberly, 30-years vividly asserts:

> "I was taught to have a lot of respect for myself and always taught to ask a lot of questions. That came from growing up with a mom that just didn't want me to be a 'hoe' [whore]. You weren't allowed to be a 'hoe' [whore] because 'hoes' [whores] had diseases, babies and other problems that good girls did not have. My grandmother always took it from a spiritual aspect, don't let anybody disrespect you."

Half (N=12) of the women told how friends, peer groups, and other social networks, including co-workers, sorority sisters, and non-profit volunteer contacts influenced their thoughts about HIV. Specifically, two HIV-negative women talked about knowing people, both family members of friends, who were infected with HIV. They told how these personal experiences aided in making HIV real for them. Likewise, it helped shape their ideas about HIV in terms of who is at risk and understanding that HIV does not have a certain look (e.g., gender, age, class, and ethnicity). The remaining 12 women indicated that HIV was typically not a topic of discussion in their social circles.

Relationships Dynamics and Perceptions of HIV Risk

All participants (HIV-positive participants, HIV-negative participants, and providers/community experts) were asked questions about relationship dynamics and HIV risk, which focused on social and cultural norms related to the broader context of African American women's lives. Here, participants discussed how gender imbalance and sexual networks shape their perceptions and beliefs about HIV risk. Salient themes that emerged from these conversations were multiple sexual partnerships which

included men who have sex with men and women and the lack of disclosure about the men's sexuality, geographic location, and trust in relationships.

Gender Imbalance

When talking about gender imbalance, where there are more African American women than available African American men, three topics emerged in the conversations as most often mentioned by participants. One topic addressed was women being willing to share men or as one woman said, "use the same partner". Participants reported gender imbalance as being both a "major issue" and a "reality" of living in Atlanta. As a result, respondents contended that women will share or be with someone even if it's part-time, just to have a man. Here Carol, an HIV prevention provider, said "some women are so willing to share a man that they will know a man has another woman, see him with the person, and still sleep with him". Likewise, it was stated that middle class African American single women who in the past would not "touch" married men are now dating them, having sex with them, and getting pregnant by them because of the gender imbalance. For example, 50 year old Demetra stated,

> "I have a few friends who say that they will date a married man. Some want to have babies, so they are having sex with these men and getting pregnant, which means they are not using condoms. I think the women have dropped their standards so to speak. This behavior also allows the men to do what they want and not be held accountable".

This leads to the next matter addressed, which is women making compromises, settling, or lowering their standards to be with a man. This was described by statements like, "Some women feel there is a time issue or a status issue and therefore have to take what they can get". In other words, some women may feel that time is running out for

them to have children or to get married; therefore they will lower their standards or make concessions for the sake of having a man. Anita, one of the provider/community experts stated, “Some women will make concessions or look the other way, whether it is being with a man with multiple women, a man using drugs, one who has a criminal history, or whatever else, all because of gender imbalance”. “At the same time, Monique, a 35-year old health scientist stated:

> “This gender imbalance for many women allows us to put up with more than we should or less than what we deserve. And so you know gender imbalance, I guess translates to a larger conversation about risk because some women I think are willing to be with men who have multiple partners, so that definitely puts them more at risk.”

Compromising or settling was the most common theme in the discussion on gender imbalance, followed by man-sharing, which Alexis, 32-years old and single, describes as

> “It may be one guy, but he may have four females, one in Decatur, one in Alpharetta, one in Douglasville, and one over here in Atlanta depending on what side of town he wants to be on for the week. And that’s not just a perception because I’ve had friends who’ve kind of experienced the man-sharing. Like they were the one in Marietta and while he is off somewhere else they were just waiting on their turn (she laughs). I’m just being honest, waiting on their turn for him to come back around to be with them.”

Women’s desperation for a man was another topic in the gender imbalance conversation. Here participants expressed their thoughts about desperate women and what some individuals will do when they believe there is a shortage of men. Responses included: “It causes some women to jump at the first man that comes along.”, “Women feel pressed to please any man that crosses their path.”, “We will take chances and play

Russian roulette with our lives", "Some women will throw the cookies out there without saran wrap." The last statement refers to women having unprotected sex regardless of the consequences. Overall study participants expressed that women will go to great lengths out of desperation for a man or because they believe there is a lack of available men.

Other issues that came up in the discussion on gender imbalance, but were not mentioned as frequently as some of the other topics were African American men having lower education and lower socioeconomic statuses than middle class African American women and high incarceration rates of African American men. For example, 37-year old Sonya said,

> When you look at the amount of college educated women and you weigh that against the amount of men who are 1) already married; 2) perhaps homosexual and 3) are locked up, then women don't have a whole lot of choices when it comes to dating in the African American community.

As a part of these conversations and a response to all aforementioned issues, two participants suggested that African American women open their minds and not only look to dating African American men. This thinking counters the views about dating and marriage among many African American women. For, as previously stated in Chapter Two, African American women are least likely to date or marry outside of their race, in comparison to women of other ethnic groups (Mays et al 2012; Adimora et al 2004; Cornwell and Cunningham 2006).

Sexual Networks

When talking about sexual networks, the providers and community experts explained how sexual partnerships and relationship interactions impact middle class African American women's HIV risk. One community expert stated earlier when talking about HIV knowledge, that African American women's HIV risk is often linked to the behaviors and sexual practices of their partners. Thus, here the importance of talking about sexual networks and their relationship to HIV transmission was emphasized, as another provider stated, "We may partner with someone who may also be partnering with other people, but do we really find out who that person is? Do we know their HIV status? Do we know their risk behaviors? If we sleep with one person in a high risk network then our chances of being at risk for HIV goes up".

Trust in relationships and notions about multiple sexual partnerships influenced many of the participants' thoughts about HIV risk. Hence, one provider/community expert believed that being in heterosexual relationships with partners who are not honest increases one's HIV risk. Here, she described how women often attend workshops, obtain HIV prevention education and information, then they go back to a partner who convinces the woman to trust them and not use condoms and in return she acquires an STI, in some cases. Thus, it was stated by one HIV-negative participant that decreasing her risk relied heavily on protecting herself (e.g., using condoms) and having open and honest communication with her partner. Eight HIV-negative participants, all in monogamous relationships, expressed trust in their partners, with the expectations that their partners are being faithful. However, three of the women said, if their partners were "to step outside the marriage" or "engage in unprotected sex with

another partner", then they would be at risk for HIV. At the same time, some of the women (in all participant groups) contended that it is not always easy to trust men. One HIV-negative participant told about her experience of infidelity with a man with whom she was in a monogamous relationship, but who, obviously was not in a monogamous relationship with her. She explained how they had been together for six years and had a child together. He was her only sexual partner and she was under the impression that she was his only sexual partner, until she contracted a sexually transmitted infection, as she states:

> "He was the only sexual partner that I had, so it never caused me to ask any questions. And then when I became pregnant with my oldest daughter, going to routine doctor visits, that's when I discovered I had contracted an STD. So it was a no-brainer who I needed to ask and I was thoroughly shocked. I actually had no idea he was seeing someone else. I was floored".

Likewise Jessica, 32 year-old banker stated:

> "It really is scary because you can trust someone but you don't know what exactly they're doing when you are not around. I think even myself in previous relationships; I have been with a person and slept with other people during the relationship. So even my partner didn't know what I might have been doing during those times. They didn't even know I stepped out. So when I think about that and also some of my guy friends who occasionally will sleep with an extra chick on the side and they may or may not use condoms, my paranoia about HIV increases."

Thus, as Jessica's comment suggests, when in a relationship, trust goes both ways. Engaging in multiple or concurrent sexual partnerships by either party creates HIV risk in the relationship.

The topic of multiple and concurrent sexual partnerships was also important in the study participants' discussion of HIV risk perceptions. Several participants believed

not knowing the totality of their partners' sexual behaviors would be causes for their increased HIV risk. For example, Melanie, who is 30 years old and single stated, "Men are usually dating more than one woman and half the time the woman does not know." Another woman stated, "For the ones that's having unprotected sex with other people and not informing their partners, the multiple partners and sexual behavior of unprotected sex with these multiple partners impacts everybody involved." Further another participant also talked about men and women in the African American community not settling down and therefore "engaging in one sex act after another, having numerous sexual partners" without knowing the full extent of their sexual behaviors or histories.

While discussing multiple and concurrent sexual partnerships, study participants also described their thoughts and perceptions about "down low" behavior, that is men who self-identify as heterosexual but have sex with both men and women and how it pertains to HIV risk. It was evident that living in Atlanta played a major role in shaping participants' beliefs, attitudes, and opinions about this subject. In this, one community expert held that perceptions about "down low" behavior were based upon geographic location. Hence she contended, "To be clear, it's location that makes the difference when we talk about the so called down low. Somebody in Utah is going to have a very different community and relationship than someone in Atlanta. Therefore the perception of the subject for someone in Atlanta I think is different based on your knowledge and your experience."

There were varying views and opinions between many of the HIV-negative and HIV-positive women and the providers/community experts, when talking about the issue

of men on “the down low”. As previously stated, most HIV-negative and HIV-positive women believed “down low” behavior to be a major issue among African American men in Atlanta. Likewise many of the HIV-negative and HIV-positive participants argued that such behavior substantially increases African American women’s risk for HIV. For example, one participant said, “I think that’s one big reason why there are a lot of women that are coming up positive because they have a down low boyfriend or husband that’s sneaking out there dealing with guys that are engaging in risky behavior.” Another woman said, “I think in affects the transmission of HIV higher than normal in the Black community.” Hence, a major concern expressed in many of the participants’ conversations was African American men’s non-disclosure of their homosexual or bisexual behavior. For example, Ronnie, who is 52 years old and HIV-positive stated:

> “If you’re going to involve yourself with a woman, you should be up front and come out and say what you’re doing. You never know the woman might still want you. But at least she should have the option to say that or not. That also gives the woman the option to decide if she wants to have intercourse with the person or not; knowing that they deal with men who are having sex with other men gives them the option to ask questions about risky behaviors.”

To that end, Leslie, who is 39, married and HIV-negative asserts,

> “As women, our risk for HIV is certainly increased by our partners if they are doing whatever they are doing because it’s something that we cannot control. But I think it still comes down to safe sex and even more it comes down to being in honest relationships; whether you are with someone who is heterosexual or homosexual.”

When talking to providers and community experts, it was evident that many did not subscribe to the down low terminology when talking about men who have sex with

men and women, yet do not identify as gay, homosexual, or bisexual. Most of them believe the term is used as means to vilify gay Black men. Likewise it is thought to create barriers and resistance for heterosexual Black men to get tested in fear of being labeled "down low". One provider/community expert explained how she believes some men are bisexual or homosexual with a heterosexual cover and living in silence and secret. As she stated,

> "I believe that there are a lot of situations where women actually do know somewhere in their heads, somewhere in their own sensitivity they know about their man's sexual activities, but they don't acknowledge them and that's different from somebody keeping the life totally secret."

Similarly, another community expert said, "Women know what their partners are doing, but sometimes they act like they don't want to know or they know and have rationalized it to be something different. So at that point, it's not about down low behavior." Moreover, the providers and community experts affirmed that there is no data to support "down low" behavior among African American men contributing to the incidence of HIV in African American women.

Other Cultural and Social Factors

Other social and cultural factors assessed in relation to participants' perceptions of HIV risk included church and religious experiences and media influences.

The Church, Religion/Spirituality, and HIV

While some participants said religion did not impact their thoughts about HIV; for others, religious beliefs and church involvement not only influenced their perceptions about HIV but also their views on sexuality. In some discussions, participants talked

about some churches associating HIV with what one participant called the “the sin of homosexuality”; therefore both the practice of same sex relationships and the virus are frowned upon. In response, one community expert contends that some African American churches and religious organizations are preaching and teaching misinformation about HIV and AIDS, where they only want to associate the disease with gay, bisexual, and homosexual lifestyles and are not talking about heterosexual transmission. Likewise, it was expressed that the judgment of people with HIV often takes place in faith communities without religious leaders acknowledging the need to show compassion and address the overall needs of people because some churches do not want to deal with individuals who are same gender loving or gay. For example one participant said, “Some Black churches come with the same old attitude, HIV or AIDS is a nasty thing and we don’t want it up here in the church.” Thus, the providers and community experts argue that these attitudes and ways of thinking, in some churches, create major challenges and barriers to providing education and information needed for HIV prevention in African American communities.

In contrast, Anita, one of the provider/community experts stated, “I have seen the power of what someone can do from the pulpit to encourage testing, to influence people to know their status, as well as being empathetic, sympathetic, and compassionate”. Specifically she talked about a senior pastor of a prominent Black Baptist Church in Atlanta, GA. who has played a major role in trying to get bills passed and policies changed, surrounding HIV issues. She also spoke about the pastor engaging other clergy and him trying to get other clergy involved in HIV efforts.

Along those same lines, some participants viewed the church as a needed institution, having an active involvement in HIV prevention efforts in the African American community. Monifa, an HIV-negative, 30 year old, college administrator said, "The church really has not made a stand on HIV/AIDS, leaders don't want to talk about it, even when they have the platform to do so." A community expert stated, "Pastors need to get educated about HIV, so they can properly educate their congregations." Moreover, Jackie, who is HIV-positive and a minister explained:

> "AIDS ministries are coming forth in churches, but it's not enough. It should be across the board and it isn't. The south is more affected by HIV and AIDS than the north and it's keeping us from helping people to live longer, better, or having healthier lives. It would help if our churches would collectively work together to bring about awareness and education instead of staying hush mouthed. We need to be a community that speaks truth to life."

A number of providers and community experts believed that some African American women perceived church and religion as a means of protection from HIV infection. For example, one provider said, "Some Christian women think if I meet him in the church then he's safe. He can't be HIV-positive". Another provider/community expert explained how because of the church mainly focusing on certain groups being at risk for HIV (e.g., homosexuals or drug users), then some middle class African American women think they are "covered or protected" because they are not "one of those people". Likewise, another provider told about some of her clients who thought if they went to church every Sunday, only had one sexual partner, and lived right, then they would be okay. She talked about two African American women specifically, who were very involved in their church, were in monogamous relationships, and were yet

infected with HIV by their husband and long-term boyfriend respectively. She says her message to these women who are now infected and other women before they become infected, “If you are having unprotected sex, then church does not save you (prevent you) from getting HIV.”

While religion/spirituality may be viewed by some as a “shield of protection” from HIV infection, it was also identified by others as a relevant source of comfort, consolation, hope, and support. For example Ronnie, one of the HIV-positive participants explained how she came from a spiritual family and background and always went to church. Thus before she was infected with AIDS, she said she thought God was on her side. She thought because she was a spiritual person, God would not allow anything like being raped or infected with AIDS to happen to her. That is what she thought back then. However since being infected, she says she understands that things happen for a reason. She discussed how learning to live with AIDS has been a process and over the years she has learned how not to consider herself a victim. She has become more educated about HIV, rape, and mental health. Additionally, she told how she now knows that she had to go through her ordeal in order to empower others and advocate for others going through the same thing and “to help them walk that path”. Jackie, another HIV-positive participant stated, “Religion and spirituality had everything to do with my thinking about HIV and living with HIV. It was the Lord that ministered to me in my time of need and if it had not been for the Lord on my side, I know I would have been dead and gone.”

Media and HIV Perceptions

All study participants were asked about the influence of media (e.g. television, movies, music, and books) on perceptions of HIV and risk in their personal lives and the African American community. As a result, nineteen participants (2-HIV-positive, 12-HIV-negative, and 5-community experts/providers) believed media shaped both negative and positive views of HIV and risk in their personal lives and society. Among the different types of media, television, movies, and books were forums most mentioned by participants as influential sources. In the discussions about media influences, several participants talked about the Tyler Perry movies, *For Colored Girls* and *Temptation*, and their focus on middle class African American women and HIV transmission. One participant told how she was impressed with Perry for "using characters that were in corporate America instead of those who were poor, to depict how the virus was transmitted". Another woman said the movie *Temptation* served as an eye opener to let her know that anyone can get HIV. In talking about the movie, she asked if I had seen the movie and I told her no. She adamantly responded by telling me that it was a movie that I definitely needed to see, especially since I was doing this research on middle class African American women and HIV.

Whereas Tyler Perry seems to influence views about HIV and risk among African American women in his movies, not all participants were in favor of his portrayals of HIV or African American women. One community expert asserted:

> " I think it's very important how people perceive things whether it's in a male-female perception of what HIV looks like and a Tyler Perry inclusion may not be the best representation of what HIV looks like or how it happen because it's not always depicted positively."

Another community expert expressed how it would have been a perfect opportunity to open up a “real conversation” about HIV among African American women and in the Black community following Perry’s movie, *Temptation*. Instead, she stated, “the movie just caused a lot of hoopla and got everybody talking around the issue and giving their opinions amongst themselves”. Again it was suggested by one of the community experts as well as another participant that I see the movie *Temptation,* so I included its viewing in my fieldwork.

Numerous participants talked about the negative aspects of media affecting thoughts about HIV, such as the portrayal of HIV as a “gay or down low disease”. Some participants discussed the media heavily focusing on homosexual or same sex relationships as the cause of HIV transmission. Here one woman stated, “The media would tell us that same sex relationships are the birth of HIV and that African American males bring it back to their heterosexual relationships”. Another participant asserted, “The media would have you think that it’s just a Black issue or a gay black male issue.” Other participants expressed how media depicts African Americans in a negative light, such as the negative and degrading portrayal of women in music and television. Here one provider/community expert stated, “Along with other stereotypes about lifestyles related to HIV, when we talk about women, people only want to hear about someone who has been on drugs or was a prostitute. That’s all they have seen in the movies and on TV, the extremes, because that’s what sells and that’s what people want to see.” Hence, Jackie, one of the HIV-positive participants argues, that the above reasons along with stigma and fear are causes for resistance in the African American community, to testing, education, and speaking openly about HIV. Additionally,

participants talked about E. Lynn Harris (author, best known for his works depicting African American men on the down low or in the closet), J. L. King (author and HIV activist whose work focuses on minority health issues and sexual orientation), their appearances on the Oprah Winfrey Show, and their books about men on the down low as media influences relating to HIV and risk. In their discussions, several participants mentioned that these media outlets were initially how they heard about the "down low" phenomenon that was discussed earlier under sexual networks. For example, Deborah, who is 35 and married stated, "In terms of media influences, I think Oprah brought the down low to the forefront. I remember a few years ago she had this guy on her show and he came out with his story and blew the lid off of everything". Another participant, Erica, who is 30 and single, said, "E. Lynn Harris and one of his books was a media source that first introduced me to men on the down low. Then I remember Michael Baisden talking about it on the radio and he made a big deal of it, not that it's not a big deal."

Yet as mentioned before when talking about so called down low behavior and sexual networks, some providers/community experts were not readily accepting of media's representation of this subject. Hence one community expert adamantly expressed that she had several issues with the media and J.L. King concerning "this whole down low thing". With all the media attention that was given to the subject, between television appearances and books, she says, they have made the "down low" both sensationalistic and taboo. Thus instead of just talking about it or demonizing individuals in the media, she contends that there needs to be more conversation and dialogue about having safe sex and learning about one's sexual history.

Conversely, a few participants did mention positive media campaigns promoting prevention efforts such as HIV-testing and knowing your status. For example, one participant said, “The media makes me more aware of what’s going on and serves as a positive note to say, hey go get tested.” Another participant talked about media showing individuals with AIDS living full lives by taking the right medication. Sharon, a non-profit exec said she appreciated R&B singer-songwriter Alicia Keyes for her participation in the new *Be Empowered - Greater than AIDS* campaign targeting women of color, which is aired on both television and radio. Likewise she expressed, that it would be good to have additional celebrity endorsements because Magic Johnson has been the only African American celebrity openly living with HIV since 1991. This is important because as she stated:

> “Cosmetics, soda, alcohol companies and everybody else use celebrities to get their messages across to us because we as Black people freaking pay attention to those. So while a lot of people say they would pay attention to celebrities for their health information, we don’t have that in terms of HIV.”

Similarly, another participant argued that more could be done in the media by way of commercial advertisements. Here she said, “Just like we see commercials on things like alcohol and smoking prevention, we need to see more in the media that will educate and influence us as African Americans and women to protect ourselves from HIV.”

HIV PREVENTION PROGRAMS AND SUGGESTED STRATEGIES

HIV Providers were asked about programs currently offered by their agencies that target middle class African American women. Two providers talked about their organizations offering the SISTA intervention, which was developed by Gina Wingood

and Ralph DiClemente. The program is funded by the Centers for Disease Control and Prevention and is available to all women of color. However, it was stated that the program may not be the most feasible for professional middle class women because of the time commitment, which require attendance to five weekly two-hour sessions. Anita, an HIV agency program manager, also talked about another program targeting professional Black women called Sister Suppers. She explained how the group meetings were quarterly and women came together to discuss the dynamics of being at risk for HIV. The caveat of the program is that it often centers around a book discussion, where group participants engage in role playing to see how their lives mirror the characters' lives. Sharon, a non-profit CEO talked about two programs offered by her agency. The first is an intervention called "Everyone Has a Story". This is a video series that is used to highlight the fact that all African American women, regardless of social status or background, have a story. She explains that it does not matter what one's story is because every woman goes through something at some point and time in their lives. However, the message behind the intervention is that the women were all able to overcome or work through their situation. As a result they can share their story with other women, in addition to the lessons learned from their story. The second intervention/prevention program is also a video series called "Many Women, One Voice: African American Women and HIV", released by National Black Leadership Commission on AIDS, Inc. The project features women various geographic locations in the United States and from all walks of life (including middle class) speaking candidly and openly, sharing their personal stories, experiences and broad knowledge about HIV. The purpose of the video is to encourage African American women to take care of and

protect themselves as well as look out for and protect one another as African American women. Additionally, the video seeks to educate and mobilize individuals, organizations (e.g., schools, churches, and community-based organizations), media outlets, and policy makers to make a difference regarding HIV in African American communities.

Denise, an HIV nurse also told how her organization targets numerous Historically Black Colleges and Universities (HBCUs) and Black professional organizations as a part of their HIV prevention initiatives. She further explains that the services provided are two-fold in that the aforementioned audiences are not just clients receiving training and education. They also serve as outlets to raise HIV awareness in African American communities, disseminate HIV information and educational material, and promote HIV testing.

Suggested Prevention Strategies

Participants were also asked to give ideas about designing a HIV communication campaign or intervention for middle class African American women. Here the women actively engaged in constructing knowledge related to HIV prevention for middle class African American women. Allowing the participants to share their ideas and sources of knowledge about potential preventions and interventions was empowering for the women and it validated the women's involvement in the research process. This process also provided an opportunity for me, the researcher, to broaden my perspective about possible HIV prevention programs and strategies. Additionally, the information shared enabled me to understand the barriers that may impede effective HIV prevention among middle class African American women. This includes provider bias, where many healthcare providers do not talk to middle class African American about HIV testing or

risk prevention because it is perceived that the women have low risk because of social status.

The participant suggestions for HIV preventions and communication campaigns included the use of technology, music, photography, books, social media, and other forms of media as ways to target and reach middle class African American women. Some ideas put forth were a photo campaign portraying images of professional African American women with a caption saying “I am Black, I am middle class, and I am HIV positive”. Another participant talked about providers using a computer app to provide HIV information to their patients and to encourage HIV testing. Other suggestions included:

- Shonda Rhimes, producer of Grey’s Anatomy and Scandal, doing an episode of Scandal focusing on African American women and HIV.

- A television show focusing on self-esteem and gender power dynamics in relationships, something along the line of *Iyanla Fix My Life* with an emphasis on relationship dynamics and HIV prevention.

CONCLUSION

This chapter assessed the knowledge, attitudes, and beliefs about HIV and AIDS in HIV-negative and HIV-positive middle class African American women. Most of the women were aware of HIV’s disproportionate affects among African Americans. Similarly, the majority of participants believed factors such as lack of communication about HIV, lack of HIV knowledge or education, not knowing one’s HIV status, and risk denial impact the rise of HIV in the African American community. HIV-negative

participants' overall personal risk perception ranged from no risk to high risk, where most women reported their risk as being low. HIV-positive women discussed not perceiving themselves at risk prior to their infection and expressed their change in attitude and message of "no one is exempt" since becoming infected. Factors identified in the socio-cultural context of African American women's HIV risk construction were: education, income, family, social networks, relationship dynamics, which include gender imbalance and sexual networks, church and religion/spirituality, and the media.

Providers and community experts gave their opinions and perspectives on HIV education, awareness, and risk in middle class African American women and African American communities. This information was based upon their professional experiences in HIV education, prevention, and intervention. Overall, the providers and community experts believed there was a large disconnect between the HIV knowledge and practice of African American women. For example, African American women may be knowledgeable about ways to prevent HIV transmission; however they do not always put that knowledge into practice. Similar to the HIV-negative and HIV-positive participants' responses, the providers/community experts thought risk denial, lack of HIV knowledge, and lack of communication between partners were contributing factors to the spread of HIV among African American women. Other factors mentioned were man-sharing and multiple and concurrent partnerships. Providers and community experts gave information about existing prevention programs targeting middle class African American women. Additionally, participants gave ideas, shared their opinions, and offered suggestions about future HIV prevention programs to reach this population.

This chapter is the first of two that discusses study results. The next chapter will present an analysis of findings from the HIV-negative participants' sexual history timelines and results from questions about their sexual relationships.

CHAPTER SEVEN:

SEXUAL DECISIONS, SEXUAL BEHAVIORS, AND HIV RISK ASSESSMENT: SEXUAL HISTORY TIMELINE AND INTERVIEW RESULTS

This chapter presents results related to middle class African American women's interpersonal relationships, sexual behaviors, sexual decision making, and HIV risk assessment. The chapter begins by looking at the relationships and sexual experiences as self-reported by the HIV-negative participants. It provides information on how the women make decisions about HIV prevention and other sexual choices, including condom use, HIV testing, and selection of sexual partners. Additionally, the chapter explores the association between the women's actual sexual behaviors and their perceived risk for HIV, which includes the women's reflection of their relationships.

HIV-NEGATIVE MIDDLE CLASS AFRICAN AMERICAN WOMEN'S SEXUAL EXPERIENCES

Aspects of the participants' HIV-related decisions and sexual practices mirror patterns and behaviors described in HIV literature. These include unprotected sex, multiple partners, concurrent partners, and sexually transmitted infections. Likewise, it is important to call attention to the contextual factors that form the environment and situations in which the women exist, such as abusive or violent relationships and cases of victimization.

The twenty-one HIV-negative women recounted and described the details of their sexual relationships from past to present (i.e., from sexual debut to most recent

relationship) using the sexual history timeline (see Chapter Five – section on sexual history timeline). Participants were asked to indicate how they met each sexual partner; whether they used condoms during sexual intercourse and how often; who made the sexual decisions in each of the respective relationships; and whether there were any significant incidents such as STIs, infidelity, or abuse associated with the respective relationships.

Sexual Experiences and Behavioral Risk

Current or most recent and past sexual relationship practices were explored using interview and sexual history timeline responses. The age of sexual debut for the HIV-negative women ranged from 13 to 24 years, with the mean age being 17.6 years. The number of lifetime sexual partners for HIV-negative women ranged from 1 to 35, with a mean of 9.1. See Table 7 for both the age of sexual debut and the number of lifetime sexual partners for each participant. Of the twenty-one HIV-negative women interviewed, nine women reported having six to 10 lifetime sexual partners. Six women reported having three to five; four reported having 13 or more, and two reported having only one or two lifetime sex partners.

Concurrent Sexual Partnerships

In assessing sexual practices like concurrent sexual partnerships (i.e., having two or more sexual partnerships that overlap in time), there were eight women that reported having a history of concurrent sexual partners. In seven of these cases, the relationships were formed or occurred while the participants were in college or in their early 20's. In the remaining case, the relationships occurred in the woman's late 20's.

Table 7- Demographic Information, Relationship and Sexual Behavior Categories for HIV-Negative Participants (N-21)

Name	Age	Marital Status	Educational Level	Occupation	Employment Status	Annual HH Income	Age of Sexual Debut	No. of Lifetime Sex Partners
Alexis	32	Single	Bachelors	Grants Compliance Officer	Employed full-time	$35-49,999	17	6
Angela	47	Divorced	Doctorate	Public Health Advisor	Employed full-time	$95-109,999	17	9
April	38	Married	Masters	Consultant	Self-employed	<$35K	19	5
Barbara	49	Widowed	Masters	Marketing Professional	Employed full-time	$110K+	19	19
Celeste	40	Single	Masters	Teacher	Employed full-time	$110K	16	8
Colleen	47	Divorced	Specialist	Teacher	Employed full-time	$65-79,999	17	5
Deborah	35	Married	Bachelors	Admin Asst.	Employed part-time	$50-64,999	24	1
Demetra	50	Single	Doctorate	Professor	Employed full-time	$80-94,999	18	13
Erica	30	Single	Masters	Counselor	Employed full-time	$35-49,999	15	9
Jessica	32	Single	JD	Banker	Employed full-time	<$3K	18	35
Kimberly	30	Divorced	Masters	Corporate Event Planner	Employed full-time	$50-64,999	13	16
Leslie	39	Married	JD	Attorney	Employed full-time	$110K+	15	4
Lisa	31	Married	Bachelors	Accountant	Employed full-time	$110K+	18	2

Table 7 (continued)

Melanie	30	Single	Bachelors	Financial Service Officer	Employed full-time	$35-49,999	16	10
Monifa	30	Single	Masters	College Administrator	Employed full-time	$65-79,999	19	9
Monique	35	Single	Masters	Health Scientist	Employed full-time	$95-109,999	22	10
Nechelle	42	Single	Bachelors	Planning Analyst	Employed full-time	$80-94,999	16	10
Phyllis	42	Married	Masters	Consultant	Employed full-time	$65-79,999	21	5
Sonya	37	Married	Doctorate	Victim's Advocate Exec.	Employed full-time	$110K+	19	4
Tanya	55	Married	Bachelors	Consultant	Employed full-time	$65-79,999	17	3
Toni	38	Widowed	Bachelors	Paralegal	Employed full-time	$50-64,999	13	7

Participants reported meeting their partners while in college (at school), at parties, through friends, or while "hanging out with friends". When asked about their decision to engage in concurrent sexual relationships, participants' responses included: "It was just a hook up thing", "I wanted to explore my options", or "I was young". One participant stated, "I was not in a relationship with either one of them [men]. It was just more along the lines of casual friendships that were just about the sex." Another woman said, "I was in college, out on my own, and interested in different people. So I wasn't necessarily interested in a relationship, but I still wanted to be sexual with people."

One participant of particular interest was Kimberly, a 30-year old corporate event planner who explained that having a boyfriend/husband in the military did not equate to her having a military girlfriend or military wife's mindset. Instead, she expressed, "in my mind, I was a college student that had a boyfriend in the military and the things I did while we were dating just carried over into our marriage". Kimberly had several overlapping sexual relationships while dating/being married to her husband, but the one relationship that was of most significance to her was the one she called her "actual affair". It lasted about two years and was a relationship that she was eager to provide explicit details about. She met this partner in college; both were students at the time the relationship formed. When asked why she began and then decided to continue with her "affair", she explained:

> "I was so enthralled with him. I don't even know how to explain it. I wanted to be with my husband because he was my high school sweetheart, but it was just something about this other person. I should have broken up with my high school sweetheart because I felt like cheating was stupid. But then I thought that if I got married it would fix everything, clearly it didn't. I was young and I had no idea what college was going to bring."

Contextual Factors and HIV Risk

African American women's victimization history or sexual assault histories can influence their risk behaviors and also affect individuals' perspectives on HIV risk. Here the HIV-negative women's sexual assault experiences or victimization histories were assessed as contextual factors, where they have unique significance for their individual situations. Two women reported experiences of sexual victimization. One woman's incident occurred with someone she knew for about a year and thought was a nice guy. However when they had sex, she said she felt like she was raped. In her account she stated:

> "He was so rough, he actually broke his condom, cut himself, and I just knew he had damaged me in some kind of way. It was not good. I later found out he had been in jail, so of course you know I thought I might have something. How all this madness occurred after I was 40, I don't know."

This incident affected the future level of trust the participant had for men. She said, "It took a long time for me to really trust a man. The next guy I actually dated was probably a year or so later and when I say trust, I mean the trust to have a relationship with him."

The other respondent told of a time when she was in college that she went to a party and was drinking alcohol and smoking marijuana. She went on to explain how she and a man she knew began kissing, but that was all she intended to do with him. She later passed out and when she woke the next morning, she was completely naked. The man she was with the night before had sex with her without her knowledge. In addition to wondering how many other women he may have done this to before her, she was also concerned about whether or not he used a condom when they had sex. In this

case and the one above, the women got tested for HIV and other sexually transmitted infections. In both cases the women's test results were negative.

Alcohol and Drug Use

Study participants discussed their alcohol and drug use (including smoking marijuana) and its impact on their sexual decision making. Fourteen participants reported that they do drink alcohol, with seven of the women indicating that they only drink an occasional glass of wine (e.g., about one or twice a month). The frequency of drinking for the other seven women ranged from a drink or two once a week to a glass of wine or two, every other day. Participants were asked if they have even been tipsy or drunk before or during sex in their current or most recent relationship. Three women who reported drinking said they have been tipsy or drunk in their current or most recent sexual relationship; however it was not enough to impair their judgment of using condoms. Here Demetra stated:

> "Drinking definitely makes me more relaxed and kind of gets me in the mood. However, I'm not going to skip a condom just because I've had a drink or two. I don't drink enough to lose control."

Three women said alcohol has played a role in influencing their decision making in their current or most recent relationship. For example one participant, who is a 30-year old counselor, said, "I'm definitely less likely to introduce a condom when I've been drinking." Likewise, another participant, who is 47-years old and divorced, stated, "When I'm tipsy or drunk, there are times when we make love or whatever and then I wake up the next morning and be like Oh God what happened." Other participants who reported drinking, said alcohol had no effect or played no role in influencing condom use

or decision making (e.g., wanting to have sex) with their current or most recent partner. No participants reported using drugs, including marijuana, at the time of the interview.

In discussing alcohol and drug use and sexual decision making, three participants told how drinking and/or smoking marijuana impaired their judgment and influenced some of their sexual decision making in past sexual relationships. Here, two participants talked about getting drunk at parities and having unprotected sex with people they did not intend to. For example, Kimberly, 30-years old, recalled a time when she was drinking with a past sex partner, they got drunk, and ended up having sex. In hindsight, she contends that she should have stayed home and should have never gone to the man's house. The difference between these occurrences and the ones reported above is that the latter two are not considered acts of victimization. Another participant, Melanie, 30 years-old, explained that when she was in college she drank more than she did at the time of the interview and she also smoked marijuana. As a result, she did not always use condoms in her sexual relationships. Herein she said, "But even after my drunken moments of realizing what happened and not practicing safe sex, I sometimes continued to not use condoms."

Gender dynamics and sexual decisions

Power and gender differences may affect participants' decisions about safer sex practices. HIV-negative participants were asked about gender and power dynamics and sexual decision making in their sexual relationships. Most of the women (N=16) said they and their partners have mutual respect for each other and that they both shared in the decision making (e.g., sex initiation, condom use, HIV testing) in their current or

most recent relationships. The other five women expressed that their partners were more dominant or possessive, made the decisions, or initiated sexual activity in their current or most recent relationships. Of the aforementioned five women, one participant had a history of violent or controlling sexual partnerships, in which those cases impacted her sexual decision making (e.g., condom use) in her relationships. For example, the participant talked about some of her sexual partners including the current partner being insecure in their relationships.

Participants were asked whether they would still have sex if their partner refused to use a condom and eight women gave a definite "no" response. One participant, Alexis, 32 years-old and single, said, "I don't know. I have never had anyone to refuse". Another participant, Barbara, 49-years old and widowed, said, "If he refused, I would want to know what that is about." Likewise Erica, who is 30-years old and single stated, "We can talk about it and we can make a compromise about it, but I just have a thing about a partner refusing. I like for it to be something mutual between us, something we have discussed." The participant then proceeded to tell about a past experience where a partner refused to use a condom and had herpes. He did not tell her about his STI and she became infected, but she was not diagnosed until after their relationship had ended. Therefore, she said "if my partner cannot have a discussion about using condoms and he just refuses, then really that's like a deal breaker for me". When the participants were further questioned about why they would not have sex with their partners if they refused to wear a condom, reasons included: lack of trust for men (2), not wanting to get pregnant (3), and being afraid of catching a sexually transmitted infection (3).

Nonetheless, Colleen, a 47-year old divorcee, who responded 'no' explained how in the past she did have sex with a partner who never wanted to use condoms, even though that went against everything she believed in. Her reason for having sex without a condom even when she really did not want to, was because she was really into her partner and she thought that he was the "one". The relationship lasted for two years and eventually ended because the participant's partner did not trust her. In regards to power dynamics and decision making in sexual relationships, another participant, Leslie, 39 years old, asserts:

> "I don't think women take enough control over using condoms. I really think it's an issue that we tend to leave it up to men to have a condom as opposed to controlling that discussion and having them available and demanding the use of them for ourselves. Black women have to learn how to protect themselves. That's the only way to significantly decrease our risk for contracting HIV."

Condom Use

Both the interview and sexual history timeline asked questions about the participants' most recent sexual relationship as a verification of reported condom use. Almost two-thirds of the women (N=13) reported infrequent use of condoms in their current or most recent sexual relationship. Specifically, twelve women said they never used condoms with their current or most recent sexual partner and one woman said that she rarely or sporadically uses condoms with her current sexual partner. Six women stated that they always used condoms and two stated that they used condoms most of the time with their current or most recent sexual partner. Nine of the thirteen women with infrequent condom use described their relationships with their current sexual partner as serious, in which six of the women were married and two were cohabitating

with their partners. The remaining four women described their current or most recent sexual relationships as casual, open, or exclusively dating/boyfriend. Table 8 provides the complete *Relationship Demographics and Relationship Sociocultural Contextual Factors by Participants.*

Participants with infrequent condom use were asked why they chose not to use condoms with their current or most recent sexual partners. Five of the women gave reasons of being in committed and monogamous relationships, therefore having no use for condoms. For example, Tanya, a 55-year old consultant, told how she and her husband have been married for 26 years, so there is no reason for them to use condoms. Likewise Angela, a 47-year old public health advisor said, “I just feel that we’re in this relationship just the two of us, so if it’s no other outsiders then we don’t have anything to worry about.” Another three women with infrequent condom use stated that they would only use condoms if needed for birth control. The remaining five women gave reasons for infrequent condom use that included responses like, “I don’t like condoms”, “I was being naïve”, “We just never wanted to use them” and “In my past when I’ve used condoms, I’ve had rashes and bad breakouts.” Additionally Toni, a 38-year old paralegal, explains that she chose not to use a condom with her most recent sexual partner because she acted on impulse as something at the spare of the moment. At the same time, she thought she “would be fine” by not using a condom. However as a result of her decision to not use a condom, she contracted an STI from her partner.

Table 8 -Relationship Demographics and Relationship Sociocultural Contextual Factors for HIV-Negative Participants (N= 21) - *(Responses for Current or Most Recent Sexual Relationship)*

Name	How you met	Relationship Type	Length of Relationship	Condom Use	Reason for Not Using Condoms	Other Contextual Factors from Sexual History
Alexis	At vacation home	Casual	Less than 1 year	Most of the time – about 80%	Impulse situation	none
Angela	Motorcycle trip	Serious- live with current partner	1.5 years	In the beginning - but none now	Committed relationship; no need for condoms	History of violent, controlling/ possessive sexual partnerships; partner used drugs in previous relationship; history of STI; issue of infidelity in marriage
April	Through mutual friend	Serious	9 years	None	Don't like condoms; use IUD for birth control	History of STI; last HIV test in 2008; rarely used condoms in past sexual relationships.
Barbara	Restaurant bar	Dating	5 months	Most of the time - one or two times we didn't.	It's just something that happened.	History of STI; history of concurrent sexual partnerships.
Celeste	Longtime friend	Friends	Less than 1 year	Always	n/a	Incident where participant got really drunk and had unprotected sex during a one-night stand.
Colleen	Through a friend	Somewhat new, yet serious	5 months	Always	n/a	Issue of infidelity in marriage and other sexual relationships.
Deborah	Through a friend	Serious/ Married	18 years	None	Monogamous and don't feel the need to.	none

Table 8 (continued)

Demetra	Social event	Serious	6 months	Always	n/a	History of STI; partner once removed condom without participant's knowledge; sexual partner with incarceration history.
Erica	On-line dating site	Serious	1 year	Rarely	Both been tested for HIV & STDs; only use for birth control.	History of STI; history of concurrent sexual partnerships
Jessica	Through mutual friends	Boyfriend	4 months	None	We just never wanted to use them.	History of STI; history of multiple and concurrent sexual partnerships; did not use condoms all the time with all past sexual partners.
Kimberly	At a party in college	Exclusively dating	9 months	None	In the past condoms have caused rashes and bad breakouts.	Did not use condoms all the time with past sexual partners; history of multiple and concurrent sexual partnerships.
Leslie	Social outing	Serious	14 years	None	We are regularly tested in a monogamous relationship.	Did not use condoms all the time with past sexual partners.
Lisa	At church	Serious	9 years	Always	n/a	none
Melanie	High School friends	Off & on serious	1 year	Always	n/a	History of STI; history of multiple and concurrent sexual partnerships.

Table 8 (continued)

Monifa	Dated in the past; initially met at a party	Serious – live with current partner	3 years	Used at first - no condom use now	Only used condoms a few times for birth control	Told of time when intoxicated, passed out, and woke up naked (only remember kissing).
Monique	Friend of a friend	Casual	One night stand	Both times	n/a	Did not use condoms all the time with all sexual partners; last HIV test was in 2010; history of multiple sexual partnerships.
Nechelle	At a party	Casual	2 months	None	Was being naïve	Recently diagnosed with herpes; history of multiple sexual partnerships.
Phyllis	Through a friend of family	Serious	2 years	None	Because we're married	History of concurrent sexual partnerships; did not use condoms all the time with all sexual partners.
Sonya	At a party in college	Husband-serious	16 years	None	None a common practice, only if fear something is wrong with birth control.	History of concurrent sexual partnerships.
Tanya	At a gym	Serious	26 years	None	We have been 26 years at it. There is no reason to.	Last HIV test was in 2010.
Toni	Playing sports	Open	1 month	None	Acted on impulse. Spare of the moment, Thought would be ok.	Contracted an STI from partner; Found out he was married; had more than one STI diagnosis.

HIV Testing

All the HIV-negative women (N=21) reported having had an HIV test, with seventeen of them having been tested within 12 months of their interview (six within one and three months; seven within four and six months; one within seven and nine months; three within 10 to12 months). In contrast, there was at least a two and a half year lapse since the last HIV test for four of the study participants. As a follow-up, the women were asked if their providers automatically offered HIV testing or if testing had to be requested when going for physicals and annual exams. There was a clear consensus among the participants, with all of them stating that their providers did not readily offer HIV testing during annual exam visits. Here, two women explained that there would have to be a reason for their providers to mention or encourage them to have a HIV test, such as being pregnant. Eleven women described how if they wanted an HIV test during their annual exam visit, they had to either verbally ask for it or check it off a listed battery of tests, otherwise their providers did not talk to them about HIV testing. In spite of not being automatically offered the test, six women noted that they request to have a HIV test done annually. Interestingly, of these six women three are in serious relationships, with two of the women (Leslie and Deborah) having been married 14 and 18 years respectively. The third woman (Angela) lives with her partner, with whom she has been for one and a half years.

Although the aforementioned women are all in monogamous relationships, they still believe it is important to have regular annual HIV testing. Angela states, “I have an HIV test annually because although I have one sexual partner, we still can’t say 100% what the other person is doing.” Deborah, a 35-year old administrative assistant tells

how she and husband have regular discussions about HIV and get tested together because health is important to her and her family. Along those same lines Leslie, a 39-year old attorney explains why testing is important by saying,

> "I'm not HIV positive and I'm married, and I'm successful and here are the things that I do to ensure I that I will never become HIV positive, or here are the ways that I decrease my risk even though I'm married, even though I believe my husband is faithful to me and I'm faithful to him, I get tested regularly."

She goes one to say,

> "If I get tested along with my annual pap smear, even though I fully believe my husband is faithful, I am saying that I control my health and that my health comes first."

One other participant actually associated getting a regular HIV test with being in control of their health. She too was also married. However, another participant contended that women should be more aware of their personal health and suggested that all women receive HIV tests as a standard practice when going to the gynecologist regardless of one's marital status.

When talking about HIV testing, one woman stated that she never had an HIV test until two months prior to her interview. She explained that her current sexual partner had an HIV scare in a previous relationship. As a result, he now makes sure that his partners have been tested and that he sees their results before engaging in sexual activity with them. Therefore, she had to get tested if she wanted to continue in the relationship with him. This was a new experience for the participant (i.e. having an HIV test and having a partner ask her to get tested). Additionally, she thought her partner's actions of requesting that she get tested and see her results before having sex

was “pretty cool” as opposed to just taking her word of saying that she was HIV-negative. At the same time, the participant stated that she felt bad because she never had an HIV test before this relationship and had not inquired about her past partners’ HIV status. Hence this was a practice that she deemed necessary to adopt for the future. As she stated:

> “I mean I’m glad I’ve been tested now, but I just feel like when I go back and think about things I have done in the past, then I just have to wonder about some of the people or you know I should have asked them more questions. You know I should have found out if they were sick or something. It is things like that that I wonder about.”

Conversely, Kimberly told of how when she and her girlfriends begin dating someone new, they always “ask to see his papers” before having sex. I asked what she meant by the terminology “seeing his papers”, and she explained that it means asking him to see his HIV test results. The woman will ask to see her partner’s latest HIV test results and she in turn will share her results with him. She went on to say that it is important to get tested regularly to make sure one’s results or “papers” are current. She also discussed how asking about someone’s “papers” sometimes makes for uncomfortable conversation, but expressed that one way to make it less awkward is to suggest making a date of going to get tested together and then sharing the test results with each other. She stated, “In my circle of friends we made a pact that it is a conversation and process that will always take place in our relationships and will happen in some form or fashion because it is important in terms of our health.” Additionally she talked about how her and her friends hold each other accountable and

will ask each other about whether or not they have seen their partner's papers, as a way of being their sister's keeper.

Sexually Transmitted Infections

Participants were asked questions about sexually transmitted infections (STIs), which included whether they ever had one, if so, at what age they were diagnosed, and their experience of being infected (e.g., who infected them and what was their reaction to the diagnosis). Nine of the twenty-one women reported having been diagnosed with a sexually transmitted disease, specifically chlamydia, gonorrhea, or herpes. Six women were infected while in college, with five of them reporting that they were in serious or committed relationships at the time of being diagnosed. When asked about their reactions to being diagnosed with a sexually transmitted infection, the participants' responses included: "I was surprised", I was shocked", I was pissed", "Glad it was something curable", and "Just thankful it was treatable".

One participant, Erica, 30-years old, explained how she contracted herpes from a previous relationship, had just started a new relationship when she was diagnosed, and was questioning whether or not she should tell her new partner about her herpes. Hence she was both upset and anxious about the situation. In the end she did tell her new partner about her herpes and everything worked out. Another one of the aforementioned women was, in fact, married and seven months pregnant at the time of her STI diagnosis. She recalled how finding out her husband gave her a sexually transmitted infection made her feel "the lowest of the low" and ultimately ended her marriage. She filed for a divorce shortly after giving birth to their son.

Of the remaining women with histories of STIs, one woman Toni, 38-years old, was first diagnosed as a teen, at the age of 16, during a prenatal care doctor's visit. She was then diagnosed again most recently as an adult (within eight months of the interview) during a visit for her annual exam. The participant said she was shocked, more specifically "floored" in both cases. These were supposed to be what she called "normal and routine exams", but resulted in her finding out she contracted sexually transmitted infections from her partners. The other two women were diagnosed with STIs as adults, in their 40's. One of the women, Nechelle, a 42-year old planning analyst was diagnosed with herpes just six months prior to her interview. In talking to her, she said her test results revealed that the herpes virus had been lying dormant in her body for some time, as explained by her doctor. Because she was asymptomatic and never had an outbreak until recently, the doctor also told Nechelle it was very unlikely that they would be able to determine who infected her. When asked about her reaction to being diagnosed with herpes, Nechelle described how disgusted she was with herself. Moreover, she said:

> "It was a very difficult diagnosis and I'm still struggling with it. I just wanted to move to Omaha and just find me a tent and live in that isolated tent out in the middle of nowhere where no one knows me. It wasn't in my cards. It's not how I planned it. It's not what I thought would happen. You know I thought I was careful and I knew you know what my partners' statuses were. But it was one of those things, one of the diseases probably you don't hear about that much; but nevertheless it's the one that doesn't have a cure, just like AIDS."

Twelve participants said they have never had a STI. Two of the women, thanked God for never being diagnosed with anything. Specifically, one woman declared after telling me she never had a sexually transmitted disease, "God takes care of babies and

fools". Given her age, it could be inferred that the participant was saying that her sexual decisions were not always wise ones, yet and still God took care of her.

REFLECTION OF SEXUAL EXPERIENCES AND ASSESSMENT OF HIV RISK

The previous chapter included discussion of how, HIV-negative participants perceived to be at low risk for HIV. Participants identified lack of communication between sexual partners, low condom use, and multiple sexual partnerships as some of the contributing factors for HIV risk and transmission. After completing the sexual history timeline and answering questions about their sexual relationships, the participants were asked to reflect upon their sexual behaviors and sexual experiences. Then they were once again asked their thoughts about their risk for HIV.

Reflection of Sexual Relationships

Participants discussed the nature of their current or most recent relationships in comparison to past relationships. Most women (N=11) categorized their current or most recent relationship as better than past relationships or as the best relationship they have had. Open communication with their partner was the most prominent reason for participants reporting better relationships than in the past. For example, Erica, a 30-year old counselor stated,

> "I can say that we have good communication, much better communication compared to in the past and we have more life experiences that we draw from compared to relationships I've had in the past. We talk more about everything in general, especially sex as opposed to just doing it and not talking about it."

Likewise another participant said, “I feel like we can talk. We communicate more about sex and being cautious”. Some participants also said they possessed more self-confidence than in their past relationships, which resulted in them having better relationships with their current partners. Here April stated,

> “In my current relationship, I’m very much myself. I’m my own person. I have a voice and I have evolved as a person. So, it’s good and I’m happy. I think I needed the other experiences to help me realize that a woman should never make a man the focus of her life.”

Additionally, another participant, 31-year old Lisa said, “I know myself better so my partner knows more about me and I’m able to communicate with him better than I was with my previous boyfriend.”

Four participants indicated that their current or most recent relationship was “not as good” as some of their past relationships. Reasons given included lack of communication with partner, lack of sexual fulfillment (e.g., partner had erectile dysfunction), partner not being stable, and partner being jealous/aggressive. Two participants said their current or most recent relationship was similar to relationships they had in the past. Specifically, Toni asserted,

> “In comparing relationships and looking back over this timeline, I was like you did the same thing you did with him (what the hell) and not much has changed.”

When asked to explain the meaning of her response, she said,

> “My selection process of sexual partners seems to be similar and my decisions seem to be a lot based on how I feel at that time versus thinking more long term or past the right now. It’s usually on impulse. In essence I keep dating the same guy over and over again.”

Moreover, three participants described their current or most recent relationship as more casual than past relationships. For example, 35-year old Monique called her most recent relationship "the most purposely causal relationship" that she has had. Here she states, "All the rest of my relationships I went into thinking they were going to lead to something, whereas with this one I knew it was going nowhere and I was ok with that."

Self Esteem and Self-Image in Relationships

Participants were asked about the impact of self-esteem on their sexual relationships. This included its effect on their choice of sexual partners, their sexual decision making, or the way they were treated in relationships. Seven women reported never having low self-esteem or self-esteem issues. Hence this affected their relationships by allowing the participants as some of them said, "to be choosy about whom they partnered with", "to not settle for a lot of stuff", or "to feel empowered to have sex with a guy because she wanted to". Specifically, 32-year old Alexis stated,

> "I am very confident about myself. I think I have very high self-esteem and I've never really had an issue with that. Like some people seem to think that I have issues with my weight, but I don't. I would say I'm ok with myself and always have been. I really have no fear about if someone thinks I'm attractive or not, because whoever is going to be attracted to me is going to be attracted to me. So as far as how that relates to sex, I feel like there's never been a situation where I've been like if I ask a guy to wear a condom they don't or they try to talk me out of it or something like that."

While low self-esteem may not play a role in the current or most recent relationships of some HIV-negative study participants, several HIV-negative women indicated that it did affect some of their past sexual decision making, relationships with

past partners, which included choice of partners and the way they were treated in past relationships. For example 30-year old Erica stated:

> "In those times when I didn't have good self-esteem because I wasn't in a healthy space in my life is when I made poor decisions. But when things improved for me as far as my self-esteem goes, when I had a lot of confidence and self-esteem, then my relationships were healthy and I was comfortable making the choice about using a condom."

Another participant, Nechelle, 42-years old, indicated that she used to be extremely overweight, which in the past affected her self-image and self-esteem and ultimately her choice of partners. She says she would get excited when a guy approached her or appeared interested in her because to know someone was attracted to her physically was a bit shocking. Here she explains, "So I'm 280 pounds and he's attracted to me. I'm like, oh wow let's see what this is about." Five years ago the participant had gastric bypass surgery and she says since losing the weight, she has become more attractive to men, she receives more compliments; therefore now she does not necessarily feel the need to follow up on every invitation or talk to every man that approaches her. Given the participant's history with low-self-esteem, I asked if self-esteem ever influenced her sexual decision making process such as using condoms. She said that she did not think self-esteem was really a factor in her not using condoms; but rather her just being careless.

Continuing the discussion on self-esteem, self-image, and relationship dynamics, Monifa, a 30 year old college administrator explained how she is now much more confident in herself than in the past. She says, "I think before the desire to be with someone meant that I may have accepted behavior that I should not have, just in terms of the way I was treated and who I dated." She went on to explain how being dark-

skinned, she was never seen as an image of beauty. Even in college, she said she thought she was ugly and did not have a lot of self-esteem because the Black men did not appear to be attracted to her and while the White guys thought she was "great and amazing", they said they could never date her because of their families not being accepting of interracial dating. Likewise people would often tell her, "You're cute to be a dark girl", which she says definitely impacted her self-esteem. As a result, she ended up dating this one man multiple times, where they broke up and got back together over a course of three years. However, he would not ever commit to her and she took that as a reflection of her personal attributes. She said, "My perception was that I was not pretty enough. I was not light skinned. I don't have the right hair. I don't have the right body. I don't have what it takes to be the woman that men want. I'm not that chick."

Similarly, 49-year old Barbara, also talked about issues of being dark-skinned, said self-esteem also impacted her relationships when she was younger. She said, in years past she did not value herself and did not know her self-worth. However, now she contends,

> "I've gotten older, I've done more, I'm more accomplished, more experienced and I'm like, I'm a goddamn commodity up in this bitch. I'm the diamond that you should be seeking. So I guess I can take you or leave you. I don't necessarily need you, if you're not going to treat me a certain way."

Still 38 year-old, Toni stated when asked about self-esteem and its impact on her relationships:

> "I actually had to have a "come to Jesus" meeting with myself to say that the sexual behavior that I was displaying was not becoming of my upbringing. So I had to draw back on some of my activities and change my thought process of how I selected the people I was with. So I just cut

> down on the number of people that I had been with and tried to choose differently and make better decisions. It didn't always work, but I did have to come to terms with the fact that what I was doing was not appropriate."

Reflections and Thoughts about HIV Risk

After reflecting upon past relationships, sexual experiences, examining their self-esteem and self-image in respect to relationships, and evaluating their current or most recent relationships; participants were asked once again about their risk for HIV. Participants' initial responses to this question were categorized as no risk, low risk, medium risk, or high risk. (See Chapter Six - Attitudes and Perceived Risk of HIV Infection: *HIV-Negative Women's Perspective*). Whereas some participants maintained their risk status the same as before (e.g., low risk, med risk); other participants gave more in depth responses when giving their thoughts on their sexual history and discussing their risk for HIV. For example, Jessica, a 32- year old banker who initially perceived her risk as low said,

> "Now that I think about it, I am like gosh I can't believe all those people. It's been like what 35 people. I was a busy bee when I was in college and law school. I think I had maybe more partners than some of my friends, my female friends have had, but I think that I maybe until the past two years have been more vigilant about condom use than other people I know. Because I know people when I was in school that had STDs, got pregnant, had abortions and things like that."

Upon completing the sexual history timeline, Jessica commented that she keeps a list of her past partners and that is how she keeps track of whom she has had sex with. She went on to say that she believes having a lot of sexual partners does not put her at risk for HIV as long as she uses condoms. It is important to note that Jessica has also had

a sexually transmitted infection. Alexis, who already perceived her risk for HIV as high, stated:

> "I would just say that looking at this, I have put myself at more risk than I should have and what's so funny is as much as I do know about HIV and I'm aware about it and I just talked about the information being saturated, I see and kind of reflect on it and say ok I have put myself at risk and I probably need to be more conscious about that and make sure I do better about protecting myself."

Similarly, Kimberly, who also perceived her initial risk for HIV as high, asserted:

> "In my sexual history timeline, the one thing that I have been able to do and come to acknowledge is that I haven't always made positive decisions when it comes to sex. Until recently I have always made negative decisions when it came to sex or whatever, but when I think about some of my past experiences, I just think to myself that I had very little discipline and very little will power. Some of the things I did, most girls don't do you know and I wasn't raised to be this way and do such things. So it just makes me want to be better and make better decisions. In terms of my risk for HIV, I just feel that I'm incredibly blessed. I fortunately have not contracted anything. So I feel like, over time for some reason God has just looked out for me and my decisions, so that I would be able to help somebody else. I would be able to let somebody know that the game isn't what you think it is."

Monique, who holds to the belief that she is at risk every time she sleeps with someone new said:

> "This practice made me think about my partners, which I don't typically do and it made me think about the quality of my sexual partnerships. It made me think about where I was in life when I accepted these partners and made me think about the growth or regression I've experienced in partnering with certain people."

Another participant, April maintains that she is not at risk for HIV; however described her thoughts about her past relationships and sexual experiences as such:

> "It's not so painful anymore to look at the past and feel stupid. As I was going through all that I have done, I just accepted it as my own learning process and I accepted the experiences and am grateful for every moment there was a pause that I could think back. I am happy for where I am now and definitely a lot of what I experienced, the games, not having a voice, played out when I eventually found someone that I felt I could be with."

Likewise another participant who initially perceived her HIV risk as mild stated, "I think I was promiscuous in college. I don't think everyone would say that, but I think I was promiscuous in college. That being said, I probably was more at risk than I thought."

Other responses from participants about past relationships or reassessed HIV risk included expressions of gratitude to God. For example one participant declared, "I thank God I was fortunate to start out with my husband and still be with him. I've had a great experience, but we still communicate and still get tested. Being married does not negate that." Similarly, another participant stated, "You know I feel that I am very lucky considering what I was doing early on. I am very lucky and thankful to Jesus that I am HIV negative. And I want to keep it that way." Additionally, it was suggested by several participants that the sexual history timeline become a common practice or "given to as many people as possible", since it asks questions that are not typically thought about (e.g., the number of sexual relationships, the dynamics of one's sexual encounters, how individuals meet). Moreover the responses to such questions and the thought processes of the individuals completing the sexual history timelines are believed to prompt honest dialogue about sexual relationships, behaviors, and overall sexual histories.

CONCLUSION

This chapter examined the sexual histories of HIV-negative study participants. Data analyzed encompassed assessing participants' sexual experiences and behaviors, which included multiple and concurrent sexual partnerships and condom use. The majority of the women reported having six to10 lifetime sexual partners and eight of the 21 participants indicated having participated in concurrent sexual partnerships. Thirteen participants reported inconsistent or no condom use with their current or most recent sexual partner. The most common reason given for not using condoms was being in a monogamous relationship and therefore not needing to use them.

Sexual decisions were also assessed in relation to contextual factors that create environments in which women exist and put themselves at risk for HIV. Factors identified were gender dynamics in sexual relationships, which include power and gender differentials, sexual victimization, and alcohol and drug use, including smoking marijuana. Most of the participants reported having mutual respect between them and their partners. Two women reported being sexually victimized. They were both tested for HIV and other STIs after their ordeals and received negative results for all tests. Four participants indicated that drinking alcohol and/or smoking marijuana impaired their judgment and sexual decision making in past sexual encounters. Additionally, nine women reported having a history of STIs (e.g., chlamydia, gonorrhea, or herpes), in which most of them were infected while in college.

After reflecting upon past relationships, behaviors, and sexual experiences, participants re-evaluated their risk for HIV as reported in the previous chapter. Many participants maintained their same level of risk perception as initially reported in Chapter

Six. However, some participants described how the sexual history timeline helped them re-examine their decision making process in terms of sexual partners and sexual decisions. Additionally, some participants expressed gratitude to God for not having HIV or contracting any other STIs. Hence, spirituality is present here as a source of protection from “what could have been”, for some participants.

The past two chapters discussed interview results and research findings related to middle class African American women’s attitudes, beliefs, perceptions of HIV risk and sexual behaviors from their perspective. The upcoming chapter will present a synthesis of these findings and discussion of existing literature on HIV risk, African American women, and social class. The chapter will offer recommendations and suggestions for future research, and will conclude by connecting the womanist theoretical framework with the research questions and study findings.

CHAPTER EIGHT:

DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

This chapter presents a detailed synthesis and discussion of findings from the semi-structured interviews of all participants (HIV positive women, HIV-negative women, and providers/experts) and the sexual history timelines of the HIV-negative participants. The sexual health risks of middle class African American women have generally been understudied in both medical and social science research. Hence, this exploratory study focused on the social, cultural, and contextual realities of the sexual experiences and attitudes about HIV and perceptions of HIV risk in a sample of middle class African American women living in metropolitan Atlanta, Georgia. This study sought to provide an understanding of how middle class African American women construct and understand their perceived risk for HIV in relation to actual sexual behaviors and the social and cultural context of their lives.

The findings of this study link existing literature on HIV, African American women, social class, and womanist thought. Likewise research results answer study questions, while identifying gaps that will expand our knowledge in HIV research on middle class African American women. The chapter concludes by offering recommendations for prevention based on literature and on the data obtained in this project. In addition, it will present future plans for research and propose venues for the dissemination of study results. Findings from this research will aid in guiding future cultural and gender-based HIV interventions for middle class African Americans and women. Moreover, study

results will hopefully help inform prevention and intervention strategies at the local, state, and federal level to address the HIV epidemic among African American women who fall outside the traditional categories of low income, low education, substance abuse, and/or sex worker individuals, who have been the focus of much HIV research.

HIV RISK PERCEPTIONS AND CONSTRUCTION OF HIV RISK

Similar to findings in past research that examined sexual behaviors and HIV risk perceptions among African American women (Johnson 1993; Kalichman 1992; Neff and Crawford 1998; Younge et al 2010), this study found that most of the women (both HIV-negative and HIV-positive) perceived themselves as having either low or no personal risk of contracting HIV. As expected, those women who were married or cohabitating with a partner reported low or no HIV risk. Here Comer and Nemeroff (2000) contend that women in monogamous relationships, such as marriage, tend to feel both physically and emotionally safe (Mehrotra et al 2009) in their relationships. Similarly, Sobo argues (1993) that "the monogamy narrative", which idealizes a monogamous heterosexual union, often serves as an adaptive response for women in long-term relationships. As a result, these women have a low perception of their risk for HIV. Yet it is important to note that some of the married or cohabitating participants attached their potential risk for HIV to their partners' behaviors. Hence, they made it known that they (participants) were not engaging in risky behaviors and are therefore not at risk as long as their husbands/partners remain faithful and do not step outside of the relationship. This thinking speaks to the fact that African American women's risk for HIV is most often

impacted by the behaviors of their partners (McCree and Rompalo 2007; O'Leary 2000; Pequegnat and Stover 1999; Mays et al 2012; Sharpe et al 2012).

Other participants' risk perceptions varied by the classification of their current or most recent sexual partner. For example, there were participants whose current or most recent sexual partners were classified as casual or the relationship was open; however the participants perceived their risk for HIV as low. On the other hand, participants who said they were in a serious relationship or exclusively dating one person still perceived their risk for HIV as high. Reasons given for the latter responses were the fact that participants were not married, so there was no formal commitment to ensure the participant that she was the only person in her partner's life. This further corroborates Comer and Nemeroff (2000) and Sobo's (1993) arguments about the perceived safety of marriage. Overall, several factors were assessed as influencing attitudes and shaping risk perceptions of HIV in the sample of women. They included knowledge about HIV/AIDS, educational attainment, income, family and social networks, relationship dynamics, spirituality and the influence of church, and media.

Most of the women possessed some form of HIV and AIDS education or knowledge. Many were aware of its disproportionate effect of the epidemic on African American women and were generally knowledgeable about HIV transmission and prevention strategies. A few women provided statistics on HIV in African Americans and African American women, while others spoke on the global impact of the epidemic. Scholars contend that knowledge is often considered a key element in influencing attitudes and behavior changes related to HIV risk reduction (Younge et al 2010; Braithwaite et al 1998). Likewise, research focusing on African American college

students showed a high awareness of HIV and AIDS, which included many women having a clear understanding of how the virus is transmitted and how to prevent the spread of HIV infection (Braithwaite and Thomas 2001; Taylor and Jones 2007; Barzagan et al 2000; Braithwaite et al 1998). Hence, higher education attainment is found to impact one's HIV knowledge. This was found in the present study as many women indicated that being college educated provided them access to resources related to HIV prevention. In addition, several participants described how educational attainment enabled them to learn more about HIV risk and the impact of the virus whether it was through course work, a degree program, or special projects.

Yet at the same time, studies also show that cognitive awareness of HIV and prevention strategies have little effect on many African American women's sexual behaviors or abilities to negotiate safe sex techniques with their partners (Katz 2003; Bazargan et al 2000; Braithwaite et al 1998). This was evident in the present study as one participant explained how she was a trained HIV and STI peer counselor, yet she seldom used condoms when having sex. Therefore, having the knowledge and education about HIV really did not influence her risk perceptions or behaviors. Providers and community experts, in the sample, similarly argued that there is a huge disconnect between African American women's HIV awareness and their actual application of safer sex practices; regardless of education level or income

Education, Income and Social Status

While poverty and low educational attainment, are often discussed as factors impacting African American women's risk for HIV (Mays et al 2012; Sharpe et al 2012; Williams and Prather 2010; Lane et al 2004; Gilbert 2003); little is known about the

influence of educational attainment and income on risk perceptions and HIV risk in middle class African American women. Research shows that increased education provides increased financial earnings and improved access to health information. Moreover, recent study findings (Painter et al 2012) suggest that having a college degree serves as a protector against HIV risk for African American women. These findings resonated with the thoughts of some participants, where three women believed being college educated meant having a lifestyle that set them apart from individuals who have a higher risk for HIV. Likewise, nine participants primarily believed that women with higher incomes had more options and could afford to make better sexual health and relationship choices.

In contrast, nine participants said education had no impact on their attitudes about HIV or their HIV risk. In comparison, fifteen women contended that income had nothing to do with their HIV risk. These statements were substantiated by participants sharing stories of knowing college educated African American women who have been infected as well as two of the HIV-positive participants sharing their personal experiences of being infected despite being college educated and having a partner with status. HIV providers and community experts assert that educational attainment and higher incomes sometimes cause middle class African American women to distance themselves from HIV and see it as a disease of “other people”. As a result they minimize their own personal risk (Quinn 1993), thinking that infection will not happen to them. The results from the present study suggest the need for more research in this area. This is crucial, since the depiction of having a college degree or higher income as

factors that reduce vulnerability to HIV can be dangerous as it potentially gives African American women a false sense of security about their HIV risk.

Family and Social Networks

Study results showed that family upbringing played a major role in shaping participants' thoughts about sexuality, HIV, and risk. Participants talked about the different aspects of parental communication and engagement that was used to address issues of sex and HIV risk. Most of the women reported "living sheltered lives". Hence there were no conversations about sex, sexually transmitted diseases, or HIV until they were grown or went to college. Several participants were raised on messages of abstinence, and some of them discussed how they strayed from their teachings. For example, one participant recounted how she was raised in a morally upstanding home, where the idea that "good girls" do not have sex before marriage was stressed. Then she jokingly said, "And I say that as I am shacking with a man". Some participants received the message of morality and judgment (e.g., sex is bad) from their families. Here participants expressed fear of having sex because of the presumed negative consequences this might bring. Additionally, some participants experienced open communication with their parents, where they were taught how to be responsible when engaging in sex as well as the consequences of not protecting oneself. In either case, most of the women stated that when having conversations about sex, sexuality, and protection, the protections messages did not reflect their current awareness of HIV; instead the messages mainly emphasized pregnancy prevention.

It is believed that parents play an instrumental role in reducing one's sexual risk taking (DiClemente et al 2001; Whitaker et al 1999; Durta, Miller, and Forehand 1999;

Miller et al 1998a, 1998b; DiIorio, Kelley, and Hockenberry-Eaton 1999). Evidence shows that African American teens perceived as having greater parental control and consistent parental presence displayed lower levels of sexual activity (Jemmott and Jemmott 1992). Additionally, research suggests that teens who communicate more with their parents about sex-related topics are more likely to practice safer sex behaviors (DiClemente et al 2001). Hence, it was interesting to hear some participants talk about their upbringing in comparison to their actual sexual experiences. Stephens and Phillips (2005) argue that the expectation messages of African American parents regarding sexual behaviors are usually expressed through beliefs, values, and behavior patterns in the home, where general communication is critical for the transmission of such values, beliefs, and knowledge (Feldman and Rosenthal 2000; Miller et al 1998a, 1998b). Here, many participants expressed deep sentiments when talking about their family ties and upbringing. Some women told how they wish they heeded the messages they received growing up; whereas others talked about not being sufficiently educated about sex. Only half of the participants reported social networks impacting their thoughts or attitudes about HIV. This included two HIV-negative participants telling their experiences of having close family friends with HIV. Also one participant talked about her and her friends holding each other accountable when they start dating someone new. Herein the women make sure that they ask their partners about their HIV status and find out when the man was last tested (e.g. ask to see their papers) before engaging in sex. Other participants said HIV was generally not a topic of discussion in their social network.

Gender Imbalance and Sexual Networks

The participants' perceptions about gender imbalance and sexual networks centered around two main subjects: 1) women comprising their standards and engaging in risky behaviors such as the practice of man-sharing and 2) men having multiple partners, which include men who have sex with men and women. The disproportionate incarceration rate of African American men, the higher mortality rate of African American men compared to African American women, and African American men's underemployment and lower education attainment compared to African American women make for an intensely competitive relationship market for African American women (Gilbert 2003; El-Bassel et al 2009; Mays et al 2012). Findings from both participants and providers/community experts reflect the severity of the gender imbalance between African American men and African women, particularly in Atlanta, GA. Consistent with research, study responses implied that African American women are more likely to engage in unsafe sexual practices or compromise their standards (e.g. date married men, have unprotected sex, deal with unsafe habits such as excessive drinking or drug use) for fear of losing their partner or not being able to find another one (Sobo 1995, Gilbert 2003; Tillerson 2008; Alleyne and Wodarski 2009).

Beliefs about sexual networks were very important in constructing participants' perceptions about HIV and risk. Findings indicate that participants' lack of knowledge about their partner's sexual behaviors or sexual histories was the greatest fear many women had. As several participants stated that if they knew what their partner was doing or who their partner was doing it with, then they could make informed decisions about their own relationship. Along those same lines, many participants talked about

issues of African American men engaging in the down low behaviors. Varying views and opinions emerged between the participants and the providers/community experts. As argued by Saleh and Operario (2009), many of the providers/community experts believed that the uncritical use of the "the down low" terminology, particularly in public health and HIV prevention strategies, can be problematic and counterproductive because it (a) stigmatizes and exoticizes secretive same-sex sexuality as a unique issue among African American men and (b) ignores the social conditions under which HIV transmission often occurs (391). The participants contend that their partners' honesty and open communication about their sexual behaviors are essential to reducing their HIV risk. Likewise, providers and community experts assert that the women have to take part in the communication process and ask questions about their partners' behaviors and sexual histories, however, the data suggest that, in reality, this is not typically happening.

Other Social and Cultural Factors

Church, Religion/Spirituality

Several women reported religious beliefs and the church as influencing their perceptions and beliefs about HIV, risk, and sexuality. This is not surprising as 20 of the 24 HIV-negative and HIV-positive participants reported being members of a church or religious institution. Moreover, 11 of the women reported attending religious services on a weekly basis. Religion plays an important role in African American culture and especially in the lives of women (Levin, Taylor, Chatters 1994). Yet, despite African American women's increased risk for HIV, few studies have explored the cultural and attitudinal effect factors such as religion/spirituality have on their risk (Muturi and An

2010). As expressed by some participants, evidence shows that some religious beliefs and values only instigate discrimination, stigma, and judgment against HIV or people with HIV. For example, many churches associate immoral behaviors with HIV and AIDS, in which the message is as stated from one participant, “sexual immorality is a curse and people engaging in sexual immorality will be cursed by God.”

Not all churches and religious leaders subscribed to the beliefs or attitudes that were previously mentioned. Some participants talked about clergy who actively engaged in HIV/AIDS prevention and intervention efforts and also encouraged others to do likewise. Hence, there are some faith based organizations that are aware of the impact of HIV in the African American community and are therefore making a conscious effort to get involved and respond to the epidemic. Additionally, participants’ reliance on God as a source of hope and protection was noteworthy. Two of the HIV-positive women described how God was their reason for still living. In that, they explained how God gave them purpose even in the midst of being infected with AIDS. Similarly, some of the HIV-negative participants expressed thoughts of gratitude and thanks to God for protecting, shielding, and keeping them out of harm’s way. Further, several of the HIV-negative women, reflecting over things done in their past, believed that God protected them from catching any diseases or being infected with HIV.

Media

Media played a significant role in shaping both negative and positive views of HIV and risk among the participants. Television, movies, and books were most commonly mentioned as influential sources. Here, research shows that media provides an enormous amount of sex scripts (i.e., organized knowledge structures that are

instrumental in helping individuals organize ideas of appropriate sexual experiences) (Simon and Gagnon 1984, 1987) for women as forms of entertainment and the sale of merchandise. However, the popular media is likely to depict African American characters in stereotypical, negative social roles or behavioral characteristics such as the jezebel, welfare queen, mammy, or matriarch (Kelly 2003; Jordan-Zachary 2009). In terms of HIV risk those stereotypes tend to be of individuals who are gay, drug users or promiscuous (Hammonds 1995; Gilbert 2003). Likewise African American women are often told that "having a man" is the prescribed gender role. Hence women are urged to be available, be subservient, which sometimes also means making unsafe sexual decisions in order to preserve their relationship (Kelly 2003). As a result the tension between societal media portraits, family values and religious beliefs about sexuality and sexual behaviors can be overwhelming (Kelly 2003). Thus, in some cases African American women become deeply conflicted by the messages reinforcing the need to attract a partner and what is deemed as appropriate or acceptable sexual behavior.

In discussing media, some participants praised actor and director, Tyler Perry for his movies that brought attention to HIV in African American women. The women who talked about the movies appreciated Perry's use of middle class African American women to bring attention to the issue of HIV as opposed to the use of stereotypical characters (e.g., poor, drug user, and prostitutes). Other women talked about Oprah Winfrey having E. Lynn Harris and J.L. King on her show and how this enlightened them about the sexual practices of some men, specifically as it relates to the practice of "down low" behaviors. As with the movies, participants said Oprah's show was an eye-opener and it made them more alert for what to look for in men when dating.

Whereas some of the providers and community experts thought there could have been more conversation around both the movies and Oprah's guests, several of the participants were pleased and found these media quite helpful. Here it is important to consider how media can impact African American women in directing their sexual behaviors and perceptions. Evidence shows that viewers of cross-cultural media generally pay more attention to characters or information with which they identify. Therefore media, such as Tyler Perry movies, and the Oprah Winfrey show whether positive or negative have the ability to shape how African American women see themselves and ultimately perceive their risk for HIV (Stephens and Phillips 2005).

SEXUAL EXPERIENCES, DECISIONS, AND HIV RISK

Some of the study participants' self-reported behaviors indicate that they may be underestimating their potential HIV risk. Some women have engaged in behaviors, such as unprotected sex, concurrent sexual partnership, and having sex while intoxicated, all of which play a major role in increasing the risk for HIV infection (Adefuye et al 2009; Adimora et al 2004; Poulson et al 2008; McCree and Rompalo 2007). Hence it is suggested that if such behaviors are repeated or continued in the future, they would further increase the risk for the women.

Similar to findings from other research (Kline, Kline, and Oken 1992; Afifi 1999; Hearn and Jackson 2002), the data from this study showed that consistent use of condoms was low in this sample of middle class African American women. Ironically, many of the participants identified unprotected sex as a factor contributing to HIV in African American women. As earlier stated, the majority of the HIV-negative participants

who were married did not feel the need to use condoms because of their relationship status. Of the 14 HIV-negative women who were not married (e.g., single, divorced, or widowed), only five reported consistent condom use with their current or most recent partner. Reasons for not using condoms varied and included choosing not to, being naïve, and getting caught up in the moment. Here, Sobo argues that "depending on the context in which choices are made, various features will affect risk perception, evaluation, and acceptance" (1993:461) of one's choices. Whereas much of the literature focusing on African American women, sex, and HIV highlights women's financial dependence on men or their trading sex for drugs as motivating factors for not using condoms, that was not the case with this research sample. In fact, the majority of the participants fall into the middle or upper middle class income bracket. Thus, with economics not being a factor, this research suggests that the type of relationship (e.g., casual or steady), substance use (e.g., alcohol consumption), and perceived risk are instrumental in dictating whether or not women choose to engage in unsafe sex (Alleyne and Wodarski 2009).

Eight women reported relationships that occurred while engaging in concurrent sexual partnerships (sexual relationships with two or more people that overlap in time), This is important because concurrent sexual partnerships increase one's risk for HIV and "permit a more rapid spread of infection through a network" than if one acquired new sequential partners (Adimora and Schoenbach 2005; Morris and Kretzschmar 1995). However, most of the concurrent relationships occurred while the participants were in college or in their early 20's. This fits with Lewis and colleagues (2000) contention that college students are especially susceptible to HIV and AIDS due to their

sexual behaviors, which include inconsistent condom use and multiple sexual partners. Likewise, it is argued that college student are likely to have multiple sexual partners over the course of their college experience (Alleyne and Wodarski 2009; Alleyne 2008). Therefore, it is also important to focus on Black female college to students as a group in HIV prevention programs to address HIV risk behaviors such as multiple and concurrent sexual partnerships (Alleyne and Wodarski 2009; Adefuye et al 2009) and alcohol and marijuana use (McEwan et al 1992; Adefuye et al 2009; Poulson et al 2008) most often occurred while participants were in the college environment.

In this study, three participants reported making risky sexual decisions as a result of drinking alcohol and /or smoking marijuana. Herein, one of the participants said her having multiple and concurrent sexual partnerships were a result of her consumption of alcohol and marijuana. As with most other risk behaviors, these events occurred while the participants were in the college environment. This falls in line with research among Black college students that shows that alcohol consumption and marijuana use alters judgment, removes inhibitions, and increases sexual risk taking (Adefuye et al 2009; Poulson et al 2009). It is, therefore important to reiterate the need to address risk behaviors of African American female college students and using HIV/AIDS prevention strategies that are culturally and gender focused towards this population.

Nine women reported having been diagnosed with a sexually transmitted infection. Similar to incidents of concurrent sexual partnerships and alcohol and marijuana use, six of the participants were infected while in college. Five of the six women were in monogamous relationships at the time of their infections. As discussed by several scholars (McCree and Rompalo 2007; O'Leary 2000; Pequegnat and Stover

1999), women most commonly acquire STIs and HIV from heterosexual contact with an infected partner. Here Baker et al (2003) contend that sexual transmitted infections are often asymptomatic in women, thus some STIs, particularly HIV are easier to be transmitted from men to women. Such was the case with one participant who had been recently diagnosed with herpes, but was not sure of how long she had the STI because she never had any symptoms of infection.

The finding that many HIV-negative participants have had sexually transmitted infections is especially important given the fact that STIs (e.g., herpes, syphilis, chancroid, gonorrhea, chlamydia, and trichomonas) have all been found to be associated with increased risk of HIV infection (Smith et al 1997; Aral and Wasserheit 1995; Ojikutu et at 2009). A recent study was conducted examining the association between educational attainments and confirmed sexually transmitted infections in African American women. In this study, it was suggested that having at least a college degree reduces African American women's risk for STIs and HIV (Painter et al 2012). However, the study population was limited to only unmarried women and those individuals who were members of a particular healthcare plan. Additionally, the study only assessed the presence of a STI at the time of the women's clinical visit (one point in time). In contrast, for this dissertation research, participants were asked to reflect upon sexual experiences spanning all their sexually active life, and explicitly asked about sexually transmitted infections. Therefore over a period of time, it was found that women were infected by their spouses, some were infected in college, some had multiple infections (e.g. at a younger age and then as an adult), and some were infected post college graduation (e.g., within 12 months of their interview). Hence, this suggests

that, by focusing only on one specific point of time, the above mentioned study may give a distorted view of African American women's STI and HIV risk in relation to educational attainment, particularly if the women are not consistently using condoms as with this study population.

Relationship Dynamics

Overall, most participants reported having mutual respect between them and their partners, in which both individuals shared in the sexual decision making process (e.g. condom use, having sex). Sobo (1993) argues that when women say that deciding whether or not to use condoms is a mutual decision it may signify several things in a relationship: 1) it can reduce feelings of powerlessness for the woman in the relationship; 2) it can camouflage social and emotional dependence on their partner; and 3) it can reflect a real desire for commitment and repress the knowledge of a fragile relationship. However, the present study found that participants most often cited equal power when describing their relationships with their partners. Trust also emerged when talking about relationship dynamics. Participants in monogamous/committed relationships reported having complete trust in their partners. Thus, as suggested by Sobo (1993) the women's expression of trust may reflect their desire for the ideal commitment in their sexual encounter. At the same time, some women stated that they would not have sex if their male partners refused to use condoms. This indicates that these women have both the control and confidence in their sexual relationships to talk about safe sex practices as well as adhere to them.

Assault and trauma are important factors to consider in assessing African American women's HIV risk; however they are often overlooked in some research

(Gilbert 2003). Very few of the women in this study reported a history of abuse in their relationships. As reported in various studies, the emotional and psychological impact of a woman's involvement in such experiences can result in behaviors or decisions that place her at increased risk for HIV (Champion et al 2001; Wyatt et al 2002; Jarama et al 2012). Three study participants reported being sexually abused. One woman stated having long term feelings of distrust for men as a result of her ordeal. Unfortunately, one of the other women was infected with AIDS as a result of her attack. In either case, prevention, intervention, and treatment programs are most beneficial as they comprehensively address sexual abuse, mental health, HIV prevention, and intervention issues for the women in need.

HIV Testing

All the HIV-negative participants reported having an HIV test, most of them within 12 months of their interview. Although many of the participants said it is important to know their partner's status, only six of the women reported that their partner had previously been tested and that they knew their partner's status. Two participants said their partners told them they had been tested; however the women could not verify whether or not their partner was telling the truth (e.g. they had not seen proof of their last test or HIV status card).

Most of the participants believed it is important for healthcare providers to discuss HIV issues and offer testing to all of their patients. Many of the women said that they did not place the responsibility of getting tested solely on their healthcare provider. Instead they would take the initiative and ask to be tested during their annual visits. Whereas a number of AIDS prevention and community-based organizations provide

HIV testing and counseling in the metropolitan Atlanta area, it was indicated that all healthcare providers do not readily provide those services to all of their patients, particularly those who they deem are not at risk for HIV. There was a general consensus by prevention providers and community experts that medical practitioners and healthcare providers are more likely to recommend or offer HIV and STI testing to individuals who live in a certain part of town, are of a certain income level, or have a certain marital status. Likewise, many of the HIV-negative participants asserted that HIV testing was something not readily offered by their healthcare providers. It was something the women had to request. Hence this provider bias potentially adds to the perception that only certain subgroups are at risk for HIV and need testing. Given the paucity of literature pertaining to the subject of provider bias and HIV testing, this is an area of research that merits further exploration.

Self-Esteem

The findings regarding participants' past and present self-esteem and self-image can also help understand African American women's sexual behaviors and decision making. Some scholars suggest that the negative self-images such as being too dark or not liking one's body shape are strongly influenced by the historic over sexualized stereotypes of African American women and the devaluation of Black womanhood (Stephens and Phillips 2003; Douglas 1999). Herein, it is believed that a woman who has a low self-image feels the need to be desired by the opposite sex and is therefore vulnerable to make unsafe sexual decisions (Robinson, Holmbeck, and Paikoff 2007). Conversely, research suggests that a positive self-image includes high self-esteem, self-control, and perceived invulnerability to poor decision making (Gullotta et al 2000).

Consistent with the literature, participants reported how self-esteem influenced their decision making and choice of partners, whether negatively or positively (Robinson et al 2007). Although low self-esteem was not a current issue for any of the participants, some of the women discussed how in the past it has impacted their self-image, affected their view of how the opposite sex perceived them, and influenced their vulnerability to making unsafe sexual decisions.

Womanist Theory

Bell hooks (1992) contends that the collective experience of Black women has been about the struggle to survive the diaspora. Given that, Taylor (1998) asserts that approaches used in women's health research, such as HIV risk in African American women, should allow us to understand the cause of the problem and what can be done to eliminate the problem (Barbee and Little 1993). Hence, the use of a womanist lens to explore middle class African American women's perceptions of HIV risk through qualitative methods does that. The face-to-face interviews and sexual history timelines used in this research project allowed the participants to be themselves and include contextual explanations for events related to sexual relationships, behaviors and personal experiences (e.g., alcohol, rape, violence, age, self-esteem, etc.). In addition these methods enabled the women to articulate their experiences about HIV and AIDS as well as about other issues (e.g., dating practices, the availability of men, self-image) that concern them as middle class African American women living in Atlanta, GA.

In carrying out this research, I was reminded of what Leith Mullings says about our task as Black womanist and Black feminist anthropologists. She asserts that we are to "illuminate the experiences of African American women and theorize from the

materiality of their lives to the broader issues of the structural factors, representation, and transformation (1997: xi). Hence, womanist theory allows me to express the combined effects and joint influence of race, gender, and class in structuring middle class African American women's perceptions and potential risk for HIV. Only by virtue of gender and race are college educated middle class African American women perceived at risk for HIV. However being a Black woman weakens their protection of class, particularly as seen by the disproportionate effects of HIV in African American women compared to women of other ethnic groups (CDC 2013a). Middle class African American women have made remarkable educational and income achievements necessary to obtain middle class status; however middle class African American women are less likely to get married. This is due to the shortage of "marriageable men", which comes as a result of disproportionate unemployment, high mortality, and high incarceration rates among African American men (Gilbert 2003; Mays et al 2012). Here again, race weakens the protection of class. Moreover, for middle class African American women living in all Black neighborhoods, their class advantage is weakened by the structural discrimination of racial residential segregation, which potentially influences their sexual networks (Patillo-McCoy 1999; Lacy 2007). Thus, all these factors contribute to African American women's risk for HIV.

Accordingly, womanist theory gave voice to the women participating in the study to name their perceptions about HIV and the effects it has had on their relationships. This was important as several women said that they never had an opportunity to talk with anyone about HIV in such an intimate setting nor have they been able to voice their opinions or concerns about HIV and AIDS. On several occasions, participants

recommended ideas for my research, like going to see Tyler Perry's movie *Temptation*. Some participants also provided insight on subjects such as HIV status cards (something I did not know existed), prevention programs geared towards professional and middle class women, and provider biases about HIV testing. Similarly, providers and community experts reiterated the fact that HIV research is often focused on low-income African American women as opposed to college-educated or middle class women. Therefore, while many of the participants provided valuable information, they also thought this study gave face to another population that is both affected and infected by HIV, but is rarely talked about or heard from. This is a dimension of womanist epistemology - assessing knowledge claims through dialogue with the participants.

Here it important to understand that African American women are not a monolithic group. Often when talking about HIV in African American women, risk is viewed in the context of how people see the disease (e.g., who you are – a drug user, a prostitute, etc.) as opposed to viewing risk in the context of individual lives (Oneuegbuzie, Leech, and Collins 2008). For this reason, the image of middle class African American women's personal and communal standing is important because of stereotypes that have historically depicted African American women as Jezebels, welfare queens, and baby mommas (Skylar 1995; Jordan-Zachary 2009). Moreover, these images contribute to society's and the medical community's view of African American women as seen through healthcare providers' biases toward talking to patients about HIV testing based on who they think is at risk. Thus middle class African American women both confronting and challenging racially gendered and classist attitudes debunks the various myths of Black womanhood (Jordan-Zachary 2009).

Further, womanism also encouraged a sense of empowerment in the participants. While reflecting over their past, some women talked about events in their lives or mistakes made and how they have taken personal responsibility to move beyond those situations. For example, one of the HIV-positive participants said she has been through a lot with being infected, but AIDS is not who she is, nor is it what she has been through. She states that she educated herself about the virus and went through mental health counseling so that she could one day be in the position to help and empower others to not be victims, especially women. A HIV-negative participant tells how she had a "come to Jesus meeting" with herself because she knew she was not living up to the standards she was raised by in terms of sexual decisions and choice of men. In these cases as well as others not mentioned, participants are empowered – seeing themselves as change agents with the personal capability to make change in their lives and also having influence over others because of their social location or credibility (e.g., HIV-positive participant empowering others by telling of her experience) (Few et al 2003). In addition, participants provided suggestions for a course of action towards HIV prevention strategies targeting middle class African American women. This active participation in the potential development and implementation of future HIV preventions empowered the participants to think about prevention practices they can use in their own lives. Moreover, it increased their ownership in the process of finding practical solutions to the problem of HIV and AIDS in African American women.

IMPLICATIONS FOR INTERVENTION AND FUTURE RESEARCH

Based on study findings, which include suggestions from participants, there are a number of implications for HIV/AIDS preventions targeting college educated middle class African American women. While much of society has the misconception that HIV only affects individuals who are deemed disenfranchised (e.g., low-income, uneducated), it is important for HIV prevention providers and other community experts to dispel those myths.

Overall most study participants perceived themselves to have no or low risk for HIV infection despite some of their actual risk behaviors. When a woman does not perceive the presence of risk, she is unlikely to practice safer sex behaviors. Accurate information is essential for HIV risk-reduction, yet research findings show that information and knowledge do not readily translate to practice. Prevention providers and community experts understand how psychosocial behaviors affect one's sexual decision making. They sit in distinctive positions to motivate African American women and inspire them to bring about change in their lives. Moreover, they have a track record of influencing policies that improve the lives of those who are unable to speak for themselves (Alleyne 2008). Hence it is important that prevention providers and community experts include prevention efforts to reach African American women from all walks of life (e.g., college educated, middle class, midlife, seniors).

This study has shown that being a female, a member of an ethnic minority group, specifically African American, and living in the South, puts some women at risk for HIV regardless of income, educational attainment, or age. Some prevention providers reported having programs that target professional women, such as the SISTA

intervention, which is a group-level, gender and culturally-relevant intervention designed to increase condom use with African American women and is funded through the Centers for Disease Control and Prevention (CDC). Another program mentioned is an intervention video series called “Everyone has a story”. It targets women who are HIV-positive, women who are at risk, as well as those who are contemplating getting tested with the purpose of lifting up the fact that everybody, regardless of social status, has a story. Hence gender specific culturally relevant prevention programs are being offered; however they are few in number and more are need. Therefore prevention providers are encouraged to continue their efforts in targeting professional, college-educated, middle class women. Additionally, healthcare providers need to be more diligent in offering HIV testing and talking to ALL their patients, especially African American women about HIV risk, regardless of income, residential location, marital status, or social status. To date, most healthcare providers target uneducated poor African American women or those living in low income neighborhoods for HIV testing, when in reality everyone should be tested (Hixson, et al 2011).

It is also suggested that the church and clergy get more involved in HIV prevention efforts. Historically, the Black church has been a place of leadership development, protection, and resourcing day-to-day needs for survival as well as a means of gathering valuable and trustworthy information. The church has served a vital role within the Black community for defining values and norms (Smith, Simmons, and Mayer 2005). It was the birthplace of the civil rights movement and a site for social and political activism (Beadle-Holder 2011). Additionally, the Black church has been

instrumental in advancing health promotion messages and successful in engaging congregations in prevention and wellness activities (Williams, Palar, and Derose 2011). However, we find that the successes the Black church has in mobilizing communities in areas such as evangelism, political activism, and health promotion in reducing chronic diseases (e.g., cardiovascular disease, diabetes, cancer and hypertension) do not readily transfer to programs for HIV prevention and education. Instead the message received is one of stigma and condemnation. This is not the case in all churches, as some participants told how their pastors encouraged their congregation to get tested. On the other hand there are churches that create barriers to HIV prevention and discourage anything other than abstinence.

Some women indicated that they want to use condoms or that condom use is essential in their sexual relationships. Hence, there needs to be interventions that target effective communication between men and women that teach the importance of consistent condom use. This could be accomplished by emphasizing the fact that engaging in protective behaviors not only protects oneself, but also one's partner Likewise, this education should stress open communication between partners and the importance of knowing your partner's HIV status and discussing one's sexual histories. In addition, the findings from this study about male partners' behaviors affecting participants' risk for sexually transmitted infections and HIV imply that there needs to be more research and intervention that focuses on heterosexual African American men who have sex with women to prevent to the transmission of HIV. This may prove more effective than solely focusing on African American women who may or may not adhere to safer sex practices when they are with their partners. Ideally, such interventions and

research would provide a forum for heterosexual African American men who are at risk for HIV to also learn prevention strategies.

Suggested Intervention and Application of Sexual History Timeline

While the sexual history timeline was used a source of data collection in this study, it is also vital for creating a link between research and practice or intervention. Specifically the sexual history timeline enables participants who underestimate their HIV risk or deny their risk for infection (i.e., HIV risk denial) (Sobo 1995) to see patterns of sexual behavior that may contribute to actual HIV infection.

The sexual history timeline provides a comprehensive visual illustration of one's sexual history and behaviors, including number of sexual partners, decision making, pregnancies, history of assault or abuse, and history of sexually transmitted infections (Bell-Scott 1994; Bell-Scott and Johnson-Bailey 1998; Stephens, Phillips, and Few 2009). Hence the use of this instrument aids participants in understanding themselves, making sense of their relationships with their partners and processing past decisions and behaviors relating to certain events or specific time periods in their lives (Few et al 2003). Additionally, the sexual history timeline promotes self-empowerment and self-reflexivity, where the women telling the stories of their sexual experiences can be a liberating process as well as source of healing. Herein they systematically reflect upon past relationships, think about past issues (e.g. infidelity, STIs), consider approaches for overcoming possible guilt, shame, self-esteem, and poor decisions associated with past sexual decisions; or celebrate positive decision-making (Belous et al 2012; Few et al 2003).

Overall, information obtained from the sexual history timeline can help prevention providers understand African American women's sexual decision making processes and the context in which sexual decisions are made. (Stephens et al 2009). Hence future guidelines for HIV prevention and programs should be developed based on knowledge gained from the women engaging in this exercise or others like it. Herein, we find that this integrative approach for participants to connect their sexual experiences with the narrative provides room for them having an "aha moment" and thus result in them re-evaluating their situation through new perspectives (e.g. change in beliefs, perceptions towards HIV risk, or attitudes about sexual decisions) (Belous et al 2012; Stephens et al 2009).

DISSEMINATION OF FINDINGS

Results of this research are being disseminated in several ways. A theoretical paper explaining the contribution of Black feminist anthropology to HIV research was presented during an invited session at the 2013 American Anthropological Association Annual Meeting in Chicago, IL. That paper was revised for submission to a peer-reviewed journal. A paper presenting preliminary results will be given at the 2014 American Anthropological Association Annual Meeting in Washington, D.C. in December. Complete results will be shared with a wide academic audience in the social sciences, with community-based and religious organizations, and with government agencies at the state and federal level to help inform prevention and intervention strategies that address the HIV epidemic among African Americans. A summary of the major findings will be presented to stakeholders, who include prevention providers,

community experts, and key informants Likewise, additional manuscripts will be written and submitted for publication from the final results.

FINAL CONCLUSIONS

There is limited information on middle class African American women's HIV risk and perceptions of HIV risk. However in doing this type of research, it should be viewed holistically. The views and opinions of HIV risk among middle class African American women may be the reflection of very distinct social and cultural norms that are uniquely tied to the women's relationships, sexual experiences, or social location. For example, some middle class African American women think that HIV only occurs among individuals who are poor. Some African American women believe that African American men on the down low increase women's HIV risk. Likewise, some middle class African American women have the idea that dating men from a better class put makes them safe or less at risk for HIV. Hence these views relate to what Reid (2000) talks about - African Americans of a certain status distance themselves from HIV; thinking that it does not affect them or people they with.

This study found that middle class African American women residing in Atlanta, GA mainly perceive their risk for HIV as low. In addition, risk perceptions are formed based on family values and upbringing, social networks, educational attainment, income, religious beliefs, relationship dynamics, and media influences. The study's findings provide important information about HIV risk perceptions within a highly understudied population. Likewise, its findings support the importance of exploring

culturally relevant factors when seeking to understand behavior constructs such as perceived risk with a population that has not received much attention in HIV research.

Factors that place women at risk for HIV are early sexual debut and partner characteristics such as multiple sexual partners, concurrent partners, and risky behaviors (e.g., IV drug use). While it is not possible to make definite claims of this study participants' HIV risk, the HIV-negative sample appeared to have some risk for HIV infection primarily due to risk factors of their partners and the participants' low condom use. Other factors associated with HIV risk of the study participants included alcohol use by the women themselves. Overall, ten of the HIV-negative women in the sample reported at least one of the above risk factors. HIV-positive participants reported not being drug users, sex workers, or engaging in other high risk behavior prior to infection; yet they were all infected with HIV and AIDS. Two of the women were in monogamous and committed relationships and reported being infected by their partner. The other participant was infected as a result of being raped. Furthermore, all of the HIV-positive participants were over the age of 50. Hence their experiences suggest that anyone can be infected regardless of income, educational attainment, relationship status, age or other circumstances.

This research has some limitations. A goal was to obtain a representative sample of middle class HIV-positive women in Atlanta, Georgia. However, as stated in the methods section, middle class African American HIV-positive women were very difficult to recruit. This was because many of the women were not willing to come forward or participate in the study due to stigma and fear of loss of status if someone were to find out their HIV status. Secondly, given the small number of research

participants, it is impossible to generalize the findings of this study. As with African American women in general, middle class African American women are a diverse group. Therefore this sample is not representative of all middle class African American women in Atlanta, GA. In addition, the metropolitan Atlanta area as defined in this study is comprised of ten counties and the city of Atlanta. Participants in this study only represented five of those counties, Clayton, Cobb, Dekalb, Fulton, and Gwinnett counties and the City of Atlanta. Therefore more research needs to be done to obtain a more representative sample of middle class African American women living in metropolitan areas.

Despite the study's limitations, it included women age 50 years and older, which speaks to the importance of focusing on HIV risk and mature African American women living with HIV and AIDS (Mallory et al 2009). Additionally, this research employed womanist theory as the conceptual framework, which allowed for exploring middle class African American women's experiences and gaining insight about HIV risk from their social location and shared stories relating to their personal risk. This study also provided suggestions for implementing prevention strategies and offered recommendations for addressing issues relating to stigma, risk denial, and prevention barriers for middle class African American women.

Anthropologists frequently draw on structural perspectives such as critical medical anthropology to explore the effects of ethnicity, gender, and class on the spread of HIV (Doyal et al 1994; Schoepf 1992; Farmer 1999; Lane et al 2004; Singer 1994). Likewise public health researchers most commonly use social structural concepts such as the theory of gender and power (Connell 1987) for explaining women's risk for HIV

(Wingood and DiClemente 2002). However, these approaches frequently overlook the social class position of middle class African American women because of their heavy focus on poverty, lack of healthcare access, and low education attainment as factors of HIV risk. However, womanist theory allowed for the recognition and naming of issues and concerns of African American women that frequently go unrecognized (e.g. the availability of men, religious beliefs, self-image, family values). Moreover, it was a goal that womanist theory would aid in bridging the gap between medical anthropology and public health models by illustrating ways that race, class, and gender hierarchies are "embodied" (Krieger 1999) and ultimately impact African American women's HIV risk.

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Appendix A

Interview Guide: HIV-Negative Women

Questions about Knowledge, Attitudes, and Perceptions [*I will begin by asking you questions about your personal knowledge, attitudes, and perceptions of HIV. Please be assured that all your responses and any identifying information will be kept confidential. One of the aims of this interview is to use this information to develop better HIV prevention programs targeting middle class African American women*.]

Tell me what you know about the current HIV epidemic.

Tell me what you know about the impact of HIV on African Americans.

Thinking about everything you know or have heard about HIV among African Americans, what are your main sources of information?

What factors do you think contribute to the spread of HIV among African Americans? Why?

As a middle class African American woman, what do you think about HIV in general? (What are your thoughts, perceptions, and attitude)?

Questions relating to Social and Cultural Norms
[*The next set of questions will ask about your perceptions of HIV risk relating to social and cultural norms associated with the African American community.*]

In general, how do you think African American women perceive their risk for HIV infection?

As a middle class African American woman, how would you perceive your overall risk for HIV? Why?

As a middle class African American woman, how do you think your education has shaped your perceptions of being at risk for HIV? *(Give examples)*

How do you think your income has shaped your perceptions of being a risk for HIV? *(Give examples)*

How has gender shaped your perceptions of being at risk for HIV? (Give examples).

As a middle class African American woman, how do you think the following has influenced the way you think about HIV? (Friends, family, or other social networks)

How have your religious or spiritual experiences influenced the way you currently think about HIV (sermons, lessons, biblical teachings, stigma toward HIV)?

How do you think the media influence perceptions of HIV risk in the African American community? For example, portrayal of gender roles, male-female relationships, and other stereotypes.

As an African American woman, how has media (e.g., TV, movies, music, etc.) influenced your perceptions of HIV risk? Why?

What do you think about there being more African American women than available African American men?

How do you think gender imbalance (there being more women than available men) affects HIV transmission in the African American community?

Tell me what you know about the "down low" or "DL' phenomenon (men who have sex with men who self-identify as heterosexual).

How do you think "down low" behavior affects HIV transmission in the African American community?

As a middle class African American woman, how would you say "down low" behavior affects the way you think about HIV?

How do you think "down low" behavior impacts your risk for HIV infection?

Are there any other factors that affect the way you think about HIV?

Questions about Personal and Sexual Relationships

[*The next set of questions will ask about your personal and sexual relationships. Remember, all your responses and any identifying information will be kept confidential and you are free to refuse to answer any questions that make you feel too uncomfortable.*]

How do think your upbringing (your family values, beliefs, or attitudes) has influenced what you think about your own risk for HIV? Explain.

Tell me about your family life growing up. How do think your upbringing (your family values, beliefs, or attitudes) has influenced your thoughts about your sexuality (i.e., the way you feel about sex, sexual activity, etc.)? Explain.

How do think your upbringing (your family values, beliefs, or attitudes) has influenced your thoughts about how you choose a mate or partner? Explain.

Tell me about your decision-making process when choosing a mate or sexual partner? What factors help you determine whether to engage in a sexual relationship with a man?

Tell me about the nature of your current sexual relationship(s*). (Sex is defined as oral, anal, vaginal stimulation/penetration).*

Probes: Thinking about the past 12 months, how often do you have sex?

Do you have a regular sexual partner? If yes, describe your level of commitment to your regular sexual partner?

Do you have sexual partners other than your regular sexual partner? If yes, how many others?

If yes, tell me how you came to the decision to have multiple sex partners?

Thinking about your current relationship, tell me what you think about your potential risk for HIV? Explain

Tell me about your condom use during sexual intercourse with your sexual partner(s).

Probes: Do you use condoms? If no, why not? If yes, why? How often do you use them?

Do you use them with all of your partners? (A*sk if respondent has more than one partner*).

Who initiates condom use in your relationship(s)?

If your partner(s) refuses to use a condom will you have sex anyway? Why or why not?

Is there anything that would make you not use a condom with 'x" partner? Explain.

How do you think drinking alcohol or using drugs (that includes smoking marijuana) plays a role in your sexual relationships?

Probes: Do you or your sex partner(s) drink alcohol or do any type of drugs (including smoking marijuana)? If yes, why? How often?

Has there ever been a time when you felt tipsy, drunk, or high before or during sexual intercourse? If yes, tell me about that.

Has your partner ever been tipsy, drunk or high before or during sexual intercourse? If yes, explain.

How do you think alcohol or drugs (including marijuana) affected your judgment prior to or during sex?

Have you ever been tested for HIV? If no, why not? If yes, when was the last time you were tested?

Does your healthcare provider talk to you about HIV testing or do you have to ask about testing?

Probes: Is HIV testing standard practice with your healthcare provider?

Other information

If you had to design a HIV communication campaign or intervention for middle class African American women, what would it look or sound like?

Is there anything else you want to talk about in relation to HIV as it applies to you as an African American middle class woman?

Appendix B

Interview Guide: HIV-Positive Women

Questions about Knowledge, Attitudes and Perceptions [*I will begin by asking you questions about your personal knowledge, attitudes, and perceptions of HIV. Please be assured that all your responses and any identifying information will be kept confidential. One of the aims of this interview is to use this information to develop better HIV prevention programs targeting middle class African American women*.]

Tell me what you know about the current HIV epidemic.

Tell me what you know about the impact of HIV on African Americans.

Thinking about everything you know or have heard about HIV among African Americans, what are your main sources of information?

What factors do you think contribute to the spread of HIV among African Americans? Why?

As a middle class African American woman, what do you think about HIV in general? (What are your thoughts, perceptions, and attitude)?

Questions relating to Social and Cultural Norms
[*The next set of questions will ask about your perceptions of HIV risk relating to social and cultural norms associated with the African American community*.]

In general, how do you think African American women perceive their risk for HIV infection?

Before you became infected, as a middle class African American woman, how did you perceive your risk for HIV?

Before you became infected, as a middle class African American woman, how did your education shape your perceptions of being at risk for HIV? *(Give examples)*

Before you became infected, how did your income shape your perceptions of being a risk for HIV? *(Give examples)*

Before you became infected, how did gender shape your perceptions of being at risk for HIV? *(Give examples)*

As a middle class African American woman, how do you think the following influenced the way you thought about HIV? (Friends, family, or other social networks)

Before you became infected, how did your religious or spiritual experiences influence your thinking about HIV (sermons, lessons, biblical teachings, stigma toward HIV)?

Since becoming infected, how has your thinking (in regard to any of the above) changed? Explain.

How do you think the media influence perceptions of HIV risk in the African American community? For example, portrayal of gender roles, male-female relationships, and other stereotypes.

As an African American woman, how has media (e.g., TV, movies, music, etc.) influenced your perceptions of HIV? Why?

What do you think about there being more African American women than available African American men?

How do you think gender imbalance (there being more women than available men) affects HIV transmission in the African American community?

Tell me what you know about the "down low" or "DL' phenomenon (men who have sex with men who self-identify as heterosexual).

How do you think "down low" behavior affects HIV transmission in the African American community?

As a middle class African American woman, how would you say "down low" behavior affects the way you think about HIV?

How do you think "down low" behavior impacted your becoming infected with HIV?

Are there any other factors that affect the way you think about HIV?

Questions about Personal and Sexual Relationships

[*The next set of questions will ask about your personal and sexual relationships. Remember, all your responses and any identifying information will be kept confidential and you are free to refuse to answer any questions that make you feel too uncomfortable.*]

How do think your upbringing (your family values, beliefs, or attitudes) influenced what you thought about your risk for HIV? Explain.

Since becoming infected, how has this thinking changed? Explain.

Tell me about your family life growing up. How do think your upbringing (your family values, beliefs, or attitudes) influenced your thoughts about your sexuality (i.e., the way you feel about sex, sexual activity, etc.)? Explain.

How do think your upbringing (your family values, beliefs, or attitudes) influenced your thoughts about how you chose potential partners? Explain.

Since becoming infected, how has this thinking changed? Explain.
Tell me about your decision-making process when choosing a mate or sexual partner, ***before you became infected with HIV***? What factors helped you determine whether to engage in a sexual relationship with a man?

Tell me about your decision-making process when choosing a mate or sexual partner, since becoming infected with HIV? What factors NOW help you determine whether to engage in a sexual relationship with a man?

Tell me about the nature of your sexual relationship(s), prior ***to becoming infected with HIV.***

Probes: Did you have a regular sexual partner? If yes, describe your level of commitment to your regular sexual partner?
Did you have sexual partners other than your regular sexual partner? If yes, how many others?
If yes, tell me how you came to the decision to have multiple sex partners?
How many sexual partners have you had in your lifetime?

Thinking about your relationships, prior to being infected, tell me what you thought about your potential risk for HIV? Explain.

Probes: Did you think you were at risk with your partner(s)?

Tell me about your condom use during sexual intercourse with your sexual partner(s) ***prior to becoming infected with HIV.***

Probes: Did you use condoms? If no, why not? If yes, how often do you use them?
Did you use them with all of your partners? (A*sk if respondent has more than one partner*).
Who initiated condom use in your relationship(s)?
If your partner(s) refused to use a condom did you have sex anyway? Why or why not?
Is there anything that made you not use a condom with 'x" partner? Explain.

How do you think drinking alcohol or using drugs (that includes smoking marijuana) played a role in your sexual relationships?

Probes: Did you or your sex partner(s) drink alcohol or do any type of drugs (including smoking marijuana)? If yes, why? How often?
Was there ever a time when you felt tipsy, drunk, or high before or during sexual intercourse? If yes, tell me about that.
Was there ever a time when your partner was tipsy, drunk, or high before or during sexual intercourse? If yes, explain.

How do you think alcohol or drugs (including marijuana) affected your judgment prior to or during sex?

How did you become infected with HIV?

Other information

If you had to design a HIV communication campaign or intervention for middle class African American women, what would it look or sound like?

Is there anything else you want to talk about in relation to HIV as it applies to you as an African American middle class woman?

Appendix C

Interview Guide: HIV Providers/Community Experts

Questions about Knowledge, Attitudes, and Perceptions *[I will begin by asking you questions about the work that you do and your knowledge of attitudes and perceptions of HIV. Please be assured that all your responses and any identifying information will be kept confidential. One of the aims of this interview is to use this information to develop better HIV prevention programs targeting middle class African American women.]*

What is your current position?

What roles and responsibilities does this position entail?

How long have you worked in this current position?

What population do you mainly serve when promoting HIV prevention and intervention programs?
Probe: Do you have a specific target population? If so, who are they?
Is there a population that you do not serve? If so, why not?

As a service provider, how much do you think African Americans know about HIV?

What do you think black people know about HIV's impact on African Americans communities?

Considering everything you know from your work experience, what do you think are African American's main sources of information pertaining to HIV?

What factors do you think contribute to the spread of HIV among African Americans? Why?

What factors do you think contribute to the spread of HIV among African American women? Why?

Questions relating to Social and Cultural Norms
[*The next set of questions will ask about perceptions of HIV risk relating to social and cultural norms associated with the African American community.*]

In general, how do you think African American women perceive their risk for HIV infection? Why?

As a service provider, how do you think middle class African American women perceive their overall risk for HIV? Why?

As a service provider, how do you think education has shaped middle class African American women's perceptions of being at risk for HIV? Explain.

As a service provider, how do you think income has shaped middle class African American women's perceptions of being a risk for HIV? Explain.

How has gender shaped middle class African American women's perceptions of being at risk for HIV? Explain

As a service provider, how do you think the following influence the way middle class African American women think about HIV? (Friends, family, or other social networks)

As a service provider, how do you think religious or spiritual experiences influence the way middle class African American women currently think about HIV (sermons, lessons, biblical teachings, stigma toward HIV)?

How do you think the media influence perceptions of HIV risk in the African American community? For example, portrayal of gender roles, male-female relationships, and other stereotypes.

As a service provider, how do you think gender imbalance (there being more women than available men) affects HIV transmission in the African American community?

As a service provider, you know about the "down low" or "DL' phenomenon (men who have sex with men who self-identify as heterosexual), how do you think "down low" behavior affects HIV transmission in the African American community?

As a service provider, how do you think "down low" behavior affects the way middle class African American women think about HIV?

Are there any other factors that you can think of that may affect the way middle class African American women think about HIV?

Questions about Programs and Prevention Strategies

[*The next set of questions will ask about programs and prevention strategies. Remember, all your responses and any identifying information will be kept confidential. You are free to refuse to answer any questions that make you feel too uncomfortable.*]

Given that African American women have higher infection rates than women of any other racial or ethnic group, what programs do you think would be beneficial for closing this disparity gap?

What HIV programs or prevention strategies does your organization provide that target middle class African American women? ***[If respondent says they do not have any programs that target middle class women, ask, why not?]***

If you had to design a HIV communication campaign or intervention for middle class African American women, what would it look or sound like?

Is there anything else you want to talk about in relation to HIV as it applies to middle class African American women?

Appendix D

Eligibility Checklist

The criteria below will be used to determine the inclusion or exclusion of participants for the study.

Do you consider yourself black or African American? _____ (Yes)

Do you live in the metropolitan Atlanta area? _____ (Yes)

Do you have at least a bachelor's degree? _____ (Yes)

How old are you? _____
(30 years or older)

Are you able to understand &speak English? _____ (Yes)

Have you had at least one male sexual partner in the past 12 months?
(Requirement for HIV negative women only) _____ (Yes)

Do you know your HIV status? _____ (Yes)

What is your current HIV status? _____
(negative or positive)

If the respondent answers according to the responses indicated in brackets, she is eligible to participate in the study.

[If the respondent is eligible, ask her to provide a first name she would like to be referred to as at the time of the interview]: _____

Schedule a date, time, and location for the interview.
_____
_____
_____

If the respondent's answers do not correspond to the answers in brackets, they are not eligible for study participation. Thank the respondent for her time and interest and inform her that she does not qualify for the study.

Appendix E - Sample Sexual History Timeline for a 35 year old Respondent with Six Lifetime Sexual Partners

Name of first sex partner: TP **Your age at that time:** 17-18 **How you met this partner**: We went to same high school

Type of relationship: serious **Length of time in relationship**: 1 year **Social status of this partner:** working class

Power dynamics of the relationship: we had mutual respect for each other **Sexual decisions made in relationship**: Always used condoms when having sex

Reason relationship ended: We grew apart. We didn't have the same goals after high school.

Significant life events associated with this relationship: None

Name of next sex partner: CH **Your age at that time:** 19-21 **How you met this partner**: We knew each other from church functions

Type of relationship: serious **Length of time in relationship**: off and on 2 years **Social status of this partner:** lower middle class

Power dynamics of the relationship: I would say he probably had more control. He was a lady's man and a smooth talker.

Sexual decisions made in relationship: We did not use condoms when having sex **Reason relationship ended:** He was a player and he loved women.

Significant life events associated with this relationship: I got chlamydia from him.

Appendix E (continued)

Name of next sex partner: DH **Your age at that time:** 20 **How you met this partner**: We met in college

Type of relationship: casual/just kicking **Length of time in relationship**: about 6 mos **Social status of this partner:** not sure

Power dynamics of the relationship: I think he had more control. He was a bad boy, but was just sexy.

Sexual decisions made in relationship: We used condoms. **Reason relationship ended:** It really wasn't a relationship, we just got together to have sex.

Significant life events associated with this relationship: None.

Name of next sex partner: MH **Your age at that time:** 22-25 **How you met this partner:** We met at a party

Type of relationship: serious for me **Length of time in relationship**: 3 yrs **Social status of this partner:** middle class

Power dynamics of the relationship: He was very controlling and didn't like me hanging out with my friends, especially my cousin. He thought she was a bad influence on me. My friends said I was just whipped and I would believe anything even when I knew he was cheating.

Sexual decisions made in relationship: We used condoms sometimes. **Reason relationship ended:** I finally got tired of his cheating and the abuse.

Significant life events associated with this relationship: I got pregnant, had an abortion. My family & friends stopped talking to me as long as we were together.

Appendix E (continued)

Name of next sex partner: BC **Your age at that time:** 27-29 **How you met this partner:** At a fraternity cookout

Type of relationship: somewhat serious **Length of time in relationship**: 18 mos **Social status of this partner:** middle class

Power dynamics of the relationship: At first I would say he was more in control and then the tables turned and I had more control in the relationship.

Sexual decisions made in relationship: We used condoms sometimes.

Reason relationship ended (specify if still in relationship): I didn't feel like we were progressing. I wanted to get married and he didn't. I also didn't like the fact that he smoked weed on a regular bases. I could somewhat deal with him drinking, but not both drinking and smoking weed.

Significant life events associated with this relationship: We had one pregnancy scare and that really made me take a long look at where the relationship was going.

Name of next sex partner: CJ **Your age at that time:** 30 - now **How you met this partner:** Through a mutual friend

Type of relationship: very serious **Length of time in relationship**: 5 yrs **Social status of this partner:** middle class

Power dynamics of the relationship: mutual respect for each other. **Sexual decisions made in relationship:** We use condoms sometimes.

Reason relationship ended (specify if still in relationship): Still in relationship. We are engaged to get married.

Significant life events associated with this relationship: I got pregnant and we have a son together.

Appendix F

IRB Approval Letter for Research Involving Human Subjects

USF
UNIVERSITY OF
SOUTH FLORIDA

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX (813) 974-7091

3/8/2013

Corliss Heath
Anthropology
4202 East Fowler Ave.
Tampa, FL 33620

RE: **Expedited Approval for Initial Review**
IRB#: Pro00011590
Title: An Exploration of Culture, Meaning and Perceptions of HIV Risk among Middle Class African American Women

Study Approval Period: 3/8/2013 to 3/8/2014

Dear Ms. Heath:

On 3/8/2013, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):
Protocol
Document(s):
HIV Risk among Middle Class African American Women Protocol-Revised

Consent/Assent Document(s)*:
Informed Consent for HIV-negative participants.pdf
Informed Consent for HIV-positive participants.pdf
Informed Consent for Providers.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR

56.110. The research proposed in this study is categorized under the following expedited review categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to,research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John A Schinka, Ph.D.

John Schinka, Ph.D., Chairperson
USF Institutional Review Board