THE VOICE UNHEARD:

THE PERSPECTIVES OF AFRICAN AMERICAN MEN WHO HAVE SEX WITH WOMEN ON HIV TRANSMSSION IN LOW INCOME, HIGH CRIME COMMUNITIES

by

KIMBERLY A. PARKER

(Under the Direction of Su-I Hou)

ABSTRACT

HIV/AIDS is the number one cause of death for African American women between the ages of 25-34 and the third leading cause of death for African American women between the ages of 35-44. The annual AIDS case rate per 100,000 persons for Black men is 8 times that of White men and the AIDS case rates for Black women is nearly 23 times that for White women (2.2). Factors such as a shift in the at-risk population, socioeconomic status, victimization, and the sex-ration imbalance, along with theories and models such as the theory of gender and power and dyadic trust, have been used to explain an increase in HIV transmission among African American women. But, a comprehensive understanding of sexual behaviors is still needed to decrease the risk of HIV infections among all African American women. Interventions geared towards African American MSM have proven to be successful, but because of the discordance between a person's sexual identity and sexual orientation, many African American women still feel they are not at risk for contracting this deadly disease. The goal of this study is to increase the level of understanding the safer sex practices of African American men who have sex with

women to inform programs that decrease the risk of HIV infection among African American women in low income, high crime Black communities.

Three focus groups were conducted with African American men who reside in the poorest segment of a major metropolitan area in the southeastern region of the United States. The group-talk and in talk interaction was analyzed using a modified grounded theory approach to construct themes pertaining to the community, HIV/AIDS knowledge and awareness, beliefs about HIV/AIDS transmission, and the participants' perception about romantic relationships.

INDEX WORDS: HIV, AIDS, African American women, African American women, Low income, High crime, Sexual behavior, Safer sex, Relationships, Qualitative research design

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CHAPTER 1

INTRODUCTION

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimated that 42 million adults and children worldwide were living with AIDS (Fitzpatrick, McCray & Smith, 2004). The United States' statistical information provides an alarming blueprint for the health of our nation. Despite comprising approximately 13% of the population in 2005, African Americans represented nearly half of all newly reported AIDS cases in the United States and continue to have the highest population rates of reported AIDS cases (Fitzpatrick et al., 2004; CDC, 2005a). Beginning in 1996, the absolute number of AIDS-related deaths in Blacks surpassed those of Whites, and in 2001, the number of deaths among Blacks was twice as high as Whites (CDC 2005a). The Centers for Disease Control and Prevention (CDC) reported that in 2001, the annual AIDS case rate per 100,000 persons for Black men (111.5) was 8 times that of White men (13.7) and more than twice the rate for Black women (49.7) (Fitzpatrick et al., 2004; CDC, 2005a). The AIDS case rates for Black women were nearly 23 times that for White women (2.2) within the same year (Fitzpatrick et al. 2004; CDC, 2005a). African Americans typify the AIDS epidemic representing 40% of all known cases (CDC, 2005a).

HIV infection, especially among African American women, is steadily increasing and heterosexual transmission has become a growing concern (Foreman, 2003). Although Black women represent only 6% of the total population in the United States, they account for 68% of reported HIV/AIDS cases for all women (Bowleg, 2004; CDC 2005b). In 2002, 26% of reported

AIDS cases and approximately 32% of newly reported HIV infections were in women. Black women also represented 63% and 66% of AIDS and HIV cases, respectively (Fitzpatrick et al. 2004).

Among Black men in the United States, men having sex with men, or MSM, represents the predominate mode of HIV exposure followed by injection drug use and heterosexual contact (CDC, 2005b). For Black women, heterosexual contact is the predominant exposure risk followed by injection drug use (Fitzpatrick et al. 2004; CDC, 2005b). In fact, 34% of African American women living with AIDS were infected through heterosexual contact (Foreman, 2003). It should be noted, however, that all women are considered to be disproportionately affected by sexually transmitted infections (STIs). Women are more biologically susceptible to some STIs than men. Also, STIs are less likely to be detected in women than in men, and STIs pose more of a health risk in women (Harvey, Bird, Galavotti, Duncan, & Greenberg, 2002). Since AIDS and other STIs are especially problematic and costly within all aspects of society, prevention efforts for African American women should be a major health and economic priority.

Significance of the problem

In 2002, HIV/AIDS became the number one cause of death of African American women between the ages of 25-34 and the third leading cause of death for African American women between the ages of 35-44 (CDC, 2005a). HIV/AIDS research and implementation development predominantly focuses on African American women who engage in heterosexual activity. Principal components that affect HIV transmission among African American women include the risky sexual behavior of African American men, an unwillingness to discuss and use safer sex practices, and the lack of influence and power African American women possess within their romantic relationship (Bowleg, 2004; McNair & Prather, 2004). African American men and

women are more likely linked historically, socially, and romantically with each other (Franklin, 2000). Therefore, the sexual behavior, beliefs, and attitudes of African American men directly influence and impact the health of African American women.

African American men who have sex with women represent 34% of AIDS cases among African American women but only 8% of these men contracted HIV through heterosexual contact (Bowleg, 2004; CDC, 2005a). Research that addresses factors concerning African American women who have sex with African American men regardless of their sexual identity is scarce (Bowleg, 2004). Behavior modification programs and research tends to focus on the sexual orientation of partners, not the variables that constitute sexual identity. Subsequently, if research does not focus on all aspects of the relationship dynamics of African American men who identify as heterosexual, then African American women will continue to be disproportionately represented among HIV/AIDS statistics.

Purpose Statement

The purpose of this study is to provide insight into the views of African American men who have sex with women and their perceptions of the influence they have on the safer sex practices of African American women. The goal of the study is to increase the level of understanding the safer sex practices of African American men who have sex with women, to inform programs to decrease the risk of HIV infection among African American women who live in a low income, high crime Black communities. The research questions are:

- What knowledge do African American men who have sex with women (MSW) have of HIV transmission in African American women?
- What beliefs do African American MSW have about their roles in HIV transmission among African American women?

- How does the sexual behavior of African American MSW affect HIV transmission among African American women?

CHAPTER 2

REVIEW OF THE LITERATURE

The review of literature examines the historical, theoretical, and social impact of HIV/AIDS in the African American community. Section one defines critical terms and concepts used within the context of the research. Section two explains the shift in the focus of at-risk populations for HIV/AIDS and the damaging effects HIV/AIDS transmission has on African Americans. Section three describes constructs and theories used to explain HIV transmission among African Americans such as sexual behavioral theories and social and contextual factors. The final section focuses on the implications for research by exploring the limitations in focusing on the behavioral aspects of homosexual African American men, and the dynamics between African American relationships as described by Black Feminist Theoretical Framework. This section also explores the need to develop additional insight concerning African American men who have sex with women for a better understanding of HIV transmission among African American women.

2.1 Definitions

The term African American is often defined as a person whose ancestry contains persons indigenous to the African continent. The term African American may at times be used interchangeably with the term "Black" within the document. Relationship dynamics pertaining to African American males and females have traditionally been defined by their sexual orientation. Sexual orientation refers to a person's pattern of sexual attraction to either men or women (Bailey, 2003). Men who are attracted to women and women who are attracted to men have a

heterosexual orientation (Bailey, 2003). Men and women who have a same sex attraction have a homosexual orientation (Bailey, 2003). Sexual orientation may also encompass sexual identity or the identity one desires for reasons other than sexual feelings. For instance, a man who prefers sex with other men may in fact still identify as heterosexual because of his preference towards heterosexual aspects of life such as marriage and the capability of rearing children (Bailey, 2003)

Because of the discordant definitions of sexual orientation and sexual identity can create, sexual behavior is defined by the gender of a person as it relates to sexual activity. The acronym MSM refers to men who engage in sexual activity with other men, WSW is women who engage in sexual activity with other women, MSM to men who have sex with women and WSM to women who have sex with men. The terms MSM, WSW, MSW, and WSM are used when illustrating sexual behavior and only encompass an insular aspect of sexual orientation and identity.

HIV (human immunodeficiency virus) is the virus that causes AIDS, or acquired immunodeficiency syndrome, and is transmitted most commonly through unprotected sex with an infected partner (CDC, 2005). HIV infection can also occur in anyone who practices other risky behaviors, such as the sharing of drug needles and syringes with someone who is infected with HIV (CDC, 2005). AIDS (acquired immunodeficiency syndrome) is the term used to describe the most advanced stages of HIV infection. HIV destroys the body's ability to fight infection, disease, and specific types of cancers by crippling and demolishing cells within the body's immune system (CDC, 2005). Symptoms of an HIV infection include fever, fatigue, and enlarged lymph nodes, and may progress to include loss of weight, persistent and frequently occurring yeast infections, skin rashes, and night sweats. During the course of the infection, a

person's viral count may decrease to less than 200 CD4 cells signifying the CDC's definition of AIDS. At this time, one may suffer from and may eventually succumb to opportunistic infections such as Pneumocystis carinii pneumonia, cryptosporidiosis, and histoplasmosis (CDC, 2005).

2.2 Shift in the At Risk Population

During the early 1980s, inaccurate and incorrect information, pertaining to the origins of the virus that causes AIDS and transmission methods, was disseminated through sources considered reliable among the general population such as physicians, medical and health researchers, and by those who were affected socially, mentally or emotionally by the disease. Health officials were charged with the task of alerting the public of the risk and fears associated with AIDS while confronting the real possibility of widespread panic. During this time, people were constantly being reassured that AIDS was unlikely to affect them if they were not (1) promiscuous, (2) gay, (3) a White male, (4) drug users, and (5) residents of large metropolitan cities (Reid, 2000). Once the purported demographics of those infected with HIV began to shift, the need for more accurate interventions was met with unmotivated delays, further strengthening the false notion many Americans had about contracting this deadly disease. Although homosexual population-specific interventions were created and proved to be effective in curtailing HIV transmission among gay White males, public awareness of the dangers faced by gay men did more to fuel the concerns many had about this new disease. According to Reid, (2000):

> In addition, […HIV interventions] brought a sense of security and relief to everyone who was not a gay man. The messages were loud and clear: promiscuous, not virtuous people.

> Further, it was widely believed that women need not be concerned with safe sex; they were relatively safe from HIV infection and AIDS. (p. 711)

One indisputable factor related to HIV/AIDS transmission and prevention is the danger associated with sexual orientation and its engendered perception of risk. Although AIDS was first characterized by its high incidence rates among gay male communities, heterosexual women have been shattered by low condom use as denoted by the growing number of heterosexual exposure cases. Data now show that 40% of all heterosexual women are exposed to HIV due to sex with a male partner. In spite of data that clearly demonstrates the danger to women, many women, especially African Americans, still remain faithful to the notion that their risk for contracting HIV is low (Reid, 2000). They are also faithful to the notion that due to their low risk of contracting HIV, there is a decreased need to utilize condoms during heterosexual intercourse (Reid, 2000).

Findings provided by the CDC continue to substantiate the disproportionate rates that HIV/AIDS affects African American women (CDC, 2005; CDC, 2005a). Therefore, the shifting demographics of the HIV/AIDS epidemic in the United States must be explained highlighting factors that affect the African American population differently. Several factors that influence African American women's increased risk of acquiring HIV have been identified within the literature. Such factors relate to the intersection of race, gender, and social class and give rise to the conditions that are frequently associated with HIV risk. These factors are commonly identified as social factors, or factors that impact a group of people similarly but are external to individuals, and contextual factors, aspects of the environment that influence an individual's perspective having importance only for that person (Logan, Cole, & Leukefield, 2002 ; McNair & Prather, 2004).

2.3 Constructs and Theories Used to Explicate HIV Transmission

Theories and models used to effectively explain and predict behavioral change related to safer sex practices such as condom use include the Health Belief Model, Social Cognitive Theory, the Transtheoretical Model for Change, and the Information-Motivation-Behavior Skills Approach (Logan et al; 2002; Rimer, 1997; Prochaska, Redding, & Evers, 1997; Glanz, Lewis, & Rimer, 1997). Theories such as these have also been used to describe an increase in HIV and AIDS cases among African American women. The lack of media exposure given to the global pandemic has impacted HIV transmission rates. Also, AIDS is no longer viewed as a new and dreaded disease and has become a danger society must live with as evident in the increase in quality of life and longer life-spans experienced by those who are HIV positive. The visibility of AIDS victims is significant for developing policy as these persons may not be readily capable to admit their status due to lack of knowledge and shame associated with the disease. Finally, some view the virtues of those suffering from the illness as a more respectable form of misfortune (Reid, 2000).

Although a person's perception of the AIDS pandemic may influence his or her actions towards combating the disease, African American women are still the least visible among AIDS patients due to a lack of "celebrity" depiction (Logan et al, 2002). The shift in HIV/AIDS focus may have also been attributed to the number of African American female drug users and prostitutes contracting AIDS and the "blaming the victim" outlook, which leads to a lack of public concern and differential community response. Regardless of which analysis researchers use to describe modified rates of HIV infection among African American women, behavioral theories may not offer a full critique of the dynamics of sexual behavior, gender-influenced

decision making, or social and contextual impetuses exclusive to African American women (Logan et al. 2002).

According to Logan et al. (2002), "understanding the empirical support for specific social and contextual factors is a key interim step in furthering knowledge, theories, and interventions targeting HIV risk behavior for women" (p.852). Social factors are variables or conditions that influence or impact groups of people similarly but are external to the individual, such as cultural beliefs, values and practices (Logan et al. 2002; McNair & Prather, 2004). On the other hand, contextual factors are defined as aspects of the environment that influence an individual and are therefore only important to that particular person (McNair & Prather, 2004). Although contextual factors may exist and affect everyone within a particular population, these factors may not necessarily be apparent to others and may include items such as relationship history, victimization experience, and levels of environmental stress (Logan et al. 2002; McNair and Prather, 2004). Before I delve into the impact social and contextual factors may have on HIV transmission, I will briefly review theoretical frameworks used to illustrate gender and race specific sexual behaviors that impact HIV transmission among African American women.

Sexual Behavior Theories

The number of HIV cases among African American women has drastically risen to epidemic proportions. Access to condom use, self-efficacy, and a number of other health-related theoretical frameworks has not been able to fully and adequately explain this uncanny phenomenon. Concepts such as the Theory of Gender and Power, the Social Exchange Theory and relationship dynamics all suggest that the role of cognitive and social factors in sexual decision-making may differ between men and women within the African American community (Colon, Wiatrek, & Evans, 2000). The Theory of Gender and Power incorporates three

overlapping but distinct structures that serve to explain and contrast the culturally bound roles between men and women. According to this theory, the division of labor, the structure of power, and the structure of the cathexis are major components that characterize heterosexual relationships (Wingood & DiClemente, 1998; Wingood & DiClemente, 2000).

The first component of the Theory of Gender and Power is the division of labor. Sexual division of labor is an allocation of specific types of work based on the gender of an individual. It is manifested in the segregation of unpaid work; mostly housework and child care for women, and inequalities in wages and educational attainment between women and men (Wingood & DiClemente, 1998). Sexual division of labor helps to explain how African American women's socioeconomic impoverished status helps to enhance their vulnerability to HIV/AIDS and other STIs. It also addresses how low levels of literacy and education may limit many of the same population's ability to access information on HIV prevention as well as understanding HIV prevention strategies, including condom use (Wingood & DiClemente, 1998). The sexual division of labor among men and women suggests that women who are economically constrained are provided only with limited educational training about HIV prevention. As the economic disparity between men and women increases in favor of men, women may become more susceptible to direct or indirect financial incentives for actually engaging in high-risk sexual behavior (Wingood & DiClemente, 1998, 2000).

Sexual structure of power, the second component, relates to issues pertaining to control, authority, and coercion within heterosexual relationships. Power, which serves as a fundamental element of all human relationships, is a concept, especially in heterosexual romantic relationships, that serves as the driving force behind this purported view (Wingood & DiClimente, 1998). Since women are psychologically, economically, and socially more

dependent within relationships, more often the male partner is able to provide beneficial assets for both to utilize. The dynamics in the relationship eventually gives way to an imbalance of power whereby the male wields the power and the female lacks the power (Wingood & DiClimente, 1998).

Sexual structure of power provides additional insight into aspects of control, such as physical force, and is able to impose and define a situation of hegemonic dominance of women. Wingood and DiClemente (1998) further explain the sexual structure of power by stating:

> Power in this nature is manifested in heterosexual relationships in the difficulty women have in negotiating safer sex with male partners, in women having little self-control or skills in using condoms, and in women perceiving themselves to have little control over their partner's use of condoms. This influence of power is also observed in the pervasive societal norms that allow men to have more sexual freedom than women resulting in men's resistance to use condoms (p. 33)

The third component within the Theory of Gender and Power aids in dictating societal norms that regulate appropriate sexual behavior for women including the emotional attachment involved in social relationships (Wingood & DiClimente, 1998; Wingood & DiClemente, 2000)). The structure of the cathexis, or emotional significance to an item, helps to produce the laws, taboos, and prohibitions that define normal behavior, restrain sexuality, and localize the cultural norm for femininity within heterosexual relationships (Wingood & DiClimente, 1998). Social rules concerning women's sexual behavior are enforced by social institutions, such as the church, and dictate views imposed upon women that are equated with normalcy. These may include values associated with motherhood and the equating of sexuality with procreation (Wingood & Diclemente, 1998; D'Emillio & Freedman, 1988). Views towards women's sexual behaviors are

also governed by social rules within the structure of the cathexis. For example, a woman's failure to negotiate safer sex practices such as condom use may result in the further strengthening of trust and intimacy within the relationship from her perspective, but may not have the same result from the man's perspective.

The structure of the cathexis also illustrates how the sex-ratio imbalance may increase African American women's susceptibility to HIV (Wingood & DiClimente, 1998). Since the number of available African American women outnumbers those of African American men seeking sustainable relationships, paired with the fact that African American women are more likely than any other race to marry within their own ethnic group, the sex-ratio imbalance reduces the negotiating power of women (Wingood & DiClimente, 1998). As reported by Wingood and DiClemente (1998):

> When this situation is coupled with women's desire to feel connected to men, women may find it difficult to exert any restrictions on their partners, particularly demands for condom use during sexual intercourse. Intensifying the situation, men may view their options as limitless, resulting in less pressure to develop commitments, greater power within the relationships, and perceive it unnecessary for them to practice safer sex, placing themselves and their sex partners at risk for HIV (p. 35).

The Social Exchange Theory is the second theory used to explicate sexual behavior among African American women. The Social Exchange Theory is a psychosocial theory built around an interpersonal definition of relationship power (Pulerwitz, Gortmaker, & DeJong, 2000; Emerson, 1981). Emerson (1981) defined power as the amount of resistance on the part of one individual that can be potentially overcome by another. Power, therefore, resides not in the individual actor, or the person serving as an agent in a relationship dynamic, but in the

relationship between two actors. Relationship power is expressed through decision-making dominance, the ability to engage in behaviors against a partner's wishes, or the ability to control a partner's actions (Emerson, 1981). According to this theory, power is based upon a number of factors including the independency one partner has over the other, the amount of valued resources one partner possesses compared to the other, and whether potential alternatives to the current relationship are perceived to exist. The person who maintains control over decision-making in the relationship, has control over his or her partner's actions, is less dependent on the relationship, possesses more resources and is perceived to have alternatives to the current relationship (Emerson, 1981). It should be noted that the Social Exchange Theory is usually combined with the Theory of Gender and Power to explain sexual behavior among African American women.

The third theory used to explicate sexual behaviors among African American women is not a theory, per se, but a number of frameworks with a common theme or element. Sexual behavior is an inherently dyadic relationship and because women have less control than men over their sexual behavior, the power dynamics between men and women represent an important but neglected aspect of AIDS prevention for African American women (Guiterrez, Oh & Gillmore, 2000). According to Guiterrez et al. (2000), "the power to negotiate, struggle, and accept, despite the larger social context, is an integral component of health practices. Inequalities within a society silence women and our expression of sexuality which in turn may endanger health and well-being" (p. 584). Therefore, variables representing relationships dynamics such as length of relationship, time spent with partner and the control of sexual decisions are typically deserving of a separate framework for explaining the sexual behavior of African American women.

Relationship themes are central to women's sexual choices. Placing high value on relationships may encourage some women to lend more importance to men's voices than their own safety concerns (Jones, 2004). Power, therefore, influences the choices about whether, when, and how to have sex and use condoms. Since traditional gender norms encourage women to be sexually passive and men to initiate sex, thus contributing to women's unsafe sexual strategies, women who may request condom use by males challenge the expectations about power and pleasure held within the norms of society (Jones, 2004).

Social and Contextual Factors

Several factors affect African American women's increased risk of contracting HIV (McNair & Prather, 2004; Logan et al., 2002). These factors are associated with the intersection of class, race and gender and may be unique to the daily lives of African American women (McNair & Prather, 2004). Social factors influence an individual and are only important to that particular individual. A person's cultural beliefs, values and practices, as well low levels of condom use, are social factors because of their influence on just one individual (McNair & Prather, 2004). Contextual factors may not necessarily be apparent to others and may include items such as relationship history, victimization experience, and levels of environmental stress (McNair & Prather, 2004; Logan et al., 2002). Although contextual factors influence an individual's actions, attitudes, and beliefs similar to social factors, contextual factors are aspects of the environment and impact may impact African American women differently (McNair & Prather, 2004; Logan et al., 2002). A majority of behavioral and risk reduction theories do not take into account the influence social and contextual factors may have towards the sexual behavior of African American women (Logan et al., 2002; Amaroa, 1995; Amaro & Raj, 2000; Bajos & Marquet, 2000; Castaneda, 2000; Miller & Neagisu, 2001). Behavioral change will not

transpire without examining psychological variables, social norms, and environmental influences at the individual level for sexually active African American females. In this section, I will describe several social and contextual factors and their corollary function within the aforementioned theoretical frameworks.

Male-female sex ratio imbalance

The sex-ratio imbalance within the African American community gives rise to women's difficulty in discussing and negotiating condom use with male sexual partners (McNair & Prather, 2004). The larger number of available African American women compared to African American men results in fewer available male partners; therefore, providing African American women with less interpersonal power in relationships. Lower levels of interpersonal power interferes with a woman's ability to initiate discussion about condom use due to concerns that the topic may lead to conflict and threaten the future of a relationship (McNair & Prather, 2004).

In order to fully understand the sex ratio imbalance, we must first examine the status of Black men within the African American community. Black men have more options of sustaining meaningful emotional relationships because of the percentage of Black women available to them. Black women outnumber Black men in the general population due to higher homicide rates, incarceration, and interracial marriages (Logan et al. 2002). Although African Americans have the highest rates of intraracial marriages among all ethnic groups, African American men are more likely to engage in interracial marriages than their African American female counterparts (Franklin, 2000). An imbalance in the sex ratio, therefore, implies that when one sex outnumbers the other, members of the scarcer sex have a bargaining advantage in male-female relationships because more alternative relationships are open to them (Logan et al; 2002). Gender roles within society place strong emphasis on the importance of being in a relationship, and with

fewer options available to Black women, the fear of committing an act that may jeopardize a current relationship dictates whether or not safer sex practices will be introduced, suggested, or used (Logan et al, 2002; McNair & Prather, 2004).

The sex-ration imbalance poses a great threat for all women, not just African American women, for many reasons. First, some women may wish to remain in relationships, regardless of whether they perceive their partners as faithful, for economic benefit and support (Bowleg, Lucas & Tschann, 2004; Adimora, Schoenbagh, Martinson, Donaldson, Fullilove, & Aral, 2000). Strain from economic demand makes the notion of a two-income household beneficial and outweighs the possibility of any adverse effects of losing financial bearing. Second, environmental stressors and race relations within society are better faced within the construct of a social support system. African American women may view acute stressors of everyday life more bearable with a partner or significant other, leading to the development of enhanced coping skills. Third, the risky behaviors in which African American males may engage in are easily overlooked as a gender norm. Women in relationships with men may overlook infidelity and sexual indiscretions, a variable which leads to the second major psychosocial factor, high rates of HIV infection among African American men and risky behavior.

<u>High rates of HIV infection among African American men and risky behavior</u>

The main source of HIV transmission for African American women stems from having sexual intercourse with an infected male partner (Dolcini & Catania, 2000). Behavior that increase the risk for contracting HIV or a STI includes length of the sexual relationship; monogamy within the sexual relationship; attitudes, beliefs and emotions related to sex; number of sexual partners; sexual orientation; drug use; and condom related beliefs (Dolcini & Catania, 2000). The rate of HIV cases among African American males is currently greater than any other

racial or ethnic group. Since African American women are more likely to date within their own race and ethnicity, it has been postulated that a majority of heterosexual African American women have had sexual contact with African American men. Subsequently, this factor, along with risky sexual behavior practiced by African American men, increases the rates in which African American women may contract HIV (McNair & Prather, 2004).

According to Timmons and Sowell (1999), African American women believed that African American men could not or were not willing to maintain sexually monogamous relationships and were thought to be naturally prone to sexual promiscuity. Therefore, African American women's expectations allowed for African American men to engage in promiscuous and/or practice risky sexual behavior with little or no consequences for their actions (Timmons & Sowell, 1999). Comments such as "a man will be a man" (p.584) were used by participants to express their concern with African American men's general sexual behavior, and sentiments such as "what am I suppose to do about it, you can give him everything he asks for and [African American men] still go look somewhere else" (p. 584) were used to cope with feelings of betrayal and neglect within relationships (Timmons & Sowell, 1999).

Another factor influencing African American women's risk of HIV transmission through heterosexual contact is the extent to which women have sex with African American men who self-identify as heterosexual but engage in sexual activities with other men (MSM). The category of MSM entails different implications since these men self-identify as heterosexual yet engage in homosexual behavior, commonly known as the "down low" (DL). In the African American community, heterosexuality is a central component to hegemonic Black masculinity. According to McNair and Prather (2004), "because African American MSM are significantly more likely than other MSM to self-identify as heterosexual or bisexual, African American

women are at considerable risk for acquiring HIV through sexual contact with MSM" (p. 110). African American MSM who do not reveal their sexual behavior present additional risk to women because they (1) have higher rates of sexually transmitted diseases, (2) report engaging in more sexual activity with women than with men, and (3) are less likely to know their serostatus (McNeil & Prather, 2004). Although vastly documented within the realms of self-reported data and qualitative research methods, this phenomenon has only recently garnered attention due to the difficulty of being labeled as a gay Black male and of family disclosure.

Condom Use

Items such as locus of control, self-esteem and self efficacy are commonly used to predict condom use. But, these variables may not take into consideration the cultural aspects many African American women face when making decisions about safer sex strategies (Sterk, Klien & Elifson, 2003). Reducing the risk of HIV infection among sexually active African American women requires examining factors associated with noncondom use during sexual intercourse (Wingood & DiClemente, 1998). It is also becoming increasingly apparent that African American women in stable relationships are at greater risk for HIV and STIs than previously thought, because condom use declines in committed relationships (Soler, Quandagno, Sly, Riehman, Eberstein & Harrison, 2000). Given the higher rates of infidelity among men and the vulnerability of women when exposed to STIs, it is important for women to protect themselves in all relationships, even the apparently more committed ones (Soler et al; 2000).

A factor contributing to low condom use among African American women is the level of trust within a relationship, also referred to as dyadic trust. Dyadic trust is the belief in a partner's benevolence or the belief that one's partner is concerned about the welfare of the dyad and honest about their concerns (Jones, 2004). According to Jones (2004):

> Belief in the partner's honesty is essential to accepting a partner's word as genuine. Faith, an essential belief that stretches beyond available evidence, is an essential aspect of trust. People and their environment are in a mutual process, and intimate relationships offer an opportunity to experience one's integral nature. Dyadic trust increases security, reduces inhibition, and frees people to share feelings (p. 186).

Therefore, dyadic trust enhances intimacy and openness by reducing feelings of uncertainty that may arise with growing intimacy (Jones, 2004). Trust, coupled with the length of time one has been in a relationship, may in fact, promotes a lack of condom use among heterosexual partners.

Some women may not use condoms because they want to get pregnant. Condom use strategies differ in relationships in which the main focus for any type of prophylactic is pregnancy prevention. Therefore, both women and men feel more comfortable discussing condom use if neither is prepared to be a parent as opposed to halting the spread of HIV (Bird, Harvey, Beckman & Johnson, 2001). Although pregnancy prevention may be a mutual decision among both parties within a relationship, males still maintain a higher level of power as it relates to suggested and actual condom use.

Social and Economic Status

According to Logan et al. (2002) a person's social status may "impact HIV risk behavior by overwhelming individuals with multiple issues related to survival, thus reducing their perception of the importance of negotiating safe sex with a partner" (853). Economically, ethnic groups most affected by HIV transmission are also most affected by poverty (Logan et al., 2002). Approximately 24.9% of African Americans live at or below the national poverty rates and 48% of African American families living at or below the poverty level were headed by single mothers (US Census Bureau, 2000; Health and Humans Services [HHS], 2002). Since poverty is related

to increased amounts of stress due to obstacles one may face while acquiring basic needs such as food and shelter, low-income African American women are more likely to experience chronic health issues and be exposed to greater environmental hazards such as polluted air and water, higher crime rates, and lower standards of living (Logan et al., 2002). Impoverished African American women may perceive themselves at risk for contracting HIV, but may be unable to practice safer sex methods if other risks appear more imminent (Logan et al., 2002; Mays & Cochran, 1988). African American women who constantly face concerns for obtaining food, shelter, and safety for themselves and their children are less likely to engage in HIV-protective behaviors (Logan et al, 2002). Also, impoverished women were more likely to be the victims of violence, limiting the amount of decision-making power and relationship control one may have towards suggesting condom use (Logan et al, 2002).

2.4 Implications for Research

Parochial view of MSW

On April 14, 2004, J. L. King made a guest appearance on the popular daytime talk show "Oprah" and announced that he was a member of a subgroup comprised of African American men living in secrecy. On that day, King introduced mainstream American to a term that has reverberated through the African American community, the Down Low (DL). King went on to explain that men living the DL identify themselves as heterosexual but engage in sex with other men (King, 2004). His remarks were simple and innocuous but the consequences, which resonated throughout the African American community, set the stage for deadly consequences. These consequences included the dismissal of HIV/AIDS transmission as a serious threat among heterosexual African American men and placed the onus of HIV transmission among heterosexual African American women with homosexual and bisexual African American men.

More than 20 years after the first reports of the HIV/AIDS epidemic in the United States, men who have sex with men (MSM) still account for the largest number of AIDS cases and the growing number of new cases of HIV infection (Mays, Cochran, & Zamubio, 2004). Among Black men in the United States, MSM represents the predominate mode of HIV exposure followed by injection drug use and heterosexual contact. For Black women, heterosexual contact is considered the predominant exposure risk followed by injection drug use (Fitzpatrick et al. 2004). One key factor contributing to African American women's high rates of heterosexual contact is African American men's sexual behavior.

The DL, also referred to as non-identified men having sex with men, is defined as Black men who secretly have sex with other men while maintaining heterosexual relationships with women (Phillips, 2005; and CDC, 2004). The key concepts within DL discourse are that it currently functions within (1) the African American community, (2) men having sex with men, (3) secrecy, (4) the appearance of heterosexuality and (5) masculinity (Phillips, 2005). Other DL concepts include gay men who are not ready to or not planning to come out, secret sex with other men even in the absence of a heterosexual relationship, and masculine Black gay men who desire to only have sex with other masculine Black gay men. Those identified as DL may also tend to remain quiet about their homosexuality especially within in the context of the Black community. Unfortunately, most HIV/AIDS research conducted with African American males focuses on concepts and preventative measures among MSM who are openly gay.

The popular NBC television show "Law and Order: Special Victims Unit" devoted an entire episode to the DL phenomenon. During the episode, which aired on April 6, 2004, a prominent African American lawyer brutally attacked and killed his homosexual lover (www.nbc.com). The impetus to the murder was fear that his homosexual lover would expose

his secret, telling his wife about their encounters, thereby, ending his marriage. The African American male was arrested but while awaiting trial, his wife was informed that she had been exposed to the virus that causes AIDS and urged her husband to confess to the crime for the sake of their friends, family, children, and most importantly, their marriage. Before his confession, she conveyed to him her love and proclaimed her faithfulness to the relationship.

The repercussion surrounding this episode and popular DL discourse alluded to the following: African American women would rather stay in relationship marred with infidelity than leave a toxic situation. Unfortunately, research pertaining to factors that influence risk and reaction to HIV shows that they are correct. Researchers have identified several factors that influence African American women's increased risk of acquiring HIV/AIDS (Logan et al., 2002). These factors are related to the intersection of race, gender and social class in the lives of African American women and give rise to conditions associated with the risk of transmitting HIV (Logan et al., 2002). For instance, social factors such as cultural beliefs, values and practices, and the sex-ratio imbalance in the African American community increases women's difficulty discussing and negotiating condom use with male sex partners (Logan et al., 2002).

The sex-ratio imbalance among African American men and women decreases African American women's interpersonal power in relationships because African American men have more options for relationships available to them (McNair& Prather, 2004). Effects of the sex-ration imbalance can be explained by the sequence of the following events. First, African Americans women have higher rates of intrarracial marriage compared to African American men (Collins, 2005). Second, African American women outnumber African American men in the general population due to higher rates of incarceration, homicide, drug use, and marital status, lowering the number of available African American males partners for African American women

(McNair & Prather, 2004; Fitzpatrick et al, 2004; Logan et al, 2002). Next, gender roles in the African American community strongly enforce a sense of family. Research conducted on smaller scales have found that although African Americans have more traditional and sometimes more sexist views of gender roles than Whites and the cultural difference within in these roles may be more profound than in any other race or ethnic group (Hill, 2002). Within the African American race, African American women have had a secondary and disadvantage status in society based on race and gender. But, confounding variables such as discrimination and oppression affect the gender roles of African American women in a manner that is more weighted and viewed as unfair by many (Hill, 2002). Therefore, in order to comply with pressures associated with marriage, African American women are more likely to remain in relationships (Bowleg et al, 2004, Bowleg, 2004, McNair & Prather, 2004).

The sexual behavior of African American men also serves as a social factor that affects the rates of HIV/AIDS transmission among African American women (McNair & Prather, 2004). According to reports conducted by the CDC, almost 30% of MSM self-identified as either heterosexual or bisexual and reported engaging in high rates of unprotected sex (McNair & Prather, 2004). African American MSM are more likely than other MSM to self-identify as heterosexual or bisexual, therefore placing African American women at more considerable risk of acquiring HIV through sexual contact with a MSM. African American MSM who do not disclose their sexual orientation presents additional risk. These men have higher rates of sexually transmitted diseases and report more sexual encounters with women than men. Also, African American MSM who are HIV positive are less likely to know their serostatus (McNair & Prather, 2004).

We must be careful not to focus our attention on one aspect of HIV research and prevention within African American males, the parochial identity associated with MSM or DL men. By doing so, notions or stereotypes associated with the DL are further perpetuated, hindering much needed measures to decrease the spread of HIV transmission in the Black community (Phillips, 2005). First, the DL is not a novel occurrence. Despite notions that the DL began in the 1990s, it has existed in the African American community for a much longer period of time (Phillips, 2005). For example, in his latest book *Beyond the Down Low: Sex Lies, and Denial in the Black Community*, Keith Boykin (2005a) vividly describes a cultural way of life in which media influences, song lyrics, and religious beliefs profoundly convey messages pertaining to the sexual behavior of a number of African American men. Also, the DL does not only affect the Black community. Discourse about undisclosed homosexual encounters have included studies such as *The Tearoom Trade: Impersonal Sex in Public Places,* which looked at the behaviors of White men having undisclosed sex in public restrooms in the 1970s (Phillips, 2005). Also, one could reference more recent accounts of undisclosed homosexual activities among White males such as the indiscretions of former New Jersey Governor James McGreevey and Congressman Edward Schrock, and the plot to the movie *Brokeback Mountain* (Boykin, 2005b). Third, DL does not only refer to men (Phillips, 2005). Assuming the virus that causes AIDS is only transmitted from males to female and that African American females do not engage in homosexuality activity vilifies those who are solely placed into this category (Phillips, 2005).

Down low discourse may actually sustain HIV transmission by allowing sexually active persons who do not use protection to abdicate personal responsibility (Phillips, 2005). By placing the onus and the consequences of contracting the disease on African American women, MSM escape the duties of protecting themselves and others. However, heterosexual contact is

the primary mode for transmission among African American women, implying, that transmission directly relates to African American women's relationship with men.

Sexual partners of African American women

Within the hegemonic or leadership structures of African American heterosexual relationships, men are encouraged to control all aspects of sex and to have multiple sexual partners (Collins. 2005; hooks, 1984; Bowleg, 2004). But, within the feminist movement and Black feminist movement, models of behavior and social justice struggle to purvey the notion of equality among the sexes. In Western discourse, the body has historically been distinct from the mind. The mind is privileged and the province of men, whereas the body is denigrated and associated with women (Kolmar & Bartkowski, 2005). Feminist theory comprises three basic functioning components. The first basic functioning component of feminist theory is a conscious stand in opposition to female defamation and the mistreatment of women (Treicheler & Kramarae, 1985). A staunch disdain view of misogyny and the view of women as "other" is made within all feminist epistemologies and the many different branches of feminist frameworks derived from this thought. Second, feminist theory addresses the belief that the sexes are culturally formed as a social group representing a defective sex (Treicheler & Kramarae, 1985). Finally an outlook that transcends the accepted value systems of the time by exposing and opposing the prejudice and narrowness of women throughout humanity serves as the third basic functioning component of feminist theory (Treicheler & Kramarae, 1985).

Black feminist thought, however, is more descriptive of the interconnected relationship of Black men and women culturally, historically, and socially (Collins, 2005). Rules that regulate love relationships in the United States focus on varying combinations of choosing partners who are the same and/or different from oneself (Collins, 2005; Franklin, 2000). Historically these

rules have worked through logic of segregation that organized all aspect of the African American society. Contemporary intimate relationships are influenced by a convergence of factors that collectively shape each individuals lived realities, as well as his or her perception of what is possible and desirable. Although the source of love may seem unidentifiable, it is profoundly affected by the political, economic and social condition of the image constructed for Blacks (Collins, 1995). Black men and women are more likely to recognize one another fully as human beings in a society that dehumanizes them both (Collins, 2005). Unfortunately, Black women must survive in both the views constructed for them by society and through the dynamics of power in their romantic relationships with Black men (Franklin, 2000).

Interventions and preventive measures to reduce HIV transmission in the Black community focus predominantly on safer sexual practices as they related to African American women. In light of the knowledge and focus on the attitudes and influence of African American men within the realms of heterosexual relationship, the goal of this study is to provide a voice to the experience of African American MSW to enhance HIV preventative measures for African American women.

CHAPTER 3

METHODS

This chapter has seven sections: research questions, research design, subjectivity statement, participant description, data collection and instruments, approval to conduct research and data analysis. In this chapter, I state the research questions and describe the research design. I discuss my subjectivity as a researcher and describe the selection of participants. I also explained the data collection method, instruments used for this study, the data analysis procedure, and identify the process of Institutional Review Board approval.

3.1 Research Questions

The purpose of this study is to provide insight into the views of African American men who have sex with women and their perceptions of the influence they have on the safer sex practices of African American women, regardless of their sexual preference or orientation. The goal of the study is to increase the level of understanding the safer sex practices of African American men who have sex with women, to inform programs to decrease the risk of HIV infection among low African American women in low income, high crime Black communities. The research questions are:

- What knowledge do African American men who have with sex with women (MSW) have towards HIV transmission in African American women?
- What beliefs do African American MSW have about their roles in HIV transmission among African American women?

- How does the sexual behavior of African American MSW affect HIV transmission among African American women?

3.2 Research Design

This study is the result of my interest in the lack of Black males in literature pertaining to the sexual behaviors of Black females. More importantly, the study addresses the impact of Black male sexual orientation, identity, and behavior towards the health and safer sex practices of Black females. To address the unheard voice of African American males who have sex with women, this study used a qualitative research design.

Qualitative research consists of using specific and itemized descriptions of events, places, and situations along with the observed behaviors of individuals and quotations from participants to gain valid and reliable knowledge (Bentz & Shapiro, 1998; Patton, 1990). Although qualitative and quantitative researchers are interested in similar constructs such as social interaction, the experience of the subject, and conditions that influence one's experience, qualitative research aims to pursue the direct link between objects and social inquiry more closely (Crotty, 1998). The method, by which social inquiry is developed through a person's way of knowing, also denoted as epistemology, then provides a better scope of how one's lived experiences transform into action (Crotty, 1998).

This study was conducted using focus groups to analyze the in-group and group talk of the participants. I was interested in discovering themes revealed by the participants regarding their community, relationships within their community, and their views and perceptions on the impact HIV/AIDS has had on the safer sex practices of both African American males and females alike. Focus groups allowed for the participants to address and interact with each other based upon a set of questions that focus on the aspects of their demographic location, their

knowledge about HIV transmission in the Black community and the generalizations some may make about heterosexual relationships. Through the group talk interaction, responses the participants made directly to me, and in-group responses, statements the participants made towards one another, personal experiences, myths and factual information about HIV transmission, and the sexual behavior of African American men served as the valid and reliable knowledge needed to examine the direct link between the participants and social inquiry more closely. Using a qualitative approach not only allowed for the voice of the participants to guide the findings of this study, it also provided an opportunity for the participants to examine their shared experiences and deconstruct their societal views as Black men within the realms of a major health crisis.

3.3 Subjectivity Statement

My subjectivity played a pivotal role in not only the design of the research, but also in the research subject matter. As an African American, I believe that the status of Black relationships must be examined to better understand the current state and condition of this population. Issues such as poverty, quality of education, access to health care, and health concerns such as HIV/AIDS impact this minority population at alarming rates. As an African American woman, my function within the community becomes better define by the pre-conceived notions created through established gender roles. For instance, I often have desired to be in a committed relationship. Subsequently, I have also experienced the negative consequences described by the Theory of Power and Gender and the Social Exchange Theory due to an imbalance of power established within the relationship. More importantly, I can attest to the phenomenon by which the sex-ratio imbalance not only influenced my behavior while in a relationship, but the modest feelings of self-doubt present once the committed relationship ended.

The initial impetus for this study was to give voice to African American women in hopes of better understanding how knowledge is constructed regarding (1) relationships involving African American men, (2) our attitudes, feelings and beliefs about these relationships, (3) safer sexual practices within these relationships, and (4) perceptions of self once these relationships end. While conducting research to complete a pilot study to explore the aforementioned themes, I noticed a reoccurring variable that had either been overlooked or narrowly addressed; no voice was given to the Black men participating in these same relationships. To examine and give voice to the experience of African American women, we must also examine and give voice to an equally important factor of the same dynamic, African American males.

As a researcher, I was aware that my membership as both an African American and as a female provided insight into the very nature of the study. It afforded me the opportunity to not only explore unassuming variables within relationship foundations but also allowed for an innovative perspective towards addressing research methods pertaining to HIV/AIDS in the Black community. In contrast, I was also aware that my involvement in these membership categories might have hindered the creation of an unbiased research agenda. Therefore, I had to bracket or eliminate my subjective influence on the design of the study and during the data collection procedure for an impartial and unprejudiced analysis (Hoyt & Bhati, 2007).

3.4 Participants

To develp a better understanding of the sexual health of African American women, I interviewed their likely partners, African American MSW. The participants self-identified as Black or African American males and willingly engaged in sexual intercourse with African American or Black women. Their sexual orienation or identity was not a factor, only the sex or gender of their past or current sexual partners. HIV-related illness is the number one cause of

death for African American women between the ages of 25-34 years and the third leading casue of death for African American women between the ages of 35-44 years (CDC, 2002). The participants selected for the study were between the ages 25-44 years to correlate with the ages of women impacted the most by the disease.

Participants were selected from three different outreach agencies and venues in a low income, high crime area of a major metropolitan area in the southeastern United States. The participants hailed from one of the metropolitan area's zoned regions. The regions were created by an AIDS partnership fund and city officials to offer HIV intervention programs and services by collaborating the efforts of area non-profit and non-governmental agencies. The AIDS partnership fund is a collaborative funding partnership between the metropolitan area's Community Foundation, the United Way, The National AIDS Fund, the Elton John AIDS Foundation, the Design Industries Foundation Fighting AIDS, Fashion Cares 2006, and other non-profit agencies. The partnership fund formed a coalition with five AIDS service organizations and community-based organizations in 2006 to greater utilize HIV prevention and intervention resources within the metropolitan area. Through an analysis conducted by the Department of Human Resources HIV/AIDS Section's Office of Epidemiology, the partnership fund decided to target its efforts within the zip codes identified for this study. This area was listed as two of the top four zip codes within the metropolitan area as having the largest HIV at-risk population of African American women within the city and region (Georgia HIV/AIDS Reporting System, 2007).

To establish a snapshoot of the community most affected by the HIV and AIDS epidemic, participants selected for the study resided in the zip codes listed as a part of the high risk impacted area of the studied metropolitan area (HRIA). The zip codes studied in the HRIA

are located south of the downtown area and includes historical landmarks such as a high schools attended by famous Civil Rights leaders and a major Historically Black College and University Center. Approximately 80,000 people reside in the studied area. (www.census.gov). The average income per household in the studied area is $24,000 and African Americans represent 80% of the population for the entire area (www.census.gov a).

I contacted the Executive Director of the metropolitan area's AIDS Harm Reduction Center (AHRC), the lead agency of the HRIA project, due to its centralized location within the target demographic area. The AIDS Harm Reduction Center conducts community and evidenced based outreach aimed at reducing the risk of transmitting HIV, STIs, Hepatitis, and other blood borne pathogens among its clients. The AIDS Harm Reduction Center is more commonly known for its unorthodox street outreach activities such as its needle exchange programs and "Safety Counts" Program, a party given at the agency to celebrate the weekly and daily accomplishments of its clients, but its greatest asset is the number of neighborhood residents who constantly view the agency and its staff as a local safe haven.

Since qualitative research does not posit a rule for a sample size, three focus groups were conducted for the study. The first focused group contained AHRC clients who were selected through purposeful sampling and the snowball technique. Purposeful sampling relies heavily upon the meaningful selection of participants who best provide information pertaining to the research questions used within a study (Patton, 1990). The snowball method, a form of purposeful sampling, is used to locate principal informants within a critical or specific case (Patton, 1990). After distributing participant recruitment flyers throughout the agency, two participants were selected for the AHRC focus group. The selected participants were then asked to inform others in their social circles about the research. By using the snowball

recruitment method, the participants' comfort level increased due to maximum peer familiarity. Men who showed an interest in participating in the project completed a participant questionnaire to determine their eligibility (Appendix 1). Everyone who completed the participant questionnaire was eligible for the study and was then contacted by either the behavioral specialist from AHRC or the researcher once the date and time of the focus group was determined. The first focus group had 10 participants and lasted approximately 90 minutes.

The second focus group comprised men who received services from and HIV/AIDS outreach non-profit service organization located in the HRIA region. The HIV/AIDS outreach organization routinely conducts HIV and AIDS testing, provides referral services for clients, and conducts capacity building trainings for partnership agencies within the AIDS partnership fund collaboration. The behavioral specialist from AHRC and I contacted the outreach coordinator from the HIV/AIDS outreach organization and distributed recruitment flyers within the agency. The snowball method for participant selection was used and those who qualified to participate in the research contacted the HIV/AIDS outreach agency's coordinator, completed a participant questionnaire to determine eligibility, and informed members of their social circle about the study. Each participant who completed a questionnaire was eligible to participate in the study and the researcher contacted all of the participants once a date and time for the second focus group was agreed upon. Due to space limitations at the HIV/AIDS outreach agency, AHRC allowed the second and third focus group to be conducted in their conference room. The second focus group had seven participants and lasted approximately 60 minutes.

To create a sample descriptive of the diverse population of African American males in the HRIA region, participants of the third focus group resided in the HRIA specified zip codes but may not have received any services from AHRC or the HIV/AIDS outreach agency.

Recruitment flyers were distributed among members of the HRIA Civic Association, and members of the AIDS partnership fund collaboration recommended participants who met the selection criteria of the study. The snowball method for recruitment was used and after completing the participant questionnaire form, it was determined that seven men met the criteria of the study. The third focus group had seven and lasted approximately 80 minutes.

Twenty-three men participated in the study. A HRIA resident who received testing services from the HIV/AIDS outreach agency participate in the second and third focus group. All of the men lived in the same zip codes and their ages ranged from 26 to 44 years. All but one of the men identified their sexual identity as heterosexual; only one self identified as homosexual. However everyone admitted to having sexual intercourse with an African American woman at some point in their lifetime. Fourteen of the men were unemployed at the time of the focus groups and of the nine that were employed, only four of them worked full-time. Seven men had attended high school and five earned a high school diploma or its equivalent; eleven men had some type of formal college education and two of them had earned a college degree. Member check was used to ensure the accuracy and validity of the information collected during the focus groups. Only one person asked to view a copy of the themes and focus group transcription. I met with him at the conclusion of third focus group so that he could review the information written about him during the first focus group.

3.5 Data Collection and Instrument

Focus groups were used to create group-talk (responses made to questions asked during the focus group) and in-talk (conversations conducted amongst the members of the focus group) interaction among the participants. According to Hollander (2004), focus groups involve "a small group of people with particular characteristics convened for a focused discussion of

particular topics" (p.606). Focus groups generally comprise 4 to 12 participants and are facilitated by a moderator who presents questions for discussion. The open-ended questions used in focus groups add qualitative depth and understanding to the participants' perspective, something typically absent in the standardized, close questionnaires characteristics of survey and quantitative research (Matoesian & Coldren, 2002).

Focus groups have many advantages. First, the data gathering method is popular across diverse disciplines because it incorporates a preoccupation with (1) the referential content of talk, (2) the decontextualization and recontextualization in discourse and (3) an evaluative summary (Hollander, 2004). Second, data is collected in a non-threatening and cost-effective environment. Third, the experimental demand of research can be reduced since the researcher can allow participants to control the discussion with little involvement (Hollander, 2004). Finally, the high external validity associated with focus groups represents another advantage towards their use. Compared with other data collection methods, focus groups mirror the kinds of conversations participants are more likely to engage in as part of their everyday life (Hollander, 2004). Although not identical to talk in everyday life, focus group participants are given the opportunity to extend thoughts, ideas, elicit stories, and in-depth explanations as in conversations influenced by others within talk-in interaction.

Upon arriving at the location of the focus groups, I informed the participants that the group interaction would be audio taped. I also informed the participants that the focus group would last one hour, and all responses would be kept confidential. I informed everyone that their responses would be analyzed for themes related to the general sexual health of women and no one would be asked to disclose information pertaining to their health or HIV status. Because of the sensitive nature of the topic, participants had the option to engage in member check to review

the accuracy of the transcripts. The consent form is included in Appendix 2. After each participant signed the consent forms, I began to record the group talk and in-talk interaction.

The data collection methods included the focus group interviews, an individual interview with the AHRC behavioral specialist, and community and field note observations. The focus group interviews were conducted with open-ended questions and the original interview guide is included in Table 3.1. In addition to taping the focus groups, I developed a research log and made field note observations to enhance the accuracy of the information shared during the focus groups. My field notes included non-verbal communication the men displayed during the conversations and notes to identify the participants as they spoke.

Table 3.1: Research Questions and Interview Questions

Research Questions	Questions and Prompts
What knowledge do African American MSW have towards HIV transmission in African American women?	Tell me about living in this area. What general/historical information can you tell me HIV/AIDS? What population do you think is most affect by HIV/AIDS? What can you tell me about HIV/AIDS in the Black community? What methods of transmission do you think greatly affects African American men/women? Why? What factors do you think influence high rates of HIV/ AIDS in the Black community? What methods are most commonly used to prevent the spread of HIV?
What beliefs do African American MSW have about their roles in HIV transmission among African American women?	What ways should couples/men/women approach the subject of safer sex practices in a relationship? What factors inhibit the use of safer sex techniques among Black men/women? What should couples/men/women know about issues pertaining to risk factors associated with HIV/AIDS (i.e. HIV status, sexual orientation, drug use, sexual behavior)? What type of conflict do you think couples/men/women may face if women initiative safer sex practices in a

	relationship? Tell me what you think actually happens when: -women ask that their male partners to wear condoms -men use condoms during sex -men don't use condoms during sex
How does the sexual behavior of African American MSW affect HIV transmission among African American women?	What generalizations do Black men make about Black women? What emotions/attitudes influence Black men's thoughts and ideas about Black women? How do these emotions/attitudes influence the behavior of Black women? How do the generalizations Black men make about Black women Impact or influence the status of women in sexual Relationship with Black men? The ability to negotiate safer sex practices in a sexual relationship? Most Black women contract HIV from their male partners. Why do you think this is happening?

3.6 Approval to Conduct Research

The Institutional Review Board at the University of Georgia granted permission to conduct the research. Verbal consent was given by the Executive Director of AHRC, the Outreach Coordinator at the HIV/AIDS outreach agency, and by members of the partnership fund. At the time of the focus groups, participants gave written consent. Results of the study were shared with the participants, the Executive Director of AHRC and members of the partnership fund. The identity of focus group participants was not shared with those who received a copy of the results.

3.7 Data Analysis

A modified form of grounded theory was used to analyze the data. Grounded theory is a process by which the data generates a theory and is used to conceptualize and refocus existing themes in literature (Glaser & Strauss, 1967). Grounded theory is also used to initiate new

themes within the data and helps to clarify existing theories and models related to the sexual behavior of African American men (Hutchison, 1990). The essence of the research is formulated from the data collected and analyzed and patterns that emerge represent the 'lived' experience of a person (Hutchison, 1990). Grounded theory serves as a guide towards the assumption of what people do and the patterns they experience while performing a specific act. The order of the pattern is concluded within the information shared by a common experience enabling the person to better understand his or her environment (Hutchison, 1990). Reality is thereby constructed through the actions of everyday life by ordinary members within a society (Hutchison, 1990). It is imperative to note that grounded theory research questions must provide the subject the opportunity to expound upon his or her experience with little input from the researcher.

Since the aim of grounded theory is to generate or discover a theory, grounded theory researchers collect and analyze data simultaneously beginning at the initial phase of research development. Theory is, therefore, derived from the data acquired through transcriptions, field notes, and personal stories, and data analysis systematically begins once data become available (Dey, 1999). Data collections concludes at the point of theoretical saturation or no new relevant data emerges from a category or theme (Glaser & Strauss, 1967). Data saturation may also occur if a category or theme is well developed in "terms of property and dimensions demonstration variation" and if the "relationship among categories are well established and validated" (Strauss & Corbin, 1998, p. 212). Within true grounded theory, a researcher may continue to collect data and expand a sample size until the data reveals no new themes or categories (Glaser & Strauss, 1967).

Grounded theory data may be collected from interviews, written material, memos, journals, field notes, observations, interviews, and focus groups (Strauss & Corbin, 1998). The

data is coded to identify patterns or concepts that serve as the foundations of the theory being developed. (Strauss & Corbin, 1998). A set of categories or themes are generated from the data through axial coding procedures and saturation (Miller & Fredericks, 1999). Axial coding is used to rearrange and place segmented data together for a new meaning by "making connections between a category and its subcategories (Strauss & Corbin, 1990, p. 97; Walker & Myrick, 2006). During axial coding, the researcher relates the properties of the each category to emphasize any relationships that can made within them (Strauss & Corbin, 1990). The use of axial coding later became a point of conflict among those who utilize grounded theory; the importance of codes versus categories has lead many researchers towards selecting open coding for a better understanding of the theory that may be found in the data as it relates to health research (Walker & Myrick, 2006).

Using a modified version of grounded theory allowed me to collect and analyze data and ensure rigor while conducting research on a much smaller scale. Also, theory generation from collected data serves as the goal of grounded theory. The result of my data analysis was to identify a set of themes as it relates to the lived experience and reality of the participants. The questions and prompts for the first focus group were generated so that emerging themes from the group talk and in-talk interaction could be compared to the themes found in subsequent focus groups. At the conclusion of the first group, I transcribed the data using inductive coding and constant comparison to establish themes to restructure the questions and prompts where fit. Inductive coding begins with a general reading of the transcripts and takes into consideration the many meanings that may be inherent within the text (Thomas, 2006). During my first reading of the text, I identified general text segments with a different color marker and placed each general segment as a category or theme on a large piece of paper. Next, I read the focus group

transcription again and underlined any segments within the text that were relevant to the identified themes in the same colored pen or highlighter. Afterwards, I compared the themes and segmented text to the questions from the first group to see if any segments of the text were coded into more than one category (Thomas, 2006). Question restructuring was minimal and additional prompts pertaining to drug use in the community and the correlation between drugs and HIV/AIDS transmission were included. I also supplemented the restructured questions to address possible scenarios for female initiated condom use. The restructured questions are listed in Table 3.2.

The group talk and in-talk interaction from the second focus group was then transcribed and analyzed using the restructured questions. The segment text relevant to the original themes and categories were added to the existing list and the emerging themes were compared in the same manner to the questions from the restructured list and the themes from the first focus group. After noticing a constant comparison between the coding used for the second focus group, I did not alter the questions and used them in their current state for the third focus group. The group talk and in-talk interaction was transcribed from the third focus group and the segmented text was added to the existing themes and categories. No new themes were discovered within the third focus group's transcription. Data collection within grounded theory concludes once the data no longer offer new and distinctive themes or labels. Therefore, data collection concluded after the third focus group. My field notes were then incorporated into the... data analysis to support information discovered within the transcripts.

Table 3.2: Restructured Research Questions and Interview Questions

Research Questions	Questions and Prompts
What knowledge do African American MSW have towards HIV transmission in African	Tell me about living in this area. What general/historical information can you tell me HIV/AIDS?

American women?	What population do you think is most affect by HIV/AIDS? What can you tell me about HIV/AIDS in the Black community? What methods of transmission do you think greatly affects African American men/women? Why? What factors do you think influence high rates of HIV/ AIDS in the Black community? How does drug use impact HIV/AIDS transmission in this area? What methods are most commonly used to prevent the spread of HIV? Where can people in this area go to find accurate information about HIV/AIDS and testing services?
What beliefs do African American MSW have about their roles in HIV transmission among African American women?	What ways should couples/men/women approach the subject of safer sex practices in a relationship? What factors inhibit the use of safer sex techniques among Black men/women? How does drug use impact safer sex practices among people of this area? What should couples/men/women know about issues pertaining to risk factors associated with HIV/AIDS (i.e. HIV status, sexual orientation, drug use, sexual behavior)? What type of conflict do you think couples/men/women may face if women initiative safer sex practices in a relationship? Tell me what you think actually happens when: -women ask males partners to use a condom during casual sex -women ask their male partners to use a condom in a committed relationship
How does the sexual behavior of African American MSW affect HIV transmission among African American women?	What generalizations do Black men make about Black women? Relationships? Infidelity within a relationship? What emotions/attitudes influence Black men's thoughts and ideas about Black women? How do these emotions/attitudes influence the behavior of Black women? How do the generalizations Black men make about Black women Impact or influence the status of women in sexual Relationship with Black men? The ability to

	negotiate safer sex practices in a sexual relationship? Most Black women contract HIV from their male partners. Why do you think this is happening?

CHAPTER 4

RESULTS

The purpose of this study was to give voice to those commonly overlooked in HIV and AIDS research, the partners of heterosexual African American women or African American MSW in low income, high crime communities. Four themes or categories emerged from the data, the HRIAs' living conditions, HIV/AIDS knowledge, beliefs about HIV/AIDS transmission, and the sexual behavior of African American men living in the HRIA. The African American men interviewed for this study were encouraged to speak freely and openly about issues pertaining to the sexual health and sexual practices of those in their community. In this chapter, I will describe the hectic and challenging environment by which the participants live in, their knowledge about HIV/AIDS and safer sex practices, their attitudes and beliefs about HIV transmission, and their views about the status of relationships within the Black community.

4.1 The HRIA Area: "Living in this neighborhood, it's not a good environment."

I began each focus group by asking the participants to describe living the HRIA area. The participants used terms and phrases such as "the lowest of the low and the cut throat of the cut throat", "the ghetto," "loud," "came here and got stuck" and "the wild, wild west" to describe the area's living conditions. Four general descriptors emerged from the group talk interaction to convey major issues within the area: (1) drugs, (2) violence, (3) the presence of police, and (4) prostitution.

Drugs have a very strong foothold on the HRIA community and dictate the way of life for a number of people. The availability of drugs is extremely high as indicated by the following statements:

> Like I [said], it's a drug infested neighborhood and people are going to do anything to get that drug. Whether it's sell their body, or steal or swindle, deceive…anything to get that drug.

> Around here, [drugs are] out. You know who is doing what. If you don't know, somebody is going to tell you who is doing it. Or you are going to ask somebody where you can get it from.

Seemingly shocking at first, many have come to realize that their community will always be plagued by the use of illegal drugs.

> I have seen, in broad daylight, I see folks walking around with their [cocaine] and I have never seen nothing like that in my life…before I moved down here.

Another participant shared how dismayed he was when he volunteered to help with the AIDS Harm Reduction Center clean needles exchange campaign. The AHRC clean needles exchange program allows clients to submit dirty needles and works in exchange for clean needles and syringes as a part of the agency's risk reduction outreach program. The participant stated that he "lost count at 5000" after collecting needles for only one afternoon.

HRIA residents contribute the area's drug use to the crime and violence many are forced to live with on a daily basis. Participants believed that those who use drugs, or are addicted to drugs, may be more incline to steal for money to continue their drug habit.

> If you drop this pen around these parts, and you close your eyes, it's gone. That's just how it is…and it [doesn't have to be a] pen, either. It can be anything. They will steal anything.

Others residents feel retaliation for bad drugs deals and a lack of payment contributes to violent crimes as well as demonstrated by one participant's statement of "killing, everyday all day…this is a way of life, you know what I am saying… everywhere you go."

One participant cited the recent example of the Kathryn Johnston shooting to illustrate how violent the neighborhood has become[1].

Drug use in the community has also created an increase of police presence in the area. Participant stated that the HRIA region has recently been labeled a disorderly conduct (DC-6) area by the police, and this labeling does not allow for common freedoms and liberties people in other areas may have. Statements such as "we live here and can't even enjoy it, without [the police] opening up on us" where echoed throughout the focus groups and one participant offered "you can't even sit on your porch and drink" to illustrate the frustration many of the residents of the area are facing. The police presence has also led to a feeling of helplessness among a number of residents as they attempted to continue with their daily activities as described below.

> You can't go to a certain area, but if you stay in the area, what can you do? Like, I stay in a DC-6, the whole [a certain road in the studied zip codes] is a drug area…I got locked up for that…and I told the police, what can I do, I stay right across the street. And when I catch a bus, they sell drugs right there, and I got to go to work, so what can I do?

Prostitution is very prevalent in the community. It was noted that women, and a few men, use sex to pay for drugs with clients who resided in the neighborhood and with those who travel in and out of the area to commit such illegal acts.

> Half of the people that come in come in to buy drugs, sell [sex], buy [sex]…but they don't live here. But, they come back…so they do their dirty work here.

Although many of the men in the focus group spoke of their community in a negative tone, a few felt as if it were an unpleasant way of life that they had to live with. One participant who recently moved from Florida to the area stated "no matter what state you go into, you will always find a Bluff " His statement was then followed by another participant who responded "yeah, but it's what you make it."

4.2 HIV/AIDS Knowledge and Awareness: "Either they don't know or they don't care"

I asked the participants to tell me what residents of the community knew about HIV and AIDS. Many of them stated that the residents know "what they hear, and not what they really need to know" because many do not want to face the devastating affects HIV and AIDS has had on the community.

> I say out of 150, some know and some don't know. They know, they just don't want to do nothing about it. But they really don't know the real [low] down on what is really happening with it.

Unfortunately, a number of participants think that residents of the HRIA region are not willing to get tested and learn their HIV status. Many of the residents believed that people in the community might not be able to deal with the stress of having the illness.

> I can kind of see why they don't want to know. And then, again, it might not be the right time, you know. If I got it, I don't think I would want to worry nobody with my problems. If I go get tested and if I got it, then [others] begin to worry. Stress will kill you, it will kill you. And that's why a lot of people don't want to know. Everyday they live; they are going to worry about it. But see, then again I think its bad because you should want to know…you can go out here and give it to an innocent person, and take their life and you will still be here. So you got two sides to everything.

The source of HIV and AIDS information was a concern for the participants due to the lack of trust many have for one another in the community. Participants stated that it was hard to trust the information from the residents of the area because, the majority of times, it was untrue. For example, one participant stated:

> You really don't know the truth unless somebody comes out and says something to you about it. And 9 times out of 10, a lot of these folks are not going to say something to you about them having [HIV]. You know what I am saying. And it's about 3 or 4 women that I know personally that folks say they got AIDS, and when they come to take a test, I know they don't have that.

Participants in the focus group admitted that they were unsure of what to believe about the virus as well. One claimed "I don't know the truth, I just know it's a virus." Another

participant illustrated the lack of knowledge many of the residents have when he explained that HIV could only be transmitted through semen. After I reviewed methods of HIV transmission with his focus group, he admitted that he did not know the virus that causes AIDS could be transmitted through blood and breast milk. The participant's lack of information was also revealed when he asked "how is AIDS transmitted orally from dude to a woman?" because he had always believed that "oral sex is alright." No one had ever explained other methods of HIV transmission to him.

Area residents also believed a number of myths surrounding AIDS and HIV transmission. For instance, many of the participants thought Magic Johnson was cured of the disease and was able to receive treatment because of his financial status.

> What's that basketball player's name, Magic Johnson? He caught it from…well look, he got the money to pay for the cure…he has gained more weight…they say he is not sick, he ain't sick no more…because he had the money to pay for the cure.

Participants also believed the virus that causes AIDS was created as "another way of population control" or "a form of genocide" to "control the Black race." A participant offered this example to describe the creation and spread of HIV/AIDS in the Black community and how myths and misconceptions still influence public opinion.

> Somebody got out there and [said] the Black Panthers are putting drugs in the community. The next thing you know, one person tell another person and somebody is going to believe it. The government has…they always wanted to control us…it's another form of war, just like in a test-tube.

Participants were unaware of other types of barrier methods one should use in order to practice safe sex and thought condoms could only be used during vaginal intercourse. Their lack of knowledge about the use of dental dams was obvious when a number of the participants requested information on how one could protect himself during oral sex and if saran wrap could be used as a safer sex method during vaginal sex if a condom was not available.

I explained that HIV and AIDS affects the HRIA at alarming rates and this area has one of the highest prevalence and incidents rates in the state the HRIA is located in. Many of the men stated they were not shocked about the statistics because of the area's high drug rates.

> Drugs play a big part in the discussion, concerning AIDS. Because when people are high, they will do things that likely when they are sober, they wouldn't do, you know. And it's very easy over here to get drugs.

As the discussion continued, one participant explained that the size of the region impacts HIV transmission in the area. He described how the cycle of drugs, money, sex, and infidelity unwilling affects those who live in the HRIA area.

> Well, the circulation. When you say it's the most in this area, than in any other area, [its] because of the circulation. Everybody in this neighborhood pretty much stays in this neighborhood. A majority of people in this neighborhood don't come out this neighborhood so you have the users, the working people, you know what I am saying, and you got the drug dealers. Everybody [in] some type of way is connecting with somebody. If the user is not doing something with a vic[tim], or trick, you got other vic[tim]s getting down with other vic[tim]s. You got a lot of vic[tim]s that might do favors for the drug dealers so the drug dealers sleep with his old lady and it's a circulation. Everybody in the neighborhood is touching somebody.

Another participant stated:

> That's like, okay, my partners ain't around so let me go on and buy this piece right here. Then I go back and sleep with my old lady. Then my back might be turned and my old lady might go sleep with another dope boy and ain't no telling who he done slept with or exchanged needles with and that's how basically…it's going in a circle.

Participants added that only a few people practice safe sex and use condoms while engaging in sexual intercourse during the "circulation" or while having sex for payment, commonly referred to as "turning tricks."

> You know, less than five minutes, she'll turn a trick and then the next thing you know, two minutes later, she's back out there turning another trick. This might go on for a period [of] six hours. In a six hour period of time, she might [have] turned 20 tricks. And [one] can't say how many times she practiced safe sex.

Some believed that men will not use a condom during these sexual encounters with prostitutes because condoms are uncomfortable and may not allow for a person to experience the "full effect." One participant explained that if a condom is not present at the onset of sexual intercourse, many of the prostitutes who use sex for drugs fear losing their potential earnings.

> Well, you look at it like this. A lot of people don't make them stop because they say well damn, I done paid my money now, she is going to handle her business.
> Cause you know she ain't giving up no money [or drugs]. She ain't giving it back.

> But what I can say is a lot of people [know] about it, more than now they are using more condoms because they are coming [to AHRC]…a lot of folks, the more they come, the more they do [HIV] classes…you learn a whole lot of stuff.

The participants stated that condoms were the most effective method of preventing HIV transmission among sexual partners and both men and women are taking a more active approach to using them during sexual intercourse. The HIV/AIDS outreach agency and AHRC were listed as community resources for condom distribution and HIV testing and they have seen an increase in the number of people who use the services of both agencies.

> A lot of women round here carry condoms. And they will…I have approached some women and I'm not going to call names and the first thing they say is you got a condom? I say okay.

Positive attitudes about condom use have also brought about a change in the number of times a person uses condoms, or ask a partner to use condoms, during sexual intercourse. Participants stated they usually carry condoms with them because they do not want to rely on the intentions of their partners. People are also more willing to discuss condom use with their partners and loved ones. One of the participants gave this example of a conversation he recently had with his son about condom use during sexual intercourse.

> You know I have a son and he is 14…he is getting to the age where he needs to know and I don't mind letting him know what's going on. And basically now, he knows because I sit down and talk to him and explain to him what's going.

Another participant shared this example to demonstrate an increase in positive attitudes pertaining to condom use in today's society:

> You know what use to crack me up? When I was young, I worked in the neighborhood drug store…And back then, you went to the drug store to get your condoms. And…it was real odd to see a woman. Every now and then, a woman would come in and buy condoms but it was mostly men. Now you had the men that come in and the time he opened the door, he is yelling give me a box of Trojans. And then you had the other one that would come, and wait for everyone to leave the store, and then call you over to the corner <whispering> can I get a dozen Trojans? Man, that use to crack me up about that. But now…everyone ask for them because they know that's part of life…

4.3 Beliefs about HIV/AIDS transmission : "Everything that looks good isn't always good."

The participants believed that everyone should utilize safer sex methods or practice abstinence to prevent HIV transmission in the HRIA region. The participants stated that it was important for everyone to use condom during sexual intercourse because of the impact a person's sexual history may have on disease transmission. One of the participants shared this thought about HIV transmission in the area:

> Now we know that, you are not only having sex with that person, you are also having sex with that person's partner and the partners' of the partners. It's just a big [tree]…the tree is like way out. So, it don't take but one on the family tree to kill the hold root.

But, as group talk interaction continued, only the female's sexual history became a factor when determining the benefits of using safer sex practices. None of the participants in either focus group discussed the impact the male's sexual history had towards determining an increased risk for transmitting HIV.

> If we engaged in sexual intercourse with a woman and we don't put a [condom on], we don't know nothing about that woman having sex with guys. We don't know her history. We don't know what she got now. You can have the prettiest woman, I mean the prettiest people, and they don't know what they got but they got to know. And you got to think to yourself well, if someone [had] sexual intercourse [with me], then I have got to put protection on. I got to put protection on, no matter what.

The participants also stated that they did not have problems introducing condom use during sexual intercourse and that it was "expected." For example, one participated stated "I am throwing mine on the table, like hey, this is what's happening." Another participant compared condoms to money because of the high prevalence of prostitution and paid sex in the area.

> Hey, it's just like money. If she asked me if I got money, you got condoms? I mean it just like that. Especially like a conversation anywhere around this area…if you meet any woman.

Another participant described how one of his former partners made condom use '"real fun" as a part of foreplay.

> She did the little lap dance, put music on, had her clothes on, then she did a little strip routine. And outside of any other woman that I have ever been with, she was about the best one as far as getting aroused and not just jumping into it, and I mean she [introduced condom use] at her pace.

Although the participants felt that people in the HRIA region understood the importance of using condoms during sexual intercourse, many of them admitted that a number of people, including themselves, were more likely not to use condoms while engaging in sexual intercourse. Simply stated by one participant, "there are a lot of people who don't like wearing condoms." Although it was previously stated that negative attitudes towards condom had decreased over time, many of the participants revealed that they, along with their partners, were still not willing to approach the subject of condom use every time they had sex. One participant shared this statement when asked by another participant how would he approach a person who did not like to use condoms:

> She told me, rubbers were made for bicycles and shoes and all that… So, I don't know what this girl got, I ain't never seen her before. So I didn't know how to proceed.

The participants added that men do not like to use condoms because of their unpleasant odor and condoms may hinder spontaneity during sexual intercourse. Condom use is also affected if a person has been drinking prior to sexual intercourse; one is more likely to engage in sexual

intercourse without a condom if he or she has been drinking. The lacks of spontaneity, and the effects of drinking and condom use, were illustrated by one of the participants in the following statement:

> and if ya'll are having oral sex, a lot of people ain't going to get up and go get no condom if they ain't already got one. You know what I am saying. They are just going to go on with it, especially if they have been drinking and something happens at times. And like he said, if somebody's been stripping…, this that and the other, a lot of people ain't thinking about that. They are going on with it, especially if you know them

According to one participant, condoms could also be introduced into a relationship if both peopled hail from a region similar to the HRIA. One of the participants relocated to the zip codes studied from New Orleans, LA, and stated that living in the Ninth Ward of New Orleans, LA was very similar to living in the HRIA[2]. The participant from New Orleans explained that many of the residents from the Ninth Ward did not "mess with each other" because of the health and social issues impacting the area. Condom use, along with HIV testing, was very important for those who lived in the Ninth Ward, as described below:

> I put it like this. If they are going to be cautions enough to use a condom and it's somebody you are dealing with or dating, then you should go the whole length. Like, where I am from, this one particular area, the Ninth Ward…we had the biggest, highest rates of AIDS. And the dudes and the chicks never messed with each other…when I met a female from Ninth Ward, that's okay, I didn't even know your name anymore, that's it. We won't even mess with each other anymore. I ended up meeting a chick and I dug on her before I found out where she was from and when she said Ninth Ward, and when she found out I was from Ninth Ward, she was like [no]…we both were like [no]…we like each other now but we both were like we shouldn't mess with each other and she was like lets go get tested together. So the female… let's get tested together if you are going to deal with each other so [you] both know what's up.

Condom use during sexual intercourse is also influenced by the type of relationship a person is in and the level of trust that has been established within the relationship. Relationships with a wife or girlfriend contain a higher level of trust than relationships that only involve casual sex. Therefore, condom use is more acceptable during casual sex. However, the participants

were still conflicted about how they would feel if a female were to ask her male partner to use a condom during casual sex.

To provide more details in understanding the difference between female-initiated condom use during casual sex and female-initiated condom use within an established and trusting relationships, I asked the participants to reply to the following the scenarios: "tell me what you think actually happens when women ask males partners to use a condom during casual sex" and "tell me what you think actually happens when women ask a male partner to use a condom in a committed relationship." First, for both scenarios, the participants firmly believed that it was the responsibility of the male to initiate condom use during a sexual encounter. But, it would raise suspicion if condom use was initiated by a female, regardless of the type of relationship. For a casual sexual encounter, one participant shared the following response.

> I am going to jump on it. It might take me a while to get hard again because now I am thinking she might have something…you know. Should I even bother with her at all. But I am going to take all of that into heed. You know, if, like I said, it's the heat of the moment and she suggested it, why don't you get your condom, you know, I am going to follow up on that thing.

A participant during the third focus group stated he would reply "yes, then we could have sex," but his statement was quickly met with rebuttals such as "you are going to think [that] she has [a disease] or is up to something" and "it's just going to make me think." Another participant stated:

> the dude [is] not going [to say no], you know, it's just going to make him think…I am saying, 9 times out of 10, most females, they don't like [condoms], at least 5 out of 7 ain't going to do that. So when you hear it, it's like why, you know what I am saying. You might think it is a good thing…really, you got to know that person. If it's a heat of the moment thing, it really might scare you. If it's somebody you met and you have known them a couple of weeks, then you pretty much know her scheme and that's a good thing. But, if you just meeting her and it comes straight off, then yeah.

The participants' responses were different when responding to female-initiated condom use within an established and trusting relationship.

The participants stated that any changes made to the current status of safer sex practices in an established, trusting relationship would raise questions on their behalf. The shared sentiment by many of the participants was, "if [you] weren't wearing a condom, then all of a sudden…you say let's wear a condom, then that's going to ring a bell." Even though it was more acceptable for males to initiate condom use, many of the participants stated that if a male began to wear a condom during sexual intercourse in an established, trusting relationship, many female partners would assume a lack of fidelity among their male partners. A participant from the first focus group gave this statement to illustrate a lack of fidelity among members of an established, trusting relationship

> Like me and my lady, we never used a condom. We had a relationship where we know it's us. She ain't never did it with nobody else; I ain't never did it with nobody else. But at the same time, I came back with something. She said you need to go get that checked out. And it wasn't nothing but a little virus, thank God. But at the same time, I had to wear a condom. For the simple fact that I broke that trust, she knows I was sleeping around. And what fool is going to say, I know you sleep around, but come on lets have sex…we ain't got to use no condoms. That's being foolish.

Female-initiated condom use, according to participants, would not lead to skepticism in a relationship if the couple were attempting to prevent pregnancy. Therefore, condom use while engaging in casual sexual encounters was expected, but, was not always practiced. Condom use among participants of an established, trusting relationship was generally not expected and female-initiated condom use will always raise suspicion unless a couple is trying to prevent pregnancy.

4.4 Sexual Behavior of African American Men: "Variety is the spice of life"

When asked to describe the status of relationships among African Americans, many of the participants felt neither the male nor female would be honest and truthful about their emotional feelings and desires for one another. One participant stated that "nobody is going to tell the truth in a relationship" and this lack of information referred to a person's relationship status, intentions within a possible relationship, and one's HIV status. Although women were not going to be honest about their sexual history, men would eventually reveal more to their female partners about their sexual preference.

> When I come to you, I'm going to come to you and put [it] on the table. This is what I want, this is what I want to do, you can take it or leave it. You know, that's just me.

Participants also felt that it was very difficult to maintain a serious, committed relationship with African American females because of the status of Black men in their community. The participants cited a difference in earning potential and income between Black men and women, a lack of trust many Black women have for Black men, and the remaining baggage or issues from previous relationship.

> It's a hard topic because, nowadays, it's very hard to have a steady relationship with a Black woman…the Black woman is overruling the Black man…because the Black woman is working more than the Black man. The average Black man is out here in the streets hustling or on dope or in jail. So right now, a Black female is…really brushing a Black man off because he ain't got nothing to provide…he ain't got nothing to give. And she [is not] going to want to carry him…you might have one or two females [that] may grab a brother and up say hey…, let me snatch you up out of this here because I see the potential in you…but, other than that…we are the swamp.

Another participant offered this explanation to describe the status of relationships within the Black community.

> Black women…are doing their thing…if they ride up in Navigators…the things you see guys riding in, and women driving trucks…because they know what they've got to do…you can't depend on nobody but you.

Others felt as if Black women are expecting their partner to bring "50/50" to the table since Black women "don't have to worry about a man" to provide for them. A number of participants with sisters or daughters also explained how they have heard similar sentiments and opinions echoed in conversations among friends and family members.

> My momma told my sister that. You don't worry about what a man won't do; you just worry about what you are going to do for yours.

> My momma worked…and left my daddy and had 12 children. So, I know my sisters have the same mentality…it wasn't how she was raised, it was how she felt about herself…if you get a woman that has some sense of self, it's a done deal. I raise my daughters the same way. You ain't going to be dependent on no man for [anything]. When you can get out and get your own. If I can provide for you as a daddy, if I am not in the house… if I provide for you, mentally, I am going to provide for you by teaching you what it is you got to do for yourself. And if she has that…she is not going to depend on no sorry man. I don't give a damn how good the [sex] is, that is only going to last for so long. You get one bad night, one bad [sexual experience] and you are done. If this woman got her [act] going on, then she ain't doing it.

According to the focus group members, it is possible for men to be unfaithful in their relationship with women. Infidelity among men was viewed as "a way of life." "Variety is the spice of life, that's what keeps a relationship going," and "that's just the dog in us" were also used to illustrate infidelity within the group talk interaction. One participant from the third focus group justified cheating, by sharing a conversation he had with his female partner shortly after being released from jail.

> I got locked up…got out of jail…and, when I got out, my girl looked at me, [and said] I know I [have got to] get you some. I told her…hey; you ain't got to worry about giving me none because I am going to get me some….and I am going to get some with you or without you…it's going to happen, period.

Another participant shared his thoughts pertaining to infidelity and the use of prostitutes within the HRIA area.

> I feel like [prostitution] is a good thing because, all these men who come out of prison, if they had them some prostitution, it would be great…I don't look at it like that, but I am

> saying…if it wasn't for prostitution, it would be a lot of rape when a man gets out of prison. So I thank God for these prostitutes.

Even though high levels of infidelity were common, many of the participants stated that most men experience some type of guilt after committing the act.

> Sometimes [cheating] does make you appreciate what you got back home…either one of two things. You are like, hell, after you get through doing it, a lot of times you have that guilt of why did I do that and when you go back home, it will be a long time before you do that again…your conscious will be like man, I got a little old lady back at home.

Another participant shared a similar statement about cheating on his wife.

> When I was married…and cheated on my wife…nine times out of ten it was a little chicken head that you pick up. She is either dumb…something wrong about it…but after you get with her, you are like damn, what the hell am I doing. And you know, when you go back home, you are saying, man, I got something good at home, why am I messing with these knuckle heads out here in the streets.

Even though it is very common for men to cheat on their female partners, many of the participants felt that a woman would not end the relationship if their partner's infidelity was revealed. Women would remain in the relationship based on the strength of the relationship or if the relationship was void of any underlying issues prior to any acts of infidelity. In other words, the participants did not believe a female would end a relationship solely based on her partner's infidelity. For example the participants from New Orleans felt that women in the HRIA region "are more likely to say with you" because "they are going to stay with you anyway," Another participant described the following circumstances by which a female would end a relationship with an unfaithful partner:

> If her reason for going out is because you deny her the sexual pleasure she wants and you ain't bringing in no money, taking care of your business…you got to take care of something as a man. That is what a woman wants you for. You got to handle her sexually, or financially, or both. And if you ain't got it, you got to get to stepping. Or you will be in the middle of a house where she is out there sleeping with who she wants to sleep with. You can forget about monogamy, when you ain't' bringing nothing to the table.

It can also be described in the following statements:

> If nothing is coming to the table, and if he ain't taking care of her, or if she is having too much drama with this guy…[but] if they have a good life, then yeah, she might stick around and say well man, this [person] is working, he got big loot…okay, I am going to overlook that.

> They don't leave because they like what they got. They might not like the situation at the time, but obviously, if they were with that person, they are feeling that person, or they might be living together and he taking [on] everything he can. He's paying all of the bills, and he is putting food on the table and clothes on her back, she don't want to start from scratch because the next person might not do that.

Although acts of infidelity were considered customary for males, women were not allowed the same concession for their acts of indiscretion. According to the participants, women do not cheat in the same manner as men. Men who engage in extramarital affairs, or have sex outside of their relationships, do so without becoming emotionally attached to the other person. Men can "go outside and cheat, and never call or see that broad or worry about her again." Women become emotionally attached to someone during sexual intercourse, "it's different because it is so much more emotional and physical contact with a woman than with a man." Due to the higher levels of emotional and physical involvement women experience compared to men during sexual intercourse, men are more likely to end the relationship if their partner's acts of indiscretion are revealed. One participant stated "it is going to eat at a dude" especially if he feels the act is going to be repeated or its going to happen again with that same person." Also, according to the participants, a woman's infidelity correlates to problems within the relationship. When women cheat, men feel as if things are "out of control" or she is retaliating for something he may have done wrong within the relationship.

> It's out of vengeance. That's just the way…at least in my experiences, that's the way is has been, out of vengeance.

> Say, I got with Ms. Lady here… and I am wondering like why did it happen?...so why are you cheating with me on your old man? And it's like, well, he did it to me.

CHAPTER 5

DISCUSSION

The goal of this study was to provide insight into the views African American men who have sex with women express and their perceptions of the influence they have on the safer sex practices of African American women, regardless of sexual preference or orientation. The research questions were: (1) what knowledge do African American MSW have towards HIV transmission in African American women? (2) What beliefs do African American MSW have about their roles in HIV transmission among African American women? (3) How does the sexual behavior of African American MSW affect HIV transmission among African American women? I conducted three focus groups with 23 African American men who reside in one of the poorest area of a major metropolitan area in the southeastern region of the United States. This study used a qualitative, modified grounded theory approach. The analysis of the group talk and in-talk interaction utilized inductive coding and constant comparison to construct themes pertaining to the sexual knowledge, attitudes, and beliefs of the participants.

5.1 Discussion of Findings

Grounded theory is used to conceptualize and refocus existing themes in literature. Grounded theory is also used to initiate new themes within the data and helps to clarify existing theories and models related to everyday (Hutchison, 1990). This study used a modified version of grounded theory to analyze the sexual behavior of African American men who reside in low income, high crime communities. One-third of African American women who have AIDS contracted the disease through sexual intercourse with a male partner (Bowleg, 2004; CDC,

2005a). If research does not focus on all aspects of the relationship dynamics of African American men and women, then meaningful interventions for African American women will be difficult to develop This study gave voice to those commonly overlooked in HIV/AIDS research, the partners of heterosexual African American women or African American MSW.

Illegal drugs use, crime and violence, prostitution, and a sense of hopelessness were general descriptors used during the group talk and in-talk interaction to describe the HRIA regions. Neighborhood conditions, such as low socio-economic status and high rates of crime, places many of the female residents of the HRIA region at a disproportionate rate of contracting HIV from their male partners. A meta-analysis of similar populations showed that African American women who constantly face concerns for obtaining food, shelter, and safety for themselves-attributes of the HRIA region-are less likely to engage in HIV-protective behaviors (Logan et al, 2002). In addition, impoverished women are more likely to be the victims of violence, limiting the amount of decision-making power and relationship control one may have towards suggesting condom use. (Logan et al, 2002).

Residents of the HRIA region are aware of the devastating effects HIV/AIDS has had on the Black community and on members of their own region. However, the source of information was a concern for the participants due to the lack of trust many had for one another. Misconceptions about the disease were also obvious among the study's participants. According to Salmon, Wooten, Gentry, Cole, and Kroger (1996), certain minority populations have been disproportionately affected by the spread of HIV due to the AIDS knowledge gap. The knowledge gap posits that:

> As the infusion of mass media information into a social system increases, segments of the population with higher socioeconomic status tend to acquire the information at a faster rate than the lower status segments, so that gap in knowledge between these segments tends to increase rather than decrease (Tichenor, Donohue, & Olien, 1970, pp. 159-160)

Salmen it al. (1996) observed that (1) the acquisition of knowledge for a topic that is heavily publicized will proceed at a faster rate for those with a better education and (2) if at any given point of time, one should expect a higher correlation between the "acquisition of knowledge and education for topics highly publicized in the media than for topics less publicized (Gaziano, 1983. p. 448;). Therefore, the gap of knowledge among those with lower socioeconomic status will continue for topics that are not highly publicized such as the impact of the HIV/AIDS among African Americans. Examples of the knowledge gap among the participants included a belief that those of a higher socioeconomic status could purchase medication that would lead to a cure for the disease, the belief that HIV/AIDS is a form of genocide currently used by the government to control the Black population, and there is little or no risk for contracting HIV/AIDS through oral sex.

The participants in the study felt that HRIA residents were less inclined to be tested for HIV or to know their HIV status because of the pressure or undue stress it would cause. A person's lived experience, such socialization, culture, and life situation, helps a person to make sense of their illness (Hardy, 1998). In order to accept the reality of a positive diagnosis, a person may accept the reality of the diagnosis and any judgments or role expectations one is perceived to experience (Valle & Levy, 2008). A quantitative study of 839 African American injection drug users and their partners showed that positive diagnosis among an African American intravenous drug user forces him or her to confront the duality of racial disadvantage or discrimination and drug dependency (Valle & Levy, 2008). Therefore, individuals at high-risk for transmitting HIV, especially intravenous drug users, may not be tested.

The participants stated that the cycle or "circulation" of drugs, money, sex, and infidelity affects those within the HRIA region because of the areas small size and high prostitution rates.

Research conducted with African Americans from low income rural and urban settings revealed that substance abusers are more likely to engage in high-risk behavior such as unprotected sex and sharing needles when under the influence of drugs (Ross, Kohler, Grimly, & Bellis, 2003; Brown & Hook, 2006). A mixed methods study collected data from rural African American women who used drugs also showed that high rates of poverty places African Americans at a higher risk for contracting HIV/AIDS by limiting resources to access to health care and basic necessities such as food, clothing, and shelter (Brown & Hook, 2006).

The participants stated that negative attitudes towards condoms have decreased over time, but many people are still not willing to approach the subject of condom use with their partners every time they had sex. Meta-analysis and literature reviews show that condoms hinder spontaneity during sexual intercourse-for both men and women-and may not be used if a person is under the influence of drugs or alcohol. Negative attitudes towards condoms also influenced condom use during sexual intercourse and one of the most important factors contributing to the rise of HIV and STDs among African Americans is the lack of constant condom use (Roberts & Kennedy, 2006; Burns, 2005; McNair & Prather, 2004; Logan et al., 2002). African American women must have a sense of control and a favorable view of condoms in order to negotiate effective and constant condom use (Bryan, Aiken, & West, 1997; Gerrard, Gibbons, & Bushman, 1996; Roberts & Kennedy, 2006). According to the participants of the study, women are still unable to negotiate condom use due to their lack of trust many men have for the women they are engaging in sexual intercourse with (Bird et al., 2001; Harvey et al., 2002; Logan et al., 2002). But, a positive change was noted; participants felt that it is now more acceptable to purchase condoms.

The participants of the study described promiscuity as "the spice of life" needed to sustain a heterosexual relationship. In a qualitative study with 19 African American women that reside in the southeastern United States, Timmons and Sowell (1999) found that African American women believe that African American men could not or were not willing to maintain sexually monogamous relationships and were thought to be naturally prone to sexual promiscuity. Therefore, African American women's expectations allow for African American men to engage in promiscuous and/or practice risky sexual behavior with little or no consequences for their actions (Timmons & Sowell, 1999). As it relates to the impact of behavioral practices among both African American men and women in the HRIA, African American women are more likely to date within their own race and ethnicity. Therefore, the impact of promiscuity on behalf of African American men does and will influence the sexual health of African American women.

The participants stated if someone initiated condom use during sexual intercourse, they would question their partner's level of trust or assume that their partner was promiscuous. And, initiating condom use during casual sex was more accepted than initiating condom use for a relationship that exhibited a higher level of trust (e.g. girlfriend/boyfriend, wife/husband). Dyadic trust, or a person's belief in a partner's benevolence or the belief that one's partner is concerned about the welfare of the dyad and honest about their concerns, determines condom use within sexual relationships (Jones, 2004). The participants believed that a committed relationship contained a higher level of trust than a casual sexual relationship. Therefore, initiated condom use in committed relationships led to questions of about possible infidelity. This also serves as a hindrance towards condom use and contributes to high-risk behavior because of the self-perceived notion of promiscuity many African American women have

concerning their partners. Qualitative and quantitative studies conducted subgroups of African American women indicated that if condom use is female-initiated, African American women believe their partner will view then as promiscuous, a item substantiated by the participants (Jones, 2004; Timmons & Sowell, 1999; Bird et al., 2001; Soler et al., 2000).

Gender roles were still very prominent within the African American community and directly impacts relationship status and the sexual health of African American women. Participants believed that is the role of the male to initiate condom use, substantiating the role males as the initiator of sexual intercourse. According to the theory of Gender and Power, the structure of the cathexis, or emotional significance to an item, helps to produce the laws, taboos, and prohibitions that define normal behavior, restrain sexuality, and localize the cultural norm for femininity within heterosexual relationship (Wingood & DiClimente, 1998). Views towards women's sexual behaviors are governed by social rules within the structure of the cathexis and a woman's failure to negotiate safer sex practices such as condom use may result in the further strengthening of trust and intimacy within the relationship from her perspective, which does not allow for her to negotiate or introduce the use of condoms during sexual intercourse.

Men who engage in extramarital affairs, or have sex outside of their relationships, do so without becoming emotionally attached to the other person. Women become emotionally and physically attached to someone during sexual intercourse and due to the higher levels of emotional and physical involvement women experience compared to men during sexual intercourse, men are more likely to end the relationship if their partner's acts of indiscretion are revealed. Black women must survive in both the views constructed for them by society and through the dynamics of power in their romantic relationships with Black men. This again places

them at a disadvantage due to the sexist and gender roles they face with the unequal structure of power and unfair sexist views of African American relationships (Franklin, 2000).

5.2 Limitation of the Study and Future Research

A major strength of the study were the participants. Interventions and preventive measures to reduce HIV transmission in the Black community focuses predominantly on safer sexual practices related to African American MSM. This study allowed for the partners of those disproportionately affected by HIV to be the focal point of the research. The selection of participants was based on the gender of their sexual partners, not on their sexual identity. I was very careful not focus my attention on the aspect of HIV research and prevention within African American males associated with MSM or undisclosed MSM. Doing so would only perpetuate common sexuality myths and stereotypes that hinder progress towards reducing HIV transmission among African American women.

The participants of the study reside in a low income, high crime area of metropolitan located in the southeast region of the United States. Therefore, the participants also served as a limitation of the study. This area was selected because of its high prevalence and incidence rates for HIV and could offer a unique perspective of HIV/AIDS on the African American community. Conditions such as high poverty rates, illegal drug use, and prostitution may be unique to this area and may limit generalizing the findings of this study to all African Americans. Therefore, the conditions that the participants live in may affect them contextually and the findings of this study should not be generalized to all African American men and women. Additional studies could be designed to address social and environmental factors that may influence HIV status and high-risk behavior in areas in different community settings such as

areas with high concentrations of Blacks who do not reside in the southeast portion of the United States, and who do not live in low income, high crime communities.

Another limitation of the study was my affiliation with well established and trusted service organizations located in the studied zip codes. The participants were selected through their affiliation with AIDS outreach agency and a civic association; each who has developed trust within the HRIA region. Participants stated that their level of trust for the information distributed by these agencies was very high compared to their level of trust for their own community members. My affiliation with the HIV/AIDS outreach agency, AHRC, the areas Civic Association, and the community partnership fund allowed me to develop a level of trust with the participants before the research began. Research that does not address the lack of trust many community members have for one another may yield different results because the participants may be unwilling to share such personal aspects of their guarded lives and the area by which the call home.

Finally, this study did not represent a true sample size of the zip codes studied. The zip codes used for this study are undergoing gentrification and new residents are moving in the area. The HIV/AIDS outreach reach agency and AHRC focus groups included participants who utilized the services offered by these agencies. The community's Civic Association focus group included members of the community who may not receive services from either agency. Although the participants were willing to share their stories during the data collection process, the participant recruitment process limited access to true sample size of the population and was saturated with those of a lower socioeconomic status. A true sample size of the area may be obtained for future studies if recruitment efforts were extended to include grassroots organizations, churches, homeless shelters, housing community associations, and businesses.

This would allow for the voice of African American MSW with a higher socioeconomic status to be included in the research.

5.3 Implications for HIV and Public Health Research

More qualitative research should be conducted to address behavioral aspects of HIV/AIDS within the African American community. Both qualitative and quantitative research is interested social interaction, the experience of the participant, and conditions that influence one's experience. However, qualitative research aims to pursue the direct link between objects and social inquiry more closely (Crotty, 1998). Qualitative HIV/AIDS research would allow for the researcher to supplement devastating HIV/AIDS statistics with the important questions of "how" and "why?" The focus group participants felt that asking about their lives as HRIA residents and the affects HIV/AIDS has had on their community, made them feel as if their voice was finally being heard. This is the goal of qualitative research.

More community specific HIV/AIDS intervention programs should be developed and utilized to address critical issues that influence a community. For example, after the second focus group, participants discussed the gentrification process currently underway in the city where the research was conducted. The participants believed that their lower socioeconomic status was not of importance to the overall restructuring plan of the city and many of the housing needs, access to healthcare, and social support systems were being destroyed as the city is rebuilding. High levels of prostitution, drug use, and crime are also affecting the participants and residents of the HRIA region. The basic premise of Maslow's hierarchy of needs states that a person's first concern is to satisfy his or her basic need of survival (Rice, 1995). Basic needs for survival include physiological needs such as food and water, and safety needs such as security and stability (Rice, 1995).

Intervention programs that address the basic concerns of those with a lower socioeconomic status may have a greater impact on sexual health. The community fund is currently addressing the issue of creating community and needs specific interventions in the HRIA area. Over the span of the community developments grant, programs that address the needs of domestic abuse for community leaders and members, additional HIV, tuberculoses, and hepatitis testing, and capacity building programs are being implemented in the area.

Grassroots organization meetings with community outreach organizations and faith-based organizations in the area are also being implemented to assess the needs and address the concerns of HIV transmission in the area as well. African Americans often distrust medical and health professionals (Alvarez, Vasquez, Mayorga, Feaster, & Mitrani, 2006). These reasons may include a history of enslavement, and abuse from prior medical clinical trials and the withholding of treatment for curable conditions (Alvarez et. Al, 2006). Members of African America communities may sense difficulty in engaging in prevention interventions and treatment programs because of a lack of trust for those who administer and deliver health services. Community outreach organizations have the expertise needed to reach minority participants that are at an increased risk for HIV/AIDS. Commonly, community outreach organizations hire staff members "that are ethnically matched and have similar life experiences to the target population (Alvarez et al., 2006, p. 545). Also, since churches play a vital role in the everyday lives of many African Americans, many community members rely on the resources provided by faith-based organizations such as financial and monetary support, educational resources, and spiritual guidance (McNeal and Perkins, 2007). Community establishments such as faith-based organizations are also effective in addressing major health concerns such as diabetes, hypertension, breast cancer, and obesity (McNeal & Perkins, 2007; McNabb, Quinn, Kerver, &

Karrison, 1997; Sutherland, Barber, Harris, & Cowart, 1982). For instance, McNeal and Perkins (2007) found that Black churches could be a potential resource and educational facility for HIV/AIDS prevention because ministers were receptive to implementing such programs for their members.

Faith-based organizations that utilize multiple health approaches for reducing HIV infection among African Americans have also been implemented and supported in Black Churches. The Sisters Informing Sisters on Topics about AIDS (SISTA) is a peer led- HIV prevention intervention implemented in 1993 (Collins, Whiters, & Braithwaite, 2007). SISTA utilizes theoretical frameworks from the Social Cognitive Theory and the Theory of Gender and Power along with a culturally appropriate curriculum to address concepts and the skills necessary to master condom and safer sex practice use and assertiveness training (Collins et. al, 2007). After the success of the SISTA program, the SAVED SISTA project was later adapted in Atlanta, GA to drug abuse recovery as well as behavioral interventions towards HIV prevention (Collins, 2007). Aspects of Christianity are woven into the SAVED SISTA program to provide a higher level of trust and to meet the basic needs of the participants through a religious entity in which the society places a higher level of esteem within the establishment (Collins, et. al, 2007). Therefore, faith-based organizations could increase their role of addressing HIV/AIDS by capitalizing on their location in the community, their established reputation for being a grass roots organization, and their record of effectively addressing other major health issues.

Although it is very difficult to change a person's attitudes about gender roles, it may be very helpful for public health and HIV/AIDS research to create interventions based on feminist theory and a feminist theoretical framework. Feminism is concerned with the equal treatment and equal rights of men and women (Kolmar & Bartkowski, 2005). A framework is a system of

ideas or structures that helps a person see, examine, understand, and change the social world (Parpart, Connelly, & Barriteau, 2000). A framework also explains how a problem should be defined and the types of questions that should be asked to address a social issue. Gender roles and sexist attitudes towards monogamy within African American relationships, negative attitudes towards condoms, and female control and empowerment towards initiating condom use serve as major problems for decreasing HIV transmission within the African American community. A feminist theoretical framework within public health and HIV/AIDS research place the inequality many African American women face while negotiating condom use at the forefront of many interventions. A feminist theoretical framework approach towards HIV/AIDS and public health research would also allow the unheard voice to be coupled with the voice most affected by this dreaded disease, African American women.

5.4 Conclusion

The goal of this study was to provide insight into the views African American MSW who live in low income, high crime Black communities express about HIV/AIDS and their perceptions of the influence they have on the safer sex practices of African American women. Although a number of models, variables, and factors address the increase prevalence and incidents rates of HIV in the African American community, a comprehensive understanding of sexual behavior theories, a shift in the at risk populations, social and contextual factors, and the impact of gender is still needed to inform programs to decrease the risk of HIV infection among African American women. Labels such as “sexuality,” “drug addict,” “high-risk,” and “infidelity” were removed so that the participants could speak freely about their lives within the HRIA region and the impact HIV/AIDS has had within the studied zip codes. The participants identified variables within the community factors such as drugs and violence, HIV knowledge

and awareness, beliefs about HIV/AIDS transmission, and the sexual behaviors of African American men as items that influenced HIV transmission in their community. The results of this study should be used to further qualitative public health research within at-risk populations, but should not be used to generalize the sexual behaviors of all African Americans. I hope the valuable insight of these men can lead to more innovative approaches for combating HIV/AIDS within the African American community. I also hope that everyone infected and affected by the disease will have the opportunity for his or her voice to be heard as well.

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FOOTNOTES

[1]Johnston, a 92-year old HRIA resident, was killed when she fired back at members of the Atlanta Police Department's Narcotics Unit during a botched drug raid of her home two days prior to Thanksgiving in 2006 (Visser, 2006). Details of the case revealed that members of the Narcotics Unit were eventually charged with lying to a judge to obtain a no-knock warrant based on false information provided to them by an informant. Many of the participants speculated that Ms. Johnston opened fired on the officers because they did not identify themselves upon entering her home to investigate claims that cocaine could be found on the property. Police reports would later reveal that the officers planted cocaine in house once they realized an innocent woman had been killed (Visser, 2006).

[2]In the decades prior to the destruction of Hurricane Katrina, the Ninth Ward of New Orleans, LA was being reshaped by factors that influenced the regions socioeconomic status (Landphair, 2007). The Ninth Ward, also referred to as the Lower Ninth Ward, is located in the southeastern region of New Orleans and borders the Mississippi River (www.census.gov b). This area of New Orleans is predominantly African American and has been plagued by violent reputation, low socioeconomic status, and its vast number of health disparities (Landphair, 2007). In 2005, a number of Ninth Ward residents, and New Orleans residents, were forced to evacuate the area once the devastating effects of Hurricane Katrina came ashore on August 29 (www.msnbc.com)

APPENDIX A

Subject Information and Informed Consent Form

I, _____, agree to participate in the research titled "**The Voice Unheard: The Perspective of African America men who have sex with women on HIV transmission in the Black community"** being conducted by Kimberly Parker, a PhD candidate, from the Department of Health Promotion and Behavior, University of Georgia (678-481-9980) under the direction of Dr. Su-I Hou, Department of Health Promotion and Behavior, University of Georgia (706-542-8206) I understand that participation is voluntary. I can refuse to participate or withdraw from the study at any time, without giving any reason and without penalty.

Purpose of the study: The purpose of this study is to examine the views, thoughts, and opinions of African American men who have sex with women, regardless of their sexual preference or orientation, regarding their influence on the safer sex practices and sexual behavior of African American women.

Procedure: If I volunteer to take part in this study, I will be asked to participate in a focus group which will take about 1 ½ hours. I will be asked to discuss general knowledge about HIV/AIDS in the Black community, beliefs about the roles African American men play in the transmission of HIV among Black women, knowledge of safer sex practices, and generalizations made within society and my community. I will not be asked to reveal any health related information about me, nor will be asked to reveal my HIV status. Refreshments will be provided during the focus group. The focus group session will be recorded and transcribed by the Principal Investigator. Only the researchers working directly on this project will have access to the audiotapes. The tapes will be destroyed one year after the content of the group discussion has been summarized and the study is completed.

Benefits and Incentives: There will be no direct benefits for me but the findings through the information I provide may help benefit the field of public health, women's studies, sexuality studies, and African American studies in developing race, gender, and sexual preference interventions and programs in order to decrease the transmission of HIV and other sexual transmitted infections.

Risk/Discomforts: This research is not expected to pose any physical discomfort or risk to me as a participant although it is possible that I might experience minimal emotional distress due to the discussion about HIV/AIDS. If I experience any emotional distress during the group discussion, I may cease participation at any time. If I wish to discuss any emotional stress, Principal Investigator will provide the name and telephone number of a trained professional that I can talk to at any time.

Since it is a focus group, the Principal Investigator cannot guarantee that all participants will keep the discussion private; however the Principal Investigator will make every attempt to keep my identity confidential. The Principal Investigator will not reveal any identifying information about me, or provided by me during the research, unless required by law. Any data containing individually identifying information will be securely kept locked in a filing cabinet or password protected computer in the Principal Investigator's office. My name or any other identifying information about me will be disassociated with any individual comments that I make.

The Principal Investigator will answer any further questions I may have about this research, now or during the course of the research study, and can be reached at 678-481-9980.

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my own records.

Kimberly Parker, MA, MPH, CHES	_____	_____
Principal Investigator	Signature	Date
Telephone: 678-481-9980		

Email: kaparker@uga.edu

_____	_____	_____
Name of Participant	Signature	Date

Please sign both copies, keep one and return one to the Principal Investigator

Additional questions regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; telephone (706) 542-3199; E-mail Address IRB@uga.edu

APPENDIX B

"The Voice Unheard"
Participant Questionnaire

Please respond to the questions listed below. Response will be kept confidential and will be used to determine your eligibility to participate in the study.

Name: _____

Focus Group Agency/Number: _____

What zip code do you live in? _____

What is your race or ethnicity? _____ **How old are you?** _____

How do you identity yourself sexually?
_____ **Heterosexual**
_____ **Homosexual**
_____ **Bisexual**

Have you ever engaged in sexual intercourse with a Black woman (please select only one)? _____ **Yes** _____ **No**

What is your highest level of education (please select only one)?
_____ **Some High School**
_____ **High school diploma or GED**
_____ **Some College**
_____ **College Graduate-Certificate or Associate Degree)**
_____ **College Graduate-Undergraduate Degree**
_____ **Some Graduate School**
_____ **Complete Graduate Degree**

Are you currently employed? _____ **Yes** _____ **No**
If yes, are employed full time or part time? _____

Would you like to be contacted after the study to review the information for accuracy in recording your statements? ____ **Yes** _____ **No**
If yes, please provide your contact information in the space below.

Address:

Phone Number:
Email Address:

Thank you for your cooperation. Again, responses will be kept confidential and will be used to determine your eligibility to participate in the study