AN EXPLORATION OF FACTORS THAT INFLUENCE SEXUAL DECISION MAKING

AMONG YOUNG BLACK WOMEN

by

AISHA K. TUCKER-BROWN

(Under the Direction of Patricia Reeves)

ABSTRACT

Sexual decision making among young African American women is complex. This study explored the factors that influence the decision making of 25 African American women between the ages of 18 and 25. They were purposefully selected and interviewed. Ten were interviewed individually, ten were participants in one of three focus groups, and five participated in both individual and focus group interviews. Interviews and focus groups served as the sole source of data for this study. This was a basic interpretive study and a qualitative research design was used to explore the factors that influence sexual decision making among these participants. Data were analyzed using the constant comparative method.

An analysis of the data revealed categories and properties related to participants' understanding of HIV, their perception of risk, and the major influences on their decisions regarding sex. The intersection of race, class, and gender also became apparent when looking at it in the context of power as well as sexual risk.

Three general conclusions were drawn from the findings: (1) Despite their knowledge of HIV/AIDS, and both familial and religious influences, young Black women still make sexual decisions that put them at risk for contracting HIV; (2) Young Black women recognize that they

are at great collective risk for contracting HIV, yet fail to acknowledge individual risk; and (3)

Issues of power and some popular media significantly influence the sexual decisions of young

Black women. Implications for practice and theory in the field of social work, study limitations,

and recommendations for future research are provided.

INDEX WORDS: African American or Black women, HIV, AIDS, Sexual decision making,

Black feminist theory, Qualitative research

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MAKING AMONG YOUNG BLACK WOMEN

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DEDICATION

To my husband, Reuben Tremayne Brown, our daughter Kaya Raye, and our unborn child Zoe-you complete me. Nothing I accomplish in this life is worth anything without all of you.

To my mother, I thank you for allowing me to stand on your shoulders as a child. I continue to reach for the moon grabbing a few stars along the way.

I dedicate this journey to all of you!

ACKNOWLEDGEMENTS

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PROLOGUE

HOW DID WE GET HERE?

My friend Susan was 19 when she found out she was HIV (Human Immunodeficiency

Virus) positive. She lived down the hall from me in school and had dated the same boy,

Dwayne, since we were freshmen. She had an HIV test at a health fair a few months after we

started school, two years prior to this one, so she knew she was not HIV positive. And, she knew

she had only had sex with her boyfriend. Since Susan had been to several HIV events on campus,

for the free condoms mostly, she knew how to protect herself. She felt a certain measure of

safety because she was in a monogamous relationship with Dwayne. Although Susan had some

doubts, for the most part she assumed that Dwayne was in a monogamous relationship with her.

Susan wanted to be safe. However, Dwayne didn't like to use condoms and would justify his

preference to Susan by explaining, "I want to feel all of you. Plus it spoils the mood." Although

she was reluctant, Susan agreed on several occasions to have sex with Dwayne without using

condoms.

And so after a five-minute wait at a health fair in the fall of 1998 Susan found out she

was HIV positive. Her life would never be the same.

Despite any knowledge that Susan had about HIV and other STIs she still chose to have

unprotected sex with Dwayne. She assumed that it would be safe. She didn't know then that

Dwayne was HIV positive.

In July of 2004 Susan died with complications from AIDS-related pneumonia. But Susan

was really killed by the triumvirate of assumptions, naiveté, and trust. This story depicts the

urgency of gaining more fruitful knowledge of how young Black women make decisions about sex and to provide a frame of reference for research on the sexual decision making of young Black women, as Susan is representative of thousands and thousands of young Black women today at risk for HIV.

From 1996, when Susan contracted HIV, to 2007 when this study was conducted African American women have been contracting HIV at an increasingly alarming rate. Today, they have essentially become the face of HIV in the United States (U.S.) and around the world. Although numerous prevention strategies have been employed in an effort to slow down the rapid contraction of HIV within this community of women, there has not been a meaningful reduction in their prevalence rates.

In 2003, the Centers for Disease Control and Prevention (CDC) reported that over the past 10 years, the number of African American women contracting HIV has continued to increase. This increase, coupled with the inability of scholars and researchers to develop truly effective prevention strategies, has lead me to ask, "What factors into a woman's decision to participate in sex that may put her at risk for contracting HIV?"

As I approach this issue the following questions come to mind: What are the main reasons for the continuous rise in HIV prevalence numbers among Black women? What factors contribute to our being less educated than others regarding HIV? What factors lead to our being less informed than others? How is safe sex education being disseminated to us? How is this related to any social issues we may have? How is sexual decision making an issue of power?

I first became interested in this issue as a 21-year-old MSW student and although I am now 27-years-old and no longer in the age range considered most at risk by the CDC, I am still interested in how Black women make decisions regarding sex, risk taking, and disease

prevention. I want to know what made Susan risk her life. The following study is an exploration of this phenomenon.

CHAPTER 1

INTRODUCTION

This chapter describes the background of the research problem and includes a problem statement. The purpose of the study and its significance are also addressed. Lastly, a glossary of terms and definitions is presented.

Background of the Problem

AIDS is an acronym that stands for acquired immune deficiency syndrome. The Human Immunodeficiency Virus (HIV) causes AIDS. When contracted, HIV enters the body and both attacks and weakens the immune system. Although it can be transmitted through sexual intercourse, HIV is not simply a sexually-transmitted disease. It can also be contracted through intravenous drug use, blood transfusion, and from a mother to a child during pregnancy or breastfeeding. Most importantly, at the present time there is no known cure for HIV/AIDS (Centers for Disease Control and Prevention [CDC], 2006).

AIDS has become one of the foremost problems in our society. There have been many efforts to explain its origin, determine its impact, and prevent its spread. Researchers continue to search for methods to prevent individuals from contracting the virus. However, despite these efforts, it is estimated that between 850,000 and 950,000 people living in the U.S. are HIV positive. Of this number, 25 percent are unaware that they have been infected (CDC, 2006). It is also estimated that approximately 40,000 new people are infected each year, 50 percent of whom are below the age of 25. In 2004, the number of teenagers diagnosed with HIV in the U.S.

was 4,883, and HIV/AIDS was the sixth leading cause of death among young adults ages 15-24 in the same year (CDC, 2004).

Although African Americans make up only 12.3 percent of the U.S. population, they represented over 50 percent of AIDS-related deaths in the U.S. in 2002 (CDC, 2004). Over 58% of women and children with AIDS are African American. Among African Americans ages 25-44, HIV is the leading cause of death (CDC, 2004). Although African American and Hispanic women collectively make up less than 25 percent of women living in the U.S., they represent more than 75 percent of AIDS cases reported to date. According to the CDC (2004), in 2002 an AIDS diagnosis among African Americans, both male and female, was nearly 11 times the rate of Whites, and African American women had a 23 times greater diagnosis rate than their White counterparts. African American women represent the ethnic group with the fastest rising HIV prevalence numbers.

As women of color are disproportionately affected by the HIV epidemic, so are their children. (Department of Human Resources [DHR], 2004). Ninety-five percent of child AIDS cases in the State of Georgia were the outcome of an HIV/AIDS positive mother passing the disease to her child during pregnancy, labor and delivery, or breast feeding. In 2003, 77% of reported child AIDS cases in Georgia were African American (DHR). This means that addressing the needs of African American women regarding HIV/AIDS risk reduction could automatically reduce the risks for children of the same ethnic background (DHR).

In Georgia, 84 percent of women with AIDS are African American. Georgia also has the eighth highest number of reported AIDS cases, and African Americans and Hispanics make up over 50 percent of the people with "full blown AIDS" (DHR, 2004). Young adults between the ages of 20 and 29 accounted for 23 percent of all AIDS cases reported in the state during the

years of 1981 and 1999 (DHR). Furthermore, approximately 78% of women in Georgia with

HIV/AIDS reported that they were between the ages of 15-44 at the time of their original

diagnosis (DHR).

Also in the state of Georgia, during the early stages of the epidemic, most of the infected

population consisted of men. Between 1984 and 1998, the proportion of female AIDS cases

jumped from 4 to 19 percent. The literature emphasized that the majority of these women

contracted AIDS from having sexual intercourse with men who were either drug users or men

who had sex with other men (DHR, 2004). The majority of women who contracted HIV were

exposed through heterosexual contact (DHR). It must be noted that Georgia has only recently

begun collecting HIV data. Consequently, the actual HIV rates in Georgia are still unknown

(DHR).

Researchers have offered several explanations for the continued increase in HIV

prevalence among the African American female population. These explanations include feelings

of powerlessness leading to feelings of helplessness, a short-term rather than long-term view of

life decisions, high rates of prostitution, relationship violence and, lastly, a minimal perception of

personal AIDS risk (Amaro, 2000; Aral & Wasserheit, 1995; De La Cancela, 1989; Ickovics et

al., 2002; Mays & Cochran, 1988).

Within the African American community, cultural values emphasize traditional family

structures, gender relations, and economic survival. Several researchers have suggested that

these must be examined within the context of racism and sexism as well as social and economic

oppression (Ickovics et al., 2002; Jemmott, Catan, Nyamathi, & Anastasia, 1995). Although

culture and socioeconomic status are two separate entities, separating the two as they relate to the

issue of HIV in the U.S. remains a difficult task (Ickovics et al.). According to the U.S. Census

Bureau (2000), 26.1% of African Americans are considered poor as opposed to approximately

11% of their White counterparts. Researchers have suggested that the issue of poverty among

minority women plays an important role in hindering safer sex practices within their community.

They have argued that women who are dealing with life stressors that include shelter, food, and

employment may simply not see HIV risk as an issue of major concern (Ickovics et al.; Mays &

Cochran, 1988; Wyatt et. al, 2004).

Despite the alarming rates of infection among African American women, their

perceptions of personal risk remain low. Earlier works such as Sunnenblick (1998) found that

among African American women, AIDS knowledge was actually related to lower levels of

perceived susceptibility. This could be a result of exposure to the idea of risk groups. Therefore,

increasing knowledge among individuals who do not consider themselves to be members of

high-risk groups may actually lower their perceptions of susceptibility, thus having no impact on

their risky behaviors (Sunnenblick). It may be more important to identify the associated factors

that cause people to view, or not view, themselves as at risk rather than to assume that being a

member of a certain group or a particular category will result in higher levels of perceived self-

risk (Sunnenblick).

In another early study of African American women the increased belief that condoms

could prevent HIV were not found to be associated with condom use (Jemmott & Jemmott,

1992). Later studies found that the use of condoms must be coupled with perceived self risk to

be effective. African American women may feel that condoms are an effective method of

preventing the spread of HIV; however, if they do not perceive their partners to be infected, they

will not use condoms (Kusseling, Shapiro, Greenberg, & Wenger, 1996). Despite numerous

media messages that only condoms and barrier methods can protect against HIV, heterosexual

African American women are still not making a connection between their risk and the need to use condoms when participating in sexual intercourse (CDC, 2003). Pioneer studies have found people tend to determine the risk of sex without a condom on a situational basis. For example, they may feel it is unnecessary to use a condom in certain instances or with particular partners, especially when the relationship is thought to be monogamous (Prohaska, Albrecht, Levy, Sugrue, & Kim, 1990; Sobo, 1993). Women who maintained a sense of susceptibility to AIDS had lower perceptions of social distance from AIDS and, consequently, did not feel that AIDS was something that existed outside of their social circle (Schieman, 1998). The failure of AIDS knowledge to facilitate appropriate changes in behavior may be due in part to the type of information provided as well as the characteristics of the person who receives the information (Ross & Kelaher, 1993).

Along with perceived risk, social and cultural pressures may affect women's ability and willingness to protect themselves from HIV infection (Stuntzer-Gibson, 1991; Wingood & Diclemente, 2000). Women who are in violent or coercive relationships may especially feel they cannot engage in AIDS preventive behavior, and are thus at significantly higher risk of infection because of their inability to negotiate with their partners. Also, women who are supported emotionally and financially by their partners may feel as though they are unable to negotiate condom use (Williams, 1995; Wingood & Diclemente). HIV prevention efforts, therefore, must not assume that power is equally distributed in heterosexual couples. Dynamics surrounding the use of prevention methods must not place women at risk for physical harm from their partners (Campbell, 1999).

For many women risk factors are associated more with the behaviors of their partners than with their own. Even in instances where women are in relationships in which they can

negotiate condom use they may not practice safer sex. In these situations, they may believe that there is no risk for contracting the disease, thus making the choice not to use condoms (Miller & Browning, 2000; Stuntzer-Gibson, 1991). Sobo (1993) explained that whether or not a woman uses a condom can also be determined by her perception that she is capable of choosing a good man who is healthy rather than one who is diseased, and so is of "poor quality." She may also feel using a condom is in conflict with her understanding and hope that she and her partner are in a trustworthy and monogamous relationship.

The factors that heavily influence whether risk behaviors are engaged in (social determinants) include attitudes about condom use and with whom they should be used, the extent to which drug use by women impedes their judgment about risky behavior, their dependence on an intravenous drug user for support, and cultural expectations about female roles during sex (Campbell, 1999; Machlica, 1997; McCoy & Inciardi, 1993).   Although it is clear that African American women are at risk for contracting HIV, their perceived risk remains low. This low perception of risk may be directly related to cultural and social pressures, young women's ability to negotiate condom use, and their ability to participate in effective communication within sexual relationships. The low perception of risk is further compounded by the issues young Black women face related to sexism, racism, and classism in their everyday lives.

Sexism and racism have resulted in neglect of the conditions confronting women with HIV (Stevens, 1995; Stuntzer-Gibson, 1991; Williams, 1995). Due to the fact that the first reported U.S. cases of HIV/AIDS were among White men, funding allotted for health prevention went primarily to them. Politically, it was "sexier" and more appealing to the general public to recognize an epidemic that was affecting those who represented the country's dominant culture (Charlesworth, 2003). It was not until health officials realized that those being affected seemed

to be men who have sex with men that the willingness of the government to take action waned. However, the socioeconomic status of White gay men as a whole allowed them to push forward their prevention messages and their prevalence numbers began to decrease (Charlesworth).

To affect a similar decrease in the HIV/AIDS prevalence rates among African American women attention must be paid to their particular issues. A Black feminist theoretical framework is useful in examining Black women's sexual decision making. According to feminist research, women have been both neglected and excluded in regards to HIV prevention initiatives. They have also been given misleading messages, as illustrated in the following statement:

> In the January 1988 edition of *Cosmopolitan*, eleven million readers between the ages of eighteen and thirty-four were told by Robert E. Gould, a psychiatrist-neither an epidemiologist nor an OB/GYN-that if women had repeated, unprotected vaginal intercourse, even with a man who was HIV-positive, they would not become infected with HIV as long as their vaginas were "healthy." A "healthy" vagina, according to Gould, had no cuts, abrasions, internal lesions, mild yeast infections, vaginitis, or chlamydia. Members of the AIDS Coalition to Unleash Power (ACT UP), in a meeting with Gould, pointed out that only a small fraction of women had what he classified as a "healthy" vagina. Despite the protestations, Gould refused to recant his statements.
> (Corea, 1992)

Some feminists argue that by exploring the construction of identity, the assignment of value, and the interpretation of HIV risk the AIDS epidemic can become more understandable (Charlesworth, 2003).

Statement of the Problem and Purpose of the Study

African American women had increasing HIV prevalence rates between 1998 and 2002, whereas other sub groups such as Caucasian men had decreasing prevalence numbers during the same time period (Boston Women's Health Book Collective, 2005). Sixty percent of the heterosexual AIDS population today is comprised of women, the majority of whom are African American (CDC, 2006). In recent years, African American women received considerable information about HIV/AIDS; however, it has not helped to decrease their infection rates. Countless deaths due to HIV/AIDS are related to the fact that African American women are economically disadvantaged and do not have the resources to *live* with AIDS (CDC, 2006). However, infection rates could be reduced if professionals working directly with this population could understand what factors influence these women and their decisions to continue to engage in risky sexual behavior, despite their knowledge regarding HIV and how it is contracted. There is a significant body of literature related to HIV prevention and African American women, however most of that literature is epidemiological.

A review of the literature reveals that there are two major gaps in knowledge regarding African American women and HIV. First, very little attention has been paid to the issue of sexual decision making. Second, there are very few qualitative studies with women who are not HIV positive, but who are at risk for contracting HIV. This is important because current prevention initiatives have relied on literature that is either a count of numbers (e.g., how many or how much) or a replication of older initiatives designed for other populations. Only through qualitative inquiry can we explore African American women's perceptions of the factors that influence sexual decision making.

This study begins to fill these gaps in that it seeks to investigate what African American women know about HIV/AIDS transmission, as well as the consequences of infection. Furthermore, it investigates how African American women describe factors that contribute to their sexual decision making. The purpose of this study was to explore Black women's sexual risk factors as well as the factors that influence their sexual decision making. The research questions that guided this study were as follows:

1. What is the general understanding of HIV among Black women?

2. What are Black women's perceptions of HIV risk?

3. What influences Black women's sexual decision making?

4. How has the intersection of race, class, and gender affected Black women's perception of power?

5. How has the intersection of race, class, and gender affected Black women's sexual risk?

Significance of the Study

History has shown that health problems can also be social problems if they are widespread and far reaching. The AIDS epidemic has certainly gone beyond being solely a health problem and has become one that affects society as a whole. Given the widespread nature of the disease, prevention and education efforts should also be widespread and not limited to particular groups. HIV is reaching into populations that were previously deemed safe. Unfortunately, the belief that particular groups were safe from the virus has resulted in high prevalence rates among these groups. Public health officials have only recently, within the past 10 to 15 years, begun to spread prevention messages to heterosexuals, women, and youth sub groups that were previously overlooked.

HIV was first thought of as a disease that only affected gay Caucasian men until the second wave of HIV came with African American women who, it would appear because of their race, gender, and, in most cases, class, were even less important for the government to invest in saving. Although funds related to HIV are increasing worldwide, it seems that even in 2007, there is still no prominent political agenda to address the rise of HIV within the U.S. Black community.

The literature reveals a startling increase in the number of African American women both contracting and dying from HIV/AIDS (CDC, 2004). Even early research showed that HIV/AIDS education and information alone does not affect decisions to participate in risky sexual behavior (Jemmott & Jemmott, 1992). The CDC (2004) recognized that race, ethnicity, and gender are not risk factors, but did point out five risk factors or challenges that African Americans are likely to face. They include:

- Poverty- Almost 25 percent of all African Americans live in poverty with poor access to healthcare and HIV prevention education.

- Denial- The African American community has been slow to recognize homosexuality within its community, so much so that many men who have sex with men within the African American community refer to themselves as heterosexual and are therefore difficult to influence through gay outreach initiatives.

- Partners at Risk- African American women are most likely to be infected with HIV as a result of heterosexual contact with a positive male. Oftentimes these men are bisexual or injection drug users and women may be unable to effectively negotiate condom use.

- Substance Abuse- Injection drug use is second to heterosexual contact as the means by which African American women are contracting HIV. The issue of drug abuse must be addressed in order for effective prevention to be possible.

- Sexually Transmitted Disease Connection- For many of the aforementioned reasons African Americans are affected by sexually transmitted diseases which increase their risk of contracting HIV.

All of these challenges put African American women at considerably higher risk of contracting HIV. Furthermore, other issues such as access to prevention, education, and exposure to violence, which are not listed by the CDC (2004), also pose as major risk factors for African American women. Both individually and combined, each challenge not only contributes to the risk of infection for African American women but also presents a barrier to prevention efforts.

According to the CDC (2003), there are eight strategies that must be employed in order to build more effective prevention programs. These are:

- Pay attention to prevention for women- It is important that women are seen as a priority with regards to HIV prevention. Further, it is important that special attention be paid to women of color who are disproportionately affected.

- Implement programs that have been proven effective- It is important that programs that are proven to have long-term effectiveness regarding behavior change are implemented with women who are infected and uninfected.

- Develop effective, female-controlled prevention methods and disseminate them widely- Women do not wear condoms which makes it increasingly difficult for them to protect themselves. More scientific strides must be made to create methods of barrier protection that are effective and readily accessible to women.

- Increase emphasis on prevention and treatment services for young women and women of color- The combination of being young and a woman of color does not in and of itself equate to being at risk for contracting HIV. However, the fact is that these women are being disproportionately affected and special attention must be paid to their prevention needs.

- Address the intersection of drug use and sexual HIV transmission- Women who use drugs or are sexually involved with men who use drugs are at an increasingly high risk for contracting HIV. Any effort to address HIV among this population must be coupled with drug treatment.

Although these strategies could be fundamental in program development, gaining first-hand knowledge from African American women who are faced with the responsibility of protecting themselves from HIV could prove invaluable in our efforts as scholars to truly affect prevalence rates.

This study provided a forum for participants to speak freely and in their own words about the factors that influence their sexual decision making. Secondly, the results of this study may inform the efforts of those attempting to develop sound prevention strategies. As there is still significant HIV prevention research needed within the African American female community, this study serves as a vehicle to move society in the direction of identifying self-reported factors that contribute to risky sexual behavior among young Black women.

<div align="center">Definitions</div>

Definitions of the terms that I have identified as being key to this study are presented in the following section. The definitions are listed in alphabetical order and are as follows:

- African American/Black: "To be African American means literally that in the continent (Africa) lies the primal origin of your people. The experiences of capture and transportation, of slavery and segregation, never diminished or erased the basic culture and character of tribal ancestries. A pride in this heritage and history has helped the people survive slavery and subsequent discrimination" (Hacker, 1992, p. 7). "Blacks or African Americans are people having origins in any of the Black racial groups of Africa" (Hacker, 1992, p. 23).

- AIDS: "AIDS is essentially a disease of the immune system. The body's defenses are destroyed and the patient becomes prey to infections and cancers that would normally be fought off without any trouble. It is transmitted primarily by exposure to contaminated body fluids, especially blood and semen" (Check, 1988, p. 15).

- Condom: "Although the word condom usually refers to the male condom, there is also a female condom. Both male and female condoms are barrier methods of contraception" (CDC, 2003, p. 3).

- Male condom: "The male condom is a sheath placed over the erect penis before penetration, preventing pregnancy by blocking the passage of sperm. It is a barrier method of contraception. Because they act as a mechanical barrier, condoms prevent direct vaginal contact with semen, infectious genital secretions, and genital sores and discharges. Most condoms are made from latex rubber, while a small percentage are made from lamb intestines (sometimes called lambskin condoms). Condoms made from polyurethane have been marketed in the United States since 1999" (CDC, 2003, p. 3).

- HIV: "HIV (human immunodeficiency virus) is the virus that causes AIDS. This virus may be passed from one person to another when infected blood, semen, or vaginal secretions come in contact with an uninfected person's broken skin or mucous membranes. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Some of these people will develop AIDS as a result of their HIV infection" (Dispezio, 1988, p. 1).

- Poverty: "Poverty in the United States refers to the condition of people whose annual family income is less than a poverty line set by the U.S. government. An absolute poverty measure was developed in the mid-sixties as part of the War on Poverty. Based on this measure, the poverty line is set at approximately three times the annual cost of a nutritionally adequate diet. It varies by family size and is updated yearly to reflect changes in the consumer price index" (http://aspe.hhs.gov/poverty/faq.shtml, p. 10).

- Racism: "The value placed on the color of the skin" (West, 1993, p. ix). "Racism is the belief in the inherent superiority of a particular race. It denies the basic equality of humankind and correlates ability with biological endowment. Thus it assumes that success or failure in any societal endeavor will depend upon genetic composition rather than environmental advantage" (Leone, 1986, p. 13). "A complex set of ideas and attitudes which translate into negative action. Racism carries connotations of hatred" (Hacker, 1992, p. 20).

- Sexism: Any attitude, action or institutional structure which systematically subordinates a person or group because of their sex (Russell, 1997).

Summary

This chapter provided an introduction to the study including its purpose and present day significance. A list of central terms was identified and defined to ensure proper understanding of the information to follow. The next chapter includes a discussion and synthesis of the literature related to African American women and sexual decision making.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this study was to explore Black women's sexual risk factors as well as the factors that influence their sexual decision making. The research questions guiding this study were as follows:

1. What is the general understanding of HIV among Black women?

2. What are Black women's perceptions of HIV risk?

3. What influences Black women's sexual decision making?

4. How has the intersection of race, class, and gender affected Black women's perception of power?

5. How has the intersection of race, class, and gender affected Black women's sexual risk?

A review of the literature revealed that although knowledge of HIV/AIDS has been in existence for over 25 years, and for at least the past 10 years African American women have been seen as an at-risk group, there is still a void in the literature related to sexual decision making. This void exists in academic literature and specifically in social work literature. The literature presented in this chapter is representative of numerous disciplines and their related databases, some of which include social work abstracts, social services abstracts, sociological abstracts, Medline, psychology and behavioral sciences collection, and PsychINFO. The literature review will be presented in four sections.

The first section includes a brief description of HIV/AIDS and the African American community and a discussion about the most common mode of transmission, heterosexual contact. Literature regarding HIV prevention, African American women's sexual decision making and socioeconomic status (SES) is presented in the second section. The third section is comprised of literature that speaks to the idea that history and socialization have placed African American women at even greater risk for making poor sexual decisions. The chapter concludes with a detailed description of Black Feminist theory and its direct relationship to the research at hand.

HIV/AIDS and the African American Community

The HIV/AIDS epidemic has been present in the U.S. for approximately 25 years and over the past 15 years has steadily become more Black and brown in its face. The communities most widely affected by the disease, both in terms of contracting it and fatalities related to HIV/AIDS, have increased rapidly. Blacks and Hispanics have been disproportionately affected by HIV/AIDS, as compared to their Caucasian counterparts (National Institute of Health, 2005). Regardless of any other characteristics (i.e., age, gender, or sexual orientation) Black people represent the dominant race of people identified as HIV positive (CDC, 2004). This can be seen in Figure 2.1.

HIV/AIDS is clearly an issue in the Black community. Although it is true that Blacks are disproportionately affected by this disease, Black heterosexual women are being affected in record numbers. As depicted in Figure 2.2, heterosexual contact is the mode of transmission for the overwhelming majority of Black women who have contracted HIV.
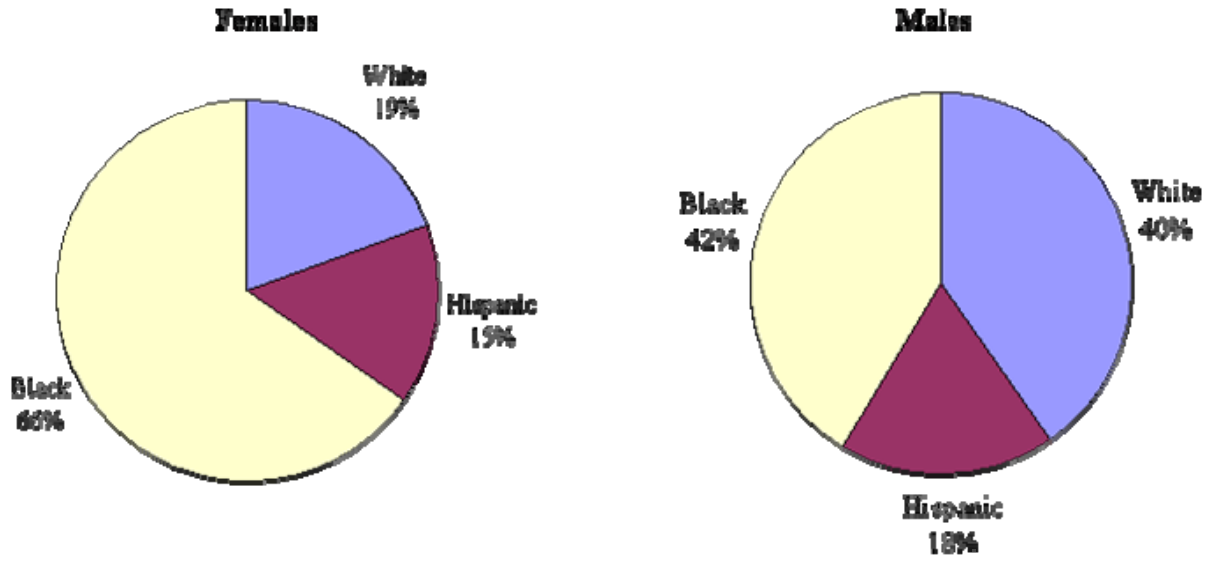
Figure 2.1. Estimated number of diagnoses of HIV/AIDS by race and gender (adapted from the CDC, 2005).
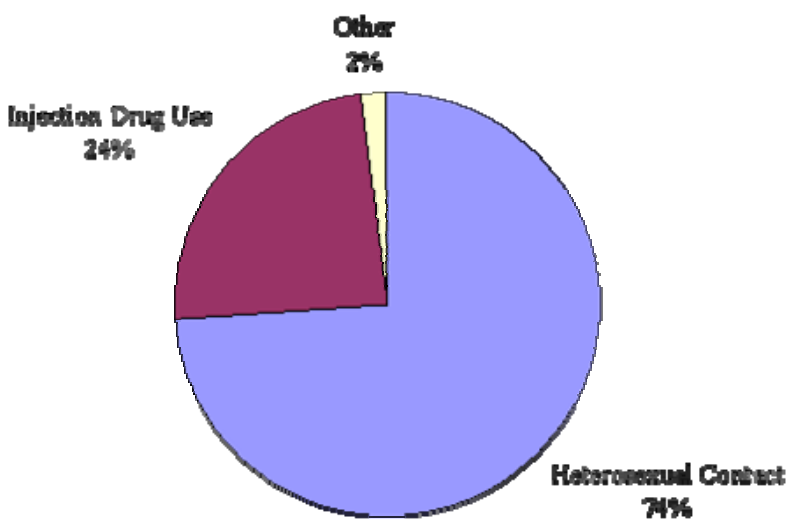
Figure 2.2. Transmission categories of Black women given an HIV/AIDS diagnosis (adapted from the CDC, 2005).

Only 26% of Black women contracted HIV through a transmission mode other than heterosexual contact. The engagement of Black women in unprotected heterosexual sex has resulted in a change in the face of HIV from generally Black and brown people to specifically women of the same hue (CDC, 2005).

<div align="center">African American Women: The New Face of HIV in the U.S.</div>

HIV has become a social problem that affects the entire world. Although there is no particular group that is safe or immune to it, African American women have been disproportionately affected by this epidemic. The following section reviews the literature regarding African American women and the HIV/AIDS epidemic, including a discussion of sexual decision making, socioeconomic status, and HIV prevention.

Sexual Decision Making

Some researchers believe that risky sexual behavior occurs as a result of African American women's lack of "bedroom power." A study conducted by Weeks, Grier, Radda, and McKinnley (1999), investigating risky sexual behavior regarding African American women and their oppression in relationships, explored the idea that much of the power that African American women give up in the bedroom is the result of numerous variables. Some of those variables include poverty, drug addiction, low self-image, and a need to give their African American male sexual partners power in the bedroom because of the lack of power they are afforded in society (Weeks et al.). Other studies (Saul, Moore, Murphy, & Miller, 2004; Wingood & DiClemente, 1997; Wu et al., 2003) discussed African American women being at risk for HIV/AIDS due to violence in their relationships. Many of these women indicated that they avoid suggesting the use of condoms with their sexual partners for fear that it could result in a violent situation. Furthermore, in a study conducted by Kalichman, Williams, Cherry, Belcher, and Nachimson

(1998) a significant number of women confessed to having participated in sex because they feared a violent reaction from their partner if they refused.

Women have historically handed authority over to men. This is also true of their sexual decision-making power. According to Pulerwitz, Amaro, De Jong, Gortmaker and Rudd (2002), gender-based power constraints have kept women from practicing safe sex. They argued that the exercising of such power was integral to condom use. In failing to negotiate condom use with their male partners women leave themselves at risk for HIV and a host of other sexually transmitted infections (STIs). Pulerwitz et al. (2002) conducted a study of 388 female participants in which relationship power was measured using a quantitative scale. The results of this study indicated that women who identified as having relationship power were five times more likely than those who presented with little to no power to be able to effectively negotiate condom use with their male partners.

In a study (Amaro & Gornemann, 1992) of 69 focus groups conducted with Latinos currently residing in the U.S., researchers found that the issues of power and gender roles act as a barrier to HIV prevention, and specifically to condom usage. This was found to be true in 75% of the focus groups (Amaro & Gornemann). In both this study and the Pulerwitz et al (2002) study the findings suggested that power is an important variable to consider when conducting research related to the process of sexual decision making. However, both studies recommended that more work be done in this area so that a component addressing relationship power could be included in HIV prevention initiatives.

There is an inherent connection between sexual (or relationship) self-esteem and sexual decision-making power (Sterk, Klien & Elifson, 2004). According to the literature (Seal, Minichiello, & Omodei, 1997; Sterk, et al.) low sexual self-esteem is common among two types

of women. The first type includes women who perceive sexual contact as simply their

responsibility in a relationship and receive virtually no pleasure from the sexual acts in which

they engage. As a result, these women tend to avoid discussing their individual sexual needs

with their partners, including the need to protect themselves. The second type of women are

those who perceive themselves as not having any control in their sexual relationships. These

women do find pleasure in sexual contact, but render all of the power and decision making to

their dominant male sexual partner (Seal et al.).

By testing personal and sexual characteristics, Seal et al. (1997) showed that there is a

direct relationship between sexual risk taking and sexual self-esteem. For the purpose of their

study, self-esteem was defined as a woman's ability to feel good about herself or her perception

of self-worth. Many existing STD and HIV prevention campaigns have neglected to include the

idea that condom use among women is directly related to their perceived power. These

campaigns have also failed to recognize that women with poor self-esteem may have an

extremely difficult time negotiating condom use with their more dominant male partner (Seal et

al.). Studies (Browne & Minicheillo, 1994; Chodorow, 1978; Seal et al.) revealed that a

contributing reason for heterosexual women's lack of assertiveness in the bedroom may be the

societal roles that they have historically been taught to adhere to throughout the generations.

Because they have been taught to serve as caregivers and to be subservient to the needs of others,

they may take these roles into their sexual relationships as well (Browne & Minicheillo;

Chodorow; Seal et al.).

A more recent study indicated that African American women make sexual decisions on a

case-by-case basis. According to Foreman (2003) semi-structured interviews with 15 African

American college women revealed that a hierarchy of sexual arrangements was established by

participants to help them make sexual decisions. This hierarchy, which was individually established and fluid in nature, included factors such as length of relationship, casual or relationship encounter, and one-night stands. The participants indicated that they made decisions to use condoms based on what kind of sexual encounter they were faced with at any given time (Foreman). This, along with the literature addressing self-esteem and power, showed that sexual decision making is complex from a cognitive standpoint and compounded further when more tangible factors such as socioeconomic status are addressed.

Socioeconomic Status

An overwhelming number of African American women who are infected with HIV/AIDS are poor, undereducated, and disconnected to community resources and healthcare (CDC, 2004; Cochran & Mays, 1993; Poppen & Reisen, 1994). In addition, another key factor that contributes to risky sexual behavior among African American women is that they are economically dependent on their sexual partners. This economic reliance may lead to a fear of jeopardizing the relationship, thus keeping these women from exercising their right to protect themselves (McNair & Prather, 2004; Peterson & Marin, 1988).

Socioeconomic status places Black women at risk for contracting STIs. Research (CDC, 2004; Foreman, 2003; McNair & Prather, 2004) has shown that inner city minorities, due to economic disparities, are at greater risk for contracting HIV and other STDs. Black women's risk for contracting HIV reflects the constellation of risk associated with their position in society (McNair & Prather). They are more likely than their White counterparts to be single, have multiple children, and head their households. Being a single parent and head of household with several children often creates a cycle of poverty that is almost impossible for Black women to overcome. As a result, Black women may depend on men for economic and emotional support,

and these dynamics may create feelings of helplessness in negotiating sexual encounters with their partners (McNair & Prather).

Research in the area of HIV and women in the United States indicates that risk occurs disproportionately among socioeconomically challenged women (CDC, 2003). A study by Barker, Battle, Cummings, and Bancroft (1998) of 15 low-income African American women revealed a direct correlation between socioeconomic status and risky sexual behavior. An intervention designed to infuse education that focused on HIV/AIDS prevention, as well as other employment and life skills training, was studied. After three months of educational training, some of the mothers expressed more trust in using condoms, which lead researchers to surmise that perhaps the participants were more receptive to HIV/AIDS information because it was coupled with job and life skills training (Barker et al.).

In a study (St. Lawrence, Eldridge, Reitman, Little, Shelby, & Brasfield, 1998) examining factors associated with condom use in a community-based sample of 423 sexually active African American women, results showed that women in exclusive relationships evidenced lower intentions to use condoms. Many of the participants who engaged in preventive behaviors perceived themselves to have lower risk and had lower rates of condom use, higher education, and family income (St. Lawrence et al.). The findings indicate that there is some question regarding whether or not higher education and/or family income would prove to be indicators of safer sex decisions among a similar population.

HIV Prevention: Where are the Gaps?

In the past 10 years more research has focused on the rate of infection in the African American community; however little has been accomplished regarding prevention. Jemmott and Jemmott (1992) stated that research on strategies to change HIV risk-associated behavior in

diverse populations is still in its infancy; this statement remains true today. Very little research has focused on determining the educational needs of minority women based on their culture. Much of the knowledge gained from studies on the rate of infection and most frequent mode of transmission has not been translated into preventive efforts for women, African American women in particular (Becker et al., 1998; DiClemente & Wingood, 1995; Jemmott & Jemmott; Nyamathi & Stein, 1997; Yeakley & Grant, 1997; Wingood & DiClemente, 2000). In the past the majority of the research utilized male participants. The success of education and prevention programs aimed at gay and bisexual men has been documented (Schieman, 1998), however the same cannot yet be said of studies and programs targeting African American women. This discrepancy is due to educational and socioeconomic inadequacies within the communities chosen to participate as well as the cultural insensitivity of researchers (Nyamathi et al., 1993; Weeks et al., 1995).

There continues to be a debate as to whether or not large-scale media campaigns can be effective in preventing the spread of AIDS. Gold and Rosenthal (1998) maintained that AIDS educators should consider one-to-one counseling and peer education programs because these methods make it easier to ensure personal relevance. In addition, these methods can be adapted to reach more people. In a sample of impoverished African American women, Nyamathi and Stein (1997) found that change in psychological and behavioral constructs was associated with extensive one-to-one counseling offered to participants. Many ethnic minority advocates state that efforts to prevent the spread of HIV in ethnic minority communities are inadequate because the government has been extremely slow to fund culturally-appropriate education and treatment programs. Stuntzer-Gibson (1991) declared that heterosexual African American women do not

often use the services of agencies that are gay- or lesbian- oriented because they believe that such agencies do not meet their needs, and the same is true today.

Media campaigns regarding HIV have not been effective with the African American female community for two reasons: (1) the messages have not been culturally relevant; and (2) public health officials assume that there is a basic trust in the government (Machlica, 1997). Culturally-relevant messages include the values, norms, and beliefs that impact and influence the behaviors of individuals (Machlica). For example, a culturally-relevant prevention initiative for Black women may include a discussion of any oppression they may feel within their sexual relationships as well as a discussion of how they were socialized in terms of their sexual and personal empowerment. For African American women, this means the messages must be ethnic and gender sensitive. Researchers must seek to understand the social influences that impact the sexual relationships of African American women and how these can be translated into effective HIV prevention messages. Although the media have made strides regarding the inclusion of preventive messages in condom advertisements, they still fail to take into consideration the fact that condoms require the cooperation of men. Therefore, media messages need to target men as well as women (Campbell, 1999).

Public health officials have assumed that there is a belief in government warnings regarding the spread of AIDS in minority communities. They are under the assumption that there is an inherent trust among the people to believe that if the government says it is not good, action should be taken to stop it. Prohaska et al. (1990) found that the level of belief and trust people have in the media, including government, news, television networks and print, can either negatively or positively influence perceptions of personal risk. Public health officials must take into consideration the history of slavery and racism in the U.S. and understand that there is a

basic distrust of the government felt by many African Americans (Carter, 1994; Dicks, 1994).

Older African American women may also remain skeptical of family planning efforts as a result

of previous government sterilization programs that continued into the 1970s (Mitchell et al.,

1997). Trust is, and has always been, essential in order to develop AIDS education programs in

the African American community (Thomas & Quinn, 1991). AIDS risk reduction programs

have to be built on assessments of community needs and beliefs, and they must include

community members in the planning, implementation, and evaluation of the program (Thomas &

Quinn).

    During the early 1990s there was a decrease in high-risk behavior among self-identified

gay men (Schieman, 1998). This decrease may have been the result of gay and lesbian

communities vigorously spreading information which led to behavior change. Despite the

decrease in risky sexual behavior in the gay community, condom use in the U.S. as a whole is

still relatively low even though there has been over 15 years of public health campaigns aimed at

increasing AIDS awareness and AIDS prevention through condom use (Tewksbury & Moore,

1997). With regard to African Americans, this could be the result of many media campaigns

portraying White, middle-class people being infected with the virus despite the reality that many

of those infected are in fact ethnic minorities and of a lower socioeconomic status (CDC, 2004;

Sacks, 1996). These messages only serve to foster a low perception of risk among a population

group at great risk.

    According to Cummings, Battle, Barker, and, Krasnovsky (1999), in a study of 142

African American women that explored AIDS-related worry and the degree to which it affected

the sexual decision making of African American women, the majority of women were not

worried about contracting HIV. Although it is known that African American women are at risk

for contracting HIV, Cummings et al. concluded that the perception of risk still remained low in this community.

The findings of Tewksbury and Moore (1997) suggest that prevention messages must focus on behaviors rather than social categories. Previous emphasis on gay men, sex workers, and intravenous drug users fostered a false sense of safety for the heterosexual community (Machlica, 1997). AIDS education should attempt to change attitudes, increase knowledge, and transform subjective norms in order to promote the use of condoms among heterosexuals (Bakker, 1999). AIDS education messages must be tailored to target groups who are motivated to engage in safe-sex programs and should encourage individuals who have low motivation to participate in the same kinds of interventions. Each target group for AIDS education must be approached differently, because the programs may ineffective if they are not designed with diversity in mind.

Nyamathi and Stein (1997) found that regardless of the tendency of African American women to underestimate their risk of AIDS, the delivery of culturally-competent programs aimed at reducing risk behaviors can result in long-term and effective AIDS risk reduction behaviors. These programs offered counseling and included other areas of concern to the women. For example, in addition to providing culturally-sensitive information (designed with the needs of African American women in mind), prevention strategies, and skill enhancement to reduce the transmission of HIV, AIDS prevention counseling also provided assistance with housing, job skills, and food. Thus, Nyamathi and Stein concluded that, along with practical assistance, interventions must be culturally competent, provide skills training in condom use, sexual communication, sexual assertiveness, and place emphasis on gender-based power imbalances.

There is general agreement that protecting oneself from HIV requires behavioral skills and self efficacy to practice these skills (Wingood & DiClemente, 1998; Yzer, Fisher, Bakker, Siero, & Misovich, 1998). Self efficacy has been defined as an individual's belief that personal control can be exerted over motivation, behavior, and social environment (Bandura, 1989). Education alone can promote beliefs in prevention, but it must be coupled with perception of self risk and increased self efficacy to evoke a decrease in sexual risk taking (Scheiman, 1999). Recent prevention strategies have focused on positively affecting individual self efficacy and have found that there is a direct relationship between power and condom use (Harvey et al., 2003; Pulerwitz et al., 2002). Young women in particular may face a high risk for HIV infection since they often attempt to engage in AIDS preventive behavior with unwilling partners. This makes addressing self efficacy with African American women even more challenging (Yzer et al.). Interventions including modeling, role playing, goal setting, and other techniques known to enhance self efficacy among gay men have been found to be associated with reductions in risk behavior. Such techniques were also found to be effective among African American women in early studies, but have not been used in more recent studies (Jemmott & Jemmott, 1992).

Perceived susceptibility is imperative in reducing high-risk behavior although viewed alone, it may have a negative effect causing hopelessness and disempowerment to those who feel that there is nothing they can do to avoid contracting HIV. Therefore, some prevention strategies have focused on coupling increased levels of self efficacy and increased levels of risk perception (Schieman, 1998). Protecting oneself from HIV, therefore, requires behavioral skills and self efficacy to practice these skills. Women tend to engage in AIDS preventive behavior when they feel both vulnerable to HIV infection and efficacious with respect to performing preventive behavior (Yzer et al., 1998).

Some research has shown that the issue of power is important when exploring sexual decision making among Black women (Harvey & Bird, 2004; Harvey et al., 2002; Monahan et al. 1997; Soet, Dudley, & Diloro, 1999; Wingood & DiClemente, 2000). Approaches that value women as having responsibility and control over their behavior and create an atmosphere that fosters this notion have reported positive results. Approaches that promote empowerment by working with women's strengths and experiences to enable them to find workable HIV prevention plans for their lives have proven to be effective (Levine et al., 1993; Wingood & DiClemente, 1998). These methods are in line with social work theoretical frameworks including the Strengths Perspective and the Humanistic Approach. When used, researchers reported successful HIV prevention programs with substantial and sustained behavioral change among the women who participated (Levine et al.; Wingood & DiClemente).

Researchers (Flakerud & Nyamathi, 2000; Kreuter & Holt, 2001) have noted an evident need for more prevention initiatives focusing on young African American women stating that HIV prevention should be addressed through holistic programs at schools, religious establishments, clinics, and in communities. African American women should receive special attention regarding prevention messages that could help save their lives. It is also important that programs be culturally sensitive and speak to the needs of African American women (Flakerud & Nyamathi; Kreuter & Holt).

Furthermore, the mission of prevention initiatives should be to effect long-term behavior change. Many of the prevention programs celebrate short-term change, which should be applauded, but should not be the focus of prevention strategies. All initiatives should be comprehensive and include both educational and psychosocial aspects to address prevention barriers. Linking HIV prevention to other services may also contribute to long-term

effectiveness. For example, associating HIV prevention with drug, tobacco, or pregnancy prevention could prove to be a positive connection that leads to increased effectiveness.

New initiatives must also tackle the issues of low perceived risk and trust among African American women. Although it has been noted that perceived risk is a barrier to prevention, little has been done to specifically address it. Increasing perceived risk is directly linked to increasing African American women's trust in government and health officials and cannot be accomplished without at least a minimal increase in trust.

Many of the preceding needs and strategies can only be addressed through direct contact with women representing this population. It is through direct inquiry regarding sexual decision making and factors that influence such decisions that we can become knowledgeable about the ways prevention strategies can be created, altered, or enhanced.

<div align="center">Sexual Roles of Women Throughout History</div>

Women's social and sexual roles throughout history have significantly impacted their ability to effectively negotiate sexual experiences, which in turn limits their ability to protect themselves from contracting STIs. From the early times of American civilization, women have been viewed as possessions of men. They were taught to be submissive and obedient. According to Zinn (2003), the biological uniqueness of women was a basis for this treatment. Because women were child bearers, they were viewed and treated as servants, sex mates, companions, teachers, and wardens to children. During the early parts of American civilization, their specific roles in society were to bear children and support their husbands. Although the roles of Black and White women were similarly constructed, each group's historical experiences have been different, and this in turn dictates both groups' self-determination regarding sexual experiences. It is clear that these roles have impacted women, especially the abilities of Black

women to effectively negotiate sexual encounters, and ultimately have been a detriment to their sexual health.

Historical Overview

The majority of the first settlers to come to America were men. Women were mostly imported as sex slaves, companions to the men, and child bearers (Zinn, 2003). During the development of American civilization, more than 90% of the population were farmers. Few men and virtually no women worked outside of their homes (Koch & Weis, 1998). Women's labor was often placed in the context of motherhood. Because of their biological closeness to infants, women were socialized to stay at home and care for their children. Men, who were powerful forces in society and who constructed social norms, believed that it was morally wrong to separate child bearing from child raising (Gordon, 1976). Sexuality was valued primarily in the context of marriage. The main factors that contributed to sex in marriage were the need for reproduction and for a woman to please her husband's sexual desires (Gordon). The economy at the time also made it necessary for women to have large families. During the colonial era, women had an average of seven children (Frey & Morton, 1986). While it was encouraged that sex be solely between a husband and wife, this rule was not enforced for men, and it was socially acceptable for them to engage in sexual relations outside of marriage. However, it was considered a crime for a woman to bear children out of wedlock (Gordon), demonstrating a double standard for men and women.

Although the social norms for women in the U.S. during the 19th century were to bear children and support their husbands, this was not the norm for Black women. Black women were slaves and belonged to the slave owners. While their roles were somewhat similar to White women in that their identities were both constructed by White men, the responsibilities of Black

women during slavery were that of housekeepers, nannies, fieldworkers, and reproductive workers whose jobs were to bear new slaves. Child rearing by slaves increased the slave owner's "stock" of slaves (Negal, 2003). Black women's sexuality was defined by their ability to produce more slaves. Because they belonged to their owners, they were often subjected to rape and other violent sexual encounters. White men who were accused of raping Black women during slavery were never punished or prosecuted. Black women lacked the legal and social support needed to bring suit in cases of rape since they were excluded from the constructs of White female sexual honor. Rape in early America was a crime whose definition was constructed by race (Negal).

According to Negal (2003), the social and sexual experiences of Black and White women during the 19th century revealed that both were oppressed, and that their social and sexual roles were constructed by rich and powerful men who controlled all financial, legal, and social venues. However, although their roles were similar, the experiences of Black and White women during this era were very different. For instance, White women were able to choose their husbands, while marriages between slaves were not legal or legitimized (Negal). Furthermore, White women were discriminated against solely because of their gender. Black women were also discriminated against because of their gender, but more so because of their race. Additionally, White women's sexuality was treated as honorable, and they were respected because they were the bearers of White children needed to continue the American way of life. On the other hand, Black women were treated as breeding machines for slave production.

According to Negal (2003), Black women were seen as sexual creatures who were so powerful that they were able to weaken strong, influential, and powerful White men. In other words, Black women were to blame for White men's inabilities to restrain from sexually

violating them. Therefore, Black women were considered as a dangerous commodity to White men. However, more than her ability to render the powerful weak, there was an economic incentive to the rape and sexual exploitation of Black women since the breeding of female slaves increased slave owners' property (Negal). Black women were helpless in negotiating sexual encounters. They were forced to have sex with their slave owners as well as participate in sexual relationships with their Black male counterparts.

In the twentieth century many middle-class women were employed as teachers. They read tirelessly and educated themselves. As a result, they wrote for magazines and communicated about social reform. These women formed movements against the double standards of sexual behavior; they became activists and participated in groups that spoke out against slavery and other oppressive practices in a male-dominated society (Taylor, 1998a). Some of those movements included the feminist, suffrage, and birth control movements. Women wanted the right to vote, economic independence, and equality in everything including sexual relationships and marriage (Taylor). Because of the social construction of women's main role as wife and mother, reproductive rights of women became a political and civil rights issue.

Throughout the 19th century, there were a few attempts at forming a birth control movement. However, it was not until the 20th century that the birth control movement became a national vehicle for women's right to voluntary motherhood (Gordon, 1976). Margaret Sanger, the birth control pioneer of the 20th century, brought national attention and gained countrywide support by feminist groups and the suffrage movement for the belief that women had the right to birth control. A popular platform of Sanger's fight for birth control was that women could not consider themselves free if they could not own or control their own bodies, and choose conscientiously whether or not they wanted to become mothers (Nelson, 2003).

The women involved in the movement believed that since a woman's body belonged to her, it was her natural right to decide when and if she wanted to have children. Furthermore, because birth control would allow women to freely engage in sexual activity with lower risk of pregnancy, the reacceptance of female sexuality was an important focus of the movement (Gordon, 1976). Sanger published a magazine during the first part of the 20th century called *The Woman Rebel*. She used this magazine to promote female autonomy, including a woman's control over her own body and a right to sexual expression (D'Emilio, 1988). She also released a pamphlet called the *Family Limitation* that discussed birth control as a means of voluntary motherhood. The birth control movement signaled a profound shift in the sexual norms that had reigned over society for so long. The advocacy of fertility control for women through contraceptive devices rather than abstinence implied an unequivocal acceptance of female sexual expression (D'Emilio).

Nelson (2003) argued that the popular feminist and birth control movement did not adequately represent the struggles of women of color and the poor. Black women often found themselves fighting against the reproductive oppression they endured, including involuntary sterilization. Although White women were fighting for the right to access birth control and legal abortions, women of color and poor women were being sterilized without their permission by doctors who were performing "population control." This represented the double standards of birth and population control in America. Birth control and abortion were viewed as race suicide by mainstream society when referring to White women because they decreased the "pure" race. On the other hand, population control was encouraged of "lesser" classes even if it was involuntary (Nelson, 2003). Furthermore, in the fight for reproductive rights Black women wanted to address issues that affected minority women such as anti-poverty politics, welfare

rights, and access to reproductive healthcare (Nelson). To Black women these issues needed to be adequately addressed by mainstream feminists before they would feel as though they had control over their reproductive rights.

History's Effect on Sexual Decision Making

Throughout history women in America have been socially and sexually dominated and exploited by mainstream society. McNair and Prather (2004) argued that as a consequence, women have been and are still unable to effectively negotiate sexual encounters resulting in their increased susceptibility to STIs. Although women have made great strides to gain social, economic, and legal equality with their male counterparts, they continue to be oppressed in many ways. Women, especially Black women, have not effectively negotiated an equal playing field regarding their sexual health. They continue to be sexually dominated by men, which makes them vulnerable to contracting STIs (McNair & Prather).

There are several factors that affect Black women's abilities to protect themselves from STIs. History and the social construction of Black women's identity cannot be overlooked. Black women have been socialized to believe that they lack interpersonal power in their sexual relationships (McNair & Prather, 2004). This has directly resulted in their being less likely to negotiate condom usage during sexual encounters. Furthermore, research has shown that there is a significantly disproportionate ratio of Black males to Black females, and Black women may be concerned about their ability to find a Black male partner (McNair & Prather; Miller & Browning, 2000). Because Black men have more options in choosing sexual partners, Black women may fear rejection and engage in sexual activities that place them at risk for contracting STIs (McNair & Prather). This fear may directly impact Black women's abilities to negotiate healthy sexual encounters.

Factors contributing to Black women's sexual decision making process cannot be examined without accounting for their social and sexual history. Throughout history Black women have been sexually exploited and violated by men in society. As a result, Black women continue to feel disempowered in their sexual relationships regardless of how the outside world may view them. Within the Black community women are viewed as providers, protectors, and nurturers, yet they often forfeit their right to sexual self-determination as a result of the social construction of their roles in sexual relationships.

<div align="center">Theoretical Framework: A Black Feminist Approach</div>

Black Feminist Thought continues to evolve. The following section provides a brief history of the evolution of Black feminism. The history is presented in "waves" marking three distinct periods of feminism. The first wave of racial oppression was reactionary. Black women were not in control of their place or movement in this phase, but rather they were simply reacting to the oppression around them. During the second wave, Black women were in the process of constructing meaning within their lives, but still within the context of racial oppression. Finally, the last wave represents Black women's active involvement in shaping their way of being in the world. This position is distinguished from the first wave by its political nature and is different from the second in that it is contextual to the geo/political/sexual reality of Black women in North America (see Figure 2.3).

First Wave

The first wave of feminism was originally linked to the abolitionist movement and ended with the passage of the nineteenth amendment (Taylor, 1998b). The abolitionist movement lasted from 1830 to 1865 and at that time the majority of African American women were slaves. Both free and enslaved women worked to create avenues that could be taken to free African
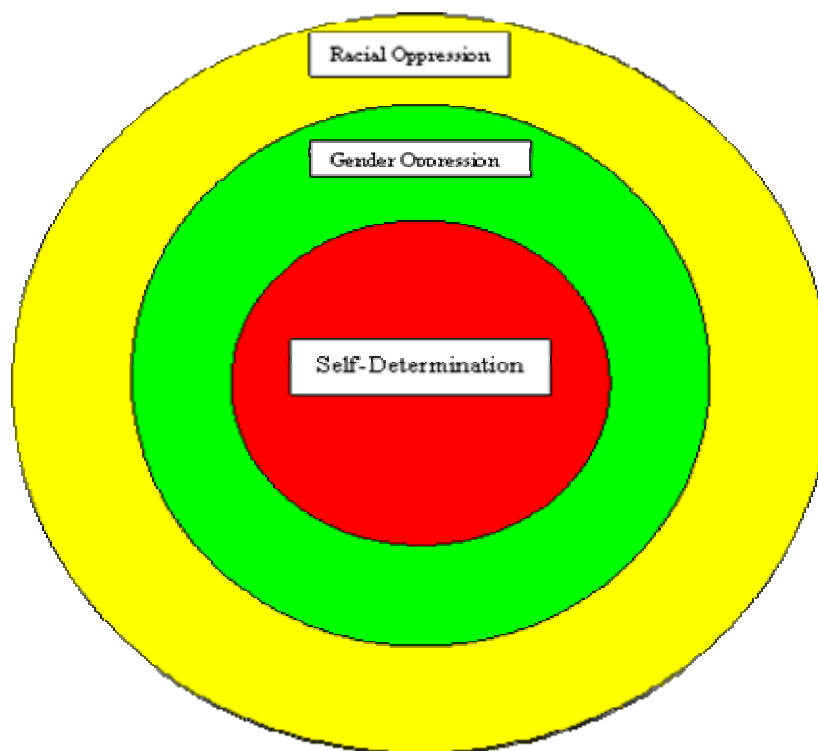
Figure 2.3. Waves of Black feminism.

Americans and end slavery. No one would argue that female slavery was any better or worse

than male slavery, but the two types were very different and resulted in very different outcomes.

The sexual nature of the abuse that African American women endured set them apart from the

abuse that their male counterparts withstood. Many stereotypes that are applied to African

American women today came as a result of this time period.

During slavery African American women were abused sexually, and it was during this

time that the myth of the "jezebel" and "mammy" was born. African American women were

seen as "loose" or "whores" and carried this label along with others such as "mammy" or

"caretaker" in the eyes of their oppressors. Regardless of their free or enslaved status these

myths followed African American women everywhere. They were seen as either nonsexual

("mammy") or hypersexual ("jezebel"), but they were never seen as "normal" or "human" (Wallace, 1996). Although African American women were denigrated by the actions of their masters, the oppression of African American men has always been seen as the major sin of slavery. The struggle and oppression of women has been minimized and even sometimes discounted (Wallace).

According to Davis (1981) Black women have continued to be enslaved even in their own homes. In the past they have had to work outside the home and been responsible for the invisible work of the home. For example, Black women have historically been responsible for cooking, cleaning and caring for the children while also working outside the home. Although their White counterparts may have shared the same responsibilities in the home, they were not required to also leave the home for work. Davis argues that Black women have in some ways never been released from slavery as they have had to work in the same way that Black men do, embody the femininity society expects from a wife and mother, and keep up with the work of the home (Davis).

During the period of suffrage, the relationship between African American women and their White counterparts was tenuous at best. African American women realized the sexism of men that bound all women together was not strong enough to negate the racism of the White women with whom they fought alongside. Although African American women such as Ida B. Wells-Barnett and Mary Church Terrell fought tirelessly with White women for the right to vote after the Nineteenth Amendment passed, they were still met with great hostility at the polls and denied the right to vote. The White women they fought with were unwilling to fight against this injustice (Taylor, 1998b).

Second Wave

Much like the first wave the second wave of feminism was also tied to an important time in African American history known as the Civil Rights Movement. The movement lasted from approximately 1954 with Brown v. the Board of Education of Topeka, Kansas to the mid 1970s with the enforcement of Title VII and Title XI of the Civil Rights Act of 1964. This period represents Wallace's (1999) "Myth of the Superwoman." While African American women were usually working full days, organizing boycotts, and participating in activities significant to the movement, they were also taking care of the home and assumed nearly every domestic responsibility.

During the Civil Rights Movement African American men attempted to relegate African American women to menial tasks and even encouraged them to cook and clean at meetings and functions rather than participate in or lend ideas to the conversation (Taylor, 1998b). It was also at this time that several White women and African American men were beginning to forge sexual relationships, which gave White women unique access to African American male leaders. This became a sore subject for African American women who were being dismissed from the movement by the men with whom they had worked alongside (Taylor). Furthermore, this was another offense to their African American womanhood when they were being "looked over" for White women who represented the "forbidden." These interracial relationships and the opinions brought forth by the Moynihan Report served as a springboard for tension among African American women and men (Wallace, 1999). African American women could not abandon the movement so they looked past the sexism and continued the struggle.

In 1973, a number of African American women came together and formed the National Black Feminist Organization (NBFO). The founder, Margaret Sloan, was interested in having an

organization that addressed the concerns of African American women. NBFO began as a small organization and quickly gathered momentum. African American women all over the country were excited about it and inquired about how to join (Taylor, 1998a). Although the NBFO was unable to gain political steam or have the major impact that other national organizations had, the Black feminist movement continued to evolve and fight for social justice.

Third Wave

Currently, the third wave of feminism is transpiring. It includes Black women who are getting involved with both health and legal affairs. Taylor (1998a) reported that it began with the rise of Black feminism and its critique of the law. Patricia J. Williams and Paulette M. Caldwell are two African American female legal scholars who have been committed to critiquing laws that are unique to African American women as well as educating African American women about the law as it pertains to them (Taylor). The Black Women's Health Networks, founded by Byllye Avery, also clearly mark the third wave of feminism. Avery saw a need for these health networks to provide an avenue where African American women's health could be discussed. She urged the beginning of a discussion about sex and birth control among these women, and she recognized that any program created for this purpose would have to be within a cultural context (Taylor).

Black Women's Health Networks in many states have a goal of demystifying health issues that affect African American women. Their mission is to promote dialogue among women within the African American community about minimally discussed health issues, such as breast cancer and AIDS. Through community programs, cities in Florida, Georgia, and North Carolina have opened clinics geared towards women's sexual and breast health. These clinics

encourage women to be tested for HIV and promote the use of mammograms within the African American female community.

As this third wave continues many Black feminists embrace the label of "womanist" as a term to describe them and their political ideology. In a comparison of the terms "womanism" and "Black feminism," Collins (1996) emphasized the importance of not allowing the name to disrupt the agenda. She suggested that both have good and bad points, but it is the social and political agenda of African American women that should win out.

Black Feminist Thought: A Synthesized Definition

Three definitions of Black Feminist Thought are discussed in this section. The first is authored by Alice Walker, who coined the term "womanist" to describe a Black feminist. The second is a definition developed by the Combahee River Collective. The last definition is provided by a University of Georgia instructor in a lecture to a Black feminist theory class. Collectively the three definitions can be used to create a broader definition with utility to HIV prevention.

Alice Walker (1983) defined womanist in two parts:

Womanist 1. From womanish. (opp. of "girlish," i.e., frivolous, irresponsible, not serious.) A Black feminist or feminist of color… Usually referring to outrageous, audacious, courageous or willful behavior. Wanting to know more and in greater depth than is considered "good" for one… Responsible. In charge. Serious.

2. Also: A woman who loves other women, sexually and/or nonsexually. Appreciates and prefers women's culture, women's emotional flexibility (values tears as natural counterbalance of laughter), and women's strength… Sometimes loves individual men, sexually and/or nonsexually… committed to the survival and wholeness of entire people,

male and female. Not separatist, except periodically, for health. 3. Loves music. Loves

dance… Loves herself regardless. (pp. xi-xii)

Some believe that there is a distinct difference between womanism and Black feminism.

According to Walker, "womanist is to feminist as purple is to lavender" (p. xi), perhaps

suggesting that there is more intensity in womanism than in feminism. bell hooks (1989) argued

that womanism and Black feminism are interchangeable and virtually have or should have the

same meaning. She contended that the focus should be less on the terms that describe Black

Feminist Thought, and more on advocating and publicizing the discussion of being Black and

being woman. Both terms are linked to an empowerment theoretical framework and exist as a

result of the lived experience of Black women over time. Most importantly, both terms

emphasize a love of woman and of all that encompasses a woman, which is integral in working

to empower women of color.

The definition developed by the Cambahee River Collective (Hull, Scott, & Smith, 1982)

is more political in nature as well as more specific and direct than the previous womanist

definition authored by Alice Walker:

The most general statement of our politics at the present time would be that we are

actively committed to struggling against racial, sexual, heterosexual, and class oppression

and see as our particular task the development of integrated analysis and practice based

upon the fact that the major systems of oppression are interlocking. The synthesis of

these oppressions creates the conditions of our lives. As Black women we see Black

feminism as the logical political movement to combat the manifold and simultaneous

oppressions that all women of color face. (p. 13)

The Cambahee River Collective definition emphasizes activism and a Black feminist political agenda. It speaks to the tasks at hand and a responsibility of Black women to be active within the Black feminist political movement. What is key to this definition is its ability to transcend time. Although it was written decades ago it is applicable to the goals of Black feminism today and in the future. As long as Black women are oppressed, the Cambahee River Collective definition of Black feminism is applicable.

The third and final definition discussed in this section was articulated by Dr. Chana Kai Lee (personal communication, January 8, 2004), an esteemed University of Georgia professor and the author of numerous publications including *For Freedom's Sake: The Life of Fannie Lou Hamer*. She suggested that there are nine major characteristics of Black feminism and contended that Black feminism:

1. acknowledges that Black women (like all humans) have multiple identities; there is no singular identity that answers the question "What is Black womanhood?"; this does not mean that Black feminism ignores the choice that some Black women have to prioritize identities; Black feminism argues that it is difficult and incomplete to do so.

2. interprets Black women's oppression as a combination of "oppressions" (racism, sexism, classism, heterosexism, etc.) that occur simultaneously; this concept is known as the simultaneity of oppression; most Black women's experiences are defined by this simultaneity of oppression.

3. promotes self reliance, self definition, and political activism as methods for achieving the goals of Black feminism; also encourages the use of traditional institutions (e.g.,

motherhood, the family) as vehicles for eliminating the various "oppressions" that affect Black women's quality of living.

4. is comprised of a body of knowledge and understanding called "critical theory," and, as such, it is an ideology that criticizes and addresses social problems.

5. contends that there can be no separation of ideas from experience (Black feminism is not a set of abstract principles; it is a set of ideas that come directly from the historical and contemporary experience of Black women and, in this regard, it recognizes a direct link between experience and consciousness (awareness).

6. pays special attention to the role of image and sexuality in accounting for Black women's oppression and their reaction to such oppression.

7. maintains that it is based on a humanist vision (i.e., Black feminism is a political perspective that assumes a contribution to understanding the human condition generally; it applies easily to the rest of humanity).

8. argues that Black women intellectuals are central to the production of Black Feminist Thought.

9. has always been highly controversial as an ideology and political movement.

This definition is clear and can be useful in understanding Black feminist theory as a whole and in the context of research with African American women. Black feminism is a movement by and for African American women to address their multiple identities and the multiple oppressions against which they struggle. Black feminist theorists stress that there is an interlocking of gender, race, and class oppression that should not be divided (Collins, 1991; hooks, 1989). Collins discussed the ethics of caring as an integral part of Black feminist epistemology based on its components of unique individual expressiveness, the appropriate

expression of emotions, and the capacity of African American women to be empathetic. She also emphasized that Black feminists must be accountable for their knowledge and claims, and be able to support them. Several authors (Collins; hooks; Johnson-Bailey, 2003) concurred that Black feminism is not separatist and does not dismiss its male or female counterparts, but recognizes the need to address issues that affect human beings who are both African American and female. Black feminism recognizes that all women are different, which means all African American women are different, but notes that the group shares a unique lived experience. Ultimately, Black feminism utilizes the unique experience of these women to create theory and practical applications that speak for and to African American women.

Although Black Feminist Thought remains controversial, it is useful in working with African American women regarding both their sexual decision making process and HIV prevention. Black feminism is synonymous with womanism, emphasizing the responsibility of Black women to act on their love of women and all that is woman. It follows that there is a collective responsibility of Black women to educate and be involved in HIV prevention initiatives directed at decreasing the number of Black women contracting HIV. In keeping with the Cambahee River Collective definition, Black women must continue to be committed to the struggle against all things that oppress Black women, including but not limited to decisions regarding sexuality and HIV prevention. Those involved in HIV prevention with African American women must be mindful of the "simultaneity of oppression" that African American women face. No initiative can be successful without acknowledging both the "simultaneity of oppression" and the idea that Black women have multiple identities that cannot be compartmentalized.

Black Feminist Thought: A Guide for the Research at Hand

It is impossible to explore African American women without first taking notice of the heterogeneous makeup of the group. It would be a mistake to look past the oppression that African American women encounter simply because they are both African American and female. When a researcher seeks to understand or explore a phenomenon within this community the research cannot be undertaken without looking through a lens that recognizes sexism and racism as the intersection of oppression that all African American women face. Black Feminist Thought may or may not be the answer to guiding such a quest but it provides an avenue worthy of exploration.

In this research, I explored sexual decision making among African American women. There are two major attributes of Black Feminist Thought which led me to believe it would be useful in guiding this research. The first is its ability to be applicable to the simultaneous oppressions that African American women face. Secondly, Black Feminist Thought uses African American women's shared experiences to create and develop theory, and the use of experience serves as an excellent cultural context when dealing with a topic as sensitive as sexual decision making.

The decisions of African American women regarding their choice of sexual partners and whether or not they use condoms is a complex one that cannot exclude their historical lack of power in sexual decision making or their complex struggle in fighting through the myths of the "mammy" and "jezebel." These decisions cannot be examined in a vacuum as they are in many cases a direct result of the historical oppressions African American women have faced. Their unique experience involving rape and violence both historically and currently cannot be divorced from the decisions they make sexually. Utilizing Black Feminist Thought to guide research with

African American women served as a vehicle to address their sexual decision making, as well as a vehicle to address other issues that have been silenced in the African American community. These issues included sex, sexual decision making, and sexual pleasure.

In reviewing the social work literature, I was unable to find one source that utilized Black feminist theory as a theoretical framework for working with African American women regarding sexual decision making or HIV. Using Black Feminist Thought as the lens to explore this phenomenon was not simply a good choice; it was the only choice for this study.

Black Feminist Thought and the Sexual Decision Making Process: Making the Connection

In discussing the connection between sexual decision making and Black Feminist Thought the idea of silence in the African American community must be discussed. In her article, "Black (W)holes and the Geometry of Black Female Sexuality," Hammonds (1994) discussed the issue of silence regarding pleasure among African American women where sexuality and sensuality are concerned. She argued that the silence that has taken place for generations has stifled Black women, and in some ways this silence has left women in a place where their core identity has been neglected and consequently not nurtured.

Hammonds (1994) stated that the African American community's silence regarding sex and sexuality has left African American women ashamed to find pleasure in who they are sexually. They have lost touch with themselves and their sensuality in fear of being seen as over-sexualized individuals. Hortense Spillers (as cited by Hammonds) stated, "Black women are beached whales of the sexual universe, unvoiced, misseen, not doing, awaiting their verb" (p. 131). Harris (1996) discussed the Black woman's inability to find pleasure in the sexual life experience. She argued that there is an absence of pleasure in how Black women view themselves sexually and how they behave based on those views. More importantly, she

suggested that the decisions Black women make about their own sexual experiences are clouded, based on their inability to feel powerful, take pleasure in, or even discuss sex as African American women. Her article, "The Pleasure Principle," leads one to ask the questions: Is the loss of pleasure really an issue among Black women? How do Black women define pleasure? What does it look like? How do Black women find pleasure again? How does the loss of pleasure affect Black women's ability to feel powerful in sexual relationships?

Douglas (1999) presented a discussion of sexuality but, unlike previously mentioned authors, included an assessment of the role of the Black church regarding sexuality. This discussion is applicable to today's popular culture as HIV, teen pregnancy, and the scandal of the "down low brotha" permeate our present-day discourse. Douglas included a discussion of the multiple identities of the Black woman. For example, she discussed the notion of the "jezebel," which she describes as the over-sexualized Black woman who participates in sexual activities that do not fall within the norms of sexual behavior. She is a woman who is identified as promiscuous and "loose" in her sexual decision making. The opposite of this woman is the "mammy" who has no sexuality. She is a woman classified as only a nurturer. She is the cook, cleaner, and the caretaker of her family but, most importantly, she performs these duties for the families of the White people for whom she works. The "mammy" and the "jezebel" are opposites, but both pose a problem as to how Black women are classified. Why must Black women be extremes? Can they not create for themselves an identity that allows them to be female, maternal, and sensual? Are these three identities mutually exclusive in the Black community? Are they mutually exclusive in all communities?

Douglas (1999) argued that silence in the Black church must end as it is causing the church to overlook many of the issues that need to be addressed within the Black community.

This lack of discussion has left Black women dying from AIDS and unable to have a dialogue about the root of the issues that may be affecting this crisis. It is important to note that the Black church has always been the cornerstone of the Black community. It has been a place of meeting, of political awareness and involvement, and of community empowerment. So, it seems only fitting that issues as prominent as HIV and AIDS and their effect on the Black community would be a priority for this establishment, which for decades has worked to mobilize the Black community and provide it with agency. Douglas indicated that the silence of the church has crippled the community as well. Its inability to take a stand regarding sex and everything sexual in nature has lead the community astray for a long time and, even now as these crises progress, still leads it in a backwards motion.

Any discussion of Black Feminist Thought and its connection to sexual decision making would be incomplete without a discussion of violence within the African American community, especially sexual violence. Violence has permeated this community for as long as Africans have been in America. African slave women were the property of their slave masters and forced to work for them in the fields, in the home, as well as to perform for them sexually. They were raped over and over again and forced to bear children for their rapist and abusers. These rapes lead to the inability of the Black man to value his female counterpart. After all she was used, dirty, and most importantly, not pure. Although these acts took place hundreds of years ago this historical precedent laid the groundwork for the violence Black women experience today (Leary, 2004; West, 1999).

According to West (1999), Black women are disadvantaged in a way that no other group is in that they are subjected to violence that has been societally sanctioned. For example, "gangsta" rap is one of the only places in the music industry where it has been socially

acceptable to write lyrics about raping and slapping women. This is Black men rapping about their acceptable treatment of Black women. For hundreds of years it has remained socially acceptable for Black women to be raped and violently attacked.

West (1999) also recognized that it is important that African American women be seen as the victim. West went further as she discussed the need for Black women to rise above the victimization they face. She argued that healing and resistance are key to Black women moving beyond the violence they have had to endure. West indicated that Black women must work to heal from the historical precedent that was set in the past. By using Black Feminist Thought to guide the exploration of decisions regarding sex, researchers may allow themselves to move one step closer.

Infusing Black Feminist Thought Into HIV Education and Prevention

There is an important role for theory in HIV prevention on every level including but not limited to the individual, community, and structural or policy level. It is essential that sound theory with proven utility be used as a framework for developing prevention programs. Theories can assist program planners in designing interventions and evaluation techniques from a place that is geared toward program participants (Center for AIDS Prevention Studies, 2002). Oftentimes those working in the field of HIV prevention apply theory to existing interventions rather than using theory to inspire new and innovative intervention strategies (Center for AIDS Prevention Studies).

The Center for AIDS Prevention Studies (2002) suggested that answering a few questions should assist providers in choosing the theory or theories best suited to guide prevention initiatives. The questions include:

1. Which communities/populations are targeted for services?

2. What are the specific behaviors that put them at risk for HIV/STDs?

3. What are the factors that impact risk-taking behaviors?

4. Which factors are the most important and can be realistically addressed?

5. What theory(ies) or models best address the identified factors?

6. What kind of intervention can best address the above factors? (p. 1)

The connection between Black Feminist Thought and prevention initiatives after just a cursory look at the answers to the questions above cannot be overlooked. Those answers respectively are:

1. African American Women;

2. Heterosexual encounters and injection drug use;

3. Poverty, denial, substance abuse, and partner risk;

4. Heterosexual encounters;

5. Black Feminist Thought; and

6. One that focuses on multiple oppressions like racism and sexism and one that focuses on multiple identities.

The Black feminist movement has been an integral part of the fight for social justice for decades. It has focused on issues such as reproductive rights, voting rights, welfare rights, lesbian and gay rights, anti-sexist organizing, and anti-racist organizing. Connecting this movement to sexual decision making and HIV prevention is simply a necessary step. The Black feminist community exists as a social and political place where women of color, specifically Black women, can discuss oppression from several different perspectives, meeting at one intersection. This is an intersection of race, gender, sexuality, and sensuality. The discussion

can include, but is not limited to, gender politics, race politics, and socialization regarding who and what Black women are and represent.

As early as 1990, African American women began to look at HIV prevention in new and innovative ways. In South Carolina a cosmetologist began offering HIV information and condoms to clients at her beauty salon. This minor activity evolved into a nonprofit organization, the South Carolina AIDS Education Network, which is housed in a beauty salon. The organization uses skits, videos, and music to increase the HIV knowledge and awareness of clients as they utilize salon services (Sadownick, 1990).

Much like the South Carolina AIDS Education Network, Voices of Women of Color Against HIV/AIDS (VOW) is a community-based intervention in New York City that is grounded in empowerment theory, and its mission is to empower women of color to be active participants in HIV prevention initiatives. The women in the organization meet to discuss major issues in prevention. Their special focus is on decreasing the incidence numbers of HIV in their community. VOW operates on every level by implementing programs that meet individual prevention needs and peer education trainings, as well as advocating for changes in legislation that will move more of the HIV prevention dollars to the Black community (Center for AIDS Prevention Studies, 2002). VOW is an example of the positive initiatives that are possible by using schools of thought such as Black feminism. However, there are very few groups like VOW.

When making the connection between Black feminism, sexual decision making, and HIV within communities of color, it is imperative to explore the simultaneous oppression that Black women face. Furthermore, it is important to explore the notion that they are put at even more risk by the oppression that Black gay and bisexual men face. Hogan (2001) discussed the

impossible position that her sister was put in after contracting HIV from her husband, who was secretly sexually involved with men. This trend of African American men who have sex with both male and female partners has increased the HIV risk for African American women. With this reality, Black women are forced to deal with issues of embarrassment and shame based on the actions of their sexual partners (Hogan).

African American women have only recently been targeted as an at-risk group, and there are few prevention messages aimed at their particular needs. There is a dearth of programs that approach prevention from a place that includes race and gender, and there has been virtually no exploration of what it would mean to develop a framework or programming to appropriately address a group suffering from multiple oppressions.

Summary

This chapter included a discussion of the literature regarding African American women and sexual decision making, HIV/AIDS prevalence and, HIV/AIDS prevention. It also included a detailed overview of Black Feminist Theory including a discussion of its evolution, history, and relevance to this study. The following chapter addresses the methods used in conducting this exploration of factors that influence sexual decision making.

CHAPTER 3

METHODOLOGY

This chapter addresses the characteristics of qualitative research design specifically a basic interpretive study, and discusses why it was the most appropriate design for this study. Second, the chapter provides a discussion of how I went about selecting a sample, including the criteria that were used in sample selection. Next, a discussion of the primary data collection strategy for this study, individual interviews, is provided. Focus group interviews and their utility in this study, as well as the method of data analysis used, were also discussed. Lastly, this chapter addresses validity and reliability, as well as researcher bias and assumptions.

The purpose of this study was to explore Black women's sexual risk factors as well as the factors that influence their sexual decision making. The research questions guiding this study were as follows:

1. What is the general understanding of HIV among Black women?

2. What are Black women's perceptions of HIV risk?

3. What influences Black women's sexual decision making?

4. How has the intersection of race, class, and gender affected Black women's perception of power?

5. How has the intersection of race, class, and gender affected Black women's sexual risk?

Design of the Study

There is a preponderance of literature related to HIV mainly consisting of epidemiological studies. Most of the literature explored for this study presents findings related to the demographics of people who either have HIV/AIDS or are at risk for contracting it. Although there is literature related to prevention, the majority of this information measures frequency of participant behavior and is provided in a numerical format. I was unable to find literature that discussed participants' descriptions of their decision making. Also, there were very few qualitative studies, and even fewer that were conducted with at-risk participants who were not HIV positive.

Qualitative methodology provides the most appropriate design to understand the factors that influence women's sexual decision making. This form of inquiry serves as a vehicle to understand these factors rather than simply the end result. It is a method in which the researcher uses oneself as a tool in an effort to glean in-depth information about a phenomenon of interest. It is used to learn more about the lived experience of research participants. In short, the purpose of qualitative research is to generate fruitful data that can lead to a greater understanding of an observed phenomenon (Berg, 2001).

Supported by Bogdan and Biklen (2007), Eisner (1991), and Merriam (1998), Creswell (2006) suggested that there are eight characteristics of qualitative research:

1. Natural setting as a source of data- all data are collected in the field and there is an emphasis on the natural environment

2. Researcher as key instrument of data collection- the researcher is the tool by which data are collected, comparable to a questionnaire in more quantitative research

3. Data are collected as words or pictures- participants are allowed to express themselves in their own words

4. Outcome as process rather than product

5. Analysis of data inductively, attention to particulars

6. Focus on participants' perspectives, their meaning

7. Use of expressive language

8. Persuasion by reason (p. 18)

Creswell (2006) articulated a definition that is succinct yet encompasses all of the aforementioned characteristics. He defined qualitative research as "…an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (p. 17). Creswell went on to list eight factors that a qualitative researcher must consider before choosing to embark on a qualitative study:

1. What is the nature of the question? The question should ask "how" or "what" rather than "why" as most quantitative questions do.

2. The topic of a qualitative study should be in need of exploration. Exploration refers to the idea that all is not known about the topic and that theories are unable to explain the behavior of participants.

3. There should be a need to present a detailed view of the topic area.

4. A qualitative approach is needed to observe individuals in their natural setting. Studying participants in their own setting helps to keep the findings within the context of the participants' surroundings.

5. One may also select qualitative inquiry because of a desire or need to write in a literary style (i.e., use of "I" or storytelling).

6. Qualitative study should only be used when the researcher has sufficient time and resources to gain an accurate and extensive picture of the participants' experiences.

7. Is your audience receptive to qualitative work? Be sure that reviewers will be intrigued rather than displeased with the use of qualitative inquiry.

8. The researcher must be able to embrace the role of active learner and be willing to present the results from the participants' view in a way that is free from judgment. (p. 20)

After reviewing Creswell's (2006) considerations, I determined that qualitative research was the appropriate methodology to utilize in conducting research in the area of HIV and sexual decision making among African American women. Specifically, this study focused on the factors that influence their decisions regarding with whom to use condoms. I was also interested in how they view their level of risk as well as their perception of personal power and its effect on their risk from each unique and individual point of view. African American women continue to be the fastest growing group contracting HIV, which provides a basis for exploration (Centers for Disease Control and Prevention [CDC], 2005). Further exploration of this topic is also needed to develop appropriate prevention messages. Given that current knowledge about HIV preventive behavior among African American women has not led to a reduction in the incidence of HIV infection in this population, there is a need to explore sexual decision making through the words of these women.

As a young Black woman, I am the face of HIV in the U.S. I have a unique and vested interest in conducting research that can help to inform effective prevention messages. As a

researcher of color, I recognize that many African American women have reservations about being the subjects of "scholarly research." Blauner and Wellman (1973) suggested that scientific research is influenced by larger society, which has not always been fair to African American women. I chose qualitative inquiry for this study not only because it met Creswell's (2006) criteria or because I had a vested interest in African American women being allowed to speak in their own voices, but also because I recognized a need for more meaningful and useful data in a topic area that could lead to the saving of lives.

Sample Selection

According to Patton (2002), one of the design strategies for qualitative inquiry is purposeful sampling. This speaks to the idea that the researcher intentionally seeks participants who have a wealth of information about the topic area or issue of interest and can, therefore, shed light on it in ways that others could not. A purposeful sample is chosen over a randomly selected sample because the purpose of qualitative inquiry is to produce rich, multifaceted information from each participant, resulting in a better understanding of the given phenomena. Statistical generalization is not a goal of qualitative inquiry, and random or probability sampling is not necessary nor does it really have a place in qualitative research (Merriam, 1998; Patton, 2002). The findings generated from this study are not generalizable to the masses, but are detailed in a way that provides insight needed for change regarding HIV prevention and African American women.

Sample Selection and Criteria

Creswell (2006) suggested that qualitative inquiry requires the researcher to seek participants who will provide the richest data available. Therefore, I utilized purposeful sampling for this study. I chose participants who agreed to speak freely and who met the criteria

presented below. According to Merriam (1998), it is important to establish criteria for selecting

participants. Criteria are determined to assist the researcher in choosing a sample that is rich in

information and that will provide data related to the purpose of the study. All participants

chosen to participate in this study met the following criteria:

- Were between the ages of 18-25 years old;

- Identified as Black, non-Hispanic;

- Self-reported that they are sexually active (not a virgin);

- Identified as unmarried;

- Were willing to speak freely about their prior sexual experiences and decisions
  regarding them;

- Were willing to speak freely about their level of power in sexual relationships;

- Were available for contact when clarification was needed with regards to the data
  collected;

- Spoke English clearly; and

- Were able to provide transportation for themselves to interview and focus group
  locations.

The CDC (2002) indicated that African American women, ages 18-24 years old, are the

face of HIV in the U.S., so the target sample for the current study was limited to this group. It

was important that the women self report prior sexual relationships so that there was some life

experience for them to refer to during the interview. The rationale for including women who

were unmarried is that being married significantly decreases the risk of HIV contraction and

although there are married women who contract HIV, they do not represent the norm (CDC,

2002).

Also included in the selection criteria was the willingness to speak freely about sexual experiences and decision making. This criterion was directly related to participants' ability to supply rich and detailed information regarding the aforementioned research questions. It was also important that participants be open to speaking one-on-one with me as well as in the focus group setting with other participants. Although attesting to this willingness to speak did not guarantee that it occurred in the interview or focus group setting, an initial attempt to establish participants' willingness was a beginning step in selecting them. Participants had to also be available to clarify any of their information while data were being analyzed so that I could ensure that their perspectives were accurately represented.

Since I, as the researcher, am fluent in English and no other language, it was important for participants to be English speakers. Additionally, all participants were required to provide their own transportation to and from interview and focus group sites. I used private rooms in two Atlanta libraries located on the MARTA line, as well as a college dormitory meeting room. The venues were private and in close proximity to participants. Each was used to conduct both interviews and focus groups.

Sampling Procedure

In order to recruit participants for this study, two types of purposeful sampling were employed. The first was maximum variation sampling. According to Patton (2002), the researcher uses maximum variation sampling in order to "…purposefully pick a wide range of cases to get variation on dimensions of interests" (p. 243). To recruit participants for the study, I first sought permission to post fliers (Appendix A) at college campuses, churches, health departments, and Planned Parenthood clinics in the metropolitan Atlanta area, specifically the 30313 and 30314 zip codes. Permission was granted for me to post fliers everywhere I inquired

with the exception of three metropolitan churches. The fliers directed interested persons to contact me by phone; I then explained the study and conducted a brief telephone interview. I used a structured screening tool (Appendix B) to determine if the participants met the study criteria, as well as to collect demographic information.

The screening tool focused on socioeconomic status, education level, and marital status; the results allowed me to select a diverse sample. I also utilized a purposeful sampling approach known as snowball or chain sampling where I relied on participants to refer peers to the study. The two sampling procedures were used to increase the size of the sampling pool so that I could identify a heterogeneous sample of sufficient size. Patton (2002) suggested that points of particular interest within the study emerge when a sample is widely heterogeneous in nature, yet participants describe similar experiences related to the given phenomenon. I recruited until I felt I had a diverse group from which to select participants for both the individual interviews and focus groups, and until I reached the point of saturation in data collection (Merriam, 1998).

Prospective study participants began telephoning in March 2006. When I spoke to the young women I asked them to refer peers they thought might be interested and who would meet the selection criteria. This snowball sampling technique, used in conjunction with the fliers in the community establishments, was sufficient for generating a sample large enough to achieve saturation and redundancy, as noted above. The use of these two procedures yielded a sample of Black women who met the sampling criteria and who were diverse in education level, socioeconomic background, and upbringing, as well as other characteristics.

After I received a number of calls indicating interest in participating in the study, I selected a sampling pool of 30 women based on the participant criteria. Although I could not determine when saturation would be reached prior to completing the study, 30 women were

chosen to participate in individual in-depth interviews and/or focus groups. I spoke to each of the 30 women by telephone and collected demographic information at that time. I carefully reviewed their demographic information in the order received and selected a sample that was as diverse as possible given the sampling pool. Since race and gender were homogeneous among the women, I focused on obtaining a sample that was diverse in age, region or place of birth, and education. I also kept track of whether or not participants were peers or familiar with each other in anyway to ensure that focus groups would not have any participants who had known each other prior to the initial focus group meeting.

At the time the interviews were conducted I asked each woman to sign an informed consent form (Appendix C), as mandated by the Human Subjects Office. Participants were reminded that the interview would be approximately 45-60 minutes in length and that they would be compensated monetarily ($20) for their time upon completion. At the end of the individual interviews, participants were asked if they were interested in participating in a five-person focus group. This interest was documented so that they could be contacted when the focus groups were organized.

Focus groups began after the individual interviews were completed. According to Krueger (1994), sensitive issues should only be discussed in focus groups smaller than seven. Because sexual decision making is a complex issue, the groups were kept small and intimate. Each focus group of five participants was organized and conducted consecutively. The three focus groups, scheduled for 90 to 120 minutes each, were comprised of two participants who were previously interviewed individually and three participants who did not participate in the individual interviews. The purpose of including individual interview participants in the focus groups was to include respondents who had already been a part of one aspect of the study and

therefore had time to reflect on the nature of the questions that were asked. All focus group

participants were required to sign an informed consent form (Appendix D) and were

compensated for their time in the form of retail gift certificates ($10). Snacks and beverages were

provided during the meeting as well as tokens for public transportation if used. All of the women

who had expressed interest in participating in the study but were not chosen for either an

individual interview or as a focus group participant were sent a thank you note for their interest

and notified that recruitment for the study had ended.

According to Patton (2002), "…there are no rules for sample size in qualitative inquiry"

(p. 244). My goal was to interview individually and collectively to the point of saturation.

Including 15 women in the focus groups added both "breadth" and "depth" to the study (Patton).

I did not choose a smaller sample because I recognized the importance of being able to gain

sufficient information about sexual decision making from a diverse group of sexually active

African American women. Furthermore, it was not until after the conclusion of the third focus

group that I felt saturation had been reached. Conversely, I did not choose to interview a larger

number of participants because I had to select a sample size I could manage given the time and

resources I had available, and I was beginning to see redundancy in the data. Based on the

research questions of interest, this sample met the needs of the study and allowed for detailed

exploration of sexual decision making.

<div align="center">Data Collection</div>

As mentioned previously, this study utilized two types of data collection strategies:

individual interviews and focus groups. These strategies were selected because they allowed me

to gain in-depth information from many participants in both individual and group environments.

Lather (1991), a leading feminist scholar, suggested that as feminist researchers focus on not

objectifying or exploiting participants, they must pose questions that speak to the centrality of

gender in the way an individual's world view is shaped. She suggested that the goal of such

studies is to "correct both invisibility and distortion of female experience in ways relevant to

ending women's unequal social position" (p. 71). Creswell (2006) suggested that when

conducting feminist research a researcher should consider engaging in the following procedures:

1. Conduct sequential interviews in an interactive, dialogic manner that entails self-disclosure on the part of the researcher and fosters a sense of collaboration.

2. Conduct group interviews that provide potential for deeper probing and reciprocally educative encounters.

3. Negotiate meanings of results with participants in the study.

4. Strive to address issues of false consciousness and conceptual determinism.

5. Be self-reflexive about what researchers experience as they conduct research. (p. 83)

Although the exploration of sexual decision making utilizing a Black feminist approach

acknowledges the centrality of both gender and race in the construction of social consciousness,

Creswell's (2006) suggested procedures still hold true. After a review of these, I chose

individual interviews and focus groups as the methods of data collection most appropriate for

this study.

Individual Interviews: The Interview Guide Approach

According to Patton (1990), there are three types of qualitative interviews: (1) the

standardized open-ended interview; (2) the informal conversational interview; and (3) the

interview guide approach. The standardized open-ended interview requires that every participant

be asked a series of questions in the same order, and the researcher makes a special effort to

present minimal affect so as not to sway the results in any manner. The informal conversational

interview is, in essence, a spontaneous interview, meaning it occurs during field work and is unplanned. Lastly, the interview guide approach consists of planned interviews that generally follow some protocol but are not as rigid as the standardized open-ended approach. In an effort to provide a moderate level of structure, this study utilized the interview guide approach.

Rubin and Rubin (1995) suggested that it is important to understand that qualitative research is not rigid or "locked in stone," but rather "flexible, iterative and continuous" (p. 43). It is with this in mind that I created the interview protocol used for this study (Appendix E). The protocol included a series of questions meant to guide the interviews and enhance the flow of the participants' responses. However, the questions were fluid in nature and by no means set in stone. For example, when participants began to discuss an issue related to the topic, but not included in the interview protocol, they were not ushered back to the scheduled questions. Much of the interesting and in-depth data gathered were the product of each participant feeling free to speak outside of the protocol parameters. Furthermore, the questions were not always asked in order. It was my goal to ask all of the questions and to probe further when necessary.

Patton (1990) described the interview guide method as the best way to accomplish some level of structure while still allowing participants to be free to give as much content as they desired. The inclusion of moderate structure exists for the purpose of keeping the interview on track as well as ensuring that research areas of interest are addressed. Maintaining a moderate degree of structure also assisted in data organization following its collection. By using moderate rather than rigid structure, the study produced in-depth information related to the process of sexual decision making by the women involved in this study. It also gave them the freedom to think, discuss, and clarify anything they wished while remaining focused on the topic.

The primary advantage of individual interviews is that they allow the participant to give more in-depth and detailed answers. They are also conducted one-on-one, during which time the participant can speak to the researcher freely and privately. In this study participants were given the opportunity to choose pseudonyms and were referred to by these names to ensure that confidentiality was maintained throughout the interview process. Although the use of individual interviews has major advantages, it is not without disadvantages. Individual interviews can require considerable time and resources. It is important to know and understand the commitment of time at the outset of the research project so that data collection can be planned and conducted in an efficient manner. Although there were many reasons to include focus groups, one of which was to minimize the limitations of individual interviews.

Focus Group Interviews

Sherman and Reid (1994) defined focus groups as

> group interviews based on topics supplied by the researcher, who typically takes the role of moderator. The information arising from interaction within the group is the primary focus of attention, and the fundamental data produced are transcripts of the group discussions. (p. 494)

This succinct definition provides the basic picture and purpose of a focus group. Berg (2001) stated that "the informal group discussion atmosphere of the focus group interview structure is intended to encourage subjects to speak freely and completely about behaviors, attitudes, and opinions they possess" (p. 111).

In a study regarding low-income women and HIV risk reduction, Carey, Gordon, Morrison-Beedy, and McLean (1997) used focus groups with 45 women. The authors reported that the focus groups provided an opportunity for open discussion among the participants. The

groups served as a place where the women could discuss HIV risk reduction and the discussion was stimulated by the other participants. It is the authors' contention that focus groups are a useful avenue for gaining information relevant to cultural and social issues regarding sexual behavior.

Berg (2001) argued that when focus groups are planned and conducted correctly they can provide a wealth of information. Group discussion allows participants to observe the contributions of other group members, which can trigger thoughtful ideas that may not surface in a one-on-one interview. Stewart and Shamdasani, and Sussman et al. (as cited by Berg, 2001) referred to the group dynamic as a "synergistic group effect" which allows the participants to "brainstorm" (Berg, p. 112) about any given topic. Additionally, Rubin and Babbie (2001) stated that there are several advantages to focus groups including the fact that they are inexpensive and offer an abundance of flexibility for probing. Some disadvantages include representativeness and group pressure. Furthermore, the data generated from focus groups can be voluminous, which makes analysis tedious and extremely time consuming. The data may also be disorganized, which is only compounded when there are multiple focus groups as there were in this study (Rubin & Babbie).

As noted, all focus groups were held after individual interviews were conducted and each participant was asked to sign a focus group consent form (Appendix D) indicating that she agreed to take part in this study. A more general version of the individual interview protocol was used for the focus groups (Appendix E). This was done in an effort to generate broader discussion about their peers and patterns they saw rather than on their own unique experiences, which may have caused some level of stress in a group setting.

Individual Interviews and Focus Group Interviews: A Comparison

Individual interviews produce individually-created responses, and focus groups are more socially constructed. Both can be as structured or unstructured as deemed necessary by the researcher. Also, both individual interviews and focus groups have the potential to produce new knowledge. Although using focus groups allows for more participants, they tend to spawn far less original thought (Berg, 2001).

Individual interviews gave this study depth by providing a method of data collection that retrieved detailed information from participants. They also created an avenue for the participant to give detail and individual information pertaining to the topic. On the other hand, focus groups provided breadth by allowing the inclusion of a larger number of participants brainstorming and discussing the topic. This inclusion of more participants did not add any major time commitment or expense to the study but provided invaluable insight (Berg, 2001).

Data Analysis

According to Patton (2002), "…qualitative analysis transforms data into findings" (p. 432). Unlike in more positivist quantitative research, there is no clear cut difference in the time where data collection and analysis are conducted in qualitative inquiry. The two not only occur simultaneously, but data collection is also informed by the constant fluidity of the process (Patton). As a result of this combined data collection and analysis phase, final analysis included not only an analysis of raw data collected during field work, but also the record of the many insights and enlightened interpretations that came to light as the data were being collected.

I utilized the constant comparative method developed by Glaser and Strauss (1967) in analyzing the data in this study. This method of analysis, simply put, involves the researcher "constantly comparing" the data as it is collected. According to Dey (2004), comparison is the

key to this process and is used when looking at "bits of data to generate categories, or comparing categories in order to generate connections between them" (p. 88). Charmaz (2002) suggested when conducting analysis it is important that the researcher not wait until the "analysis phase" to begin reviewing and making meaning of data. There should be "constant comparison" of the data collected and analysis should be ongoing throughout the study (Charmaz). As I collected data, I simultaneously performed data analysis tasks to increase understanding of the information prior to moving forward with more data collection. If clarification was needed after each individual or group interview, I contacted participants for further explanation. Only the first two individual interview participants were contacted by phone and met with in person to gain further information and clarity.

Specifically, each day after I collected data I listened to the interview at least once before any other interview was conducted. I scribed a journal entry where I wrote down nonverbal cues present in the interview, the participant's appearance, and my overall perceptions about the interview or focus group. After receipt of each transcription I read it a number of times while listening to each interview and making corrections and additions to the written document. My transcriptions were numbered by line, and large margins were left to ensure that space was provided for my notes and identification of common themes. I continued this process for each piece of data, looking for similarities and differences as well as the emergence of new themes not previously derived. Becoming more familiar with the data enhanced my listening skills, and I found it easier to hear the commonalities in the midst of the interview by the time data collection reached the point of saturation.

Researchers have identified several methods of data analysis including computer software, file folders, and index cards (Merriam, 1998). However, I elected to use the "cut" and

"paste" function of Microsoft Word to manage the over 400 pages of data collected upon completion of the interviews and focus groups. I cut and pasted direct quotes from participants under one of the five research questions to which they pertained. This not only gave me a clear view of where there was a preponderance of data, but also facilitated use of specific chunks of data in specific places. This form of data analysis worked well in terms of data management but also provided me with an actual illustration of the commonalities so that I could create themes and/or categories that were representative of the data. As analysis continued, recurring categories were identified. During the final stage, after all data had been collected, I utilized the study transcripts, memo list, and my personal journal to re-check the data.

With this abundance of information, I realized that some was not directly related to the research questions in this study. When data were important to the study but not preponderant I included it in either the participant's description or the discussion. My goal was to present the preponderance of data while still including data important to understanding the participants as well as the phenomenon.

<div align="center">Validity and Reliability</div>

Although the scientific process involved in quantitative and qualitative data collection is different, qualitative inquiry is still scientific in nature (Patton, 2002). This means that, qualitative inquiry is not only systematic, but has a set of "strategies for establishing validity and reliability, strategies based on the different worldview and different questions congruent with the philosophical assumptions underlying this perspective" (Merriam, 2002, p. 24). Consequently, validity and reliability exist in qualitative research in an effort to understand a world as it is seen and experienced by participants in the study (Patton, 2002). It is imperative that issues of validity and reliability be addressed so that readers can trust that a certain level of rigor has been

met. This is even more important when it is hoped that findings will be used as a basis for change in practice that will directly impact consumers. Stakeholders can only trust that the end products of research are worth implementing in practice when some account for validity and reliability has been included (Rossman & Rallis, 2003).

Internal Validity

The term internal validity speaks to the accuracy of the study's findings. Lincoln and Guba (1985) referred to this as "truth value." There are several strategies that can be used to enhance the internal validity of a given study (Merriam, 2002; Patton, 2002; Rossman & Rallis, 2003). They include an audit trail, reflexivity, a statement of researcher biases, peer review or examination, member checks, triangulation, long-term observation, and participatory or collaborative research. I utilized the first six to enhance the internal validity in this study.

According to Merriam (2002) an audit trail, which is a detailed account of the steps taken in the research, is an excellent method of controlling for researcher bias. At every stage of the study I kept meticulous notes regarding recruitment, data collection, and analysis to ensure that the rationale for all decisions made was well documented. I wrote this information in a journal format so that it could be reviewed at any time. Reflexivity was enhanced through the use of a personal journal. My journal was comprised of reflections regarding myself, study participants, and the audience I was reporting to in an effort to assist me in balancing all of these during both the analysis and reporting phase of this research project.

Both Patton (2002) and Merriam (2002) posited that it is important for the researcher to state personal biases at the outset of the study. In an effort to enhance internal validity I not only noted my connection to the subject matter in the prologue at the beginning of this document but also reported my assumptions in a later section of this chapter. Additionally, I kept a journal of

my personal thoughts related to the study throughout each phase of its implementation as a record of the assumptions or biases I may have held.

Without compromising confidentiality or anonymity I utilized members of my dissertation committee as well as other colleagues in the field to act as peer reviewers by assisting in the review of raw data to identify themes and similarities. They were also asked to review the findings and give their own thoughts as to their authenticity (Merriam, 2002).

Member checking was utilized as well. Merriam (2002) described member checking as the action of taking preliminary findings back to some of the study participants and asking whether or not the interpretations are accurate. Although it is not the most common view of triangulation, Patton (2002) suggested that member checking can be seen as a form of triangulation. He also suggested that the use of triangulation even in the form of member checking increases the credibility of the findings by dispelling any myths that the findings could be the product of a single person's interpretation. Three of the study participants were asked to participate in member check, and they were chosen solely based on their availability. Lastly, I used data source triangulation in an effort to further strengthen internal validity. According to Mathison (1983) this is a form of triangulation where more than one source is used to glean data. In this study both individual interviews and focus group interviews were used as data sources. As previously discussed the two sources have unique strengths and weaknesses, and the use of both served to strengthen the study.

External Validity

According to Firestone (1993) the issue of external validity speaks to generalizability. That is, can the findings of this study be applied to other young African American women? Merriam (1995) suggested that the goal of qualitative research is to gain in-depth knowledge

about a phenomenon rather than one truth about many people. Therefore, the goal of this study was not to be able to generalize in a statistical sense, but to gain in-depth information about sexual decision making as it pertained to the women who participated in this study.

According to Merriam (2002), reader generalizability is the most common way that external validity is addressed in qualitative inquiry. She went on to note that "in this view, readers themselves determine the extent to which findings from a study can be applied to their context" (p. 28). It is not the researcher but the reader who determines if the findings of a study can be utilized in other situations. Merriam suggested several strategies for enhancing the external validity of a qualitative study. Two of those strategies were used in this study. The first is to provide rich and detailed description. I included a thorough description of the study and its participants in the following chapter, so that readers can make a well-informed assessment as to how closely their situations match this study, as well as provided the reader with sufficient evidence to support the findings of the study. The second strategy, maximum variation sampling, was discussed in-depth in the sampling section of this chapter.

Reliability

The central component of reliability in a positivist sense is the ability to replicate research findings. This is a purely quantitative approach to reliability (Merriam, 1998). As replication of "one true" reality is not the goal of qualitative research this understanding of reliability cannot be applied. When conducting qualitative inquiry the issue of reliability relates to whether or not the study findings are consistent with the data collected (Merriam). The question of reliability is a question of whether or not the results make sense. The measure of reliability is more closely related to whether other researchers viewing the same data would agree with the results (Rossman & Rallis, 2003). With that in mind, in qualitative research the issue of reliability is

judged by the study's rigor and whether or not the results are dependable and consistent with the data collected.

Many of the ways that I enhanced the internal validity of the study also helped to ensure its reliability. An audit trail, member checking, and statement of my researcher biases all helped to ensure that the study findings are dependable and assist in accurately conveying the rigor of the research. The inclusion of all of these components will allow consumers of this research to make a decision as to whether or not the study was well designed and conducted.

Researcher Bias and Assumptions

There is no one fact or circumstance that ignited my interest in HIV prevention and African American women. A number of considerations including, but not limited to, my own thoughts regarding how women negotiate race and gender as it relates to sexual performance played a major role in my interest. I spent years working in arenas that focused on sexual behavior or HIV, or both. Throughout my career I provided services to women of all ages who were HIV positive as well as at risk, and all of these experiences shaped my opinions regarding prevention and decision making. My own unique experience as a 28-year-old African American woman contributed to my academic curiosity and directly influenced the lens through which I viewed participants, formulated questions, and analyzed data.

My personal and professional experiences come together to create several assumptions and biases on my part. Having had a friend contract HIV in my early twenties gave me an increased level of passion when it comes to HIV prevention. I believe that being Black and female automatically put the participants of my study at higher risk because of the oppression they face as a result of their identity. I also believe that the decisions they make regarding sex are directly related to how they were socialized as Black women. Although I cannot eliminate

my assumptions and biases from who I am I attempted to minimize them by journaling and exercising reflexivity throughout this research process.

Summary

This chapter included a discussion of the methods used to conduct this research. It included sections related to sampling, data collection and analysis, validity and reliability, and researcher biases and assumptions. The following chapter provides a rich and detailed description of the characteristics of the study participants as well as the results of the study.

CHAPTER 4

FINDINGS

The purpose of this study was to explore Black women's sexual risk factors as well as the factors that influence their sexual decision making. The research questions guiding this study were as follows:

1. What is the general understanding of HIV among Black women?

2. What are Black women's perceptions of HIV risk?

3. What influences Black women's sexual decision making?

4. How has the intersection of race, class, and gender affected Black women's perception of power?

5. How has the intersection of race, class, and gender affected Black women's sexual risk?

This study utilized a qualitative design and was conducted from March 2006 to April 2007. During this time African American women were recruited via fliers and snowball sampling to participate in the individual interview phase of this study. All fliers were posted at the County Health Department, Planned Parenthood, and two historically Black colleges. Of those recruited, 15 young women were interviewed for 45 minutes to an hour. These face-to-face interviews took place in a variety of settings which included private rooms at both a public library and a college library, as well as a meeting room in a college dormitory. A "thank you" card with a $20 bill enclosed was given to each participant at the conclusion of the interview. All of the interviews were tape recorded and professionally transcribed.

Participants who agreed to participate in the individual interviews were asked if they could be contacted later either to review their transcription or to be asked clarifying questions. All of the participants granted permission to be contacted at a later date. Two were contacted by phone to schedule a follow-up meeting in an effort to shed light on some of the statements that were made during the initial interview. I met with them individually, for a brief face-to-face meeting. These meetings were recorded, transcribed, and included as a part of the interview data. Three of the participants were also asked to meet with me to assist with member checking. I met with each of them individually and reviewed the transcripts from their individual interviews.

Five of the individual interview participants also agreed to serve as members of focus groups which took place after the individual interviews were completed and transcribed. Three focus groups were conducted. Each of the first two included two participants who had previously been interviewed individually, and the last group included one participant who had previously been interviewed individually. Originally, I planned to convene four focus groups, but recognized that saturation was reached after three, so a decision was made to end data collection at that point.

The three focus groups were conducted in private rooms at a campus library, a public library, and in an on-campus dormitory meeting room. There were five participants in each of the three groups, and of the 15 participants, 10 had not participated in the individual interview portion of the study. These 10 participants were recruited via fliers that were posted at the beginning of the study and were asked to participate as focus group members only. A "thank you" card with a $10 retail gift card was given to all participants at the conclusion of each focus group. All three focus groups were tape recorded and professionally transcribed.

This chapter has three sections. The first presents individual profiles of participants in the order in which they were interviewed, as well as a description of each focus group and group setting in the order in which it took place. Pseudonyms chosen by the participants were used in order to keep their true identities confidential. It should be noted that the five young women who participated in both the individual interviews and focus groups used the same pseudonym. The second section presents data from both the individual interviews and focus groups to support the categories and properties. Lastly, the final section provides a summary of the chapter.

<div align="center">The Participants</div>

Twenty-five Black women who live in a large metropolitan city and who reside in one of two neighboring zip codes in the southeastern U.S. participated in this study. Ten participated only in the individual interviews, and 10 participated only in the focus groups. The remaining 5 women were participants in both the individual interviews and focus groups.

Individual Interviews

The individual interview participants were diverse in terms of age and place of birth. Their ages ranged from 19 to 24 years. All identified as being Black and were born in different U.S. cities. Every participant identified as Christian, with two indicating that they were Roman Catholic. All participants completed high school or obtained a GED, three completed some college, and four finished a Bachelor's degree. Participants' parents had varying levels of education. All indicated that both parents had completed high school or obtained a GED, with the exception of two who stated they did not know the level of education of their fathers. Every participant revealed that she is heterosexual. Table 4.1 provides a summary of the individual interview participants.

Table 4.1

Summary of Individual Interview Participant Information

Participant	Gender	Age	Place of Birth	Religious Affiliation	Level of Education	Parents Education (Mother, Father)		Sexual Preference
Sabrina	F	22	Miami, FL	Christian (AME)	Bachelor's degree	Bachelor's degree	Master's degree or higher	Heterosexual
Andrea	F	22	Philadelphia, PA	Christian	Bachelor's degree	Bachelor's degree	High School	Heterosexual
Chloe	F	23	Rome, GA	Christian (Baptist)	High School	Some College	High School	Heterosexual
BB	F	24	St. Louis, MI	Christian	High School	Some College	High School	Heterosexual
Essence	F	19	Baltimore, MD	Roman Catholic	High School	High School	High School	Heterosexual
Allyce	F	22	Flint, MI	Christian (Baptist)	Some College	Master's degree or higher	High School	Heterosexual
Shayla	F	23	Little Rock, AR	Roman Catholic	Some College	Bachelor's degree	Bachelor's degree	Heterosexual

Table 4.1 continued

Participant	Gender	Age	Place of Birth	Religious Affiliation	Level of Education	Parents Education (Mother, Father)		Sexual Preference
Peace	F	21	San Francisco, CA	Christian (Baptist)	Some College	Associate's Degree	Don't Know	Heterosexual
Whitney	F	19	Detroit, MI	Christian	High School	Master's degree or higher	Don't Know	Heterosexual
Tameka	F	21	Columbia, SC	Christian	High School	Associate's Degree	High School or GED	Heterosexual
Jordon	F	21	Vallejo, CA	Christian (Baptist)	High School	Master's degree or higher	Master's degree or higher	Heterosexual
Lasha	F	19	Long Beach, CA	Christian	High School	Some College	Some College	Heterosexual
Karen	F	21	Oklahoma City, OK	Christian (Baptist)	High School	High School or GED	High School or GED	Heterosexual
Stacy	F	21	Birmingham, AL	Christian	Bachelor's degree	Master's degree or higher	High School or GED	Heterosexual
Johniece	F	21	Birmingham, AL	Christian	Bachelor's degree	Some College	Associate's degree	Heterosexual

Below is a detailed description of the individual interview participants. Their own words have been used wherever appropriate to provide a better sense of their individual personas.

Sabrina. Sabrina is a 22-year-old, single woman who recently graduated with a Bachelor's degree in biology from a historically Black college. She completed her degree in four years and decided to take the next year to study for a medical exam in hopes of gaining acceptance to medical school in 2007. She lives alone in her first apartment and is both disappointed that she did not get to go to medical school this year and excited that she will one day be a doctor (pediatrician) "regardless of the road" she has to travel to get there.

Sabrina is the youngest of three children and the only female. Now divorced, her parents were married while she and her two older brothers lived at home, and both her mother and father have played an integral role in her life and how she was raised. Sabrina expressed being heavily influenced by her siblings: "They're both males. That was definitely influential" to the woman she has become. She took pride in stating "I could look at my father … having positive … males in my life, it is easier to go to them and … talk about anything or any type of … situation or issue… those type of things really do make a difference."

Sexual decision making is something Sabrina thinks is important, and she noted that most of her opinions about it come from her family and how she was raised. She is articulate, well read, and is adamant that more awareness is needed in the Black community regarding HIV and STDs. She also indicated that there needs to be more conversations about the issue of sex. Sabrina stated of her own upbringing: "My mother definitely made sure that she had conversations with me."

Andrea. Andrea, a 22-year-old African American female, is the youngest of three children. She was born and raised in an urban metropolitan city in the northeastern U.S. and was

planning to return there for medical school in the fall of 2006. She recently graduated from a historically Black college with a Bachelor's degree in biology and was preparing to move at the time of her interview.

Although only one of her parents has at least a Bachelor's degree, her two siblings both acquired terminal degrees, and Andrea, the youngest of three, is hoping to complete medical school in the next four years. She sees sexual decision making as important because "HIV is most prevalent with African-American females," and she concedes that she and her peers are at "great risk" for contracting it. She is unwavering about the fact that "there needs to be a cure" and hopes to one day be a part of finding it.

Andrea described herself as being very religious and although she has had sex, she has made a decision to be celibate at the present time. With a very sure tone in her voice she shared, "I don't believe … in casual sex. So for me, I'm not going to have sex." Although Andrea is small in stature she spoke with conviction and noted that her religious beliefs guide all of her decisions, including those regarding sex.

Chloe. Chloe is a 23-year-old young woman from a rural city in northwestern Georgia. She is the only child of her parents, who are married and live in the city where Chloe was born. After completing high school she moved to the Atlanta metropolitan area to live with a friend while working and attempting to save money to get an apartment of her own. Chloe affectionately described herself as a "kinda short and Black girl curvy." She is happy with where she is right now and is "talking" to someone she really likes.

Although Chloe believes sexual decision making is important she noted that it is not something that she thinks about often. After a moment of reflection regarding HIV she described it as "a disease that is deadly," but admitted she does not think about it when deciding to have

sex. Chloe believes sex is overrated and that much of the reason she and her peers engage in it is because they are affected by the media images they see on television.

Chloe feels that "a lot of times … women aren't happy with their decisions. Hollywood hypes sex up." Although she suggested that she is swayed by both what people think about her as well as what she sees on television, she tries not to make decisions based on these influences. Chloe emphasized that most of her opinions about the roles of women come from observing her parents' relationship.

BB. BB, a 24-year-old woman originally from St. Louis, Missouri, works as a full-time waitress. She explained that she moved to the south to live with a cousin who was a sophomore in college at the time. Her parents hoped that moving would get her out of a bad relationship that she had been in for two years, and BB herself explained that she hopes to be able to save enough money as a waitress to pay for college. She lives with her cousin near several colleges and universities, and although she is not a student she seems very entrenched in the college and university culture.

When interacting with BB one notices an aura of confidence and security that surrounds her. She described herself as "tough and strong" and expressed a sense of resiliency and a desire to overcome any obstacle. BB stated with confidence, "I believe that women have to realize that, honestly, we have the power."

Regarding sexual decision making, BB believes that the risk of contracting HIV is at an all-time high for her as well as her peers, and this belief has lead to the decision to become celibate. She stated with noticeable concern on her face, "I just think that we need to get to a place in our mind and realize that sex isn't everything and you can go without sex and, if you go without sex, you might get a little more than you did before you even had sex with this person."

BB indicated that her beliefs about sex have evolved from her experiences in "unsuccessful relationships."

Essence. Essence, a 19-year-old Baltimore, Maryland native, was a college freshman at the time of her interview. She described herself as "shy" and "quiet" and said she was overwhelmed with the transition from high school to college. Although she presents as nervous and timid, Essence appeared extremely focused during the interview and made it clear that HIV as well as other sexually transmitted infections (STIs) are issues that constantly invade her thoughts.

She expressed great trepidation about the fact that many of her colleagues and peers are meeting young men and women on the Internet and, in turn, ending up in risky situations. She went further to say that a lack of confidence was the primary reason for their "bad sexual decisions." Although she feels secure about how she makes decisions, she expressed that she was in the minority among her peers regarding confidence and thoughtfulness about how sexual decisions are made.

Essence's beliefs regarding sexual decision making are largely shaped by her personal experiences. Her father was ill and died when she was a child. Recalling the circumstances of his death she explained:

> I was nine years old when my father passed away, and I didn't know that he passed away of AIDS until after I was like ten, and I just knew my father was sick, and he had kidney failure, but his kidneys failed because…he had …full blown AIDS. So, that was my first ever exposure.

She went on to say, "My … biggest fear is to die the way my father died. I…I'm not afraid to die. I'm just afraid to die in that way, like, to die from a horrible disease, such as AIDS."

Allyce. Allyce is a 22-year-old college junior at a historically Black university in southeastern Georgia. During her interview she presented as strong and confident and did not express any nervousness or reservation about the sensitive nature of the interview topic. Allyce is the president of her sorority, the founder of a women's health initiative on her campus, and a member of her sorority's step team. She described herself as a "born leader" and emphasized that she loved being in school.

Allyce expressed concern and sadness regarding the fact that African American women have the highest HIV prevalence rates. She included herself and her peers when she said, "we need to evaluate ourselves and our lifestyles." Although she admitted that she does not think about sexual decision making on a regular basis, she does try to make healthy decisions in her life overall, which includes decisions she makes regarding sex. Allyce indicated that her decisions in general are influenced heavily by her father. Even though she did not live with him as a child, she is very close to her father and emphasized that her relationship with him has shaped how she thinks about sex and men.

Although she is not currently in a "serious" relationship she did indicate that there is a man in her life with whom she is involved sexually. This relationship works for her because she enjoys being "independent" and she does not like "titles" (e.g., boyfriend, girlfriend). It is important to note that she does not see herself as any more at risk for contracting HIV or any other STI because she is not in a monogamous relationship. Allyce believes that "none of the girls in college are in a monogamous relationship, they just don't know it."

Shayla. Shayla is a 23-year-old African American woman. She was a junior in college at the time of her interview. Shayla described herself as "Afrocentric." She explained that she strives to be in touch with who she is regarding her connection to her ancestors. She is small in

stature, but her voice came across in a resounding roar when she stated, "I am who I am." "Take me or leave me" is Shayla's life motto. It is because of this stance that Shayla decided after her first sexual experience that she would not have sex again until she was married. She explained that something "clicked" inside her that said, "I think it has to be somebody that's worth it … and I haven't found anybody that I feel is worth it, not to be in a conceited … but just, I think it's [my body] a gift from God." She added, "if I'm going to share myself with someone, then it has to be the person for me."

Shayla explained that she is extremely disciplined and puts a tremendous amount of thought into all of the decisions she makes in her life including but not limited to sex. She was raised in a strict Roman Catholic home with her mother, father, and sister. She noted that the strict religious upbringing affected her in a positive way but had the opposite effect on her sister. Although she has made the decision not to have sex, she expressed deep concern about her sister's sexual decision making.

Peace. At the time of her interview, Peace, a 21-year-old college student, was enrolled at a community college in a southeastern metropolitan city. Peace described herself as "strong" and "intelligent." She was raised as a Baptist, but admitted she does not always follow the teachings she learned as a child. An only child raised in a single parent household, Peace indicated that she tries not to make decisions that could have a negative effect on her life. Additionally, her mother works very hard to send her to college, allowing her to live at home while she matriculates through school, and Peace does not want to disappoint her.

After taking some time to contemplate her sexual decision making Peace expressed that she has made some "stupid" decisions regarding how she has protected herself. Thinking about how many times she has put herself at risk she commented, "once I looked back on it, it's like

how -- how could I be so stupid…to make that decision without going through…without going through the right steps? It was just a stupid decision."

Peace expressed disappointment about some past sexual decisions, but seemed very proud of where she is now regarding her sexual decision making. "Now, I use condoms with everyone" she said in a very serious, no-nonsense voice, underscoring the change in her behavior.

Whitney. Whitney, a 19-year-old African American woman, was originally from Detroit, Michigan, and recently moved to attend college. She was a first-semester freshman at the time of her interview and expressed having had feelings of loneliness since she arrived and began school. She was slightly older than other freshmen because her mother kept her back in kindergarten. Since that time she has been a good student, and she is doing well in her current classes.

Although her demeanor was one of strength and self awareness, Whitney described herself as shy and a loner. She has not dated anyone since her move, but was involved in sexual relationships prior to leaving Detroit. Whitney admitted that she does not know her new friends well and stated, "I know that my friends have sex, but I don't know if they're having unprotected sex or with a condom or anything… I don't know whether or not or if they're being protected." She went on to say, "In my circle of friends, I think they make good decisions, but there may be some things that I don't know that they could be concealing … I don't want to be around people that make bad decisions."

Although she is unsure about the sexual decision making of her friends, she is very clear that her decisions regarding sex are well thought out and good. She acknowledged having made

some mistakes but said she is "confident that for the most part" she has made "very good decisions" regarding sex.

Tameka. Tameka, a 21-year-old receptionist at a dentist's office, was born and raised in a small southern U.S. city. Her mother, who has an Associate's degree in nursing, and her father, a postal worker, have worked very hard to provide for Tameka and her six siblings. Tameka completed high school and attended a small Christian school for college, but became pregnant and subsequently withdrew from the program.

A year and a half prior to our interview Tameka learned that she had lupus, which is "a chronic inflammatory disease that can affect various parts of the body, especially the skin, joints, blood, and kidneys" (www.lupus.com, p. 3). This disease has caused her significant pain and discomfort and has altered her appearance drastically. She noted, "I am twice the size I used to be. I'm like, three shades darker and my skin has gotten kinda weird. I'm just not pretty like I used to be."

Although prior to her diagnosis she had been sexually active, the physical changes, along with her desire to postpone any other sexual contact until marriage, significantly affected her decision making regarding sex. She stated, "I felt like it brought me closer to God by not having sex because I knew I was doing something wrong…I just stopped." She added, "it's like I don't have a desire to have sex right now and I feel like … it's something that you shouldn't do before you get married. I plan on marrying my boyfriend, and he understands and respects that."

Jordon. Jordon is an energetic, vivacious, young African American woman. She is 21 years old and described herself as an "artist" who expresses herself in many ways. She sings, writes poetry, acts, and aspires to one day be a professional dancer. According to Jordon, her best trait is that she is "eclectic" and talented in a variety of ways. Born and raised in Vallejo,

California, to two well-educated parents, Jordon described living in the southeast as "way different than home."

Regarding her sexual decisions, Jordon indicated that although she has had sex in the past she is not having sex right now. She spoke about her reason for this decision during our interview: "Right now, I don't think I'm at risk at all because I'm not having sex, but I was in a four-and-a-half-year relationship with my boyfriend or whatever and I lost my virginity to him." She also shared, "I had unprotected sex with him for four years, and then that's when I first got tested. I didn't have HIV, but I was still at risk because … he cheated on me and [the other young woman] ended up having a baby." After pausing for a moment and reflecting she uttered, "thank God, it was a baby and not a disease … It's just by God's grace that I didn't catch anything."

This experience changed Jordon's life in terms of how she thought about her risk and her peers being at risk for contracting HIV or other STIs. She indicated that though she has made the decision to refrain from having sex, it has not been easy. She proclaimed, "so, right now, I'm not having sex. Lord have mercy … It's rough!"

Lasha. Another California native, Lasha was born in Long Beach and moved to the southeast when she was entering middle school. At the time of her interview she was a high school senior and has since graduated. Lasha is the youngest child of three and the only girl. She was raised by her father and grandmother. Although she knew her mother, and had a relationship with her, it was strained due to her mother's battle with substance abuse.

When asked what she thought about the HIV/AIDS epidemic she said emphatically:

It scares me, it really scares me, like, that it's affecting me literally, a Black woman. It just scares me because, I mean, Black women, I mean we're special people and to know

that something like that is really killing us and to know that people know they're

affecting us, and they just don't care, you know, just scares me.

Lasha went on to say that the fear that she has about HIV shapes her sexual decisions. She is

"cautious" and "careful" when it comes to making decisions regarding sex.

Karen. Karen, a 21-year-old bartender, was born in Phoenix, Arizona, and raised in

Oklahoma City, Oklahoma. She is bi-racial, specifically, African American and Pilipino, and

although she has taken a few college courses, she has not made any decisions about her career.

She has decided to tend bar while she contemplates what she "really" wants to do. But in the

meantime, she is quite happy with her life.

Karen admitted that she does put herself at risk for contracting HIV more than she

should. She explained that she is not in a committed relationship, but she is "talking" to

someone. She defined talking as "hanging out with a guy that you're not totally locked down

to." She described a time where this put her in an at-risk situation:

…one guy in particular, in the beginning I thought it was just me. I found out that, okay,

it's not just me. Okay, so what do I do…I can't be mad because we're not together and,

you know, he knew that…I could do what I want and he's never said that, "Yeah, I had

sex with other girls." But I know he's dating other girls and he's a guy, so I know he's

having sex with other girls. I say that as long as he's having protected sex with me then

I'm fine. As long as I don't have any kind of unprotected contact, oral, or anything like

that, then I shouldn't have anything, but sometimes it's not always protected.

Karen expressed that she is "nervous" about every HIV test she has and does take her

sexual decisions seriously. However, it is her belief that nobody can be totally safe.

Stacy. Stacy is a 21-year-old college graduate. She is originally from Alabama and moved to Atlanta to attend college. Recently, she graduated with a Bachelor's degree in psychology and is preparing to return to school to pursue graduate studies. Stacy is well spoken and described herself as "cute" but "shy." In her family, Stacy is not the first to graduate from college, but there are few other family members who have done so. She feels blessed to have had the opportunity to attend college and is looking forward to attending graduate school.

Stacy takes sexual decision making very seriously and feels that more should be done in the area of prevention, especially on college campuses. When asked what she thought about prevention programs she attended in college she replied, "they mainly gave statistics. It was more geared towards African-Americans, so they gave statistics for…the African-American community." She went on to say, "Of course, they talked about ways to prevent it, by abstinence or regular condom usage. Uh, it was more like informational type seminars…They were kind of boring." Although Stacy personally feels she is knowledgeable regarding how to protect herself, she expressed deep concern about her peers stating, "Folks in college today are wild."

Johniece. A recent graduate at the time of our interview, Johniece was filling her days looking for a job as a teacher. She is a 21-year-old African American woman who describes herself as a "southern girl." When asked what a southern girl is Johniece explained humorously, "I'm beautiful, polite, and raised right." She used words such as "smart" and "religious" to describe herself, and said that she credits most of what she thinks about sex to her mother. She explained that her mother does not believe that a woman should have sex before marriage and though she has had sex outside of wedlock, she is trying to practice abstinence right now.

With a questioning tone in her voice Johniece said that when she stops to think about whether she should have sex with someone she wonders, "Like, is he a ho … is he worth me

risking, putting myself out there for an STD, for pregnancy, for anything, you know what I'm saying, that can come from this? Do I think that he…he's clean?" She went on to add, "I have to – first, have a relationship with this person before I do any type of activity with them. Not a boyfriend-girlfriend relationship, but I have to know them. I have to know their behavior, how he acts, how he thinks."

Johniece implied that she is very influenced by her mother's thoughts and opinions of her and wants to make her proud. She also expressed great relief that she made it through college without contracting HIV or any other STI.

Focus Group Interviews

The focus group participants were diverse in terms of age, education, place of birth, and parents' education. The participants' ages spanned 19 to 24 years. All identified as being Black and were born in various U.S. cities. Fourteen noted a Christian heritage, and only one indicated that she has no religious affiliation. All participants completed high school or obtained a GED, one had an Associate's degree, and six had obtained a Bachelor's degree. Although there were differences among the participants in terms of parents' education, all indicated that both parents had completed high school or obtained a GED except for two, who said they did not know their father's level of education or their father did not complete high school. All participants revealed they are heterosexual. Table 4.2 provides a summary of the focus group participants.

The three focus groups were conducted at different settings, and each group was composed of five participants. The first group was held in a private room at a public library, and all five participants were 22-year-old college graduates. The second group was very different from the first. It was convened in the meeting room of a college dormitory, and the participants

Table 4.2

Summary of Focus Group Participant Information

Participant	Gender	Age	Place of Birth	Religious Affiliation	Level of Education	Parents Education (Mother, Father)		Sexual Preference
*Sabrina Group 1	F	22	Miami, FL	Christian (AME)	Bachelor's degree	Bachelor's degree	Master's degree or higher	Heterosexual
*Andrea Group 1	F	22	Philadelphia, PA	Christian	Bachelor's degree	Bachelor's degree	High School	Heterosexual
Tykensie Group 1	F	22	Philadelphia,PA	Christian	Bachelor's degree	Associate's Degree	High School	Heterosexual
Maria Group 1	F	22	New Orleans, LA	Christian (Baptist)	Bachelor's degree	Bachelor's degree	Don't Know	Heterosexual
Sarah Group 1	F	22	Opelika, AL	Christian (Baptist)	Bachelor's degree	Bachelor's degree	Master's degree or higher	Heterosexual
*Allyce Group 2	F	22	Flint, MI	Christian (Baptist)	Some College	Master's degree or higher	High School	Heterosexual
*Karen Group 2	F	21	Oklahoma City, OK	Christian (Baptist)	High School	High School or GED	High School or GED	Heterosexual

Table 4.2 continued

Participant	Gender	Age	Place of Birth	Religious Affiliation	Level of Education	Parents Education (Mother, Father)		Sexual Preference
Angela Group 2	F	19	Los Angeles, CA	Christian (Baptist)	High School	High School or GED	High School or GED	Heterosexual
Marisol Group 2	F	20	Atlanta, GA	None	High School	Bachelor's degree	Don't Know	Heterosexual
Lilly Group 2	F	19	Atlanta, GA	Christian (AME)	High School	Associate's Degree	No Diploma	Heterosexual
*Stacy Group 3	F	21	Birmingham, AL	Christian	Bachelor's degree	Master's degree or higher	High School or GED	Heterosexual
Kimberly Group 3	F	23	Indianapolis, IN	Christian	Associate's degree	Some College	Don't Know	Heterosexual
Trisha Group 3	F	22	Durham, NC	Christian (Baptist)	High School	Master's degree or higher	High School or GED	Heterosexual
Michelle Group 3	F	23	Chicago, IL	Christian (Baptist)	Bachelor's degree	Bachelor's degree	Some College	Heterosexual
Ashley Group 3	F	24	Atlanta, GA	Christian	Bachelor's degree	High School or GED	Associate's degree	Heterosexual

participated in individual interviews and focus groups

ranged in age from 19 to 22 years. Lastly, the third group took place at a public library, and the

participants ranged in age from 21 to 24 years. All three meeting places were accessible by

Metro Atlanta Regional Transit Authority (MARTA), private, and quiet. The participants who

traveled to the meeting places by MARTA were given tokens for their commute.

<center>Overview of the Properties and Categories</center>

The purpose of this study was to explore Black women's sexual risk factors as well as the

factors that influence their sexual decision making. Data analysis revealed two categories in

regards to participants' understanding of HIV. Generally, they reported having basic

transmission information and key prevention information. Concerning perception of risk, two

categories emerged from data analysis. The participants perceived themselves to be at great

collective risk, but minimal individual risk regarding their exposure to HIV. Analysis revealed

two categories pertaining to major influences on the participants' decisions regarding sex. They

reported both internal and external influences as being important considerations in decisions

regarding sex.

When examining the intersection of race, class, and gender, in response to the question,

"How has the intersection of race, class, and gender affected Black women's perception of

power," two categories emerged when looking at the relationship to power and when exploring

their connectedness to sexual decision making. Participants reported that race, class, and gender

came together to increase their self efficacy and to promote personal power and responsibility.

When examining the same intersection regarding sexual risk, participants indicated that the

effects of slavery still permeate the Black community and influence sexual decision making.

They also indicated that media messages in popular culture are a major factor in the sexual risk

of young African American women. These categories and their associated properties can be

found in Table 4.3. It is important to note that three of the category and property titles were

extracted verbatim from the transcripts.

Table 4.3

Categories and Properties

Research Questions	Categories and Properties
What is the general understanding of HIV among Black women?	BASIC TRANSMISSION INFORMATION KEY PREVENTION INFORMATION
What are Black women's perceptions of HIV risk?	GREAT COLLECTIVE RISK Down low "brotha" "Everybody's just sex, sex, sex, sex, sex" MINIMAL INDIVIDUAL RISK
What influences Black women's sexual decision making?	INTERNAL INFLUENCES "Keeping the man" Attraction EXTERNAL INFLUENCES
How has the intersection of race, class, and gender affected Black women's perception of power?	INCREASES SELF EFFICACY PROMOTES PERSONAL RESPONSIBILITY
How has the intersection of race, class, and gender affected Black women's sexual risk?	"SLAVERY'S STILL GOT US" MEDIA MESSAGES IN POP CULTURE

General Understanding of HIV

In order to investigate what participants actually knew about HIV/AIDS, I asked a number of questions regarding what came to mind when they thought about HIV/AIDS, the prevention initiatives they had been a part of, and where they received information regarding HIV/AIDS. Participants' responses centered around two distinct themes: basic transmission information and key prevention information.

Basic Transmission Information

All participants reported having basic knowledge about how HIV is transmitted. Although they received information from a variety of places, they generally knew how HIV was contracted, how it affected one's body, and the fact that there is currently no cure. Comments from Chloe, a 23-year-old young woman from rural Georgia, aptly reflect participants' basic knowledge of HIV transmission:

> I know it's a disease that is deadly. There's not a cure. Um, they're working on a vaccination but have not found one … you pretty much get it from either drug use or needle sharing, or playing risky sexual behavior.

Johneice, a 21-year-old college graduate, also captured the knowledge of the participants when she stated, "this is a disease that is rapidly growing and you can get HIV through sex, sharing needles, needles and syringes." She further explained, "you can't get it from like shaking hands with a person who has HIV or by sitting on a toilet right after someone who had HIV … but you have to be careful with sex and drugs and stuff." Additionally Essence, who has been personally affected by the HIV/AIDS epidemic, explained, "it is deadly, and if folks use condoms and don't do drugs nobody new would get it."

Although participants communicated a similar understanding of HIV, they discussed it from both a transmission and prevalence perspective. For example, Sabrina, a well-educated biology major, in sharing her thoughts about HIV and the knowledge she had regarding it, emphasized that it is a "Black disease." Others such as Shayla, "an afrocentric sistah," discussed the notion of African Americans being disproportionately affected by the disease. When she thought about HIV, she considered her own mortality and that of other African American women, as the following remark illustrates: "I just think any of us could get it, as long as you're having sex, even people who are married." She went on to note: "the only Black women who are safe are like nuns, or people who [are] just not having sex." Like Shayla, Peace, who described herself as "strong" and "intelligent," also discussed abstinence and HIV/STD prevalence among African Americans:

> Abstinence is the best way to prevent yourself from getting, um, the disease, but if not abstinence then condoms, having one sexual partner, getting tested regularly, making sure that this partner isn't having sex with Jane and whoever else...
>
> It's a disease that affects the immune system and it is a STD that's on the rise in the African American population … it's a very deadly disease. There's no cure for the disease and right now African Americans are at the top of the chart when it comes to HIV.

Expressing the same sentiment, Lasha, one of the youngest participants, commented "when I think of HIV, I think of Black women." She went on to note, "they say it's an epidemic."

Like Shayla, Peace, and Lasha many participants focused solely on their knowledge of HIV transmission and prevalence in the Black community, but a number of them expanded their

discussion to include an understanding of AIDS and its relation to HIV. Karen, for one, who is

bi-racial and of African American and Pilipino descent, stated:

> HIV or AIDS, I just think that HIV is a disease that you can catch it as easily as any
>
> STD…So, it just scares me when someone says HIV or AIDS, and I know HIV leads to
>
> AIDS, and AIDS leads to death. There's no cure. I know it's sexually transmitted or you
>
> can…get it by sharing needles, any transfer of bodily fluids, or blood, or anything like …
>
> not kissing, but any blood transferred or having unprotected sex, things like that.

Like Karen, Jordon, who is a singer, poet, and dancer, connected HIV to AIDS in her discussion

of what she knew, and she shared her opinions about its effect on Black women. She remarked,

"I know AIDS is when you have the full-blown disease and there's absolutely no cure, and I

know with HIV, that's like the beginning stages of AIDS." She added, "It's sad … and it makes

me mad Black women are getting it more than anyone else."

As she discussed what she knew about AIDS, BB, who described herself as "tough and

strong," revealed her knowledge about some of the changes in appearance people infected with

the disease might face. She explained that they could appear "skinny, look sickly, their eyes

might start drawing dark around." Essence, whose father died of a complication related to AIDS

when she was a child, also talked about a change in appearance in those living with HIV/AIDS.

With tears in her eyes as she recalled her father's physical state toward the end of his life she

said, "he was really skinny and broken looking and his eyes got real big cause the skin kinda

drooped." She went on to note, "he had kidney failure, but his kidneys failed because of – he

had, you know, full blown AIDS."

One might assume that Essence would be more knowledgeable than others because she

had a family member who died of AIDS, however, she described what she knew about HIV and

AIDS as "the basics": "Everybody knows the basics, it don't stop them from doing anything, but they know." BB also referred to her knowledge regarding HIV and AIDS as "basic." She explained that "anybody who has ever taken a health class knows the basics, and hell, that's pretty much everybody."

Interestingly, all participants with the exception of one, Stacy, were emphatic with regard to what they knew about HIV/AIDS. They spoke with conviction and confidence about their understanding of HIV/AIDS transmission, its prevalence in the African American community, and trainings in which they had participated. Stacy, however, despite being a 21-year-old college graduate whom many would expect to be knowledgeable about HIV/AIDS information, expressed uncertainty related to whether or not there was a cure for HIV. She commented:

> Um, I know that HIV is, like, a precursor to AIDS. You have HIV before you have AIDS. Um, I believe if caught early enough and treatment is received that HIV -- that AIDS can either be prolonged. I'm not sure if it can be cured, but I know it can be prolonged … It breaks down your immune system, making any illness that you do have after that, even the common cold, could be life threatening.

Key Prevention Information

All participants in both the individual and group interviews underscored the availability of prevention information. Twenty (eleven individual interview participants and nine focus group participants) specifically reported having attended or having been part of a prevention initiative. The remaining five received prevention information pertaining to HIV/AIDS from the Internet, health classes, pamphlets, parents, or television programming. Essence, for example, reported that some of her information regarding HIV prevention was gleaned from the media, whereas Karen noted that she'd "read about it on the Internet."

Participants who were individually interviewed indicated that information regarding HIV prevention had been readily available to them. According to Lilly, "it's everywhere, clinics, college campuses, health centers, you name it." Stacy shared that much of her prevention information came from counseling sessions at the women's clinic after being tested. It is interesting to note that Stacy, in addition to being the one participant who confessed uncertainty regarding her knowledge of HIV/AIDS, was also was the only participant who mentioned being tested for HIV. According to Stacy, the information she received during the post-test counseling sessions was invaluable:

> Every time I get checked, I always get briefed on HIV and AIDS. So, of course, they talked about ways to prevent it, by abstinence or regular condom usage. They talk a lot, and you know when you are at the testing place the information is right [correct].

Like those individually interviewed, focus group participants also noted that HIV/AIDS prevention information was easily accessible. Participants in two of the three focus groups agreed that information regarding transmission was readily available in many of the places they utilized for education or health purposes. Both Lasha and Whitney, who were the youngest participants, specifically referenced the availability of prevention information in their high schools, and reported that on at least one occasion they had been involved in an HIV prevention initiative while in school. It should be noted that the first focus group, comprised of five college graduates, did not report having access to prevention information in these places.

Although participants reported the accessibility of prevention information through a number of sources, some stated that they had been given the opportunity to participate in trainings or outreach initiatives that were focused on HIV prevention education. They described being involved in specific prevention initiatives, and noted that they learned about HIV/AIDS

and prevention through their participation. BB described an initiative that she was a part of in detail:

> It was like a year and a half long … Actually, it was called Afiya Strength and Health at Emory … it was basically a sex education class, but they did focus on HIV and AIDS. They basically tried to get – tried to persuade us to be abstinent, giving us other alternatives and – and trying to teach us if we are going to have sex, the best ways to do it. They gave us condoms and stuff.

Andrea, too, was a part of a health initiative that included information regarding HIV/AIDS prevention:

> Um, my sophomore year I did something called SHAPE, which is the acronym for Student Health Associates and Peer Educators. So basically what we did was, um, like, there's … there's, um, different sectors of the organization, but, um, so I think it's like informative health, chronic illnesses, um, what else? I don't know, but HIV and STDs is one. So we had to have training, on that. I was in that committee, but everybody had to do the training. So, that's probably about it as far as being informed. Oh, and we got condoms and learned how to use them.

Like BB and Andrea, Shayla reported being involved in a formal prevention initiative. She was trained and certified to teach peers about HIV and STD prevention. She explained that she "went to a workshop at Morehouse School of Medicine and following a course for the day they gave certificates." She went on to say, "It allows me to teach my peers or younger people, you know, the gist of STDs and AIDS." It is important to note that among the participants who had been involved in formal prevention initiatives, most are college educated, suggesting that access to prevention programming is more readily available on college campuses.

In addition to media and prevention initiatives, many of the participants reported being educated about HIV prevention from their parents, specifically their mothers. Lilly noted that when she was 12 years old her mother discussed the facts about HIV and AIDS with her after the death of a family friend. She stated, "like my mom started teaching me about HIV and AIDS, but her friend who died was gay so, I guess, she did make it sound like it was a gay thing." Essence recalled, "My mom didn't tell me my dad had AIDS until he was dead, then she told me what AIDS was and that he had it, and that I needed to protect myself from it. I was only like 10 then, though." Essence also noted, "I think she didn't tell me because he was gay or down low or whatever, 'cause I know he didn't use drugs. We don't talk about that though."

Some participants shared that information they received from their parents regarding HIV and AIDS was intended to scare them. For example, Marisol, the oldest of four sisters who grew up in public housing and in a home headed by her grandmother, stated, "I had been getting into trouble with boys and what not, and my mom was like you better use a condom 'cause AIDS and stuff kills." Tykensie, a focus group member, received a similar message from her mother: "If you keep being fast you gon get HIV from one of those dirty boys. You better wear a rubber."

Whether they obtained information through the media, formal prevention initiatives, or from parents, participants knew a great deal about HIV prevention. Essence's matter-of-fact remark clearly captured this knowledge:

I know how to use a condom, how to put on a condom. I know about sex and about, uhm, about our sex drive and things like that, how to prevent HIV and ways to contract it.

Like it's abstinence first, then condoms is the next best thing, and don't use drugs.

In short, all of the participants described methods of prevention differently but they consistently referred to abstinence and condom usage as their main methods of prevention.

Although Sabrina, like other participants, noted abstinence and condom usage when discussing HIV prevention, the central point she made differed from other participants in that she was emphatic that the most important aspect of prevention is awareness. Her passion is reflected in her statement:

> You know, awareness for … awareness for everyone, really, but more specifically African Americans, Hispanics, people like that. The minority communities that are seeming to be on the rise, you know, seem to be contracting the disease because obviously there is probably some type of miscommunication. Prevention starts in those communities. Awareness is the best prevention. If you know better, you can do better.

In summary, participants evidenced having a general knowledge of HIV and AIDS, including what they are, and how HIV is both transmitted and prevented. They also seemed well informed about how to protect themselves from contracting HIV and were concerned about its spread within the African American female community.

<div align="center">Perceptions of Risk</div>

Participants' responses to questions designed to examine their perceptions of HIV/AIDS related risk were quite similar. It was evident that they perceived themselves to be at great collective risk. They expressed repeatedly that Black women are at high risk for contracting HIV/AIDS, and for a variety of reasons. Conversely, the participants did not see themselves as being at great individual risk. Specifically, they did not view themselves as affected in any significant way by the risk impacting their larger community.

Great Collective Risk

Most of the participants agreed that Black women are at high risk for contracting HIV. BB immediately said, "a lot of Black women are becoming exposed to it." Chloe's comments

were similar to BB's, as revealed in this statement: "Um, well, statistically they say that…African American women are the ones who have, like, AIDS and things. I guess when you first said that, my first instinct was thinking of the African American woman." BB and Chloe's comments were only two examples of participants' perceptions in this regard. In fact, when asked to describe a person with HIV, an overwhelming majority, all except three, indicated that their first thought was "a Black woman," a response that some might find surprising. Interestingly, the three women who did not indicate that an African American woman was he first person to come to mind identified the down low "brotha."

The theme "great collective risk" has two dimensions which include the down low "brotha" and "Everybody's just sex, sex, sex, sex, sex," which denotes promiscuity among the participants and/or their peers. These two dimensions are discussed below.

Down lo "brotha." The issue of the down low "brotha" was mentioned by every participant in both the individual interviews and the focus groups. The young women spoke passionately about this phenomenon and how they feel it is putting Black women at risk. Sabrina's statement is an example of the sentiments expressed by all:

> Just how, um, how the alarming rate that they are contracting it and I think about … the whole undercover brother phenomenon … because we have our African American male counterparts sleeping with, you know, straight or homosexual African American males and not telling their African American female counterparts and therefore … you have this vicious cycle where she's probably sleeping with this man thinking that, you know, they're in a heterosexual relationship and … they're really not, you know, so to speak and … the disease is being passed along that way. It's becoming a lot more prevalent now.

So, that issue, that really comes to my mind, too, because this is one of the main ways that African American women are contracting the disease.

Andrea, a member of the first focus group, articulated the same feelings shared by Sabrina and others, but in her statement she underscored the issue of trust regarding the down low "brotha" phenomenon:

Down low, whatever you want to call them, but they're definitely here. I'm sure they are other places, but it's just very strong here, I would say. And, like, I've even had some friends where their boyfriend that they were with for, like, a year or maybe longer, um, and they were sexually active with, come to find out, um, he was gay, and he had been with guys while they were together. So, I mean, it's out there. It's real, because, you know, I have a friend that experienced it.

The issue of trust is not the only one Andrea addressed. She also shared thoughts about the problem of denial among Black women, including their inability to see male counterparts as being on the down low. Her beliefs are illustrated in the following statement:

So, um, just that fact that, you know, guys are out there with other males and whether they're using protection or not, just the fact that they're out there and then they come back and then they're with these females and they're not, you know, saying that they're with guys. They're not about to tell the girl that they, you know, were with a guy. I think that…that makes Black females even more at risk 'cause they don't even realize that they are at such a risk. They don't think that the guy that they're with is out here with these other guys.

When participants were asked if they had been involved with anyone on the down low or if they knew of anyone who had, all except one emphatically replied "no." Only Allyce

suggested she did not know and shared that the phenomenon had not become real to her until only recently, when she had seen someone she knew in a store where sex paraphernalia was sold. She explained the situation during her individual interview and though the incident had taken place months prior to our meeting, she still seemed to be in a state of shock as she explained:

>That's – that's the first thing that comes to mind because, it's kind of like… I think that's one of the main reasons that HIV has really escalated in African American women and I honestly and truly believe that the d-l-brother, the down low brother…I think that these men are really out here in this homosexual world and they're bringing STDs, AIDS, HIV, all of them, back to their wives and girlfriends and not educating them on what they're doing. And, I've seen instances, like, in Atlanta, like - Insurrection? The sex store? Guys meet there. Like, they park on the side, and I – I wasn't paying any attention to it. Somebody else brought it to my attention, because they know somebody that knows it – and they – they meet on the side of Insurrection and they'll pull up and they'll exchange cards and they leave and they come back, and I didn't notice it until I saw somebody who I knew from the neighborhood there and I was, like, wow, this is for real, and then they go home to their wives and they just out here and they're – they're bringing it back to their homes and their girlfriends and just don't let them know what they're doing.

It is interesting to note that although all of the participants expressed concern that there are men in their community that identify as heterosexual yet participate in homosexual activity, they were unwilling to entertain the idea that they had ever been involved sexually with anyone who could have been identified as a down low "brotha." It is fitting to note at this point, and it will be further addressed when participants' individual risk is discussed.

Although neither expressed being involved with a down low "brotha," both Jordon and Shayla attributed the phenomenon to homophobia in the Black community. Jordon suggested that Black men should just "say who they are." She went on to add:

Okay, as far as, like, what I know now, since a lot of Black men are on the down low, I mean there are women who are on the DL, too, but a lot of Black men are on the down low or whatever and they're catching it from other, you know, other gay men or whatever. And Black men are too afraid. Their pride is too good too [sigh] to let somebody know, "Look, this is how I really am," but you know White people, they tell it like it is: "Hi, I'm gay, or take it or leave it." You know what I'm saying? Or "honey I don't want you anymore, I want him." But Black people, we just, we shy away from stuff. We even do that with our heritage, you know what I'm saying?

Although Shayla agreed with Jordon, she suggested that coming out for a Black man is not easy:

We have a lot of people … who are on down low and so that's another mode of contracting the disease. I mean women are, particularly African American women, are really at risk because it's grown real rampant in our communities cause we don't do gays. If you're gay you can't tell anybody. You just have to fake it.

It should be noted that of all of the participants only Shayla and Stacy discussed the issue of the down low "brotha" being linked to homophobia in the African American community. Stacy, similarly to Shayla, indicated that "if people could just be who they were, we wouldn't have all of this deceit." She went on to add, "even if they are screwing dudes it's on us to not be blind and protect ourselves. If we stop having sex with every Tom, Dick, and Harry we wouldn't have to worry about any of this."

"Everybody's just sex, sex, sex, sex, sex." As was the case with the down low "brotha," the issue of heterosexual promiscuity was also mentioned by all of the participants. Many reported having sex with men whom they knew were having sex with other women. They also reported a collective inability to trust men because they are "out there" having sex with "every and anybody," as Whitney so poignantly put it. Allyce, whose words were adopted for the name of this property, remarked:

> I think it's – I think it's sad. I think – I think it's really sad and I really think that we need to evaluate ourselves and our lifestyles, because it would be different if the fact of the matter was a particular group of African American females, maybe in this region, or maybe in that region, you know, but it's across the board. So, it's something that we're doing wrong or it's something that we're allowing to be done to us that's putting us out there like that, and I really think that it just goes back to – to men and to allowing – I think that it's – I think it's when a lot of women put their trust in a man as far him saying, "you're the only person I'm having sex with." 'Cause, you have some women that have a sexual partner and, originally, their sex partner didn't have it [HIV], but somewhere along the line, they got it and then gave it to their mate. So, it's kind of, like, you're putting your trust into this person and, you know, your mate may be saying, "You're the only person I'm having sex with," or "I use a condom all the time," and that's not always the case. So, I really think we need to evaluate ourselves and we need to evaluate what we're allowing other people to do to us.

Although Allyce suggested the issue of promiscuity is a matter for Black women generally, many of the women discussed being concerned about whether or not their friends, not themselves, were at risk or had contracted HIV because of promiscuous behavior. Chloe spoke

with concern when she shared the experiences of a friend: "Well, she went abroad, to Africa specifically, and, you know, was real promiscuous there, and, um, you know, she's promiscuous here, and so, you know, I just don't think she always takes care of herself. She went on to add, "I know she's had an STD in the past…like an incurable STD. It concerns me that she is still all wild and stuff."

BB, on the other hand, expressed that although she is not concerned about her friends she does have associates, whom she defines as "people I kick it with," whose behaviors cause her concern. With a tone of disappointment in her voice she commented:

> My immediate friends, I don't consider them at risk at all because we are kind of all in the same boat, but some of the people I be talking to, sometimes when we be having conversations just based on their actions, what they be telling me, it don't necessarily be like, "okay, you're at risk for HIV," but HIV falls in the category of the stuff that they're, like getting pregnant or whatever. Plus I swear, people be having sex with everybody! Good God!

It is interesting to note that BB was the only participant who brought up pregnancy in the context of our discussion. Other participants talked about Sexually Transmitted Infections (STIs), but no other participant mentioned pregnancy.

STIs were a definite concern for Essence, a college student, whose experience supported the comments of other participants. She felt that "everybody is talking about sex and drugs and partying. You are very at risk because just the Atlanta University Center itself has a high STD rate." Essence went on to tell a story about a friend, which supports her opinion of her college environment:

I have a home girl who, in the last…in the last semester, like from Christmas to now, has had, like, six new sex partners, all of which she works with, all of which, you know what I'm saying, she…she don't even know these people for real, for real; don't know what they were doing before she met them and she used condoms with most of them, but not the whole six. So, you out here having sex with this person, you not making them, you know, put on a condom, you don't know who they were with before you, you don't know what they're doing now because you're not in a relationship with this person, so it's no trust. Like, he has no reason to be faithful to you because y'all not in a relationship, y'all just having casual sex.

Allyce, Sabrina, and Andrea shared views similar to the one stated by Essence, agreeing that sex is everywhere for college students. Allyce shared the perception that, "it's even worse when you're Greek. Guys just want to bed you because you're a Delta or an AKA." She went on to add, "girls are just as bad, though, because they will have sex with a guy just 'cause he's a Q-Dog [Omega] or an Alpha or Kappa. People are just crazy as hell in school."

In sharing their opinions about college students and sex, Sabrina and Andrea discussed the irony that they, as college students and graduates, are regarded as the "talented tenth" yet do not protect themselves. Sabrina pointedly noted with unease: "If those of us who are educated don't protect ourselves, what can we expect from other Black women?" Andrea articulated a similar sentiment remarking, "it's crazy 'cause we know what AIDS is, we know all about it and we still make dumb decisions. I don't know what it's going to take." The 13 participants who were college students or graduates expressed some level of worry about sexual behavior on college campuses -- both their own and that of their peers.

Although all of the participants articulated concerns pertaining to sexual promiscuity and their high level of collective risk, Lasha, in particular, seemed deeply affected by their collective promiscuous behavior. With mounting anger in her voice she said:

> They're at risk, yeah, and sometimes, I want to ask, like, can you ask the guy, um, to take a test or has he taken a test. But, I know that's bogus and nobody's going to answer. But a lot of them are, like -- I, gosh, there's some people that are way open, just too open. Like, um, they're -- they're not consistent with one sexual partner. They hop, like just for the fun, just for the hell of it. It's just, I mean, it's for that moment to get the thrill and end up just having sex and then -- I mean, granted nothing's happened yet to what we know, to our knowledge, but one day, I'm sure one of my friends or somebody…I mean, it's almost bound to happen.

Like Lasha, participants were quite willing to discuss their concerns regarding collective risk related to HIV/AIDS, but were unwilling to see themselves as being at individual risk for contracting HIV/AIDS. This is further explored in the following section.

Minimal Individual Risk

Although participants were virtually unanimous (24 of 25) in their belief that African American women were at great collective risk only a small majority (16) acknowledged individual risk. They held to this belief despite reporting having had sex with men they were not in monogamous relationships with, occasionally not using condoms, as well as having had sex with partners they knew were sexually promiscuous in the past. In short, they did not see themselves as being "at risk" for contracting HIV. Andrea, for one, stated with certainty that she was not at risk because she was using condoms with the partner she was currently having sex with. She remarked:

Um, I mean, I mean, I would say I'm not at risk but you never know… But as far as, you know, I'm not going to get it through sexual, um, you know, anything sexual 'cause I'm using condoms right now, or I have been for a while. But, um, and I mean, so right now I would say I'm not at risk, but, I mean, that could change. You never know.

Other participants also shared that they did not see themselves as being at risk based on the fact that they were currently using condoms with their partners. Interestingly, Karen stated that even though she was sexually involved with more than one person and she knew at least one of those persons was sexually active with other women, because she used condoms, she was not at risk. She was not alone in her unwillingness to see herself as being at risk. Peace echoed this belief stating, "I am not at risk, I try to use condoms all the time and the times when I didn't it was with a boyfriend that I had a long time." She added, "I think a lot of people are at risk 'cause they don't know who they're sleeping with, but that is not me. I get to know a person before I even think about laying it down." Much like Peace, Marisol stated:

I know a lot of people who are at risk for a lot of things like AIDS and getting pregnant and stuff, but that is not me because I don't get down with no dirty folks. People will have sex with people who they know are having sex with every and anybody and they expect to not get anything. That is unrealistic. I am picky about who I would even consider having sex with. So, I know I ain't gon' get nothin' but some girls just don't think. They trust dudes too much.

Many participants based their perception of minimal personal risk on belief or trust in their partner. They expressed a feeling of trust in their male partner that allowed them to feel confident that they were not putting themselves at risk for contracting HIV. For example, Chloe expressed a level of confidence that her partner was being truthful when he indicated he was not

participating in any behavior that would put her at risk. This made her feel comfortable with her partner not using condoms when they had sex. In a shy voice, as though she thought I might disapprove, she admitted:

> Um, I mean I don't always do what I need to do but, I mean, I feel like I don't use drugs, you know. I don't always use a condom but I feel pretty confident with my partner. We have talked about it, so we don't really, you know, I don't feel like I'm at risk.

Peace similarly shared, "My boyfriend and I have been together for over a year so we don't use condoms anymore, but I trust him." She added, "I know that AIDS is real and stuff, but you have to trust somebody. What kind of life is it if you can't trust anyone? That is crazy."

Other participants indicated that if people were in a committed relationship it was okay to not use condoms. Johniece, who stated she was in a committed relationship, admitted that she does not always use condoms but does not consider herself to be at risk:

> I would say, I'm not – I'm not – I'm not at a really high risk and I say that because I always use protection when I have sex. Even though there is a chance that, you know, condoms can break, but I always use condoms before I even…with the exception of the last person I had sex with [her boyfriend], every person, when we get ready to say, "Okay, we're going to start having sex," like, I go get tested with them.

When asked why the last person she had sex with was treated differently than other partners she simply said, "it just happened, you know sometimes it just goes down like that." Johniece is not an anomaly among the participants. The majority did not consider themselves as being at risk even though they talked about having participated in risky sexual behaviors on one or more occasions. In short, the participants acknowledged a collective risk for contracting HIV among Black women but were unable to see themselves as being at risk.

Influences on Sexual Decision Making

A series of probing questions were asked in an effort to explore what influenced the

sexual decisions of participants. Although they mentioned a number of considerations, a

preponderance of data indicated that both internal and external influences weighed heavily in

their decisions.

Internal Influences

For the purpose of this study internal influences are considerations that emanate from

within the participants. Participants articulated these influences as self esteem, self worth, or

various types of attraction, but the common thread is that these influences originated within

participants. The respondents discussed the issue of self esteem within the context of their own

reflective assessment as well as in regard to their ability to "keep the man." The category of

internal influences has two dimensions: "keeping the man" and attraction.

"Keeping the man." The name of this property is used to denote an inner desire by

participants to maintain their relationships. It indicates a yearning to "keep the man" at all costs.

During her interview Chloe, whose words were used to name this property, spoke about not

feeling "confident" with regard to men. She explained that she always questions if she has what

it takes to "keep the man." Although our discussion was lengthy her brief statement below

concisely illustrates her self reflection:

> Self esteem issues that I have with myself that I have to work out ... I mean … you just
>
> always want to feel pretty enough and, and smart enough, and sexy enough and … just
>
> want to … really fit … you just want to be accepted and sometimes you do things just to
>
> get … gain that acceptance of the other person, so he'll stay with you.

Chloe's sentiment was repeated by a number of participants who used phrases such as "I don't want to be alone" and "I have to meet their [male partners'] needs" to describe their thoughts about their relationships, especially in moments of reflection regarding sexual decision making.

Participants also commented on the self esteem of their peers. For example Marisol, who was solely a focus group participant, remarked that she was saddened by many of the decisions her friends made. All of the other members of her focus group agreed with her regarding the poor self esteem they have witnessed among their peers. Marisol stated:

It maybe is not, like, their self esteem issue but it's some internal issue that you have that would cause you to do whatever you do, and whether it's … lack of something and you're looking to fulfill it and you feel like you can fulfill that through sex or whatever, or you're just, you have something and then you want to give it, and you feel like you can give it through sex. Regardless, you're not whole.

Four members of her focus group affirmed Marisol's declaration with remarks such as "Yeah that's true," "You got it," and "You ain't neva lied." After Marisol's aforementioned statement, Lilly noted, "It's weird, you know. No matter how strong you are or how tough, everybody wants to get old with somebody. And, everybody wants to have that one person." She went on to say, "that's why girls sometimes do crazy stuff, they don't want to look up and their man is gone and with some other girl."

Other participants also made reference to being concerned about the self esteem of their peers as well as how their peers "see" themselves. Lasha stated, "everybody wants to be the prettiest and the one all the guys want." Andrea offered her opinion about both herself and her peers:

I feel like a lot of my friends, there are self esteem issues, you know, which we all have different ones … It's not just appearance. It's just different types of issues that we have and that we are all looking for this ideal man who's going to sweep us off our feet, and life's not like that. I feel like sometimes we get caught up in that whole hype of just this romantic fairy tale and we feel that, you know, if we go ahead and sleep with them whether we've gotten to know them, known them for 10 years, or 5 years, or however long … then you're expecting this big return and then you don't get that return. So, you are disappointed. You feel guilty, you feel whatever, but you still find yourself in that same place, by yourself. Most of us will graduate and still be alone after all this sex.

Andrea's reference to being alone was mirrored by most of the participants. Both Sabrina and Stacy mentioned in their individual interviews, "Nobody wants to be alone." Sabrina also added, "I think already, if I graduate and I haven't found a husband I'll never find one. That means I have to study, make friends, and find a man while I am here."

All of the college participants (five) and recent graduates (eight) shared Sabrina's sentiments. Stacy, for example, expressed nervousness about the fact that she had graduated and did not have a "steady boyfriend." She said:

My mom tells me now that the pool just got cut in half. Once you leave school, where do you go to find an educated Black man? Plus, when you find him every other Black woman's going to be trying to get with him, too.

Michelle and Ashley, two other recent graduates who also noted the difficulty in finding a partner post graduation, shared their thoughts regarding what women will do to maintain a relationship. Michelle stated:

It's not a joke. Since I got out of school I just, straight up, see less men. I mean at school you see guys everyday, everywhere, but after you graduate you don't see them. You see the people at work and you see a lot of guys at clubs and happy hour, but that isn't where you want to go to pick up a man. It's hard out here. It is bad to say but really it's like, once you get one you're not trying to let him go. For some people that might mean making some decisions that put them at risk, but they don't see it that way.

Ashley, who was a member of the same focus group in which Michelle participated, also discussed her thoughts with the group. She noted:

I mean it does sound bad when we talk about it but it is a reality. If it is important to you to have a man you have to trust that he won't do anything to have you end up with something [STIs or HIV/AIDS]. I mean you can't get into every relationship and think he's going to give you AIDS. You'll never get a man if you go at it like that.

Participants who were not in college or recent graduates also talked about the shrinking pool of African American men from which they had to choose.

Many participants indicated that they did not know where to find a "good man." Karen and Angela both shared their thoughts regarding what Karen referred to as "a needle in a hay stack." Karen remarked:

All the Black men are gay, in jail, or jobless and the ones who are not, well, everybody wants them so they end up being hoes. It's like, the men who look the best to a chick are the ones with a girl 'cause they know he's cool with having a girl. It's almost like, you can't win for losing. You either can't find a man worth having or everybody wants your man. That's why you have to try so hard to keep yours because there is always somebody out there who will take him if you let them.

Karen added, "Personally, I don't think it has anything to do with self esteem, it's just a reality. You gotta do what you gotta do if you want to keep him with you." Like Karen, Angela reported, "I know girls do things sometimes that they shouldn't because inside something is telling them this one is good, don't let him get away." She also noted, "if it is low self esteem then we all have it because I don't know anybody who just wants to be alone."

Among the participants there seemed to be a consensus regarding the importance of finding and keeping a man, especially "a good man." Interestingly, although participants expressed a fear of being alone, very few made reference to their own self esteem. Their discussion centered primarily on the self esteem of their peers.

Attraction. Along with self esteem, attraction also emerged during analysis as a major internal influence in sexual decision making. Participants described different types of attraction including physical, emotional, and sexual attraction. Although all of the participants mentioned the fact that before having sex with someone they must be attracted to him, only one, Stacy, acknowledged that it is a major influence in her sexual decision making. In fact, she described it as the most salient factor:

> A lot goes into my decision, I guess, like, based on what they tell me. You know, you can't really go off what someone tells you but that's really all you know about someone is what they tell you. So from what I can gather from that person, how clean or healthy I think they might be, um, and I guess attraction would be one of them … 'cause attraction is the biggest factor when you're having sex with someone.

Although Stacy was the only participant who said attraction was highest on her list of considerations when making sexual decisions regarding safe sex, all of the participants made reference to attraction as being important. For instance, Johneice emphasized that attraction

plays a "big role" in her decision making. She stated, "You also have to take attraction into consideration. It is not everything but it is something." Sabrina and Allyce also reported that attraction influenced their sexual decision making. Sabrina noted, "I can't have sex with anyone I am not attracted to. I don't know how anyone has sex if there is no attraction." Similarly, Allyce remarked:

> There is no sex without attraction. Anyone who doesn't say attraction plays a part in figuring out if you should have sex with someone or not is lying. I mean you have to think about a lot of things but attraction is big. Nobody is going to have sex with anyone they're not attracted to … Well, I know I'm not. We have to be vibing in some kind of way.

Other participants specifically noted the importance of "physical attraction." Peace emphasized, "I know we should be thinking about other things, but I mean you can't pretend the physical isn't there. It is important to feel a pull or connection to a person." Both Johneice and Shayla expressed, "there has to be physical attraction." BB's statement regarding this provides a vivid example of the sentiments shared by others. She stated, "Whatever you call it, a connection, chemistry, attraction, a heat, it is something and when you have it with someone it is hard as hell to control." She went on to add, "we act like the physical is nothing, but it is something if you feel it and you got all that other relationship stuff in your head too … it is hard to just say no to that."

As BB noted, a number of words can be used to express attraction. Lilly and Tykensie discussed attraction in the same way as other participants, but they used the word "emotion" to denote the feelings of attraction expressed by others. In the following statement, Lilly described how her emotions dictate her decisions:

A lot of females I know personally, like myself, everything is based out of the emotion. Like, it's nothing else. I mean, attraction, emotion, it does play a factor … like, in my one decision in my whole life, it was based off emotion. It wasn't anything else.

Also using the word "emotion" to describe the internal influence that affects her sexual decision making, Tykensie stated:

I am lead by my emotions, especially when it comes to guys … I mean I have to be emotionally connected to them. Our spirits have to blend and we have to connect on an emotional level before I consider having sex. It's all about the emotion and the connection.

Rather than physical or emotional, Andrea indicated that sexual attraction must exist before she considers a sexual encounter. With an intense gaze and a tone that exuded confidence, she stated:

Um, I guess of course there has to be some type of sexual attraction there. Um, you know, I'm just not going to hook up with somebody that I'm not sexually attracted to.

It is important to note that all of the participants discussed attraction and expressed that it played some role in their sexual decision making. While the degree to which attraction influenced their decisions varied, it is significant to note that they were all influenced by it in some way.

External Influences

Participants also expressed being affected by external influences when making sexual decisions. Religious upbringing and parental values were repeatedly identified as two factors that influenced their sexual decisions. Specifically, participants talked about not wanting to get pregnant and being a disappointment to their parents. Essence humorously underscored this point when she remarked in a matter-of-fact manner, "my mother would kick my ass, forget

AIDS, have you met my momma?" Absent the drama, other participants stressed the role their

religious beliefs and upbringing played in their decisions regarding sex. The scope of external

influences in sexual decision making is detailed below.

All but one participant indicated some religious affiliation. The effects of these

affiliations on sexual attitudes and behaviors were examined in both individual interviews and

focus groups. Many participants distinguished religious upbringing from parental values, but

some intermingled the two as they explained their influences on sexual decision making. A

majority of the participants indicated that while they maintain membership in a religious

organization and had a religious upbringing, it was their parents' religious teachings that most

greatly influenced their sexual decision making. For example, Johniece stated:

> Some religions where you wait until you [are] married to have sex, and it's – one person,
>
> one lady, she believes that, and she holds that to her heart dearly. Me, I believe it, but it
>
> ain't really that deep, you know. I mostly think about it 'cause that's how I was raised
>
> [by my parents].

Of the 24 participants who mentioned some religious affiliation, all indicated that it influenced

their sexual decisions, but only Andrea said it was the number one influence guiding her life.

She stated:

> I follow the teachings of the Lord and that means I don't fornicate. It isn't like I haven't
>
> before. I have sinned in a lot of ways, but I try not to. I try to put God first and let him
>
> be the number one guiding thing in my life.

Andrea also added:

> I don't believe, like, I don't believe in casual sex. So for me I'm not going to have
>
> sex…first of all, I'm religious. So, like, I don't even think I should be having sex, first of

all, and when I do, I feel bad afterwards, in some shape or form. But, like, I mean, I'm human.   I don't know if it's like my moral standard or, like, my values, I don't know, but I just, I don't believe in casual sex.

Andrea was not the only participant who referred to morals influencing her sexual decisions. Most participants felt that their "morals" and "standards" were a direct result of their religious upbringing. They also expressed concern about their peers' lack of moral judgment. Peace suggested, "… that's why people are having so much sex, they don't even care about God anymore." She went on to explain, "even if I do have sex, I am like, 'Oh lord, I'm all in a bed of sin.' Other people just get up and find another [bed] to hop into."

Like Peace, Shayla, who was raised in a strict Roman Catholic home, described similar feelings of guilt and shame after sex. She noted, "Anytime I have done it I feel bad. I feel like it wasn't all that and God didn't like it either, you know?" With personal and general disdain she stated, "people just use God. One minute they in church, the next they with some new dude gettin' smashed [having sex] … It's ironic how they can switch it up." She went on to add, "sex is a sin like everything else but, damn, people have sex like they cuss, all the time."

Much like Shayla, Lilly also shared her view that there was irony in how "people have all kinds of wild sex Saturday with any and everyone, but Sunday they are right in church, singing and clapping and all that good stuff." She added:

> I was raised in the church and in my house there were rules. I followed the teachings of my dad and the church, but my sister went the opposite direction. She just did whatever and acted like it was okay. My brother followed my sister and got into all kinds of trouble. They used to be on church trips in high school having sex with folks. I think

your parents beating you over the head with the bible can only go so far. I mean after a

while people just don't care.

It is important to note that although most of the participants discussed religion, it was in the

context of their parents' traditions, specifically their upbringing. The influence of parents and/or

family seemed to weigh heavily on participants.

Statements regarding parental influence and values were prominent throughout the

interviews. Many of the participants referred to their parents' teachings and influence as being

an integral component of their decision making regarding sex. Several used the phrase, "how I

was raised," to indicate that some part of their upbringing affected the decisions they make

today. In a statement about her mother Peace recalled:

I would say my mother always told me, you know, as a Black woman you need to -- you

need to, um, protect yourself. You need to respect yourself at all times because Black

women, we're looked at, you know, more.

A number of participants talked about how their parents (mostly mothers) juxtaposed

their behavior against that of White girls and warned them not to be like them.

Tameka articulated this point particularly well:

I feel it's instilled into me, I guess from, like, I know from my parents and the people

who I hang around are like that. They don't want to be, you know, talked about and they

don't want to be looked upon, like, as White women, like easy. 'Cause that's how it is,

everybody thinks White women are easy. Like, I don't want you to think that I'm easy.

No dude is going to sit here and run over me.

Tykensie, who attended a predominantly White private school, affirmed this point, commenting

that her mother constantly reminded her, "You're not like those White girls." She went on to

add that although her parents wanted her to have the best education, which they felt could only

be obtained in a primarily White environment, they were concerned that she would take on the

values of the other girls at school.

Andrea admitted that as a child she did not really know what her mother meant in her

efforts to point out White privilege. She would always tell her, "Those White girls out there

ain't got nothin' to prove. You're not like them." After a moment of reflection she added, "my

mom used to always say, 'You don't have time to make mistakes and find yourself. You need to

get it right the first time'."

While many of the participants learned these values from their mothers, there were some

who were influenced by strong male role models present in their lives. Sabrina and Allyce both

made remarks in their individual interviews about the need for a male influence in the lives of

young girls. Sabrina said emphatically:

> For me … it doesn't really even have to be, you know, a father or a brother, I mean, just
>
> any positive male role model, you know what I'm saying, would probably … make a little
>
> difference, but, for me personally…they [father and brothers] taught me how to read men
>
> and make good decisions.

Allyce's statements regarding the male role model influence on sexual decision making

specifically referred to the father. She noted, "a majority of the friends that I have, that let men

manipulate them didn't have a father and your father is the one that teaches you how to pick

men." She went on to say:

> Like, one of my … girls [peers] … she's never met her father, never met him … Growing
>
> up, you know, her mom did a good job in raising her, but still, there wasn't a man there.
>
> And like, even – you can tell, it's so interesting listening to Mary J Blige. She had a song

on her CD, "Breakthrough," and she's basically singing to her mate saying, "I need the

father in you because I didn't have a father growing up and she breaks it down."

Although Allyce reported having a positive relationship with her father, she stated, "my dad

wasn't always there. My mom raised me by herself for the most part because she and my dad

weren't together."

Lilly expressed concern about one of her peers who was not raised with her father in the

home. She stated,

I got one friend that, she only dates older men. Her father was never in the home, so

when I say older men, I'm saying, she's 21. She dates like 35, 36 year olds all the time

and if you're not above 30, she ain't messing with you, and I think because she didn't have

that love of her father, she's just out here trying to find it – trying to find it from

somewhere.

Conversely, many participants did not report the absence of their fathers as being a

negative influence on their sexual decision making. In fact, a number of them talked positively

about being products of single family homes. Although their fathers were not in the home, they

learned life lessons from their mothers. Essence explained how the lineage of womanhood in her

family has affirmed how she sees herself and how she makes decisions:

A lot of women in my family are like the thing that holds us [family] together. Women

are the glue in my family. Some families, it's men. But, in my family, it's women. I was

taught [by women] at an early age about self respect and how to respect other people in

things that you do. So, in reference to, like, sex and in reference to, like, being at risk in

the whole HIV/AIDS thing, it's kind of, I guess, kind of a gray area because I'm kind of

unsure. But I know for me it's a lot of my family influence.

The terms "self respect" and "respect" were used by others as well as Essence to connote how respect for oneself and one's parents directly impacts sexual decision making.

Interestingly, some participants made a connection between self respect and the respect one shows to a parent. Lasha paused for a moment during the interview to reflect on the behaviors of her friends. When she spoke, she commented that her friends who respect their parents "aren't as loose." She elaborated:

I haven't met all of my friends' parents, but the one girl whose parents that I do know, when I see the way she is with her mom, it's interesting to me. Like, she can talk back to her mom. She can come home when she wants. Like, it's crazy. So that, and then when I hear some of the stories she told me about when she was in high school, like sneaking out, sneaking people in, I'm like, "Well that's probably why. Her mom doesn't make her respect her. So, how is she suppose to respect herself?" It's the parenting.

During the focus groups Sarah, Michelle, and Ashley made similar assessments of peers regarding the dynamics of their parental relationships and how sexual decisions are made. There was a consensus among the participants that religious upbringing and parental values directly impacted sexual decisions.

Race, Class, and Gender: Its Effect on Black Women's Perception of Power

Participants revealed that they have the knowledge and skills necessary to protect themselves from contracting HIV/AIDS. When asked about whether or not their race, class, and gender played a role in how powerful they perceived themselves to be, many agreed that being a Black woman made them more powerful than other women. Some went further to say that in the cases where violence was not an issue, they felt they were more powerful than men. Although participants were asked to discuss power within the context of their race, class, and gender, they

focused primarily on race. The discussion regarding gender was limited, and comments related to class were virtually nonexistent.

An overwhelming majority (22) of the respondents indicated that being Black contributed to making them more powerful than other women. They suggested on a number of occasions that as Black women they were more assertive than women of other races. Tykensie stated, "We're not like White girls, we don't just let dudes have control over us." Andrea also shared, "Black women are just socialized to be in control of everything, so we try to always be in charge. Women of other races are socialized differently." Participants clearly made a connection between their sense of power and being Black.

For most of the participants class was simply not an issue. They seemed to define class only as it pertained to money or status [popularity] and most women, even after some probing, did not report class as an influential factor in their perception of power. Comments made by Lasha exemplified what most participants reported. She stated:

I mean nobody wants a guy who is going to bring you down. Everybody wants somebody who is doing something with their lives, but I don't feel like I am better than anybody, including guys, just because I have more [money and/or material possessions] than them.

Lilly expressed a similar notion when she said, "Who cares about money or status? Maybe guys with money get more action [sex], but I don't know if it means they have more power." She added, "Money doesn't make anybody better than me or vice versa. It's just money."

Participants clearly saw the intersection of their race and gender and rarely segregated them. They used the phrases "as a Black woman" or "as an African American woman," clearly indicating this interconnectedness. Class was rarely a factor in the discussion on race or gender,

which indicates that participants may not see an inherent connection or intersection between race, class, and gender.

As previously mentioned, respondents generally expressed similar thoughts regarding class. They did not see it as an issue in their lives. Furthermore, they did not think it had any effect on their perceptions of power. Most expressed that it was their identity as Black women that made them powerful and gave them the ability to make good sexual decisions.

Overall, participants articulated feelings that by simply being Black women they have the power they need regarding how to protect themselves from contracting HIV. For the purposes of describing the participants' views regarding race, class, and gender and their effect on power, self efficacy and personal responsibility are discussed below.

Increases in Self Efficacy

There is general agreement that protecting oneself from HIV requires behavioral skills and self efficacy to practice these skills (Wingood & DiClemente, 1998; Yzer, Fisher, Bakker, Siero, & Misovich, 1998). Self efficacy has been defined as the belief that a person can exert control over motivation, behavior, and social environment (Bandura, 1989). For the purposes of this study self efficacy is related to the ability and the participants' perceived sense of power to make positive decisions. They overwhelmingly agreed that they are well informed regarding methods of protection and have the ability to protect themselves with regards to HIV. Furthermore, this ability or high level of self efficacy empowers them in their sexual decision making.

Participants shared that they had been taught how to protect themselves through various means. For example, Johniece noted that, "they always give you info at the clinic. Anybody who goes there knows that condoms and no sex are the only way to not get AIDS." Many other

participants reported the same experience as Johniece. Chloe, for one, stated that, "every time I go to the clinic I get the speech about what is really going to protect you and what isn't." She went on to add, "They don't just tell you what to do. They also show you how to use a condom so that there's no guessing."

The majority of the participants underscored the fact that as Black women they feel they are most targeted in the dissemination of information regarding HIV and therefore are empowered to protect themselves from contracting the virus. It is important to note that all of the participants mentioned that in their experience, information related to HIV is everywhere. Peace shared:

I guess gay men are probably targeted the most, but I don't see that. All I see is everywhere you turn they are telling you that Black women are at such high risk and offering information on what to do to protect yourself. It is crazy for anybody around here not to know. I mean we even have billboards now. It's just crazy.

Some, however, expressed a potential backlash to the heavily targeted message. For example, Shayla stated:

I mean nobody hears about AIDS more than Black women. The way they push prevention and stuff you would swear that we are all dying in the street from it. I guess that is good though because we get a lot of info about it [HIV/AIDS] and about how to protect ourselves from it. You know, we end up with more information than others because of our statistics.

As mentioned earlier, self efficacy speaks not only to knowledge and information, but also to the fact that the participants feel they have the capacity and power to protect themselves.

Lasha spoke candidly concerning how as a Black woman she feels that she is more empowered than women of other races regarding protecting herself from HIV:

> I mean I feel like as Black women we have been conditioned to protect ourselves from everything and everybody. So, you know, since we know how to protect ourselves, I feel like we can protect ourselves better than anybody else. We don't always do it but we know how and we know we need to.

Like Lasha, Stacy's comments illustrate the opinions of the other participants regarding their perception of power in protecting themselves from HIV:

> We don't get a lot of advantages as Black women but, the fact that there are a lot of programs and stuff to teach us what to do is a plus. I think if you ask any Black woman if they can protect themselves from HIV they would say, "Yeah." I mean we have the ability to protect ourselves. I actually think we know better than most, except for like gays 'cause they know too, being that they are a target group. As Black women, though, we know better than most [people].

Respondents all seemed to agree that they had the power to protect themselves and that their capacity was greater than others because as Black women they were targeted as an at-risk group.

Jordon, Tameka and Whitney all discussed how being Black somehow enhanced their capability to protect themselves. During her individual interview Jordon reported, "Black people know how and have the power to protect ourselves. Just because our numbers are high doesn't mean we don't know how or have the power." She also added, "People always think cause you're Black … you don't know or you can't. That's just not true."

Both Tameka and Whitney similarly indicated that, historically, Black people have had to find the power and resiliency to overcome a number of issues, implying that they were more

equipped than others to overcome HIV/AIDS in their communities as well. For example, Tameka suggested that knowledge increases power noting:

> Black people have been beat down for hundreds of years and we constantly overcome.
> This is no different. When the slaves learned how to read … they became educated and
> dangerous to the White masters. The more we learn about HIV and how to protect
> ourselves, the better we will be at protecting ourselves. Leaning on what connects us …
> being Black is what will get us through.

Whitney expressed some of the same sentiments as Tameka when she stated, "It's funny that we are even talking about Black women and power. We are the survivors of slavery, remember?" She went on to say, "It [HIV/AIDS] is taking its toll on us, but we will overcome this just like Black folks overcome everything else."

Allyce and Sabrina also expressed their opinions regarding their self efficacy. Allyce stated, "It's weird, I think being Black and being female totally adds to us being able to protect ourselves. We are raised to be independent and in control." She added, "Other women are raised to buy into the man and do what they say. We are raised to take control." Sabrina similarly shared:

> When you think about it, it's weird I mean, being strong Black women, it is a part of us to
> protect ourselves, families, etc. We don't wait for anyone else to protect us and I think
> those qualities give us what it takes to protect ourselves from HIV.

Interestingly, Sabrina and many others focused primarily on race in comments pertaining to self efficacy. That is, their discussion coalesced around their identity as Black women. Only two participants, Marisol and Lilly, made comments regarding their gender that did not include race.

Both shared the opinion that just being women empowered them to protect themselves more vigilantly than men. Marisol stated:

> It's not that I don't think men can protect themselves, but they are weak. As women we are stronger, and tougher, and smarter. So I think clearly as women we are in control of if condoms are used when it goes down. It's on us. You know?

Lilly and Marisol were members of the same focus group and after Marisol's comment Lilly stated, "It's not rocket science. Men think with their, you know [penis]. If we just think at all we can protect ourselves better than they can protect us!"

All of the participants expressed an increased sense of self efficacy based on their socialization as Black women and the fact that they had been targeted as a group that was at risk for contracting HIV. Many expressed that the socialization of Black women gave them the power to protect themselves. Participants reported that this power along with their access to information regarding HIV definitely equipped them with the skills and mandate necessary to protect themselves. They even added that as Black women they were responsible for their own protection and definitely had the power to ensure it.

Promotes Personal Responsibility

Participants expressed that they felt an increased sense of personal responsibility based on the fact that they are Black women. The idea most reported by the participants was that it was their responsibility to avoid contracting HIV. Peace shared, "I can only be in charge of if I get it or not, but you know, I am responsible for not adding myself to the numbers." Other participants noted their feelings regarding power and responsibility. For example, Marisol reported, "Only I am responsible for protecting myself and it's not like I don't have the power to do it." She

added, "As a Black woman you know that you have to be responsible for yourself because as long as it's affecting us ain't no White scientist gon' find no cure."

Most participants expressed a sense of agency regarding their ability to protect themselves from contracting HIV. Sabrina shared with a sense of conviction, "I definitely have the power. If I don't want to do it, I'm not going to. Like, if I say 'wear a condom' that's what it is." She went on to add, "The only person responsible for me is me. Hell, nobody has been responsible for protecting Black women but Black women, since slavery. It is what it is, you know."

Statements by Peace also illustrate quite well the sentiments of other participants regarding power, control, and responsibility:

> I'm in control. I'm totally in control. I am a Black woman, control is my middle name … I'm not giving up my sexual, you know, my control. If I say no then that's what it is. I would never put that much power into the hands of a man because once you … lose that it's like, what else do you have? You know, 'cause sex could take over your mind. It's a lot of things that a man could do to you if they have sexual control over you. So that's one thing that I can't see, I can never see myself giving up my sexual control to a man. And, I'm never going to depend on a man to protect me either. I'm totally in control and it is my responsibility.

It should be noted that participants were overwhelmingly consistent in their responses. All expressed that they had the power to make whatever sexual choices they desired. However, as Essence pointed out, even though all of her decisions were not the best decisions they were still hers: "I have been in charge of all of my decisions. They're not always good but they are mine."

She added, "I think people think that you don't have power because your decisions aren't the ones they think you should make but that just isn't true."

Like Essence, BB acknowledged that although she had made some bad decisions she still felt a sense of power and responsibility regarding her sexual decision making. She reported:

When I look back, I don't really regret anything that I did. I would say that I could have made some better decisions … I would have waited longer to when I initially did it [first sexual encounter] anyway and then after that like I said, the guy did have the power of persuasion when I was younger, and I think that I wish my mind was where it is now, where I could have said, "No, I don't have to, you know, do it to keep you around." When I look back, yeah, I think I could have changed some things. At the end of the day, though, protecting myself is my responsibility. I have the power to do whatever I want, which includes protecting myself.

Much like BB, Ashley noted:

I don't regret any of my decisions. People assume that because all of your decisions aren't textbook or they don't go with what all the pamphlets and stuff say, then you are out of control. I mean, I think that is crazy. People can be in control and have power without following all of the stuff in the pamphlets to the letter … Every relationship is different, you're not always going to use protection and that doesn't make you any less in control or responsible for your own body.

Allyce and Chloe also discussed their views regarding the responsibility of Black women to protect themselves from contracting HIV. Allyce noted, "I think the reason we keep getting HIV and our numbers are so high is because we have been depending on others to protect us."

She also added, "It has always been the responsibility of Black women to protect ourselves. We can't get away from that now." Expressing a similar sentiment, Chloe reported:

> Black women need to remember from whence we came. I mean we want to blame everybody but ourselves for why we have AIDS, but it's really only us to blame. We have been expecting the man to take on the responsibility of protecting us, but we have the power to protect ourselves, and we are our own responsibility.

Participants generally expressed a sense of power and responsibility regarding their sexual decisions. Interestingly, they also used phrases like "in charge" and "in control" to denote power. However, no matter what words they used, it was clear that the majority of the participants felt that as Black women they have an inherent sense of agency and personal responsibility that includes, but is not limited to, their sexual decision making.

<center>Race, Class, and Gender: It's Effect on Participants' Sexual Risk</center>

A number of questions were raised to gain insight into the participants' ideas of how race, class, and gender intersect in their lives to affect their perception of sexual risk. Many discussed their ideas regarding this issue in both their individual interviews and focus groups. From the overall research question, "How has the intersection of race, class, and gender affected Black women's sexual risk?" responses diverged into two distinct themes: "Slavery's still got us" and media messages in pop culture.

"Slavery's Still Got Us"

"Slavery's still got us," the verbatim words of Sabrina, denotes the fact that Black women are still affected in many areas, including that of sexual risk, by their history as descendents of slaves. Respondents discussed slavery in the context of being Black women. They acknowledged the impact that their race and gender had on the connectedness between their

history and risky sexual behavior among themselves and their peers. However, much like their discussion regarding self efficacy and personal responsibility, class was mentioned only incidentally, which can be seen in the participants' responses below.

Participants raised interesting issues as they discussed slavery and its impact on the sexual history of women today, but it is important to note that only the college educated women (11 participants) brought up slavery. Sabrina's remarks represent the thoughts of the other participants:

> We can take it all the way back to slavery … when we talk about Black women having their intimacies taken by slave masters, and being, so desired by them and then hated by the mistress, and then complicating their own relationships with their counterparts that they actually did love and have feelings for, you know…talking about in the Black community, where, a lot of…it's a taboo, how a lot of Black females have been raped … It's…it's very complicated, dealing with sexuality, and then … it stems from way back then and it's still a major issue for us African American women and our sexuality. It's very, very complex.

Sabrina acknowledged that although she sees slavery as a topic worthy of discussion as it relates to the sexual risk taking of Black women today, it is not something that "permeates her mind." She added, "if it weren't for this interview I probably wouldn't be just thinking about it and I definitely don't think about it when I am about to have sex."

Both Michelle and Ashley underscored Sabrina's perspective, that had they not been participants in this study they would not be thinking about the relationship of slavery to risky sexual behavior. However, after Michelle paused to give the idea some thought, she shared:

Being Black and female it is hard because we are taught to take care of our family and trust our men. It's like a slap in the face to ask him to wear a condom. I mean it really says, "I don't trust you. I don't trust where you've been." It sounds stupid saying it out loud, but that doesn't make it any less true. Female slaves had to stroke their man's ego and remind him that he was still a man after the owners had belittled them. We still do the same thing. We … still remind them they're men and sometimes that means giving them our unwavering trust.

Echoing the same view, Ashley who was also a participant in the same focus group as Michelle stated, "I tend to agree. It's hard, you have to balance control with taking care of your man and that is definitely a result of … slavery."

Andrea had also given thought to the notion of slavery and its relationship to Black women, family, and sex. Interestingly, she emphasized that only a certain class of women link slavery to the sexual risk of Black women today as she suggested that only women of a certain "education level" would even think about such a connection. She stated:

I don't think people think about it. I think because I've been educated about the topic I know about it and I know its origins and I know it came from Africa with the whole history of how African women were stereotyped and then it transferred into African-American women with slavery and things of that nature. So I feel like once you reach a certain education level then you can connect to it, but the average woman on the street, who maybe graduated from high school or didn't graduate from high school, would not connect those two factors.

Andrea's statement is a microcosm of the participants' opinions, which holds that the average American Black woman would not link slavery or its history to sexual risk. This is further

emphasized by the fact that only the college educated women even mentioned a connection between the two. It is also important to note that although all of the women who discussed slavery acknowledged that it still affects risky sexual behavior in the Black community they had a difficult time connecting it to their lived experience.

Both Sarah and Maria shared their views regarding the disconnectedness of slavery to their generation. They discussed the fact that although they understood history, they felt no connection to it. Sarah stated, "I get that slavery spans generations and oppression and all that, but we weren't slaves. It has nothing to do with us getting AIDS." Maria added, "I agree, it is hard to even think about how what happened hundreds of years ago is affecting my decisions." She went on to say, "I get the thought, and I know it is complicated, but I am not sure I agree with the idea that it affects what we do now."

Sabrina further emphasized the disconnectedness between her generation and their ancestors of the past in stating that, "It really all relates to Black people becoming middle class. A lot of our connection to the past was when we were poor and in the struggle." She went on to add, "The more we get the more we forget. We think we are like everybody else, but we're not. We're Black women and nobody else is forgetting but us." After being asked to elaborate on her statements Sabrina noted:

> It's almost like we have bought into the hype that the things in the past don't affect us today. We believe that being Black keeps us from getting jobs or keeps us from moving into nice areas, you know. But we can't believe that after hundreds of years society still wants to portray us as hoes. I don't know why people can't see that, and Black folks get a degree and a little money and they just go blind to that.

Offering a different perspective, Stacy and Allyce suggested that the behaviors of generations in recent past probably affected them more than slavery. For example, Stacy remarked, "like, my grandma's mama, and stuff were oppressed and held back and had to go through women's suffrage and stuff. When they talk about that, I carry that today. I don't carry slavery." In her individual interview Allyce reported:

> If our parents and grandparents would have talked to us about sex folks wouldn't be so loose. Nobody can tell me now that men leave and don't take care of their kids in 2006 because they were separated from their family during slavery. They try to tell you that in school, but I just don't buy it.

Essence, a freshman in college, was the youngest participant to share thoughts on the issue of slavery and its connection to sexual risk. Her thoughts were significantly different than some of the other participants who did not believe in a connection between slavery and Black women of her generation. She said with great conviction:

> The whole thing is we are Black and women. We're used to getting bought and sold, so we do it to ourselves. I don't know if slavery will ever be over for us. We not picking cotton, but not much else has changed.

Media Messages in Culture

Along with slavery, participants agreed that media messages in pop culture have an impact on the risky sexual behavior of African American women. All agreed that the portrayal of Black women in the media affects their decisions to take sexual risks. They also emphasized that their race and gender are the primary focus of popular culture, expressing that men and no other race of women are portrayed in the media in the same way that they are, specifically as sex objects. They went on to explain that what they denoted as "status," which seemed to be how

they articulated class, was very closely related to being involved in the "industry" or popular culture. Participants expressed that they are bombarded with sex. Sex is visible in party ads, club fliers, television, and especially music videos, which was the primary focus of the participants. Although I originally set out to capture multiple expressions of popular culture in the media, participants focused solely on music videos. Even after probing about their perceptions of the messages in magazines and in television shows, participants' attention consistently came back to music videos, specifically rap videos.

While many of the participants discussed the effect of videos on both themselves and their peers, Sabrina and Maria shared their views regarding the influence of videos on younger African American girls. Maria noted, "young girls, they definitely are looking at the videos," whereas Sabrina similarly stated, "like teenagers and younger kids, it definitely affects their decisions." Essence readily admitted that despite its effect on younger girls the music video industry has an effect on girls in her age group as well:

> Because, like, a lot of people see, like, that video girls or dancers on TV, and it's like,
> well, "I want to be a video girl"…well, "You've gotta have sex…" "Oh, I can have sex to
> be a video girl, that's no problem," you know what I mean?

Jordon expressed that the video industry will not change because, "girls are always willing to hoe [prostitute] themselves out for it." Underscoring Jordon's comment, Johniece explained that in her environment, especially in the city where she lives, "there is always a call for videos, and girls are always willing to jump through hoops to get in." She went on to add:

> They don't see the video. They see the life in the video and think, "Well, this is real."
> But half of these cars are rented. And these models are paid and they do this and that on
> the side. But they don't see that. They just see, "Oh, I like her in the video. She's feeling

on this celebrity. She's probably had sex with him. I would love to have sex with him."
It's like a lot of things… I can just walk down the street and hear people talk about
different…different things in reference to media. "Oh, I want to be in this video shoot, or
they're having the casting for this video. I want to get there to see this celebrity."

Other participants also mentioned that there are numerous casting calls for music videos in their
area. Furthermore, they expressed concern about the tactics other women would use to be
chosen for the video. For example, Shayla was one of the participants who discussed at length
the notion that young women she knew were trading sex to gain access to music video shoots.
She shared:

A lot of times, they try to use their body to get there. And it's just strictly sex. "Well, I'm
going to have sex with him. He works for such and such, he'll get me on the set. I'm
going to have sex with him, yada, yada, yada." But that's not what goes on in real life. I
mean for some people, like some of them are just smiling in the video, you know, they
just get paid to stand there and look pretty. But on the other side, they have sex, they
drink, they do drugs, there's so much on the other side of the media in videos and music
that are influencing people to have sex.

Expressing a similar sentiment Stacy added:

Music videos are like the black girls' Hollywood. I mean White women have been
turning tricks on some man's couch for decades trying to get a two liner in a movie.
Young black girls do the same thing for videos … They have sex, they let themselves be
all loose, and they let dudes paint them as hoes. I remember in that Tip Drill video where
some dude slid a credit card down the crack of a girl's butt. That was gross, but hey,
that's what she was willing to do to be there, you know.

Many of the participants talked about being shocked by not only what people were willing to do to get into videos, but about how much videos have changed since they were younger. Sharing her feelings about the changes in music videos since she was a child, Allyce's comments echoed that of many other participants and illustrate what they reported regarding Black women and sex in music videos:

Ooh, being Black and being female. It's crazy when you turn on the TV and everything is sex. Like, everything, like, the music videos. I know people always use that example, but it's like sex sells everything. And, it's like, you turn on BET and all these Black women are just selling sex and it's crazy because, I feel, for the – for the young girls that's growing up – 'cause, you know, when we were younger, you know, we had music videos, but the only girls, you know, for real that you see in a video was like Queen Latifah, MC Lyte and, you know, like they doing their thing, but it's not – it's not revealing.

Fueled by Allyce's comments, Lilly added:

You got little girls that's lookin' at Trina and you got young girls that's looking at, you know, Kalise. You got them looking at these women and they out here talkin' 'bout how "my milk shake brings all the boys to the yard" and then you turn and you even look at the guy performers, and all of a sudden now – all the songs that are heard now are glorifying stripping.. I don't know if you pay any attention, but "I'm in Love with a Stripper" – that T-pane. Then, you have "Rodeo" by Juvenile that just came out, his video, glorifying stripping. As far as his whole video, it's set up in a strip club and it shows all these strippers and they're all out, It's – it's– I don't know.

Both Karen and Angela commented on the theme of the stripper that is now a part of modern day rap. Karen noted, "Everything is about being a stripper now. It's all over the songs. Hell, girls

even hang at strip clubs now. The new spots are Body Tap and Strokers." Angela added, "They are so brainwashed by the music. It's funny; people act like they aren't, but why else would you be hangin' at the strip club? I mean girls go in there with drinks and shit just to hang out. Whatever!"

Sabrina and Andrea, who were members of the same focus group, indicated that they were not surprised at the attraction of their peers to being in or watching videos. Sabrina shared:

It is really sad because they're [videos] degrading but it's one of the only places where we [Black women] are seen as sexy. We don't have to be a size two with no curves. You can have butt and hips and be juicy and that sells the video. There's nowhere else where that's sexy. So I am not surprised that people are willing to jump into the videos if they can.

Following Sabrina's comment Andrea added, "You are right it is sad, but true. Especially if you are the type of girl who needs somebody else to tell you, you are beautiful."

In addition to seeking approval regarding their appearance participants expressed that being a part of music videos had a lot to do with what they called "status." Peace reported, "You get the bling [diamonds] when you are a video girl" noting, "Everybody wants to wear Gucci or Prada and at our age how else are you going to have that kind of money?" Sabrina also emphasized that girls her age just "want to be known and have stuff." Although the participants did not use the word "class," their discussion regarding "status" and "being known" indicated that they are giving some thought to class and its impact on sexual risk.

The participants agreed that media messages play a major role in whether or not they make risky sexual decisions. It is important to note, however, that music and videos were the

main avenues of media that participants discussed, which may show that these are the most influential media modes available to them today.

Chapter Summary

The purpose of this study was to explore Black women's sexual risk factors as well as the factors that influence their sexual decision making. The research questions guiding this study were as follows:

1. What is the general understanding of HIV among Black women?

2. What are Black women's perceptions of HIV risk?

3. What influences Black women's sexual decision making?

4. How has the intersection of race, class, and gender affected Black women's perception of power?

5. How has the intersection of race, class, and gender affected Black women's sexual risk?

In order to understand the factors that influenced decisions regarding sex this study focused on participants' HIV/AIDS knowledge, their perceptions of risk, factors they identified as being influential in their decisions regarding sex, and their actual power and ability to act on that power. Lastly, perceptions of their unique position of being Black, female, and of various classes and these perceptions' bearing on sexual risk was discussed. These factors were presented in detail within this chapter and are discussed in summary below.

Having basic knowledge about HIV/AIDS in terms of its transmission and prevention was useful to the participants in that it provided them with an accurate picture of the risks of unsafe sex. More formalized training translated into more knowledge as women who had

participated in courses and prevention initiatives were well versed and more articulate in their discussion of the facts regarding HIV/AIDS and, in some instances, other STIs.

In addition to HIV/AIDS knowledge, participants discussed in detail their perception of risk, and there was a general consensus among participants that as Black women they were automatically at risk for contracting HIV. Although all affirmed the belief that their collective risk was high the majority indicated that their individual risk was low, regardless of any risky behavior they had engaged in. Participants specifically identified the phenomenon of the down low "brotha" and sexual promiscuity as being especially harmful to their sexual health, as well as the primary reasons for the high HIV incidence rates in the Black female community.

Both internal and external influences were identified as factors that women consider when making sexual decisions. Many participants indicated that their emotions played a large role in their sexual behavior. Self-esteem was also acknowledged as a contributor to the decisions of these young Black women. Religious upbringing and parental values were salient throughout the data as being important considerations in the decisions that these young women made regarding with whom to have sex and whether or not to use protection.

Many of the participants made reference to the notion that the history of being enslaved still had some effect on the sexual risk of young Black women. The misogyny of Black women was also discussed by several participants as they addressed their image in music videos and in the popular media. They expressed feelings that not only were they were affected by it, but so were their younger counterparts.

CHAPTER 5

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to explore Black women's sexual risk factors as well as the factors that influence their sexual decision making. The research questions guiding this study were as follows:

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2. What are Black women's perceptions of HIV risk?

3. What influences Black women's sexual decision making?

4. How has the intersection of race, class, and gender affected Black women's perception of power?

5. How has the intersection of race, class, and gender affected Black women's sexual risk?

Twenty-five African American women between the ages of 18 and 25 were purposefully selected and interviewed. Ten were interviewed individually, 10 were participants in 1 of 3 focus groups, and 5 participated in both individual and focus group interviews. These interviews and focus groups served as the sole source of data for this study. A qualitative research design was used to explore the factors that influence sexual decision making among these participants, and data were analyzed using the constant comparative method (Glaser & Strauss, 1967). Face-to-face, semi-structured interviews and focus groups were conducted. Participants were recruited from the health department, Planned Parenthood, and two historically Black colleges and universities.

An analysis of the data revealed two categories related to participants' understanding of HIV: basic transmission information and key prevention information. Two categories of findings also emerged from data analysis concerning participants' perception of risk. They perceived themselves to be at great collective risk, but minimal individual risk regarding their exposure to HIV. Analysis revealed two categories pertaining to major influences on the participants' decisions regarding sex: internal and external influences.

When examining the intersection of race, class, and gender, two categories emerged when looking at their relationship to power, as well as when exploring their connectedness to sexual risk. Participants reported that the intersection of race, class, and gender come together to increase their self efficacy and to promote personal responsibility. When examining the same intersection with regards to sexual risk, participants indicated that the effects of slavery and media messages in popular culture influence the sexual decision making of Black women. This chapter includes detailed discussion regarding the general conclusions of the study, implications for theory and practice in the field of social work, and limitations of the study. It also includes recommendations for future research.

<div align="center">Conclusions and Discussion</div>

Based on the analysis of the data, three general conclusions were drawn from the findings. The conclusions are:

1. Despite their knowledge of HIV/AIDS and both familial and religious influences, young Black women still make sexual decisions that put them at risk for contracting HIV.

2. Young Black women recognize that they are at great collective risk for contracting HIV, yet fail to acknowledge individual risk.

3. Issues of power and some popular media significantly influence the sexual decisions of young Black women.

Despite their Knowledge of HIV/AIDS, and both Familial and Religious Influences, Young Black Women Still Make Sexual Decisions That Put Them at Risk for Contracting HIV

It is generally acknowledged by researchers that HIV education has very little bearing on sexual decision making (Wingood & DiClemente, 1997, Wu et al., 2003). In this regard, the responses of the participants in this study support this finding in the literature. All reported having general or basic knowledge of HIV transmission and prevention, yet many admitted to making sexual decisions that put them at risk. Only one respondent, Stacey, admitted having any doubt as to the accuracy of her knowledge, but the remaining participants reported that despite their knowledge other factors, (i.e., familial and religious influences and the length of time they had been involved in a relationship) played a role in their decisions regarding sexual behavior.

Much of the knowledge that participants gleaned regarding HIV/AIDS came from organized prevention interventions. It should be noted that earlier literature (Barker, Battle, Cummings, & Bancroft, 1998; Nyamathi & Stein, 1997) concluded that interventions must be culturally-sensitive, provide skills training in condom use and sexual communication, and place emphasis on gender-based power imbalances as well as sexual assertiveness. According to the women in this study, they participated in interventions that included many of the previously mentioned emphases. This suggests that some improvements have, in fact, been made to address historical critiques of HIV prevention strategies, but even these improved models have not resulted in behavior change.

One respondent, BB, described a prevention program offered by a private university in which she had been involved and through which she had received training regarding how to use a

condom, and how to increase her level of comfort related to having discussions with her partner about sex. However, she felt there were no components that made the prevention program culturally sensitive or specific to Black women, which is understood to mean that the intervention provided no activities specifically geared towards the population of the group (Lam, Mak, Lindsay, & Russell, 2004). BB said, "It was cool, it could have been for anybody, though, not just Black girls." She went on to add, "It was only Black girls there, but that doesn't make it about us, you know." So, although participants did indicate that perhaps strides had been made to improve prevention efforts among young Black women by providing skills training in condom use as well as sexual assertiveness, BB's statement highlights what has been found in the literature (Loue, 1999; Ro, 2002): HIV prevention programs, are still, for the most part, not culturally specific. This absence of cultural relevance may play a critical role in the inability of African American women to connect HIV prevention knowledge to behavior change. For example, it was clear in this study that the participants were indeed knowledgeable about HIV transmission and prevention; however, the knowledge alone did not keep them from participating in risky sexual behavior. Perhaps with programs geared directly to them and their interests including, but not limited to popular music and rap culture, the importance of putting prevention knowledge into action would be better understood.

Beyond their level of knowledge regarding HIV, participants in this study also expressed being influenced by their families and religious beliefs. Although their discussion did imply that both impacted their sexual decisions, actions they reported contradicted such statements. For example, many participants noted a desire to refrain from sexual intercourse because they saw it as a "sin." However, even though they subscribed to this belief, they still chose to participate in sexual activity. The same is true regarding participants' reports related to familial influences.

They expressed a desire to avoid disappointing parents or other family members, yet they continued to make high-risk sexual decisions. It seems clear, based on this study, that HIV prevention messages need to address the disconnectedness between all of the these influences and behavior change, and if this could be done in a way that is culturally specific, it may possibly be the first step in designing HIV prevention strategies that work for Black women.

The literature emphasized that there is a need for more culturally specific prevention initiatives focusing on young African American women (Flakerud & Nyamathi, 2000; Kreuter & Holt, 2001; Lam, et al., 2004). This need should be met through holistic programs at schools, religious establishments, clinics, and in communities. Given the high HIV infection rates among African American women, it is self-evident that they require and should receive specific attention and that appropriate prevention messages could help save lives. Although many HIV education programs target Black women, the participants do not see them as being culturally specific. For example, Andrea, who reported having been involved in a prevention initiative sponsored by her college, reported that, "although it was informative it wasn't really geared towards us … on a historically Black college campus of women, that was the time to really make it about us." The notion of a program's cultural competence is nebulous at its very core. Judging the cultural specificity of a program is at best difficult and extremely subjective, which begs two questions: Have HIV education programs become culturally specific? Also, if they do become culturally specific, will HIV education then play a major role in the decisions young women make regarding sex?

As previously mentioned both the participants in this study and the literature (Flakerud & Nyamathi, 2000; Kreuter & Holt, 2001) support the fact that intervention initiatives need to be more culturally specific. Literature (Flakerud & Nyamathi; Kreuter & Holt) suggests that

prevention initiatives can be made more culturally appropriate by inviting individuals who represent the same demographic population as the target participants to make cultural recommendations for prevention programs. For example, BB suggested, during our interview, that facilitators need to be more in touch with the lived experience of the participants. She said, "They don't have to be Black but they need to at least know about us." Andrea emphasized that facilitators should be aware of the kind of music young Black women listen to, how they express themselves to one another, and how sex is talked about in their communities. This kind of feedback could be helpful in attempting to increase the cultural specificity of a prevention program. The second question, regarding whether or not cultural specificity plays a role in HIV education and the decisions young women make regarding sex, can only be answered if improvements are made regarding the cultural specificity of prevention programs. These questions need to be answered to make concrete conclusions as to whether or not education can be more effective in HIV prevention. If, in fact, it cannot be more effective both researchers and practitioners must realize that although HIV education is necessary, it is not enough to meet young African American women's prevention needs.

Another issue among the participants is that there seems to be a disconnect with regard to acknowledging risky sexual behavior and acting upon this awareness. Respondents in several interviews indicated that they always used protection, although later, while responding to another question, reported a time or a number of times when they had not protected themselves during a sexual encounter. This is illustrated in two statements from Peace's interview. First, she stated firmly, "I use condoms with everyone" and then when asked, "Is there anyone you didn't use a condom with?" she replied "yes." The inconsistency in Peace's responses was not unique; it was a pattern noted in all of the interviews. After the discussions related to HIV knowledge, parental

influences, and/or religious upbringing, nearly all of the respondents reported always using condoms and never participating in sex without a condom, but later in the interview as sex and what factored into their decisions regarding sex was explored, many of the participants reported that there had been instances when they had not used condoms.

Some of the participants reported "trust" as one of the key factors influencing their decision to not use condoms despite their knowledge of the many consequences of unprotected sex. Although trust was not an issue brought up by a majority of the participants, it is important to discuss because a number of participants made reference to the fact that trust played a role in their decisions to have sex, and furthermore, to have sex without condoms. Jordon shared that as she considered having unprotected sex with her boyfriend, she thought to herself, "I trust him." She went on to say, "Once dudes got your trust they got ya, that's a rap." Research (Foreman, 2003; Pulerwitz, Amaro, DeJong, Gortmaker, & Rudd, 2002; Wingood & DiClemente, 1998) has shown that certain types of sexual relationships (e.g., committed with steady partner or casual sexual relationship) are instrumental in dictating women's condom use.

Previous studies provided evidence showing that while young women ages 18-25 are at risk for contracting HIV, those in steady relationships (where trust is assumed) are less likely to use condoms than those who are not (Foreman, 2003; Misovich et al., 1997). Young women in this age group tend to have multiple partners over the course of their young adulthood and may consider their current committed or monogamous relationship as permanent and "safe" (Lewis et al., 2000; Misovich et al.). Research with high school and college students has shown that the longer women of this age group are in a relationship, the more inconsistent condom use becomes (Misovich et al.). This indicates that the longer the duration of the relationship, perhaps, the more trust increases, resulting in less participation in safe sex practices.

According to Saul, Norris, Bartholow, Dixon, Peters, and Moore (2000), persons who are more committed to their intimate relationships tend to make certain decisions to maintain that relationship. Those decisions may include engaging in sexual relations without condom usage. Consequently, when the need to ask a partner to use a condom arises, such persons may have difficulty being assertive because of a fear of losing the relationship (Saul et al.). Wingood and DiClemente (2000) suggested that women in a steady or committed relationship are more likely to refrain from using condoms. This increases a woman's risk for contracting HIV/AIDS because sexual relationships outside the primary relationship are hardly ever disclosed.

Knowledge of HIV/AIDS, familial and religious influences, trust, and a host of other factors make sexual decisions difficult for young African American women. According to Foreman (2003), sexual decision making is complex from a cognitive standpoint. Decisions regarding sex are influenced by any number of factors including many of those identified by the participants in this study. Furthermore, beyond any of the factors that influence sexual decision making, women must first acknowledge they are at risk. If individuals do not recognize they are at risk, no amount of education and prevention will work to influence behavior change (Jemmott & Jemmott, 1992).

Young Black Women Recognize That They are at Great Collective Risk for Contracting HIV Yet Fail to Acknowledge Individual Risk

Cummings, Battle, Barker, and Krasnovsky (1999) conducted a study with African American women in which the purpose was to explore AIDS-related worry and how it affected sexual decision making among African American women. This study reported that the majority of women were not worried about contracting HIV. Although in 1999 it was known that (heterosexual) African American women were at highest risk for contracting HIV, the

researchers concluded that the perception of risk in the African American female community still remained low. In many ways the results of this study eight-years later affirm their conclusions. Although, for a variety of reasons, African American women see themselves as being at great risk for contracting HIV, most of the participants reported that they do not see themselves as being at risk in their individual lives.

Participants shared personal experiences including having sex without condoms, having sex with multiple partners, and promiscuity among young men and women, yet many, like Stacey, voiced with conviction, "I'm not at risk. Some of my friends are, but I don't think I am." According to research (Jemmott & Jemmott, 1992; Schieman, 1998; Sterk, Klien & Elifson, 2004), despite the education or prevention activities that individuals receive, if they do not perceive themselves as being at risk it is probable that they will not be consistent in condom usage. Schieman used the term perception of risk to describe how at risk individuals see themselves. Although there is not a quantifiable way to describe risk, early studies involving African American female participants focused on whether or not they described themselves as being at high risk, low risk, or somewhere in between (Schieman). No literature was found regarding the difference between how Black women perceive the risk of their community as a whole and their individual risk. However, results of this study do support conclusions found in the literature (Sterk et al.) that participants must perceive themselves to be at risk before any prevention initiative can be effective. As previously noted, all of the participants reported being knowledgeable about HIV/AIDS, but many indicated they did not categorize themselves as being at risk, despite the risky sexual decisions they had made.

Based a number of the reasons mentioned earlier, most participants did not acknowledge themselves as being at risk. However, they did see their community as being at great risk. Much

of this risk was attributed to men living on the down low, which Allyce described as "guys who have sex with their women and then have sex with other guys." She also added, "They say they're not gay but to me, they're gay. You have sex with a guy, you're gay. They might not want to be gay, but they are." The idea of the down low "brotha" was first introduced in fictional writings by E. Lynn Harris (1997) and Pearl Cleage (1998) in the late 1990's. However, since the nonfiction writing of J. L. King (2004), there has been a wave of publicity and hysteria among Black women surrounding the phenomenon of the "brothas" living on the down low.

According to King (2004), a self-described down low "brotha" who has broken his silence, the down low "brothas" are Black men involved in heterosexual relationships with women, concurrently having clandestine sex with other Black men. As did King, many of these men go on to marry and have children while still participating in this covert lifestyle. The most disturbing truth about this phenomenon is that many of these sexual encounters are happening without the use of condoms. In the past two years, since the release of King's book and his appearance on the Oprah Winfrey Show, the now-disclosed secret of the "down low" has become the leading, accepted reason for the rise in the numbers of African American women contracting HIV. This was revealed in this study as well, as all 25 participants weighed in on the issue and some, like Chloe, went as far as to say, "They [men on the down low] are why Black women are getting AIDS. We weren't getting AIDS before that; now, we getting AIDS left and right because they don't want anybody to know that they [are] gay."

The issue of the down low "brotha" was salient throughout the transcripts, however participants did discuss their own promiscuity as well as that of their partners as being contributory factors to the rise of HIV in their communities. As described in Chapter Four, many

of the participants indicated that their peers were not cautious in terms of their decisions regarding sex. For example, they did not put much thought into when they had sex, with whom, or whether or not to use condoms. They explained that promiscuity was rampant among both their male and female friends, and that casual sex was extensive in their circle of friends.

The participants in this study seemed concerned about this epidemic of promiscuity and casual sex among their peers. Allyce said of her peers, "Everybody's just sexin' everybody, it's like the thing to do." The majority of the participants were emphatic about the fact that they were not a part of the promiscuous group many of them described. Andrea specifically noted, "I don't believe in casual sex." However, many gave examples of the behaviors of their friends or aquaintances who were regularly having sex with people they did not know well, without condoms, or with multiple partners. Participants readily acknowledged that this sort of behavior definitely left Black women at risk for contracting HIV.

Although participants did concede their collective risk, their inability to do the same for their individual risk focused attention. According to the literature, initiatives must tackle the issues of low perceived risk among African American women as the lack of perceived risk is a considerable barrier to prevention (Nyamathi & Stein, 1997). The fact that after 10 years of research, prevention, and the acknowledgement that African American women are contracting HIV more rapidly than other populations, it is noteworthy that among this sample of Black women, perceived individual risk still remains low.

Issues of Power and Some Popular Media Significantly Influence the Sexual Decisions of Young Black Women.

Much of the literature suggests that sexual behavior that puts many Black women at risk is directly related to a lack of power (Saul et al., 2004; Wingood & DiClemente, 1997; Wu et al.,

2003). According to Wingood and DiClemente some women feel that either they do not have sufficient power in their sexual relationships to demand that protection be used or, for any number of reasons, they are not self-efficacious and therefore cannot act on that power (Weeks et al., 1999). In her focus group interview, Marisol discussed her assessment of why she thought her friends curbed their expression of power in some relationships. She used the word "dominance" to denote power: "Just, they'll just use that dominance against them, and then some women will kind of tone the dominance down, so they won't break the self esteem of the male in the relationship." This supports the literature on power in relationships (Weeks et al.; Wingood & DiClemente, 2002) that suggests that much of the power that African American women give up in the bedroom is the result of numerous variables. Some of these variables include poverty, drug addiction, low self-image, and a need to give their African American male sexual partners power in the bedroom because of the lack of power that these men are afforded in society (Weeks et al.; Wingood & DiClemente).

Although some participants shared Marisol's sentiments related to power, the majority emphasized the fact that they had power in all of their relationships. Lasha was adamant about this when she declared, "I have all the power, I mean all girls do. That doesn't mean I don't slip up, but that don't have nothing to do with power. Regardless of what, I got all the power." Although the literature suggests women have historically handed authority over to men (Pulerwitz et al., 2002), the participants of this study did not subscribe to this notion. Pulerwitz et al. have argued that it is because of gender-based power constraints that women have been unable to exercise their power in regards to safe sex. They also suggested that power is directly related to condom use.

Even though this exploration in no way provides sufficient evidence to negate the claims of earlier research (Pulerwitz et al., 2002), it does raise some questions regarding the notion of power. For example, if there is a connection between power and the decision to use protection during sexual encounters, why do the participants of this study see themselves as powerful, but choose not to use condoms in certain situations? Although participants indicated that they were "strong," "in control," or "powerful" when it came to making decisions regarding sex, they still admitted to making poor decisions in many situations.

The issue of power was addressed by Pulerwitz et al. (2002) in an earlier study of 388 female participants where relationship power was measured using a quantitative scale. The researchers found that women who identified themselves as having relationship power were more likely to use condoms than those who reported feeling powerless (Pulerwitz et al., 2002). This sentiment was not reflected among the participants of this study as they reported having relationship power, but still made decisions to have sex without condoms. Other researchers (Harvey & Bird, 2004; Harvey et al., 2002; Monahan et al. 1997; Soet, Dudley, & Diloro, 1999; Wingood & DiClemente, 2000) obtained results similar to Pulerwitz et al.; participants with increased relationship power are more likely to use condoms during sexual intercourse. A lack of power has been identified as a barrier to prevention but does not hold true on the basis of this study with participants interviewed. They all indicated that they felt powerful in their relationships, yet still chose to participate in risky sexual behavior on various occasions.

The concept of power can also be analyzed within the context of popular culture, specifically rap music, as this was the popular media to which participants referred most often. Much of the discussion regarding the portrayal of women in the media and in music has focused on men, but in the past 10 years female rap artists have become very explicit in their lyrics and

have chosen to rap about sex. This graphic music by female artists, according to Allyce, makes,

"women sound like they run the bedroom." This can be seen in lyrics performed by a female rap

artist known as Trina:

> See I don't need Nann Nigga; Jockin' me, slowing me down; Or stoppin' me; Climbing all
>
> on top of me; If he ain't gonna fuck me properly; It's got to be, possibly; A dick that ain't
>
> too soft for me; Nigga get your ass up off of me
>
> Besides your dick too small for me; I gots to be fucked right, sucked right
>
> In the butt right like a slut like; In the bright lights, every day all night
>
> Now talk to me, why you fuck me violently? Calling me names that apply to me;
>
> Cumming all inside of me; Don't lie to me, now tell the truth; Is this pussy good to you?
>
> Grip for you, good and tight; But full of juice; Why wouldn't you?
>
> Why shouldn't you? Scream while I am riding you; Over you making this pussy stroke
>
> for you; Like your bitch supposed to do; Close to you and I'm feeling most of you; Deep
>
> for me, we can meet; Fuck me till I fall asleep; Not unless there three nuts for me; Or get
>
> your ass up off of me; Ol' tired ass nigga besides
>
> You ain't even all that any way; FUCK YOU!

In this context, power is seen differently than in the academic literature, but both must be taken

into consideration as researchers explore power and popular culture. Although many would

disregard this shift in power as unimportant and misguided, it exists and increasingly more

young women are identifying it as significant. There has been an increase of misogyny in the

popular culture as a whole, and many of the participants in this study agreed that this culture is

very influential in sexual decision making.

Misogyny is not a new phenomenon in the Black community; it has simply become more public and widely accepted by Black women. It is also important to note that the issue of misogyny was not brought about solely by hip-hop and music videos. They are simply a manifestation of what is seen in our culture over all. According to Dyson in an interview by Meta DuEwa Jones (2006):

> The reality is that patriarchy and sexism and misogyny are tried and true American traditions from which hip-hop derives its own gender self-understanding, its articulation of how men and women should behave and what roles they should play … In other words, it ain't hip-hop that's teaching the broader culture how to dog a woman. It's the broader culture's ways, rules, and ruses, when it comes to gender, that are keyed in by hip-hop rhetoricians and lyricists. (p. 788)

Much like Dyson, Douglas (1999) suggests that Black women have been seen as promiscuous and "loose," and this has influenced their construction of their own identity throughout generations. Although much of this discourse has included the myth of the "jezebel" and her opposite persona, the "mammy," in present-day culture, it seems as though the notion of the "mammy" has disappeared and the idea of the "jezebel" has come to the forefront. Many participants indicated that the myth of the "jezebel" has been personified by many of their peers. For example, according to Sabrina, Allyce, BB, Tykensie, and others, "sex is everywhere" in their lives and that of their peers. During the focus group, Tykensie looked for the affirmation of her group members when she stated, "Tell the truth, girls don't even care if folk think they hoes nowadays. They don't care what people think." After her statement, many of the group members nodded their heads or spoke in agreement. Based on the work of Douglas (1999) and

Hammonds (1994), this negative historical portrayal of Black women has been manifested in popular culture and affected the image that young Black women have of themselves.

According to Collins (2004), in modern America where community institutions of all sorts have eroded, popular culture has increased in importance as a source of information and ideas. African American youth, in particular, can no longer depend on families, churches, fraternal organizations, school clubs, sports teams, and other community organizations to help them negotiate the challenges of social inequality. Mass media has taken over to fill this void, especially movies, television, and music videos that market Black popular culture aimed at African American consumers. With new technologies like iPods, blogs, and MySpace, the possibilities for information creation and dissemination are endless, and it is through these avenues that young Black women are learning to define themselves. Furthermore, it is through these channels that women are constructing a sense of power.

Collins (2004) encouraged the Black community, especially its youth, to move beyond the commodified definitions of themselves (i.e., bitches, hoes, thugs, pimps, sidekicks, sissies, and modern mammies) offered by the mass media. Many of the participants affirmed the view in the literature that Black women are still being affected by the vestiges of slavery with regard to their sexual decision making. It should be noted that, though the literature does acknowledge that slavery still affects Black women today it is important that it is not used as an excuse to render black women powerless. For example Davis (1981) emphasizes that Black men must be held accountable for their role in attempting to render Black women powerless. Black women must also take control of any sexual decisions that put them at risk. It is not sufficient to acknowledge the vestiges of slavery still being in existence, as a society we must also acknowledge accountability. Although as reported in Chapter Four, Andrea believes this is

something that is manifesting itself subconsciously, for most women her age, she maintains that it is still affecting them. The issue of power among young African American women is complex, and culturally relevant prevention should consider this factor for inclusion in prevention messages.

<div align="center">Limitations of the Study</div>

The limitations of this research rest in the methods employed in conducting the study. The findings may have been affected by the small number of purposefully selected participants, by the fact that all participants had to be fluent in the English language, and by the possible constraint that participants may not have felt comfortable in either the individual or group interviews to speak freely about their decisions regarding sex.

In light of the fact that participants' thoughts were represented in words and not in numbers and that they were interviewed in-depth, the sample size was small when compared to most quantitative studies. Although I assembled a sample with maximum variation, it was not random and therefore the findings of this study are not generalizable to other populations in a statistical sense. In-depth understanding was the true goal of the study, but I am aware that critics may see the lack of generalizabilty as a limitation.

Furthermore, some aspects of the sampling methods that were viewed as assets to this study at the outset actually limited the conclusions and applicability to a wider age range (beyond 18-25). For example, when identifying the sample group for this study, choosing a group of women that had access to HIV information (e.g., Planned Parenthood patients, college students, etc.), were concentrated in one particular area (ZIP codes 30313 and 30314), and who, at least by virtue of age, were relatively new to sexual experiences seemed like an ideal choice. However, selection of such a population may have minimized the opportunity to explore

differences between rural and metropolitan women of the same age range, with the possible exception of those participants who had relocated from small towns. Perhaps rural women of the same age range feel very differently about factors that influence their sexual decision making than did the participants in this study.

The successful completion of this study may have also been hindered by participants' lack of candor and ability to speak freely regarding their sexual decision making. My understanding of the phenomenon rested largely in the participants' ability to express their thoughts both truthfully and effectively. I attempted to address this issue in my initial conversation with the participants before they were chosen to be involved in the study. It was my hope that the initial screening tool (Appendix B) would assist in discerning which individuals would speak freely and truthfully.

Also, the fact that all of the participants had at least a high school diploma may have served as a limitation. Many of the participants were either in college or supporting themselves through current employment. Choosing this group may have been at least one of the reasons why the issue of class rarely surfaced during both the individual interviews and the focus groups.

An additional limitation in the study is the age range of the participants. Nearly all of the participants indicated either in their individual interviews or their focus group interviews that they had engaged in sexual relationships since they were adolescents. Many reported that their first sexual experience had been either before or during high school. Replication of this study using a sample of younger African American girls may yield useful information, since this is the age when many are having their first sexual experiences.

Lastly, another limitation of this study was that there was no way of discerning how truthful the participants were in their answers. If the participants were reluctant to share their

true feelings and gave what they deemed to be socially desirable answers, the results may have been skewed. For example, they may have been reluctant to suggest that they were not powerful in their sexual relationships, or that they were not happy with decisions they had made regarding sex. Attempts were made to minimize this limitation by emphasizing confidentiality and the use of pseudonyms. However, this may not have been enough to ensure entirely truthful answers, especially in the focus groups where participants may have felt pressure from the other members.

<div align="center">Implications for Theory, Social Work Practice, and Policy</div>

Previous studies (Liau et al., 2002; Pulerwitz et al., 2002; Wingood & DiClemente, 2002) on African American women's sexual decision making, risky sexual behavior, or other relevant topics have primarily been quantitative in design. They also focused on whether or not the participants were using a barrier method of protection, how often they used this method, and for how long (6 months, 1 year, etc.). Employing theoretical frameworks primarily used in the public health discipline, they did not encompass any cultural specificity. This study was different from those studies in three key ways. First, the current qualitative study explored sexual decision making and gave participants the opportunity to discuss this in the context of their own lives and in their own words. Second, this study was not concerned with how many times participants reported using protection, for how long or how consistently. Rather, it was more concerned with what participants described as integral factors to their decision making regarding sex. Lastly, this study utilized Black feminist theoretical framework in its design. Because participants responded in their own words and gave insight into the factors that contribute to their sexual decision making, findings from this study, though not generalizable in a statistical sense, offer both theoretical and practical implications for social workers and others working in the area of HIV prevention.

Theoretical Implications

This study sought to utilize Black feminist theory and the concept of simultaneous and multiple oppression in understanding the sexual decision making of African American women. Furthermore, it was important to explore the notion that young Black women are put at even more risk by the oppression than Black gay and bisexual men face within their communities. Two key Black feminist theoretical concepts were prevalent during the analysis of the data collected in this study. The first concept is the notion that Black women today are even now affected by the psychological chains of enslavement. The horrific ways that Black women were treated during the historical time of U.S. slavery still affect young women today, specifically in their sexual decision making. The second concept is the idea that the "mammy" and "jezebel" exist presently and can be seen regularly in the popular media (Wallace, 1996). According to some participants, these two concepts weigh heavily on Black women's sexual decision making. Sabrina, the first participant interviewed for the study reported:

> We can take it all the way back to slavery, you know what I'm saying, when we talk about Black women having their intimacies taken by slave masters … So it's very complicated and it just is…it stems, you know, from way back then and it's still a major issue for us, African American women and our sexuality. It's very, very complex.

The complexity of the slavery issue goes far beyond the scope of this study, but the discussion of slavery among the participants definitely suggests that this is a multi-layered area of exploration. According to Leary (2004), who has written extensively on Post-Traumatic Slave Syndrome, there has been an intergenerational trauma that originated with slavery and has been affecting the Black community since that time. Although Sabrina and others support the findings of Leary that the effects of U.S. slavery still exist today, many participants underscored their

belief that women are influenced by these historical references without any real knowledge or awareness of them. This sentiment fits with the literature (Leary, 2004; Taylor, 1998b) in that women do not have to be well read or historically astute to be affected by their history and that of their ancestors. There are behaviors that are passed down without knowledge of origin, yet are still passed down.

According to Wallace (1996), it was during slavery that the myth of the "jezebel" and "mammy" was born. African American women were seen as "loose," "whores," "mammy," or "caretaker" by their oppressors. Regardless of their free or enslaved status, these myths followed African American women everywhere. They were seen as one of two extremes, either nonsexual ("mammy") or hypersexual ("jezebel") (Wallace). The data collected in this study support the notion that young Black women still see themselves portrayed as "the jezebel." As presented in the previous chapter, the participants explained that the media, specifically music and music videos, continue to portray them in this way, and the portrayal has become increasingly more prominent and impossible to miss. Young Black women participating in the music videos are often referred to as video "hoes" and, in large part, this is related to their apparel and connection to sex. The lyrics of "hip-hop" and "gangsta rap" songs are comprised of predominantly sex and violence, and contribute to the misogyny of women. Recording artist T.I. raps in his song "Get Loose":

Ay shawty, bust it open for me; Let me see you get loose

If you really wanna show me that you love me, get loose

No Grey Goose, if you don't get loose

Get up out the coupe if you won't get loose

Bend it over, reach for yo toe, get loose

Hold on to the pole, drop it low and get loose

No x-o if you don't wanna get loose

No more dro unless you gonna get loose

This is only one example of how Black women are portrayed in the media, but it is an example of a major barrier to effective prevention. For instance, the second line of this verse, "If you really wanna show me that you love me, get loose" suggests that in order to prove love in a relationship, sex must be present. If participants and their younger counterparts are influenced by the urge to "prove their love," it is not difficult to imagine that prevention education will not be enough to effect behavior change. The results of this study suggest that the inclusion of Black feminist theory as a framework in prevention initiatives with African American women is a viable one. Incorporating lessons of sexuality throughout Black women's history, as well as messages of empowerment, could prove to be powerful theoretical concepts in prevention strategies. Although researchers (Liau et al., 2002; Nyamathi & Stein, 1997; Pulerwitz et al., 2002; Williams, 2003; Wingood & DiClemente, 2002; Yeakley & Grant, 1997) have had some success with prevention using only public health and behavior focused theoretical frameworks, the number of Black women contracting HIV is still increasing (CDC, 2005). The results of this study suggest that prevention strategies need to be more comprehensive and cultural in nature.

Practice Implications

Although HIV is clearly an issue researched by those in the medical field, a host of related psychosocial issues has extended the subject into many disciplines. For example, self-esteem, self-efficacy, socioeconomic status, and addictive behaviors are just a few of the psychosocial issues tangled in the web of HIV. Efforts made to stop the spread of the disease,

educate individuals about the disease, and to provide services to individuals living with the disease have come from workers in the public health arena, as well as social workers.

Social workers struggle daily as practitioners, evaluators, intervention and prevention specialists as well as program planners to both develop effective prevention strategies and provide services and support to individuals who have already contracted HIV. Working alongside other individuals interested in being change agents in the field of prevention, they have both studied and identified high-risk populations and prevention education models. HIV/AIDS is not just a medical issue, but a political, social, and ethical one as well.

This study impacts the social work profession at several different levels. It provides social work practitioners with more information related to outreach gaps in the African American female community as well as beneficial information for social workers regarding how to proceed further in their efforts of HIV/AIDS prevention in the African American female community. For example, the results of the study suggest that prevention strategies for Black women must address the issue of power. As previously mentioned some literature (Saul, Moore, Murphy, & Miller, 2004; Wingood & DiClemente, 1997; Wu et al., 2003) concluded that many black women are at risk for contracting HIV based on a lack of power. Whether or not the participants of this study have a lack of power cannot be determined. However, the results do indicate that they do not perceive themselves to be lacking in power. This sense of fearlessness and power must be addressed in prevention initiatives and channeled into a desire to practice safe sex. Apart from changes to prevention initiatives, the information gained from this study can also provide social work evaluators with some suggestions from which to work when evaluating the effectiveness of social work outreach programs (i.e., measuring increases in knowledge is not sufficient to prove effectiveness). Furthermore, the results may also better equip social workers

in the prevention counseling of populations comparable to the one sampled in this research study.

The social work profession's emphasis on client empowerment can be extremely useful when working with a population akin to the one used in this study. The data collected in the interviews and focus groups showed a relationship between self-esteem and sexual decision making. Some empowerment interventions implemented within this population could prove to be useful in efforts to decrease risky sexual behavior among young African American women. The implementation of empowerment programs may also assist in enhancing the ability of this population to advocate for themselves as equal participants in their sexual relationships.

It is important that social workers use information, such as the results of this study and those similar to it, to create both culturally-sensitive and gender-specific interventions, in hopes of reaching the enormously diverse population of African American young women. Utilization of components related to popular culture, especially music and music videos, discussions related to positive relationships, and the inclusion of lessons and struggles of Black female history are some examples of steps practitioners can take to make programs more gender and culturally relevant.

Social workers are well suited to create and plan self-esteem focused HIV prevention programs in an effort to reduce risky sexual behavior. Furthermore, their knowledge of the importance of psychosocial factors in decision making as well as their understanding of behavioral change could prove to be effective when planning and implementing new HIV/AIDS prevention programs. Social work practitioners must be committed to advocating for appropriate programs for African American women in an effort to decrease contraction rates of HIV/AIDS.

Implications for Policy

Because social workers and their ideas greatly influence policy, they have a significant advantage in making sure that new policies include an effort to be sensitive to all high-risk populations. For Black women the best avenue to set up outreach may be through the Black church. However, inroads must be made to make this sort of outreach possible. According to Douglas (1999) there is an unwillingness among members of the Black church to acknowledge anything that has to do with sex. This includes sexuality, promiscuity, homosexuality and AIDS. This study serves as an example of this being true 8 years later, as I explained earlier that the only place that I was met with resistance regarding recruitment for this study was at three Black churches.

The CDC (2006) has taken on a new initiative to involve Black churches in the dialogue about HIV prevention. This governmental agency is currently attempting to bring Black religious leaders to the table regarding this issue so that strides can be made regarding HIV in the Black community. It is the position of the church that abstinence be the school of thought utilized to educate its masses, but these programs have proven ineffective (CDC, 2006). Social workers may be well suited to work toward the planning of creating of programs that meet the prevention needs of Black women as well as the needs of the Black church. Their knowledge of the importance of psychosocial factors on decision making, as well as, their knowledge of the fact that one must change thought in order to change behavior, could prove to be invaluable in the planning of new HIV/AIDS prevention programs. Social work practitioners must be committed to advocating for programs better suited for African American females, in an effort to decrease their contraction of HIV/AIDS.

Until there is a cure for AIDS, social workers must continue working toward efforts that decrease risky sexual behavior among all populations, but specifically high-risk populations such as African American women. It is important that social workers contribute to the literature on HIV/AIDS from a psychosocial perspective, so that studies continue to exist to aid program developers in their creation of new and innovative initiatives. Social workers must be change agents in this society's "War on AIDS," which cannot be done without listening to the voices of Black women and understanding the factors that contribute to their sexual decision making.

Recommendations for Future Research

The purpose of this study was to explore Black women's sexual risk factors as well as the factors that influence their sexual decision making. A qualitative methodology was used to facilitate the exploration. Based on the research findings, the following recommendations are proposed for future research:

1. Explore further the relationship between individual risk perception and collective risk perception.

2. Explore further the relationship between HIV knowledge and behavior change.

3. Repeat this study with adolescent African American girls.

4. Conduct studies with Black men who identify as being on the "down low."

5. Probe further into the concept of power, specifically regarding how it is understood and acted upon by young African American women.

6. Use additional methods of qualitative inquiry to investigate the themes that emerged in this study.

7. Use other research designs in examining correlates and predictors of risky sexual behavior among African American women.

8. Explore the link between Black history, including but not limited to slavery, and sexual decision making.

A discussion of each of these recommendations is included below.

Explore Further the Relationship between Individual Risk Perception and Collective Risk Perception

One of the most interesting findings of this study was the differences between how participants saw their collective risk as black women and how they saw their individual risk. This issue must be explored further. It is important that individual perception of risk be addressed among the young Black female population. Research much be conducted in this area as perception of risk may greatly affect risk reduction behaviors among Black women and may prove to be invaluable in prevention initiatives.

Explore Further the Relationship between HIV Knowledge and Behavior Change

It is imperative that research initiatives be undertaken to further investigate why, despite being knowledgeable about HIV and expressing the ability to protect themselves, young African American women continue to participate in risky sexual behavior. Effort must be made to understand how knowledge and behavior change can be linked. It is important to explore what factors are instrumental in motivating behavior change among this population. This exploration is the key to HIV prevention among African American women.

Repeat This Study with Adolescent African American Girls

As discussed earlier in this chapter, it may be important to replicate this study with younger African American females. In both the individual and focus group interviews, it was apparent that many of the participants had their first sexual encounters during their teenage years. Some of the participants indicated that it was in these relationships that they had practiced

unsafe sex. Karen was one of many of the participants who discussed sexual relationships that had occurred during high school when she spoke about being afraid she was pregnant on numerous occasions: "When I was in high school and I had a long-term boy friend [sexual partner], and I thought we were getting married and all kind of stuff, and we had unprotected sex, and had baby scares." If young African American adolescents are having sex in their early teenage years, it is important to understand the factors that contribute to their sexual decisions while they are adolescents. The teen years may actually be the point for the most effective and long-lasting intervention.

Conduct Studies with Black Men Who Identify as Being on the Down Low

The mention of the down low "brotha" was constant during this study. It was one of only a few terms that all 25 of the participants mentioned. There seemed to be a real concern about this phenomenon that was present in all of the interviews and focus groups. Although there have been many studies that focus on men who have sex with men, there has been very little research regarding men who identify as being on the down low (King, 2004). Jabir (2004) addressed the issue most eloquently in his article, "Up From the Down Low," when he reported the real roots of the down low issue:

> While the increased rates of HIV for African American women is certainly cause for
> alarm, keep in mind that the down low is a creation and function of homophobia—a
> homophobia supported by Black religious conservatism, social and cultural constraints,
> and unhealthy popular notions of Black masculinity. (p. 10)

Further research in this area could prove to be invaluable in terms of understanding the needs of this population and assistance needed to empower these men to be more honest with their sexual partners. Information in this area could lead to great progress in terms of HIV prevention.

Probe Further into the Concept of Power, Specifically Regarding How It Is Understood and Acted Upon by Young African American Women

As previously presented in the discussion section of this chapter, the notion of power and the reality of who has it and who does not regardless of what individuals believe is important. If, in fact, young African American women do feel powerful in relationships and feel some sense of power in their ability to protect themselves, the question remains, why don't they? The notion of power must be explored in greater depth. It is important that we understand how this population defines power. It is equally important that there is some general comprehension of the difference between who has power and who is perceived to have it. HIV prevention is a very complex issue in the Black community, and the concept of power is central to this discussion.

Use Additional Methods of Qualitative Inquiry to Investigate the Themes That Emerged In This Study

This study utilized individual interviews and focus groups and although the data were full and detailed, further exploration could provide a greater understanding of each category and property described in Chapter Four. For example, a study of the lyrics of popular, rap, and rhythm and blues music could be very valuable in gaining a realistic view of music's influence on the lives of young African American women. A document analysis could be done on the images of young Black women in magazines. These explorations could inform the design of future prevention initiatives. Many participants indicated that they are bombarded with media and acknowledged its impact on both how they are expected to perform in sexual relationships as well as how they make sexual decisions. Additional investigation is this area could be very constructive.

Use Other Research Designs in Examining Correlates and Predictors of Risky Sexual Behavior among African American Women

As discussed earlier, many of the participant responses in this study suggested that sexual relationships are occurring during early adolescence. A large scale study examining what factors correlate with young African American girls participating in risky sexual behavior could be valuable in designing prevention initiatives. Beyond that, a large scale study that identified predictors of certain sexual decisions would be an important addition to the literature.

Explore the Link between Black History, Including but Not Limited to Slavery, and Sexual Decision Making

There is a major gap in the literature regarding sexual decision making and the impact of the historical experiences of Black women. Although this study addressed it, the work here is not nearly enough. Further inquiry of these issues could be helpful in addressing sex and HIV with regards to Black women. The role slavery still plays in the Black community has not been explored in relationship to the HIV/AIDS epidemic or its impact on the Black community at large.

Chapter Summary

The purpose of this study was to explore young African American women's sexual risk factors as well as the factors that influence their sexual decision making. The research questions guiding this study were as follows:

1. What is the general understanding of HIV among Black women?

2. What are Black women's perceptions of HIV risk?

3. What influences Black women's sexual decision making?

4. How has the intersection of race, class, and gender affected Black women's perception of power?

5. How has the intersection of race, class, and gender affected Black women's sexual risk?

This study adds to the expanding body of sexual decision making literature regarding young African American women. It investigated the factors that influence young Black women's decisions related to sexual decision making. Three general conclusions were derived based on the analysis of the individual and focus group interviews of 25 young African American women. They included: (1) Despite their knowledge of HIV/AIDS and both familial and religious influences, young Black women still make sexual decisions that put them at risk for contracting HIV; (2) Young Black women recognize that they are at great collective risk for contracting HIV, yet fail to acknowledge individual risk; and (3) Issues of power and some popular media significantly influence the sexual decisions of young Black women. These conclusions, along with the implications of this study in relationship to theory and social work practice, as well as recommendations for future research were provided.

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APPENDICES

APPENDIX A

Recruitment Form
$20 for 90 Minutes of Your TIME

My name is Aisha Tucker-Brown, and I am a doctoral candidate at the University of Georgia's School of Social Work. I am interested in talking to you about factors that influence sexual decision making for my study entitled "AN EXPLORATION OF FACTORS THAT INFLUENCE SEXUAL DECISION MAKING AMONG YOUNG BLACK WOMEN." The purpose of this study is to explore Black women's risk factors as they relate to knowledge about HIV/AIDS, social and emotional factors that influence sexual decision making, and self-reported perceptions of risk and power. I am not interested in any information regarding the specifics of your sexual history, but I will be asking participants to speak freely about the decisions they make regarding sex. I am hoping that the results of this study will help to inform prevention initiatives directed at young Black women and would be grateful if you could join me in this exploration.

In order to be a participant in this study you must:
- Be between 18 and 25 years of age
- Be or have been sexually active
- Identify as Black

There are two ways to contact me if you are interested in participating in this study:

If anonymity is of concern:
- Choose a pseudonym (name, not your own) for the study
- Call me at 678-777-8488 (this number does not have caller id)
- Identify yourself by the name you have chosen. (If we do not make contact please leave a message and try again later) (If contact is made we can talk about the details of the study) For the duration of your participation in the study I will address you by the pseudonym you have chosen.

If anonymity is of no concern:
- Call me at 678-777-8488 or
- Email me at aktb@uga.edu or
- Send me a note by mail to:
  - Aisha Tucker-Brown
    University of Georgia
    School of Social Work
    Tucker Hall
    Athens, GA 30602
- Please include your name, daytime and evening phone, best time to call and, email address.

Thank you for your interest in this study.
I look forward to discussing it further with you.

APPENDIX B

Participant Demographic Information and Screening Tool

1.   What year were you born? _____

2.   Where were you born?_____

3.   Would you consider yourself: (circle one)

      (1) African American, (2) Caucasian, (3) Latino, or (4) Other

4.   What is your religious affiliation? (If none answer n/a) _____

5.   What is your highest level of education completed? (check one)
- Elementary School
- Junior High School
- High School
- Associate's degree
- Bachelor's degree
- Master's degree
- Other: _____

6.   Please indicate your parents' highest educational level.

Mother or guardian (check one)
- No Diploma
- High School or GED
- Some College
- Associate's Degree
- Bachelor's Degree
- Master's Degree or Higher
- I Don't Know

Father or guardian (check one)
- No Diploma
- High School or GED
- Some College
- Associate's Degree
- Bachelor's Degree
- Master's Degree or Higher
- I Don't Know

7.   How would you describe your sexual preference: (circle one)

      (1) Heterosexual, (2) Homosexual, (3) Other

Thank You For Your Time

APPENDIX C

Interview Consent Form

I, _____, agree to participate in a research study titled "AN EXPLORATION OF FACTORS THAT INFLUENCE SEXUAL DECISION MAKING AMONG YOUNG BLACK WOMEN" conducted by Aisha K. Tucker-Brown, a doctoral student from the School of Social Work at the University of Georgia (telephone: 678-777-8488; email: aktb@uga.edu). under the direction of Dr. Patricia Reeves, School of Social Work, University of Georgia. I understand that my participation is voluntary. I can stop taking part without giving any reason, and without penalty. I can ask to have all of the information about me, to the extent that it can be identified as mine, returned to me, removed from the research records, or destroyed.

I understand that the purpose of this study is to explore Black women's risk factors as they relate to knowledge about HIV/AIDS, social and emotional factors that influence sexual-decision making, and self reported perceptions of risk and power.

If I volunteer to take part in this study I understand that:
- I will participate in a 90-minute individual interview session.
- The researcher will ask me personal open-ended questions regarding my past sexual relationships, knowledge of and perception of risk regarding HIV/AIDS, and any factors I consider in my decision making as they relate to my sexual relationships.
- My interviews will be audio taped and pseudonyms will be used in an effort to keep my identity confidential. The audio tapes will be locked in a secure file cabinet located in the researcher's on- campus office, and will be only accessible to the researcher. All audio tapes will be retained only until the completion of the study and will be destroyed immediately following its completion (June 1, 2007).
- I may be asked by the researcher to suggest other participants who may be wiling to participate in the study.
- I may be contacted by the researcher to participate further in the study by attending a small focus group meeting where I will be asked to discuss many of the points of my interview in a group setting. My decision to participate would be strictly voluntary.

I will receive $20 to compensate me for my participation in this study. The researcher is also hopeful that my participation in the study will in some way empower me through my own retrospective look at my decisions regarding sex, and that my participation could lead to informing new HIV prevention initiatives geared toward Black women. No risk is expected, however if I experience any discomfort or concern about my participation, I may contact the researcher at any time during or after the completion of the study.

The investigator will answer any further questions about the research, now or during the course of the project (678-777-8488). No information identifying me will be shared with others without my written permission. All information concerning me will be kept confidential.

I understand that by signing this consent form, I am agreeing to take part in this research project and understand that I will receive a signed copy for my records. Please sign both copies, keep one and return one to the researcher.

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 records.

_____   _____
Signature of Participant   Date

_____   _____
Aisha Tucker-Brown   (Investigator)   Date
(678)777-8488
aktb@uga.edu

Additional questions or problems regarding your rights as a research participant should be addressed to Chris A. Joseph, Ph.D. Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu

APPENDIX D

Focus Group Consent Form

I, _____, agree to participate in a research study titled "AN EXPLORATION OF FACTORS THAT INFLUENCE SEXUAL DECISION MAKING AMONG YOUNG BLACK WOMEN" conducted by Aisha K. Tucker-Brown, a doctoral student from the School of Social Work at the University of Georgia (telephone: 678-777-8488; email: aktb@uga.edu). under the direction of Dr. Patricia Reeves, School of Social Work, University of Georgia. I understand that my participation is voluntary. I can stop taking part without giving any reason, and without penalty. I can ask to have all of the information about me, to the extent that it can be identified as mine, returned to me, removed from the research records, or destroyed.

I understand that the purpose of this study is to explore Black women's risk factors as they relate to knowledge about HIV/AIDS, social and emotional factors that influence sexual decision making, and self reported perceptions of risk and power.

- If I volunteer to take part in this study I understand that:
- I will participate in a 90 to 120 minute group interview session.
- The researcher will ask me personal open-ended questions regarding my past sexual relationship, knowledge of and perception of risk regarding HIV/AIDS, and any factors I consider in my decision making as they relate to my sexual relationships, and I will be expected to talk about them with the group.
- The interview will be audio taped and pseudonyms will be used in an effort to keep my identity confidential. The audio tapes will be locked in a secure file cabinet located in the researcher's on- campus office, and will be only accessible to the researcher. All audio tapes will be retained only until the completion of the study and will be destroyed immediately following its completion (June 1, 2007).
- I will be required to keep both the content of the group discussion as well as the identity of the group members confidential.

I will receive a $10 gift card to compensate me for my participation in this study. The researcher is also hopeful that my participation in the study will in some way empower me through my own retrospective look at my decisions regarding sex, and that my participation could lead to informing new HIV prevention initiatives geared toward Black women.   No risk is expected, however if I experience any discomfort or concern about my participation, I may contact the researcher at any time during or after the completion of the study.

The investigator will answer any further questions about the research, now or during the course of the project (678-777-8488). No information identifying me will be shared with others without my written permission. All information concerning me will be kept confidential.

I understand that by signing this consent form, I am agreeing to take part in this research project and understand that I will receive a signed copy for my records. Please sign both copies, keep one and return one to the researcher.

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 records.

_____   _____
Signature of Participant   Date

_____   _____
Aisha Tucker-Brown   (Investigator)   Date
(678)777-8488
aktb@uga.edu

Additional questions or problems regarding your rights as a research participant should be addressed to Chris A. Joseph, Ph.D. Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu

APPENDIX E

Interview Guide

1. **What is the general understanding of HIV among Black women?**

   a. When I say HIV or AIDS tell me a little about what comes to mind.

   b. Have you ever been involved in any HIV prevention education classes or initiatives? If so, what did you learn?

   c. What do you think they were missing? What could be added?

2. **What are Black women's perceptions of HIV risk?**

   d. When I say, a person is HIV-positive or that he or she has AIDS, describe the type of person who comes to mind. What characteristics come to mind?

   e. What, if anything, do you think of when you think of Black women and HIV?

   f. How at risk would you consider yourself (or an African American woman with the same lifestyle as you)?

   g. Do you think Black women are at risk for contracting HIV? What puts them at risk? What keeps them from being at-risk?

3. **What influences Black women's sexual decision making?**

   h. Walk me through the process of how you decide whether or not to have sex.

   i. How do you decide when to use a condom and when not to use one?

   j. How do you decide who to have sex with and who not to have sex with?

4. **How has the intersection of race, class, and gender affected Black women's perception of power?**

   k. How do you think being Black and female affects how you make decisions regarding sex?

l. How, if at all, does money influence those decisions?

m. Do you feel like you are in charge of decisions regarding sex?

n. What are some ways that you have expressed that power? or What are some examples of others having power over your decisions regarding sex?

5. **How has the intersection of race, class, and gender affected Black women's sexual risk?**

o. How do you think being Black and female affects your sexual risk?

p. How, if at all, does class influence those decisions?

q. What role does history play in your sexual decisions?

Focus Group Guide

1. **What is the general understanding of HIV among black women?**

a. When I say HIV or AIDS tell me a little about what comes to mind.

b. Have you ever been involved in any HIV prevention education classes or initiatives? If so, what did you learn?

c. What do you think they were missing? or What could be added?

2. **What are black women's perceptions of HIV risk?**

a. "When I say, "A person is HIV-positive or that he or she has AIDS," describe the type of person who comes to mind." What characteristics come to mind?

b. What, if anything, do you think of when you think of black women and HIV?

c. How at risk would you consider an African American woman with the same lifestyle as you?

d. Do you think black women are at risk for contracting HIV? What puts them at risk? or What keeps them from being at-risk?

3. **What influences black women's decisions regarding safe sex practices?**

    a. Walk me through the process of how a young woman like you decides whether or not to have sex.

    b. How do young women like you decide when to use a condom and when not to use one?

    c. How do young women you know decide who to have sex with and who not to have sex with?

4. **How has the intersection of race, class, and gender affected black women's sexual risk and perception of power?**

    a. How do you think being Black and female affects how young women make decisions regarding sex?

    b. How, if at all, does money influence those decisions?

    c. Do you feel like young women like you are in charge of decisions regarding sex?

    d. What are some ways that this power is expressed? or What are some examples of others having power young women's decisions regarding sex?