12-14-2015

Nurses Utilizing the V.O.I.C.E.S. HIV Prevention Intervention in the Black Church Community

Jason Richard
University of South Carolina - Columbia

Nurses Utilizing the V.O.I.C.E.S. HIV Prevention Intervention
in the Black Church Community

by

Jason Richard

Bachelor of Science
San Francisco State University, 2004

Bachelor of Science
University of South Carolina, 2009

Submitted in Partial Fulfillment of the Requirements

For the Degree of Doctor of Nursing Practice in

Nursing Practice

College of Nursing

University of South Carolina

2015

Accepted by:

Laura Hein, Major Professor

Stephanie Burgess, Committee Member

Abbas Tavakoli, Committee Member

Stacy Smallwood, Committee Member

Lacy Ford, Senior Vice Provost and Dean of Graduate Studies

DEDICATION

I dedicate this dissertation to my family – Yvonne Maxey (my beloved grandmother), Darryl Richard, Melva Lee, and LaCreacia Mpu. Also, I dedicate this to my *best friends for life* – Dr. Lisa T. Williams, Dr. Ashley Sirianni, and Ms. Alia Mujadidi. Thanks for your unconditional love, unwavering support, and continuous encouragement! You all have helped me persevere through my darkest hours and pushed me to move forward at times when I felt hopeless, discouraged, and insecure. I do not know if I would have completed this dissertation without you all being my faithful cheerleaders to the very end. When I think of you all, I smile, and thank God. I am truly blessed to have each of you in my life – y'all really-really rock!

ACKNOWLEDGEMENTS

I would like to acknowledge and thank each and every one who help me complete this arduous dissertation. First, I give glory and honor to my personal Lord & Savior Jesus Christ who had made all things possible! Second, I thank my *Black African Queen* – my grandmother Ms. Yvonne L. Maxey, who raised me and has been my rock of support throughout everything. Third, I thank my fabulous parents Mr. Darryl Richard and Mrs. Melva Lee for their unwavering support, words of encouragement, many-many prayers, and being a source of motivation during my darkest hours. I give a special thanks to my dear sister Ms. LaCreacia Mpu whose divine wisdom and tremendous wealth of knowledge has blessed me throughout my academic journey, especially during this dissertation.

And to all the "*People in the Village*" who helped me complete this journey, I thank God for you guys and I would like to take this special opportunity to acknowledge y'all. Thanks to my wonderful editor, Ms. Melissa Dugan, who has been a joy to work with and made the writing process fun. Thanks to my San Francisco State University colleagues who were "mini-mentors" that helped me think outside the box: Ms. Sherrita Cobbs, Dr. Karthic Ekambaram, Ms. Liza Maulino, Ms. Lala Motlhabi, Dr. Christine Natan, Mrs. Kinjal Nayar, and Mrs. Norma Traverso. Thanks to my USC colleague, Dr. Donna Becker, who was my biggest cheerleader keeping me motivated to cross the finish line. Thanks to my "*Black Girls That Rock*" who gave me tremendous in-sight during this doctoring process: Dr. Sonia Campbell, Dr. Denise Crawford, Dr. Sheryl Mitchell, and Dr. Lisa

Williams. Thanks to my church family and friends who gave me unprecedented foresight when implementing this project: Mrs. Angela Burrell, Ms. Tomika Johnson, Mr. Elimuel & Mrs. Calotta Porterfield, and Mr. Jean-Marie & Mrs. Emilienne Watonsi. I also would like to thank Project F.A.I.T.H for allowing me to use their HIV Stigma Survey: Dr. Coleman, Dr. Gaddist, Dr. Lindley, and Dr. White. Last, but not least, I would like to thank the following community leaders for providing the V.O.I.C.E.S. intervention materials: Dr. AnnDenise Brown (The Balm in Gilead), Mr. Dean Edwards (Palmetto AIDS Life Support Services), Mr. Chestly Price (South Carolina HIV/AIDS Counsel), and Ms. Stephanie Upton (Center for Disease Control).

ABSTRACT

The Human Immunodeficiency Virus (HIV) epidemic is a significant problem in the United States, especially in the "Bible Belt" Deep South where the epidemic is hitting this region the hardest. The HIV epidemic in the state of South Carolina is very real, significant, and quite alarming. In fact, the Center for Disease Control and Prevention (CDC) labels South Carolina as an HIV "hot spot." All racial and ethnic groups are susceptible and impacted by HIV. However, evidence shows that African Americans – especially young adults 18-35, bear the brunt of the burden to the extent that the "new face" of the HIV epidemic is Black. Consistent with national trends, African Americans residing in the state of South Carolina are disproportionately impacted by the HIV epidemic versus all other racial/ethnic groups. The HIV healthcare crisis African Americans are facing in South Carolina is very problematic and evidence suggests that the Black Church can play a significant role to counteract the HIV epidemic within the African American community.

In order to provide HIV prevention to young adult African Americans in the Black Church setting, evidence suggests it is imperative to target church leadership and gain their consent to do so. This evidence-based practice quality improvement project entails introducing Black Church leadership to the community-based CDC-approved HIV intervention titled *Video Opportunity for Innovative Condom Education and Safer Sex* (V.O.I.C.E.S.). A sample of 32 leadership participants from four South Carolinian Black Churches was introduced to the four core elements of the V.O.I.C.E.S. intervention. A leadership survey was administered to participants to obtain their input whether the

V.O.I.C.E.S. intervention is appropriate to implement in the Black Church setting in its original form or whether it needs to be modified. An HIV-stigma survey was administered to participants to assess their level of HIV knowledge and HIV stigma and determine if there is a relationship in leadership's opinion in the adoption of the intervention in the church setting.

A mixed method research design was employed. Results show that South Carolinian Black Church leadership who are more knowledgeable about HIV were more likely to agree that the V.O.I.C.E.S. intervention is appropriate to implement in its original form in this setting. Also, leadership from different Black Church denominations appear to differ how HIV prevention should be presented to their young adult parishioners. Implications from this evidence-based practice quality improvement project suggests that nursing can collaborate/negotiate with Black Church leadership to tailor the V.O.I.C.E.S. intervention to suit the needs of their parishioners while adhering to church doctrine.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

AIDS ..... Acquired Immunodeficiency Syndrome

CDC ..... Centers for Disease Control and Prevention

CBO ..... Community-Based Organization

DHEC ..... Department of Health and Environmental Control

DL ..... Down Low

EBP QI ..... Evidence-Based Practice Quality Improvement

FBO ..... Faith-Based Organization

HBM ..... Health Belief Model

HIV ..... Human Immunodeficiency Virus

MSM ..... Men who have Sex with Men

NAACP ..... National Association for the Advancement of Colored People

NHAS ..... National HIV AIDS Strategy

PALSS ..... Palmetto AIDS Life Supports and Services

PI ..... Principle Investigator

PLWHA ..... People Living With HIV/AIDS

SCHAC ..... South Carolina HIV/AIDS Council

STD ..... Sexually Transmitted Disease

TRA ..... Theory of Reasoned Action

TPB ..... Theory of Planned Behavior

V.O.I.C.E.S ..... Video Opportunity for Innovative Condom Education and Safer Sex

DEFINITIONS

Bishop – an individual who serves in a pastoral role whose rank is greater than a pastor in terms of leadership hierarchy. A bishop is an overseer who may pastor or direct activities in more than one church.

Pastor – the central leader over one church. A pastor preaches to a group of parishioners and directs the activities of the church.

Elder – a formal title designated to a licensed minister who is under the direction of the pastor. They assist the pastor in their role, and are equipped to preach to parishioners when the pastor is absent.

Evangelist – an individual who ministers the word of God. Individuals holding this formal title ministers at their designated church; may have speaking engagements at other churches locally, national, and/or international.

Minister – an individual that teaches the word of God. They help meet the need of pastors, elders, deacons, and parishioners within the church.

Deacon – an individual who ministers to parishioners. Under the direction of the pastor, they execute both administrative and ministerial duties.

Church Mother – an elderly woman in the church, who is mature in the Word of God, who teaches women how to conduct themselves as single or married Christian individuals.

Church Secretary – serves in an administrative role who assists and ministers to the pastor. They serve as a liaison between pastoral staff, administration staff, and parishioners within the church.

HIV/AIDS Director – an individual who trains and educates ministerial staff regarding HIV/AIDS and directs departmental activities that will be executed within the church. Leaders holding this title are ministers who help their local church by providing HIV/AIDS information to parishioners.

CHAPTER 1

INTRODUCTION

1.1 Significance

In June of 1981, the first cases of Acquired Immunodeficiency Syndrome (AIDS), later known to be caused by the Human Immunodeficiency Virus (HIV), made headline news, provoking panic across the nation as a new deadly disease. Ever since its discovery, clinicians, scientists and community officials have been working feverishly trying to eradicate and control the HIV epidemic; unfortunately, there have been no signs of complete containment or a cure (Avert, 2012).

More than 1.8 million individuals in the United States are estimated to have been infected with HIV, including the more than 650,000 people who have already died from the virus (Kaiser Family Foundation, 2013). Now in the third decade of the epidemic, HIV continues to be a major national health concern with more than 1.2 million people living with HIV and 1 in 8 people (12.8%) unaware of their infection (CDC, 2015). Although the epidemic may have been yesterday's shocking headline news, the crisis of acquiring and transmitting HIV persists today. Fortunately, HIV infection rates have decreased from the 1980s peak, but evidence suggests the HIV transmission rates remain steady (Kaiser Family Foundation, 2013). In the United States, more than 50,000 Americans become infected with the virus each year. In fact, the CDC reports every 9 ½ minutes, a person acquires the infection (CDC, 2009).

HIV is reported to affect people in all 50 states, including the District of Columbia and United States dependencies. However, the impact of the epidemic is not evenly spread across all states and national regions (Kaiser Family Foundation, 2013). Surveillance rates show HIV infection rates in the Southern "Bible-Belt" region of the United States are disproportionately heavily concentrated, with urban metropolitan communities bearing the greatest burden (Kaiser Family Foundation, 2013; Prejean, Hall & Tang, 2013). Compared to the rest of the country, the South is home to the largest percentage of the United States population and is differentiated from other regions of the country because it is comprised of the highest percentage of Black people, or African Americans (18.5%), versus the rest of the nation (8.2%) (Prejean, Hall & Tang, 2013). Since African Americans, who predominately reside in the South, are disproportionately affected by the HIV/AIDS epidemic, this may explain why the Southern region of the United States is highly impacted by HIV. Unfortunately, HIV is so prevalent within the Bible-Belt region that the South is in a state-of-emergency (Prejean, Hall & Tang, 2013).

In the Deep South, Southern states like South Carolina consistently rank among the nation's top states for highest HIV prevalence rates annually (Reif, S., Pence, B., Hall, I., Hu, X., Whetten, K., and Wilson, E., 2014). In fact, South Carolina is designated as an HIV "hot spot" for the United States. Evidence from the AIDS Benefit Foundation of South Carolina (ABFSC) suggests for the past four years South Carolina ranked first in the nation regarding heterosexual-associated HIV transmission rates (ABFSC, 2014). According to the Department of Health and Environmental Services (DHEC), the HIV/AIDS epidemic in South Carolina is continuing to grow with an average of nearly 780 new cases of HIV infections reported each year (DHEC, 2012). At the end of 2011, DHEC (2012) tallied up

that approximately 14,945 South Carolinians were living with HIV/AIDS, yet this number does not include persons diagnosed in other states who now reside in the *Palmetto* State (DHEC, 2012). In the Midlands, Columbia, South Carolina's largest city, ranks sixth among the nation's metropolitan areas for new AIDS cases (AIDS Benefit Foundation of South Carolina, 2014).

1.2 HIV among African American People

The HIV/AIDS epidemic is a tremendous threat to the health and well-being of many communities across the nation, but for African American people, the epidemic is a major healthcare crisis. Compared to all other racial/ethnic groups, African American people are the racial/ethnic group most severely affected by the HIV/AIDS crisis here in the United States (AIDS.gov, 2015). Although African Americans embody only 12 to 14% of the U.S. population, they account for nearly half (49%) of all HIV infections (Pryor, Siu, Guilbault & Ofuatey-Kodjoe, 2009). African Americans accounted for 18,121 (49%) of the near 40,000 new HIV/AIDS cases in the country during 2005. That same year, Latino Americans only accounted for 18%, Whites for 31%, Asian Americans/Pacific Islanders for 1%, and American Indians/Alaskan Natives for less than 1% of new reported HIV/AIDS cases (CDC, 2007). In 2010, adult African American women were 20 times more likely to acquire an HIV infection compared to their White women counterparts and nearly 5 times higher than Latina women (CDC, 2012). Adult African American males were seven times more likely to acquire new HIV infections versus their White male counterparts, twice as high compared to Latino/Hispanic men and approximately three times higher than adult African American women (CDC, 2012).

Among the teenage population, African American teens make up approximately 15% of the U.S. population, yet they accounted for 70% of new AIDS diagnoses among teens during 2010. In 2009, Black men who have sex with men (BMSM) represented nearly 75% of new HIV infections amongst all African American men (Huff Post Black Voices, 2013). Overall, African Americans are 8.5 times more likely to be diagnosed with HIV infections. Compared to White people in 2010, African American adults (ages 18-64) were more likely to have been screened for HIV even though their infection rates were higher (Huff Post Black Voices, 2013).

Compared to all other racial/ethnic women, African American women are the most impacted by the HIV/AIDS epidemic in the United States. African American females, ages 13 and older accounted for 64% of all new HIV cases among women during 2010 (CDC, 2015). Most HIV/AIDS cases reported among African American women were acquired via high-risk heterosexual contact — having high-risk male partners who have been incarcerated, use IV drugs, have multiple sex partners, or have a partner who also has sex with other men (CDC, 2007). Because women are deeply affected by the HIV/AIDS epidemic, the next generation of African American children and infants are at risk too. Studies show there is a possibility that HIV-infected women can pass HIV to their offspring during pregnancy, labor and delivery or while breastfeeding. And for women who are HIV positive, they are encouraged not to breastfeed their offspring in order to prevent vertical HIV transmission (CDC, 2010). Fortunately, mother-to-child HIV transmission has declined substantially over the last decade, but for children under the age of 13, having a diagnosis of AIDS is over-represented among African Americans (CDC, 2007).

Although most HIV infections occurring among African American women are attributable primarily to heterosexual activity, among African American men this appears more varied. In 2010, men accounted for 70% (14,700) of all HIV/AIDS cases among African Americans (CDC, 2015). African American males aged 13 and older accounted for nearly 45% of all HIV/AIDS diagnoses among all men. According to the CDC, almost half (48%) of all HIV/AIDS cases among African American men were related to male-to-male sexual contact compared to injection drug use HIV acquisition (23%) and high-risk heterosexual contact (22%). Black men who have sex with men (BMSM) account for the highest rates of HIV prevalence compared to all other African American subgroups that may have acquired the infection other ways (e.g. intravenous drug use, sex work, heterosexual men and women, or in utero) (Avert, 2015; CDC, 2015). Men who have sex with men (MSM), or males who have sex with males, is the colloquial nomenclature used to describe male-gendered persons who have sexual intercourse with members of the same sex, regardless of how the individual sexually identifies himself — gay (homosexual), straight (heterosexual), bisexual, or questioning (bi-curious) (World Health Organization, 2010).

1.3 Barriers and Vulnerability for HIV

During the early 1980s, most HIV/AIDS cases were among gay White men. As a consequence, today, many African American people may think HIV/AIDS is not a concern or threat to American-Americans, as it is historically thought to be a gay White man's disease (CDC, 2007). Denial about HIV susceptibility within the African American community can be a reason why the infection is growing and why those who are infected do not get tested and unknowingly transmit HIV to others. The facts show HIV is

transitioning into a predominantly African American problem. Although racial background and ethnicity alone are not risk factors for HIV acquisition, historical and current social-cultural barriers within the culture may continue to keep African Americans at risk for HIV (CDC, 2007). It is within the context of the Black Church, a prominent social structure within the African American community, that this evidence-based practice quality improvement (EBP QI) inquiry will be conducted.

The factors that keep African Americans at risk for HIV are multi-factorial, complex and pose as cultural barriers. Because HIV is predominately transmitted by sexual contact, addressing the epidemic is problematic. Talking openly about issues pertaining to sexuality, promiscuity, homosexuality, and sexual relations outside of the confinement of marriage are very private and sensitive matters many African Americans find culturally taboo (CDC, 2007). In addition, historical issues such as racism, oppression and discrimination, medical profession/governmental institutional misconduct (e.g. Tuskegee Institute Study), limited access to health care, higher unemployment rates, low-income, poverty, and limited education pose as barriers to African Americans and make African Americans more vulnerable to HIV infection (CDC, 2007).

Sexual networks may cause African Americans to be vulnerable to HIV as well. Evidence shows that African American women have limited partner selection due to the fact that there are few African American males available within African American communities (Adimora, Schoenbach & Doherty, 2006). Female gender surplus within African American communities can place females at a disadvantage when negotiating and maintaining a mutually monogamous relationship due to the fact that African American males can readily find another sexual partner if they perceive their primary relationship as

problematic (Adimora, Schoenbach & Doherty, 2006). Some African American males may maintain concurrent primary relationships while having sexual relationships with other women or men, while their primary partner (e.g. girlfriend, fiancé, or wife) is unaware. Such behavior can make African American females vulnerable for HIV acquisition.

Higher incarceration rates among African American men are a barrier that increases HIV risk in the African American community as well. Because sexual relations are discouraged among inmates, condoms are not disseminated or accessible within jails and prison, which increases infection acquisition and transmission (Braithwaite & Arriola, 2008; Sylla, Harawa, & Reznick, 2010).). HIV/AIDS studies among incarcerated populations show that the rate of AIDS cases in jail is four times the rate of general US population (Braithwaite & Arriola, 2008). Unfortunately, African American males are over represented in penitentiaries versus in institutions of higher learning (Braithwaite & Arriola, 2008; NAACP, 2015; Valbrun, M., 2015). And for some incarcerated African American males, whether gay/non-gay-identifying or heterosexual, due to their circumstances, they may engage in sexual activity with other inmates while incarcerated, creating a situation in which they are very vulnerable to acquiring HIV. HIV may later be transmitted to others while incarcerated or to the community when released from jail/prison (CDC, 2012).

Other factors that pose as barriers and make African Americans vulnerable to HIV include both physiological and psychological components. Sexually transmitted diseases (STDs) may increase one's risk for the acquisition/transmission of HIV secondarily due to the compromise of the integument's integrity—the first line of defense (CDC, 2010); the

presence of STDs may serve as gateways to increased HIV susceptibility and transmission (CDC, 2010). Evidence suggests African Americans have higher rates of STDs. In 2005, African Americans had higher rates of diseases, like gonorrhea, chlamydia and syphilis, versus any other racial/ethnic group (CDC, 2007). Psychological issues like substance abuse (IV drug use, alcohol abuse, or being under the influence during sex), mental health problems (e.g. depression, internalized homonegativity), childhood sexual abuse and other psychological stressors may be other issues some African Americans deal with which can make them vulnerable to protecting themselves and/or their partners from HIV (CDC, 2007).

1.4 HIV Impact: Morbidity & Mortality

African Americans are bearing the brunt of the HIV crisis in the United States. African Americans receive more AIDS diagnoses and experience more HIV-related morbidity and mortality compared to any other racial/ethnic group here in the United States (WebMD, 2013). America is a highly industrialized country with many resources available to African Americans, and yet African American HIV/AIDS rates resemble the high HIV/AIDS rates of developing countries. Moreover, if African Americans were a freestanding nation alone, African Americans would rank 16th in the world for the number of people affected and living with HIV (Wilson, Wright & Isbell, 2008). And compared to White people, African Americans are more likely to know either someone living with HIV/AIDS or someone who has died from AIDS (Laurencin, Christensen & Taylor, 2008; Wilson, Wright & Isbell, 2008).

According to the CDC (2013), HIV has been a leading cause of death for African Americans aged 25-44 since the late 1990s. HIV is the sixth leading cause of death among African American males aged 20-24, sixth leading cause of death for ages 25-34, and the fifth leading cause of death among males 35-54 (CDC, 2013). Among African American females, HIV is the seventh leading cause of death for ages 20-24, sixth for ages 25-34, fourth leading cause for 35-44-year-olds and sixth leading cause of death for African American females between the ages 45-54 (CDC, 2013).

Mortality rates from HIV infection are disproportionately high among African Americans. Even though White Americans outnumber African Americans by a ratio of more than six to one, the total number of AIDS related deaths among African Americans (218,000) closely equals that of Whites (239,529) who have died from AIDS (Wilson, Wright & Isbell, 2008). On average, the survival time for African Americans with a diagnosis of AIDS is lower than all other racial/ethnic groups (WebMD, 2013). Reasons why African Americans experience higher mortality rates compared to Whites or any other racial/ethnic groups are multi-factorial, including, but not limited to: (1) higher incidence of poverty, (2) incarceration, (3) lack of access to care, (4) medical distrust, (5) homophobia, (6) HIV serostatus awareness, and (7) HIV associated stigma. These factors all commonly play a role in delayed diagnosis of HIV infection among African Americans (Laurencin, Christensen & Taylor, 2008; Wilson, Wright & Isbell, 2008).

Those aware of their HIV diagnosis access to care has been difficult to sustain for many, which also accounts for the higher morbidity and mortality rates seen among African Americans. Access to care requires health insurance. Evidence suggests African Americans are significantly more likely than Whites to be uninsured; nationwide, 21% of

African Americans do not have health insurance. Uninsured rates among non-elderly African Americans are particularly high within the Bible-Belt region where most African Americans reside, and HIV infection is the most burdensome (Kaiser Family Foundation, 2013; NAACP 2013). Access to HIV treatment is not cheap; the burden of HIV therapy makes continuity of medical care difficult to sustain, especially without health insurance. On average, HIV therapy costs roughly $25,000 per year, of which pharmacotherapy is only a portion of a patient's comprehensive healthcare needs (National HIV/AIDS Strategy for the United States, 2010). And for African Americans living with HIV, nearly 59% rely on Medicaid to cover their cost of care (Huff Post Blackvoices, 2013).

1.5 Current Practices

Because the HIV epidemic is a significant problem and leading cause of preventable death in the U.S., national guidelines from Healthy People 2020 and the National HIV/AIDS Strategy (NHAS) have set objectives, strategic plans and goals to reduce the incidence/prevalence of HIV/AIDS and its associated illnesses and death. Healthy People 2020 suggest HIV prevention efforts should be exercised to reduce infection transmission. Although prevention efforts are key to reducing the incidence/prevalence of HIV, Healthy People 2020 encourages routine testing be equally important so people can know their status and can make behavioral lifestyle changes, especially if HIV positive, to improve individual's health and reduce risks of transmitting HIV to sex and/or drug-using partners (Healthy People 2020).

Healthy People 2020 set four major objectives for the nation to achieve to control the HIV epidemic. These goals pertain to the following categories: (1) HIV prevention, (2)

HIV testing, (3) diagnosis of HIV/AIDS, and (4) medical care, survival and death after HIV/AIDS diagnosis. The national objectives include, but are not limited to, the following:

> (1) increase the proportion of sexually active unmarried males/females aged 15 to 44 years who use condoms.
>
> (2) increase the proportion of adolescents, adults, MSM and pregnant women who have been tested for HIV in the past twelve months.
>
> (3) increase the proportion of persons living with HIV who know their serostatus.
> (4) increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.
> (5) increase the proportion of new HIV infections diagnosed before progression to AIDS.
> (6) reduce deaths from HIV infection.
> (7) reduce new HIV diagnoses among adolescents and adults.
> (8) reduce the rate of HIV transmission among adolescents and adults.
> (9) reduce new AIDS cases among adolescent, adult heterosexuals, MSM and adults who inject drugs.
> (10) reduce newly diagnosed prenatally acquired HIV cases.
>
> (Healthy People 2020, 2013)

In addition to Healthy People 2020's setting national goals to reduce HIV/AIDS, in 2010 President Obama released the National HIV/AIDS Strategy (NHAS), which captures Healthy People 2020's concepts and also fights the burdensome domestic HIV epidemic occurring within the African American community. Having full awareness of this domestic epidemic—which demands renewed commitment, increased public attention and leadership from all federal, state and local levels—, President Obama tasked the Office of National AIDS Policy with developing the NHAS to enhance national efforts to combat the fight against HIV/AIDS (NHAS, 2010). Created by people living

with HIV, healthcare providers, policymakers, business leaders, and community/faith leaders, the NHAS is a 30 million dollar plan, backed by Congress, produced to meet national needs with three concepts at hand: (1) HIV prevention, (2) extending HIV treatment and (3) helping to decrease the health disparities that feed the epidemic.

President Obama states that the NHAS enables all-inclusive preventive strategies via expanding HIV testing, so people can know their status; it disseminates education, so people can know their risky behaviors; and it provides access to drugs in order to prevent mothers from passing the virus to their children. The NHAS includes providing treatment in order to extend the lives of HIV infected persons and to prevent HIV positive people from transmitting the disease. This national strategy circumvented prior barriers in the healthcare system via providing leverage to HIV infected persons in getting the treatment they need by creating a marketplace where people can buy affordable care (NHAS, 2010). And under the new healthcare law, the Affordable Care Act, health insurers cannot deny coverage based on pre-existing conditions (NHAS, 2010). The National HIV/AIDS Strategy aims to reduce health disparities. Because African Americans historically face social obstacles and social health disparities (e.g. racism, poverty, lack of access to care) that feed the current HIV epidemic, the NHAS is sought as an innovative means of helping communities where the need is greatest.

At the state level, South Carolina has a variety of HIV/AIDS organizations and initiatives with the mission to decrease the incidence and prevalence of HIV infection, in alliance with Healthy People 2020 and President Obama's NHAS. In accordance with Healthy People HIV initiatives, the South Carolina 2012-2014 Ryan White HIV/AIDS

Statewide Coordinated Statement of Need (SCSN) and Comprehensive Plan (CP), under the division of DHEC bolstered by people living with HIV/AIDS (PLWHA), stakeholders, providers, and Ryan White funded programs and state agencies, have set goals/strategies to reducing HIV-related service need barriers across the state. One such goal is to increase the number of HIV-infected people who receive HIV care/treatment that is consistent with current evidence-based practice, and to increase the proportion of African Americans living with HIV who actually know their serostatus (DHEC, 2012). Another SCSN and CP goal in alignment with Healthy People 2020 is to (1) increase HIV screening so people can know their status, (2) for newly diagnosed HIV(+) people to smoothly be linked-to-care while (3) increasing the number of HIV(+) people's retention rates for those currently receiving medical care and support services (DHEC, 2012).

Accessing care and navigating the healthcare system has been a barrier for South Carolinian residents, especially for HIV-positive minorities; increasing access to HIV care is a goal SCSN and CP have that is consistent with President Obama's National HIV/AIDS Strategy. For example, NHAS's goals are to increase access to care, improve health outcomes and reduce HIV-related health disparities. Both SCSN and CP address this national goal by strategically planning to screen for early HIV diagnosis, link-to-care newly diagnosed persons, promote medication adherence to reduce infectivity and improve HIV(+) people's retention rates in HIV medical care/support services. With all of the preceding goals, SCSN and CP have set a great focus on reaching underserved populations, like African Americans, where the need is great (DHEC, 2012).

The South Carolina 2012-2014 Ryan White HIV/AIDS Statewide Coordinated Statement of Need and Comprehensive Plan place emphasis on three types of populations classified as People Living with HIV/AIDS. These three groups include: (a) those who are already receiving care by providers, (b) people who know their positive status but are not linked to HIV medical care, and (c) those who do not know their HIV(+) status (DHEC, 2012). Two broad goals set forth by CP include improving client retention in HIV medical care/support services and increasing the number of HIV(+) people, who know their status, to be linked to care when newly diagnosed (DHEC, 2012).

Both the Statewide Coordinated Statement of Need and Comprehensive Plan aim to alleviate long-standing barriers PLWHA face that enable HIV infection to flourish within South Carolina. Evidence suggests that PLWHA in South Carolina face myriads of barriers such as: (1) transportation, housing, and unemployment issues, (2) dealing with politically-socially conservative HIV-provoked stigma, (3) substance abuse and mental health needs, (4) competing health concerns and client fatigue and (5) healthcare system limitations like inadequate staffing, provider turnover, staff that lack cultural competency, and insurance coverage (DHEC, 2012).

To reduce HIV acquisition, exacerbation and disparities in the *Palmetto state*, closing the gaps in HIV care is another objective for SCSN and CP. Preexisting gaps in care include, but are not limited to, expanding routine HIV testing in healthcare settings, implementing intensive case management linkage-to-care for those newly diagnosed and formulating a mechanism to transition HIV(+) people to long-term management after successful initial linkage. They also aim to close the gap via coordinating services

between Ryan White and non-Ryan White funded providers of HIV prevention and care services to prevent duplication of services as HIV funding is limited in South Carolina. In the midlands, HIV organizations such as South Carolina HIV/AIDS Council (SCHAC) and Palmetto AIDS Life Support Services (PALSS) contribute their dedicated efforts to addressing the crisis via developing and planning strategies to reduce the HIV/AIDS epidemic both locally and across the state. PALSS helps Carolinians fight the war against AIDS by offering free services to African Americans at risk for contracting HIV as well as providing service and support to individuals diagnosed with the infection and their loved ones (PALSS, 2013). Echoing PALSS's services, SCHAC provides (1) HIV education and awareness, (2) mobilized street outreach, and (3) a bridge between individuals and community resources and HIV/AIDS services (SCHAC, 2013). Both organizations consist of a staff that are sensitive to the needs of African American people and target African American residents, who have been hit the hardest by the epidemic.

1.6 Practice innovation by utilizing the Black Church as HIV prevention platform

With 39 million African American people living in the United States, 54% of African Americans report attending church on a weekly basis among the currently 21,000 Black Churches located across the nation (NAACP, 2013). Eighty-five percent of African Americans identify as Christian (Wilson, Wittlin, Munoz-Laboy & Parker, 2011). Evidence shows African Americans are the most religiously committed racial/ethnic group here in the United States, as they attend church services more frequently than any other racial group. And African American people are more likely to engage in or to support social, humanitarian and political issues when religious institutions disseminate

information and bolster the movement (Nunn, Cornwall, Thomas, Callahan, Waller, Friend, Broadnax & Flanigan, 2013). For African Americans who report not being affiliated with a church, three in four still testify that religious matters are either somewhat or very important to their personal lives (Wilson et al., 2011).

The Black Church serves as a hub where information and social change propagates through the African American community. In the 1950s and 60s, it was the bedrock moving the Civil Rights Movement forward; today, it still mobilizes African American communities to facilitate positive change in pressing social/health issues (Wittlin, Munoz-Laboy & Parker, 2011). In present times, the church assists with basic needs (e.g. food, shelter and clothing), such as child daycare, elderly care, healthcare, and transportation services, as well as providing the usual psychosocial-spiritual needs many African Americans are accustomed to receiving. In addition, the Black Church serves as a platform for health professionals to educate African Americans about heart disease, diabetes, teen pregnancy, cancer, violence, weight loss and exercise/nutrition programs (Baker, 1999; Nunn, Cornwall, Thomas, Callahan, Waller, Friend, Broadnax & Flanigan, 2013).

Although the current HIV/AIDS epidemic is hitting African Americans the hardest, many Black Churches have remained lukewarm in their involvement and not responded with the compassion and intensity of which they have previously shown they are capable (Baker 1999; Nunn et al., 2013; Wilson et al., 2011). The stigma surrounding HIV—variations of human sexuality with the sin and shameful lifestyle behaviors associated with HIV transmission, along with denial, homophobia, and insufficient

knowledge about local epidemics—have perpetually blocked the Black Church from fully mobilizing to respond to the HIV/AIDS epidemic (Wilson et al., 2011; Nunn et al., 2013). Moreover, the concept of educating risk reduction strategies like needle exchange, condoms, and dental dams may conflict with the Black Church's values or doctrine, thus further explaining why HIV/AIDS prevention has not been warmly embraced within most churches in the African American community (Baker, 1999).

In spite of these historical barriers, Black faith-based organizations have a tremendous and critical role to play in raising awareness about the HIV/AIDS epidemic and closing the gap to reduce the disproportionate racial disparities of HIV infection (Nunn et al., 2013). Fortunately, evidence suggests faith-based organizations have assets and strengths that can bolster the success of HIV prevention within its boundaries. The strengths churches have to promote HIV prevention include: (1) having congregants who usually engage in church-based programs, (2) having respect within their communities while also having social capital and credibility among their members, and (3) the power of influence to decrease HIV stigma within the African American community. The Black Church also plays an important role in the lives of many youth/young adult members through faith-based organizations possessing the capacity to reach out to African American youth, who are most vulnerable to HIV infection, beyond their local communities (Aaron, Yates & Criniti, 2011).

More recently, some churches have recognized the dire need to combat the epidemic and fight associated HIV stigma as evidenced by establishing HIV/AIDS ministries or allowing their Health Professional ministries (constituted of nurses,

healthcare providers, educators, etc.) to educate and empower the African American community regarding this health disparity (Aaron, Yates & Criniti, 2011; AIDS Alert, 2007). Since the Black Church has the power to reach 20 million parishioners, nurses who serve within churches have a great potential role and platform to help deliver HIV/AIDS outreach interventions within faith-based organizations. Data shows nurses usually are held in high esteem within Black Churches, secondary to their long-standing professional reputation of trustworthiness, altruism and unprecedented commitment to the care for the sick, unfortunate, and those in need (Baker, 1999). Nurses' training in transcultural care, health promotion/disease prevention and their holistic approach places them in a unique position to help counteract the HIV/AIDS epidemic via using the Black Church community as a platform to educate, influence and perhaps even enhance African American's healthcare practices (Baker, 1999).

In times past, nurses have been instrumental in informing the Black Church community about various diseases that affect African Americans the most (e.g. heart disease, diabetes, and breast cancer). Today, research suggests nurses could work within Black faith-based organizations informing congregants about the current HIV epidemic disproportionately affecting African Americans to promote HIV awareness, health promotion and disease prevention. Also, research suggests nurses have the ability to link African American congregants to healthcare services, if indicated (e.g. high-risk behavior and/or HIV positive), and facilitate interdisciplinary collaborative care; however, in times past, interdisciplinary collaboration among Black Churches, public health, and HIV medical institutions have been underused in HIV prevention programs (Aaron, Yates & Criniti, 2011). Interdisciplinary collaboration is defined as a complex relationship

between multiple disciplines that follows a problem-focused, patient-centered approach upon which disciplines have shared objectives, goals or visions and responsibilities all working together to achieve a common outcome (Petri, 2010). Nurses working within Black Churches have the potential to serve as interdisciplinary constituents bridging congregants to other allied health professionals, like HIV providers, psychologists, and social workers, or to local HIV/AIDS organizations, like PALSS or SCHAC, when necessary.

1.7 Purpose

The HIV/AIDS crisis in South Carolina is real, alarming, and is disproportionately affecting the lives of many African Americans in a negative way (DHEC, 2013). It is unfortunate that HIV is very problematic in the *Palmetto State*. Not only that, what is so devastating is that South Carolina's youth and young adults (who are our future) are impacted the most by this illness. Compared to all youth and young adults during 2010, African American males aged 13-24 year old residing in Columbia, South Carolina had the highest HIV diagnoses rate in the nation. Meanwhile African American females aged 13-24 residing in Columbia, South Carolina ranked ninth highest for those infected with HIV (CDC, 2013; Reif et. al, 2013). South Carolina DHEC (2012) reports that by age, the majority of new HIV cases are among persons aged 25 to 44 years old. Persons aged 24 and under are the next group with the highest rates of new HIV cases. For these reason, this evidence-based practice quality improvement project will focus on HIV prevention/education among young adult African Americans ages 18-35.

Healthcare professionals, such as nurses, a profession having deep roots in the foundations of Christianity and a compassion for mankind, offer great implications for addressing the HIV epidemic within faith-based organizations to combat the social ignorance, stigma, and barriers that keep many South Carolinian African Americans vulnerable, marginalized, and victim to the HIV epidemic. No longer should a great body of nurses be concentrated and confined to the Nurse's Station bogged down typing care-plans, passing out medications to the masses, being bombarded with administrative duties, or getting caught up in the conventional crossfire of nurse lateral violence while many within the African American community are acquiring/transmitting a preventable disease. Instead, nurses should be charged with compassion and enthusiasm to meet African Americans where they are – the Black Church, where they can be instrumental in encouraging, empowering, and educating young adult African Americans on matters pertaining to HIV prevention in a familiar/comfortable setting many African Americans congregate.

Since the Black Church is a local where many young adult African Americans congregate and in recent times has been used to provide HIV prevention services (to some extent), the purpose of this evidence-based practice quality improvement project (EBP QI) is to confirm the literature that nurses can utilize the Black Church as a platform to provide HIV prevention/education services to them. Specifically, the CDC-approved community-based HIV prevention intervention titled V.O.I.C.E.S., which specifically targets African Americans, is an effective tool nurses can potentially utilize in the Black Church setting to prevent the spread of HIV among young adults. Because obtaining consent from Black Church leadership is essential in order to provide HIV prevention/education services to

young adults, this QI project focuses on nursing introducing leadership to the V.O.I.C.E.S. intervention and verifying if this intervention is appropriate to implement, in its original form in this setting, to increase HIV knowledge, decrease HIV stigma, and promote the use of condoms or practice of abstinence among young adult African Americans aged 18-35.

1.8 Theoretical Framework

Developed in the 1950s and utilized as a theoretical framework for the prevention of HIV acquisition/transmission among the targeted population for this evidence-based project, the Health Belief Model, or HBM, is a patient-focused psychological model that explains and predicts an individual's health-seeking behaviors (University of Twente, 2014; Rosenstock, Strecher, and Becker, 1994). The main emphasis this theoretical framework explains is that health-seeking behavior is determined by an individual's perception about an illness/disease and the resources available to the individual to prevent or decrease the risk of acquiring the medical condition (Edberg, 2006). Thus, if an individual believes they may be vulnerable to a certain illness and there are resources available to prevent the medical condition, the individual is likely to engage in health promotion/disease prevention behaviors to decrease their susceptibility to the medical condition. Consisting of six major constructs, the HBM has been applied to explaining HIV perception measures among African Americans, and it serves as a theoretical framework upon which many HIV prevention intervention programs are based (HHD, 2006; Abenaa, 2011). As per Edberg (2006), the major constructs of the HMB are as follows: (1) perceived seriousness, (2) perceived susceptibility, (3) perceived benefits, (4) perceived barriers, (5) cues to action, and (6) self-efficacy.

The first construct in the HBM is perceived seriousness, which is operationally defined by the U.S. Department of Health and Human Services (U.S. D.H.H.S., 2005) as the beliefs about the seriousness of a condition and its consequences. Perceived seriousness alludes to an individual's personal belief about the seriousness or severity of acquiring an illness and/or disease (Edberg, 2006). In this depiction of the HBM, perceived seriousness may be based upon the individual's personal medical knowledge about an illness as well as an individual's beliefs about how acquiring the illness or disease can impact them. For example, catching the influenza virus for someone in the general population may be perceived as feeling "run-down," fatigued and febrile for a couple of days. But for an asthmatic individual, his or her perception of the disease severity may be viewed in a different light. That is, an individual who has asthma may view catching the influenza virus as a risk for being hospitalized and possibly dying (Edberg, 2006). Therefore, the perception of the seriousness of an illness/disease may be based upon one's medical knowledge and personal experience (Edberg, 2006).

The second construct in the HBM is perceived susceptibility. The operational definition of perceived susceptibility is the belief about one's chances of acquiring a condition (U.S. D.H.H.S., 2005). Perceived susceptibility is thought to be one of the most powerful constructs in the HBM in that if an individual can perceive themselves to be at high-risk for acquiring an illness, the individual may adopt healthier behaviors in order to reduce the risk for contracting the illness/disease (Edberg, 2006). For example, the construct of perceived susceptibility is what may prompt a young Black MSM to use condoms during every act of sexual intercourse in order to decrease his susceptibility to HIV acquisition (Edberg, 2006). Inadvertently, some African American females in long-

term monogamous relationships may not use condoms and practice safer-sex measures with their partners because they do not perceive themselves to be at risk for HIV infection (Edberg, 2006; Paxton, Villarreal, and Hall, 2013).

The third construct in the HBM is perceived benefits. The operational definition of perceived benefits is defined as the beliefs an individual has regarding the effectiveness of taking action to reduce the risk or seriousness of contracting an illness or developing a disease (Edberg, 2006; U.S. D.H.H.S., 2005); Rosenstock, Strecther & Becker (1994) report perceived benefits as the believed effectiveness of strategies designed to reduce the threat of an illness. The gist of this particular construct is that people tend to adopt a new healthier behavior when they appreciate that the new behavior will decrease their chances of contracting a disease or illness. The concept of perceived benefits plays a significant role in secondary prevention, such as health screenings for disease. An example of this is screening for HIV. According to the CDC (2013), screening for HIV has significant benefits regardless of an individual's HIV status. For individuals who test HIV positive, screening for the illness provides the gateway for treatment and medical care. Knowing one's HIV positive status makes it possible to receive effective HIV treatment, lower one's viral load, possibly live a healthier productive life, and further reduce the spread of HIV (CDC, 2013). To those who test negative for HIV, screening for the illness provides the mechanism to link individuals to HIV prevention services so they can remain HIV-free (CDC, 2013).

The fourth construct in the HBM is perceived barriers. Perceived barriers is operationally defined as the potential negative consequences an individual identifies resulting from taking particular health actions (Rosenstock et al., 1994). This particular

construct is thought to be one of the most significant concepts in the HBM model in that it values the subjective nature of pre-existing problems an individual perceives that hinder behavioral modification. The construct of perceived barriers is juxtaposed with perceived benefits in that it takes into account the risk versus benefit process an individual may contemplate in adopting a new behavior; if the individual perceives the benefits as out-weighing potential/pre-existing barriers, the chances of adopting a new healthier lifestyle is more likely despite the barriers that may be impeding an individual to adopt healthier behaviors (Edberg, 2006). According to the literature, in order to decrease the spread of HIV, it is imperative that individuals get tested for the illness; however, HIV testing poses as a perceived barrier for some individuals within the African American community. In Abenaa's (2011) study reporting that social factors such as isolation from society, feelings of invincibility, and HIV stigma may be some of the biggest perceived barriers to HIV testing among heterosexual African American college males.

The final two constructs in the HBM include cues-to-action and self-efficacy. The construct of cues to action is operationally defined as the events, people, or things that move an individual to change their behavior (Edberg, 2006); it is the stimulus, either internal (e.g. experiencing cold/flu-like symptoms) or external (e.g. death of a friend, presented health information), needed to trigger an individual's decision-making process to accept a recommended health behavior (Boston University School of Public Health, 2013). For example, an individual may experience a behavioral change cue to action if the individual experiences cold/flu-like symptoms, witnesses the death of a loved-one succumbing to an illness, receives advice from others, and/or retrieves information from a healthcare provider (Edberg, 2006). Lastly, the construct of self-efficacy is defined as the

belief in one's own ability to perform a behavior successfully (Boston University School of Public Health, 2013; Edberg, 2006; Rosenstock et al. 1994). The application this construct refers to is that an individual generally does not try to do something new unless they believe they are capable of doing the behavior successfully. That is, if an individual perceives that a new behavior is useful, yet does not think they are capable of performing the behavior, the odds of trying out the new behavior is very unlikely (Edberg, 2006).

In summary, the beauty of the Health Belief Model is its flexibility to be adapted to explore the mechanisms for both short-term and long-term health-seeking behaviors among individuals, along with being applicable to explaining an individual's risk-taking sexual behaviors in relation to HIV acquisition/transmission (Rosenstock, Strecher, and Becker, 1994). The scientific underpinnings of this model will be used in this evidence-based project as it provides a basis for health promotion/disease prevention motivation in relation to health-seeking behaviors for the prevention of HIV.

Because human behavior is dynamic, varied, and quite complex, the Theory of Reasoned Action, or TRA, is also utilized in this evidence-based project serving as an adjunctive framework to the Health Belief Model to enhance the efficacy of health promotion/disease prevention among the target population who may be at risk for HIV. Introduced in the 1970s by Fishbein and Ajzen and further enhanced to what is currently also known as the Theory of Reasoned Action and Theory of Planned Behavior, or TRA/TPB, this framework emphasizes that behavioral intention is the single most important determining factor of an individual performing a behavior (Sharma & Romas, 2012). TRA/TPB is used to explain or enhance health-promoting behaviors, such as HIV risk reduction, as it can be used to provide a basis in predicting an individual's intention to

use condoms in order to prevent the acquisition and/or transmission of HIV (Beadnell, Baker, Gillmore, Morrison, Huang, and Stielstra, 2008; Sharma & Romas, 2012). As HIV is on the rise within the African American population and practicing safer-sex measures is paramount, the TRA/TPB explains that in order for behavior modifications to occur, an individual must have the intention to change (e.g. change from practicing high-risk sexual behaviors to safer-sex measures). Intentions to change, according to the model, are influence by two major factors: (1) attitudes towards the behavior and (2) subjective norm about the behavior (Washington, 2008). The fundamental basis of the TPB is that individuals are motivated to change based upon their perceptions of norms, attitudes, and control over behaviors (Fertman & Allensworth, 2010). The beauty of this theory is that it provides a basis about the role that the conscientious thought process plays in an individual's decision making capacity regarding engaging is specific behaviors. In terms of using condoms as a safer-sex mechanism in preventing HIV within the African American community, the TRA/TPB fits the basis of this evidence-based project as it may be used to assess the ideology an individual may have towards safer-sex before they decide to practice or refrain from this specific behavior (Sharma & Romas, 2012).

According to the TRA/TPB, in order to practice safer-sex via utilizing condoms during every coital act, an individual's intent to practice or refrain from practicing safer-sex is influenced by two major constituents—personal factors and social influence. Formulating this basis, The Theory of Reason Action/Planned Behavior is based upon eleven constructs. The constructs in the model are as follows: (1) behavior, (2) behavioral intention, (3) attitude toward the behavior, (4) behavioral beliefs, (5) outcome evaluations, (6) subjective norm, (7) normative beliefs, (8) motivation to comply, (9) perceived

behavioral control, (10) control beliefs, and (11) perceived power (Sharma & Romas, 2012). The construct of behavior is renowned to be the foundation of this theoretical framework, referred to as the single action exhibited by an individual upon which their behavior is observed among others. According to the model, behavior is operationally defined as the witnessed action performed by an individual in which behavior is comprised of target, action, context and time (TACT) (Sharma & Romas, 2012). An example of this is the African American individual (target) who desires to prevent the acquisition/transmission of HIV (context) will use a condom (action) every time they engage in sexual activity (time).

The second construct in the model is behavioral intention, which is the main construct that the TRA/TPB is based upon. Behavioral intention is operationally defined as the thought process an individual has prior to performing the specific behavior in which one's intent is the immediate precedent factor to any given behavior manifestation (Sharma & Romas, 2012). The third construct, attitude toward the behavior, refers to an individual's perception (like or dislike) of a specific behavior. That is, the more favorable an individual's attitude is towards a given behavior, the greater the likelihood the individual will intend to practice the behavior (e.g. use condoms to prevent HIV). Conversely, if an individual has an unfavorable attitude towards a specific behavior, then the odds the individual intends to practice the unfavorable behavior is also very unlikely (Sharma & Romas, 2012). Behavioral beliefs, the fourth constructs in the TRA/TPB, is operationally defined as the belief, or perception, an individual has that performing specific behaviors lead to specific outcomes. The fifth construct, outcome evaluations, refers to the notion that individuals place value on outcomes of practiced behaviors (Sharma & Romas, 2012).

The next three constructs in the TRA/TPB framework—subjective norm, normative beliefs and motivation to comply—take into account the social elements that influence an individual's behavior. The sixth construct, subjective norm, refers to the individual's perception of those who are significant to and their presumption the individual should or should not engage in a specific behavior. For example, a person contemplating using a condom during sex may reflect on what they think their peers would suggest the individual do. Whereas the seventh construct, normative beliefs, refers to the aspect of how an individual perceives those who are significant to the person on how the individual should behave in a given situation (Sharma & Romas, 2012). That is, prior to engaging in sexual activity, an individual may reflect on whether they should use a condom; if they think their peers think they should not use a condom, then the individual may behave in a like manner. Lastly, the eighth construct, motivation to comply, takes into account the extent to which an individual would like to conform to the social norms based on how they think their significant other(s) would like them to act in a given situation (Sharma & Romas, 2012).

The first nine constructs of the TRA framework pertain to the volitional power an individual has by which they perform behaviors. The final three constructs – perceived behavioral control, control beliefs and perceived power—were added to the original TRA to what is now renowned as the current combined TRA/TPB, and provide the theoretical basis to explain how an individual's behavior is expressed out of antecedents that may be beyond an individual's internal or external control (Sharma & Romas, 2012). Dependent on the constructs of control beliefs and perceived power in the TRA/TPB, the ninth construct, perceived behavioral control, is operationally defined as how much control an individual feels they have in performing a specific behavior (Sharma & Romas, 2012).

Control belief, the tenth construct, refers to the internal or external factors that may hinder or help an individual to express a specific behavior. The last construct in this framework, perceived power, is operationally defined as the perception an individual has regarding the level of difficulty of performing a specific behavior and the level of control an individual feels they having in doing a specific behavior (Sharma & Romas, 2012).

In conclusion, the Theory of Reasoned Action/Planned Behavior, like the Health Belief Model, is a powerful framework that will be used in this evidence-based project not only because it has been applied to that target population for the prevention of HIV acquisition but also because it serves as a mechanism to understanding why individuals may engage in high-risk sexual behavior (e.g. not use condoms, having multiple partners, etc.) (Beadnell, Baker, Gillmore, Morrison, Huang, and Stielstra, 2008; Frew, Archibald, Martinez, Rio, and Mulligan, 2007; Kanu, 1997; Williams, Ramamurthi, Manago and Harawa, 2009). Understanding an individual's intention to practice high-risk behaviors or knowing perceived barriers to practicing safer-sex enables professional nurses to transform an individual's misconceptions about HIV and to empower individuals with health promotion/disease prevention tools, whereby African Americans at risk for HIV may instead choose to engage in HIV prevention behaviors.

1.9 Specific aim and PICO question

Given the alarming statistics in the state of South Carolina and the potential the Black Church can have to prevent the spread of HIV among young adult African American parishioners, the specific aim for this EBP QI project is to determine the acceptability of the CDC's V.O.I.C.E.S. HIV prevention workshop to Black Church leaders. Therefore, the

PI has chosen to present this EBP QI project to Black Church leaders informing them that the V.O.I.C.E.S. intervention may be effective in reducing HIV rates in African American parishioners aged 18 to 35 years old.

The V.O.I.C.E.S. HIV prevention program has been shown to be effective in public health settings such as STD clinics and Community Based Organizations (CBOs), but has not been tested within the context of the Black Church yet. Nurses are a highly trusted profession and parish nurses could provide the V.O.I.C.E.S. HIV workshop to congregants if the program is deemed acceptable by church leaders. If Black Church leadership approve, the V.O.I.C.E.S. workshop may be an effective culturally-relevant EBP HIV prevention intervention nurses can utilize in a setting these parishioners are familiar and comfortable in.

The PI is investigating the Black Church leadership's overall approval of the V.O.I.C.E.S. HIV workshop for young adult African American parishioners within the Black Church setting. The PICO question the PI is seeking to answer is the following: *"in the Black Church, is leadership more willing to permit adoption of the V.O.I.C.E.S. program to increase knowledge of HIV, reduce HIV stigma, increase the use of condoms and/or promote abstinence among parishioners ages 18-35 in its original form or in a modified form."* Other inquires the PI would like to know include the following:

(1) Are HIV knowledgeable Black Church leaders more willing to adopt V.O.I.C.E.S. in its original form?

(2) Will lower levels of HIV stigma among leadership correlate to increased acceptance of V.O.I.C.E.S.in its original form?

1.10 Assumptions

It is assumed that HIV knowledge and HIV stigma are variables that play a significant role regarding the acceptability of the V.O.I.C.E.S. intervention in the Black Church setting. It can be assumed that leadership, who know more about HIV (e.g. basic knowledge about the virus, how it is acquired or transmitted), will be more likely to agree that V.O.I.C.E.S.is appropriate to do in the church setting in its original form versus leadership who are less knowledgeable about the virus. Also, it can be assumed that leadership who have low levels of HIV stigma will be more likely to agree that this intervention is appropriate to do in its original form in the church setting versus leadership who have high levels of HIV related stigma towards people living with or at risk for HIV/AIDS.

CHAPTER 2

LITERATURE REVIEW

This chapter begins with a synthesis of the literature describing the HIV/AIDS epidemic within the African American population. It illustrates trends documented over time that have resulted in the current HIV/AIDS epidemic within this population. Socio-demographic and epidemiological information detailed in this chapter places emphasis on how the epidemic has effected people living in the South, particularly in the state of South Carolina. A review of how HIV is impacting African American males and females will be conducted along with an explanation of the risk factors that make this population vulnerable. The following risk factors will be discussed in detail: (1) high STD rates, (2) incarceration, (3) the exchange of sex for money or drugs, (4) poverty, (5) racism, (6) unemployment (7) HIV stigma and (8) gender specific risks. In addition, an overview of HIV interventions that have been implemented in the African American community will be discussed, as well a description of how HIV stigma within this community perpetuates the epidemic. At the conclusion of this chapter, details regarding how the Black Church can be utilized by healthcare professionals, specifically nurses, as a platform to provide HIV health promotion/disease prevention information to the African American community at large will be explained.

2.1 HIV/AIDS significance among African Americans

The first documented cases of HIV/AIDS were observed among homosexual White males suffering from what was then considered rare and bizarre illnesses/pneumonias in Los Angeles, San Francisco, and New York. By the mid-1980s/early 1990s, the number of HIV/AIDS cases among homosexual and bisexual African American males increased enough to warrant significant attention (Isler 2009; Clarke-Tasker, Wutoh & Mohammed, 2005). As the infection's reach spread, the African American population represented 25% of all AIDS diagnoses in 1985 and nearly half of all the AIDS cases by 2004 (Fullilove, 2006). Initially, the school of thought concerning HIV/AIDS by many within the African American community was that the virus exclusively targeted homosexual White males. However, trends have changed to the point that the "new face" of the HIV/AIDS epidemic is African American; many within this population know someone or know of someone suffering from the infection. In fact, leading health experts inform us that HIV/AIDS infection rates within the African American community, or "Black America," is comparable to those in developing countries (Roanoke Times, 2004).

Currently, more than 1.2 million people are living with HIV in the United States. More than 50,000 people are infected annually, at a rate of one infection every 9 ½ minutes. One in 8 of those people living with HIV are unaware of their infection (AIDS.gov, 2013; CDC, 2015). African Americans account for nearly half of all the new HIV infections (CDC, 2013). Evidence shows that African Americans, from infancy to adulthood, lead the HIV epidemic, with higher incidence, prevalence, morbidity, and

mortality rates compared to all other racial/ethnic groups, regardless of socioeconomic status and gender (Clarke-Tasker, Wutoh & Mohammed, 2005). Compared to Whites, African Americans are usually diagnosed in later stages of the disease, and more African Americans die prematurely from the infection (Davidson, ND). In 2010, HIV/AIDS was the 5th and 7th leading cause of death among African American males and females, respectively, among those aged 25-44 years old (Kaiser Family Foundation, 2014).

Since the beginning of the HIV epidemic, infection rates have steadily increased across the country despite massive campaigns, government funding, community awareness, safe-sex/IV drug interventions, and the production of effective pharmaceutical agents. For African Americans in particular, the number of new HIV/AIDS cases has dramatically increased over the course of the epidemic. When comparing the 1980s to the 1990s, the number of AIDS cases among White MSM declined versus the rising number of AIDS cases documented among African American males and females (Laurencin, Christensen & Taylor, 2008). Clarke-Tasker et al. (2005) report that in the mid-1980s African Americans represented only 25% of the HIV/AIDS cases. By the early 2000s, African American's HIV/AIDS rates represented more than 50% of newly diagnosed HIV infections in the United States. From the disease's beginning in the U.S. until 2005, more than 211,559 African Americans have died from HIV/AIDS (Davidson, ND). The CDC (2013) suggests that one in 16 and one in 32 African American males and females, respectively, will be diagnosed with HIV during his or her lifetime. It is estimated that 1 in 50 African American males and 1 in 160 African American females are HIV positive (Clarke-Tasker, Wutoh & Mohammed, 2005).

According to the HIV data-base compiled from data collected from the 33 mandatory reporting states, African Americans accounted for 18,991 (or 50.5%) of all new HIV/AIDS cases national during years 2001 to 2005 despite them making up only 13% of the United States population (CDC, 2013). In 2005, the estimated annual HIV/AIDS diagnoses among African American males and females were 124.8 per 100,000 and 60.2 per 100,000, respectively. During 2005, African American males were 3.1 times more likely to be diagnosed with HIV/AIDS than Hispanic/White males and 6.9 times more likely to be diagnosed with HIV/AIDS than White males. That same year, African American females were 5.3 times more likely to be diagnosed with HIV/AIDS compared to Hispanic/White females and 20.1 times more likely to be diagnosed with HIV/AIDS than White females (Laurencin, Christensen & Taylor, 2008). For African Americans residing within the Deep South, like South Carolina these comparative rates appear worse (Reif, Whetten, & Wilson, n.d.; SC DHEC, 2012).

HIV/AIDS affects African American males and females in various ways. African American homosexual and bisexual males, also known by the colloquial term *Black men who have sex with men* (Black MSM), are affected most with HIV, followed by heterosexual African American females. The CDC (2013) reports that African American males account for 31% of all new HIV infections in the United States. New HIV infection rates for African American males are more than six times greater than the rate for White males and are affected more than twice compared to Hispanic males and African American females. However, for Black MSM, the epidemic poses the greatest threat, compared to any other subpopulation defined by race/ethnicity, age, or gender.

From 2008 to 2010, the number of new HIV infections reported among African American females has decreased by 21% (CDC, 2013). Despite their recent decline in HIV incidence rates, African American females still account for 13% of all new HIV infections and represent 64% of all new HIV infections compared to all other racial/ethnic females in the United States. For example, the literature shows that African American females currently have a HIV prevalence rate 20 times greater than White females and nearly 5 times greater than that of Hispanic females (CDC, 2013).

Both race and ethnicity play a factor in social determinants of health. Evidence shows that racial/ethnic groups who experience higher rates of poverty and discrimination, lower levels of education attainment, and lower incomes experience higher rates of illness, chronic disease, disease severity, and poorer health outcomes (American Sociological Association, 2005). Such is the case for African Americans. Evidence confirms that race/ethnicity alone is not a risk factor for HIV/AIDS. But the social determinants of health African Americans face, combined with HIV risk factors, appear to make African Americans more vulnerable to HIV infection (American Sociological Association, 2005; CDC, 2013). Socio-cultural factors like high rates of poverty, the experience of racial discrimination, and mistrust of the predominately White-run medical community have been historical problems that still linger at varying degrees within the African American community. Those factor combined with limited access to healthcare, low-income, cultural taboos surrounding sexuality (e.g. homosexuality or promiscuity) and HIV-stigma appear to be contributory factors that disenfranchise African Americans in terms of HIV infection rates (Augustin & Bridges, 2008). Socio-cultural factors in conjunction with HIV risk factors appear to influence infection transmission and distribution patterns within the

African American community (Dean & Fenton, 2010). HIV risk factors among the African American community include, but are not limited to, the following: (1) IV drug use, (2) multiple sex partners, (3) the exchange of sex for money/drugs, (4) high incarceration rates, (5) high STD prevalence rates, (7) lack of HIV awareness and (7) homophobia and/or concealment of homosexual behavior (CDC, 2007; Davidson, n.d; Fullilove, 2006).

2.2 HIV among African American females

Early in the course of the epidemic, the United States invested substantial resources, time, and effort to reduce and eliminate the spread of HIV. Despite heroic efforts to contain this problem, the result shows suboptimal success controlling the epidemic, especially among subpopulations like African American females. Paradoxically, in spite of all the initial national efforts to stop the spread of HIV, infection rates among African American females today are far worse than in the early years of the epidemic (Mays, Maas, Ricks, and Cochran, 2012). During the early phase of the HIV epidemic, few American women and female adolescents had been diagnosed with HIV. African American females were not significantly affected, either, especially in reference to the devastating effects the infection was having among MSM and IV drug users (Mays et al., 2012). Indeed, African American females were only a small fraction of the infected population during the initial phase of the epidemic; HIV prevention efforts for African American women were but an afterthought, since so much scientific attention and research was concentrated on other populations (Mays et al., 2012). Scientific research and public health strategies focused on the MSM and IV drug users, since the HIV epidemic appeared to primarily affect those two population risk groups (Mays et al., 2012).

Evidence suggests that during the early course of the epidemic, subpopulations within the African American female community were more at risk for HIV acquisition/transmission than females of other racial/ethnic groups. Risk factors for African American females had included those whose partners were MSM, IV drug users, or had male partners of whom they were not aware. Conversely, some females engaged in their own high risk behaviors, such as using IV drugs, having multiple sex partners, or engaging in the sex work industry, all while knowingly or unknowingly increasing their risk for HIV acquisition/transmission (Mays et al., 2012).

Now more than 25 years into the epidemic, trends show that females account for more than 25% of all new HIV/AIDS diagnoses in the United States, with African American women disproportionately affected compared to all other ethnic/racial females (CDC, 2008). Despite the great strides made by scientists in advancing HIV treatment modalities and improving the quality of life for those living with HIV and the fact that epidemiologists have confirmed decreased HIV rates for various at-risk groups HIV infection and HIV/AIDS-related death rates have not, unfortunately, abated nor significantly declined for African American females (Rose, Sharpe, Raliegh, Reid, Foley & Cleveland, 2008). Fortunately, researchers have identified that among that causes that place African American females at risk for HIV/AIDS causal heterosexual contact is a significant risk factor that place African American females at risk for HIV. So the perception that HIV primarily affects homosexual White males or IV drug users is an old ideology. In its present state, the HIV epidemic has become so burdensome for the African American female population that their infection rates outnumber ethnic heterosexual males and females, only trailing White and Black MSMs (Payne, 2008).

African American females make up approximately 12% of the total United States female population but represent the majority of all new HIV infections among all racial/ethnic women (Rose, Sharpe, Raliegh, Reid, Foley & Cleveland, 2008). Of the 126,964 females living with HIV/AIDS in 2005, the majority of those females were African Americans (64%), followed by Whites (19%), Hispanics (15%), Asian/Pacific Islanders (1%), and American Indian or Alaska Natives (less than 1%) (CDC, 2008). Regarding morbidity and mortality rates, their HIV mortality rate was higher than that observed in every group except African American males (Kaiser Family Foundation, 2013). To be noted, however, researchers find that age is a variable that plays a significant role regarding the distribution of the infection among African American females. Whitmore, Satcher & Sherry (2005) report during years 1999 to 2002, 62.2% of African American women aged 25 to 34 years old were infected with HIV, followed by 31.1% aged 35 to 44 years old, 14.6% aged 45 to 54 years old, 11.6% 20 to 24 years old, 5.8% 13 to 19 years old and 55(+) years old. During 2004, the CDC confirm that HIV infection was the leading cause of death for African American females aged 25 to 34 years old, and the third and fourth leading cause of death for African American females aged 35 to 44 years and 45 to 54 years, respectively (CDC, 2008).

Evidence also shows that the distribution of HIV/AIDS among African American females is unevenly distributed across the United States. African American females living within the Southern region of the country are more impacted by the HIV/AIDS epidemic than other regions in the nation. The National Alliance of State and Territorial AIDS Directors (NASTAD) (2010) reports that "six of the ten states with the highest cases of [HIV/AIDS affecting African American women] are in the South with the District of

Columbia topping the list" at 100 per 100,000 persons (NASTAD, 2010). Whitmore et al. (2005) reports that the South, during years 1999 to 2002, accounted for the largest number HIV/AIDS cases for African American females among all 50 states including the District of Columbia. Fifty-four percent of African American females who had an HIV/AIDS diagnosis resided in the South, compared to 32.1% in the Northeast, 8.9% in the Midwest and 4.6% in the West. Reif et al. (n.d.) confirm that African American women living in the South had the highest HIV incidence rates during the 2005 to 2008 period compared to other racial/ethnic females during that time.

Resembling neighboring Southern states, South Carolina has a disproportionate number of African American females impacted by the HIV/AIDS epidemic. Evidence shows that during year 2010, the HIV/AIDS prevalence rate for African American females living in South Carolina was 12 times greater than that of White females and that African American females accounted for 26% of the HIV/AIDS related deaths in South Carolina during that same year (SC DHEC, 2013). During 2011, more than 4,499 females were estimated to be living with HIV/AIDS in the *Palmetto state*. Among the 4,499 females living with HIV/AIDS in South Carolina, evidence showed that more than eight out of 10 of these women living with HIV were African American (SC DHEC, 2013).

2.3 HIV/AIDS risk factors in African American females

African American females face a variety of socio-cultural contextual issues, as well as social determinant risk factors that increase their vulnerability to HIV (Sharpe et al., 2012). Such risk factors include but are not limited to the following: (1) poverty, (2) financial dependence on male partners, (3) lack of access to medical care, (4) belief in an

HIV conspiracy, (5) high-risk male partners, (6) relationship power differential, (7) gender surplus within the community, and (8) a lack of self-esteem or confidence. In addition, sexual networks, substance abuse behavior, and feelings of invincibility appear to be other risk factors contributing to HIV acquisition and transmission within the African American female community (Bontempi, Eng, & Quinn, 2008; CDC, 2008; Davis & Sullivan, 2012; Harvey & Bird, 2004; Hodder et al., 2010; Ivy, Miles, Le & Paz-Bailey, 2013; Nunn, Dickman, Cornwall, Kwakwa, Mayer, Rana & Rosengard, 2012; Pittiglio, Jackson & Florio, 2012; Sale, DiClemente, Davis & Sullivan, 2012; Sharpe et al., 2012; Stampley, Mallory & Gabrielson 2005).

2.4 Socioeconomic status

Evidence shows that socioeconomic issues and limited resources place African American females at risk for HIV/AIDS. Sharpe et al. (2012) report that nearly one in four African Americans live in poverty. Compared to Asian, Hispanic, and White females, African American females earn, on average, less annual median income, have fewer resources, and face more socioeconomic hardships (Sharpe et al. 2012). Socioeconomic hardships combined with limited resources force many African American females to live in communities where HIV/AIDS and other STDs tend to cluster and flourish (Sharpe et al. 2012). Limited resources have caused some African American females to be co-dependent on one or more male partners for financial stability and even exchange sex for money/shelter just to obtain basic living necessities. Some do so just to pay the bills or meet life's basic necessities, placing these African American females at risk for HIV. In Nunn et al.'s (2012) qualitative analysis of 19 African American women in Philadelphia engaging in concurrent sexual partnerships, participants report that limited financial

resources prompted their involvement in concurrent sexual partnerships. Participants in the study stated that having concurrent relationships was a means of getting money from their male partner(s) in order to meet life's basic needs, like buying clothes, putting gas in the car, being able to pay for a babysitter or enjoy few of life's basic pleasures, like dining out, going to the bar, or buying recreational drugs (Nunn, Dickman, et al., 2012). Inadvertently; some male partners of African American females may depend on them economically, and (unprotected) sex, being the mutual agreement between the couple, may place women in these relationships at risk for HIV infection (Nunn, Dickman, et al., 2012).

Evidence also shows that while some African American females maintain concurrent sexual relationships due to financial dependency, others may simply trade sex for money or drugs to stay financially afloat. This situation also places African American females at risk for HIV infection. In a national HIV Behavioral surveillance system (NHBS) survey consisting of 4,463 African American females from 20 metropolitan statistical areas across the nation, Ivy et al. (2013) illustrate the relationship between the socioeconomic circumstances African American females face and HIV risk/acquisition. The study sample consisted of low-income African American females who were HIV-positive-unaware compared to uninfected females recruited from 20 U.S. cities. The findings show that when compared to females whose last sexual encounter was with their main partner, those whose last sexual encounter was an "exchange for sex [or drugs]" were more than twice as likely to be unaware of their HIV-positive status (Ivy, Miles, Le, & Paz-Bailey, 2013).

Not all African American females face socioeconomic challenges or have limited resources that cause them to maintain concurrent sexual relationships for survival. Some

African American females may facilitate high-risk sexual relationships simply to maintain the comfortable lifestyles they have acquired and become accustomed to. However, having financially stable male partners who have the ability to pay their bills and engage in high risk behaviors may place some African American females at risk for HIV. This is evident in Goparaju & Warren-Jeanpiere's (2012) observational study of 36 participants, aged 25 to 60 years old residing in Washington D.C., which assessed African American females' knowledge, attitudes, beliefs, and behaviors towards having male partners *on the DL* or *"down low*." *On the DL* is a colloquial used to describe African American men who identify as heterosexual yet put their female sexual partners at risk for HIV due to secretly having sex with other men (Bond, Wheeler, Millet, LaPollo, Carson, & Liau, 2009). Commonly held attitudes in the study showed that although they would not like the fact that their partner was *on the DL* most would maintain the relationship and tolerate their male partner having sex with other men because they were unwilling to give up the comfortable lifestyle to which they had grown accustomed. (Goparaju & Warren-Jeanpiere, 2012).

2.5 HIV conspiracy and decreased perceived risk

Some African American females continue to mistrust the predominantly White medical establishment because of historical racial prejudice, medical misconduct, and cultural barriers (Freeman, 2010). The tainted legacy of medical misconduct from the Tuskegee Syphilis Study (1932 – 1972), in which preventive medical information/curative treatment was deliberately withheld from the African American community, is a harsh reminder lingering in the minds of many African American females, compelling them not to seek care or participate in research (Stampley, Mallory, & Gabrielson, 2005). Mistrust

towards the medical community manifests in not seeking healthcare providers for HIV information and even formulating HIV conspiracy beliefs, which may inadvertently increase HIV infection acquisition risks among African American females (Freeman, 2010; Bontempi et al., 2008)

In Brontempi, Eng & Quinn's (2008) qualitative study of 24 North Carolinian African American females aged 18-57 years, report the impact relationship dynamics/power has on their ability to practice safer-sex, the participants expressed the HIV conspiracy beliefs some African American females hold. Participants in the study claimed that even though they regularly test for HIV, they are not convinced by the disproportionate HIV rates in the African American population that scientists/epidemiologists report. One participant explained her belief in the myth of the HIV conspiracy by suggesting that she believes "just as many White people have got it but [scientists] not going to show the statistic because they paying them doctors under the table not to record it" (Bontempi et al., 2008, p.74). In addition, the participant says that the current HIV rates reported among African American females are merely a "cover up" post-Tuskegee-era, of governmental genocide whereby HIV was "given" to African Americans to spread the infection around to kill each other off. Most of the participants believe HIV is equally prevalent among males and females in all racial/ethnic groups to the extent that African Americans need not to believe the hype regarding the alarming rates nor take any extra-preventive precautions (Bontempi et al., 2008).

Long-held beliefs that HIV is a White person's disease, a gay White man's problem, or an illness that primarily affects IV drug users or prostitutes still lingers in the minds of many African Americans. Such ideological thinking appears to place African American

females at risk for HIV. Some African American females hold the misconception that HIV "only happens to sex workers, drug addicts and homosexuals" - this ideology may increase their risk for HIV acquisition/transmission (Vaughns, 2004, p.1). Stampley, Mallory, & Gabrielson's (2005) descriptive literature review of African American females aged 40 and older indicate how females, especially older females, may perceive themselves to be at no or a low-risk for HIV infection despite reported HIV/AIDS rates disproportionately rising among those over the age of 40. Their findings are consistent with other evidence that older females (aged 40+) perceive their chances of becoming infected with HIV is low or unlikely. Having this misconception, many older African American females rarely know their partner's HIV status or bother to practice safe-sex measures (Stampley et al., 2005). Instead, older African American females may rely more on maintaining monogamous relationships as HIV risk reduction methods and neglect to discuss sexual matters, like condom use, with their male partners, compared to younger females (Stampley et al., 2005).

2.6 Self-Esteem, self-efficacy and confidence

Lack of self-esteem, self-efficacy, and confidence hinders some African American females' ability to negotiate condom use or other safe sex behaviors, which may put them at risk for HIV/AIDS acquisition (Hodder et al. 2010). Sales, DiClement, Davis & Sullivan (2012) qualitative study of 50 Georgian African American females aged 18 to 23, who previously participated in a randomized controlled trial measuring the effectiveness of an STI/HIV prevention intervention, report associated factors why some females continue not to use condoms despite exposure to HIV prevention intervention programs. A significant finding in the study included that participant's lack of self-esteem, self-efficacy, or

confidence is a contributory factor to why some females continue not to use condoms after HIV prevention programs. A commonality the investigators noticed among participants was that having low self-confidence or self-efficacy contributed to participants' avoiding the discussion of condom use with male partners or lacking the confidence to end an unhealthy relationship. These attributes result in the belief that change is very difficult. For example, one participant says that changing old habits are hard because an African American woman may fear she will forfeit her relationship with her partner if she confronts him regarding his promiscuous lifestyle. The participant reports that "if it's not the condoms, then it's just having the confidence to come to your partner [stating that] I know or I notice [him] cheating, [but oftentimes] I don't say anything" (Sales, DiClement, Davis & Sullivan, 2012, p. 1097).

Pittiglio, Jackson & Florio's (2012) mixed quantitative/qualitative study of 33 Michigan African American females aged 25 to 43 years old capture the phenomenon that low self-esteem among African American females are placing them at risk for HIV infection. In their study, Pittiglio, Jackson, & Florio (2012) report African American females have difficulty negotiating condom use with their male partners due to the lack of using condoms consistently. They also report that low self-esteem is correlated with their inability to initiate condom use with male sexual partners. Participants in the study reported lack of self-esteem makes African American females vulnerable to HIV infection because they lower their standards and settle for males who would not ordinarily be their ideal because they are promiscuous, domineering, inadequate, etc. One participant stated that African American women "want to be in a relationship, so a lot of the time they are willing to accept and lower their standards for something that rationally they would not"; another

participant offers the same perspective in that "self-esteem plays a big part [in HIV risk behavior] … a lot of girls nowadays have low self-esteem. They feel like if I don't do it with this guy he will no longer be around, he won't be with me. They will take whatever he gives them" (Pittiglio et al., 2012, p. 18). In summary, the participants in their study confirmed that lack of self-esteem leads African American females to risky behaviors in that "…when your self-esteem is low they (men) can do whatever" (Pittiglio et al., 2012, p. 18).

Sterk, Klein, and Elifson's (2005) cross-sectional study of 250 Georgian African American females averaging 35 years old report the relationship of self-esteem to the involvement in sexual/HIV-related risk behaviors. The study measured the number of times participants had oral sex and intercourse with paying partners, incidences of sexual risk-taking events, the number of different HIV risk behaviors practices during previous year and condom use attitudes and self-esteem. Consistent with other evidence, they report that lower levels of self-esteem are associated with higher sexual/HIV-related risk behaviors. That is, compared to most of the women in the study who had high levels of self-esteem those females who had lower levels of self-esteem participated in more acts of oral sex, had more sex with paying partners, a higher occurrence of sexual risk-taking events, more negative attitudes towards using condoms and decreased condom use self-efficacy (Sterk, Klein, & Elifson, 2005).

2.7 Heterosexual partners, gender surplus and power dominance

Most African American females partner with African American males – a population for whom HIV infection rates are higher than other racial/ethnic male groups

(Paxton, Williams, Bolden, Guzman & Harawa, 2012). Heterosexual contact with an infected male partner is the predominant mode of HIV transmission among African American females, and unprotected sex appears to explain why HIV is prevalent to the extent it is reported within this population (Bontempi et al., 2008). Evidence shows that the number of African American females available outnumbers African American males, which has created a female "gender surplus" within the community. This female gender surplus, or "male shortage," along with differences between male-female relationship power appears to place females at risk for HIV acquisition (Bontempi et al., 2008; Harvey & Bird, 2004); Paxton et al., 2012).

Evidence shows that African American females between the reproductive ages of 15 to 49 years old, outnumber their male counterparts. African American females outnumber males available largely due to males experiencing higher rates of homicide and incarceration, having lower birth sex ratios, and experiencing unemployment hardships forcing males to relocate with varying migration patterns (Pouget, Kershaw, Niccolai, Ickovics & Blakenship, 2010; Bontempi et al., 2008). Subsequently, this "male shortage" creates a power difference between the genders, in that males experience the benefits of increased sexual bargaining power. On the other hand, females have less sexual power to negotiate their concerns and have fewer alternative sexual partners available (Kershaw, 2010). Several studies suggest some African American females perceive they cannot insist on condom use because they have insufficient power in their relationship with African American males (Harvey & Bird, 2004).

The male shortage, or female gender surplus, is noteworthy to the extent this phenomenon creates a power dynamic between the genders and impacts the utilization of

condoms (Bontempi et al., 2008; Kershaw et al., 2010; Paxton et al., 2013). Bontempi et al. (2008) report that a many African American females do not bother to negotiate condom utilization or safer sex practices with their male partners simply because of fear. The fear they may experience in this situation is due to the thought of losing their partner to another female who may be more accommodating to his sexual idiosyncrasies meeting his need to have sex without a condom or tolerating his concurrent relationships. Circumstances like these pose as social determinants of health in terms of HIV acquisition/transmission for African American females. For African American females who reside in disproportionate sex ratio areas, (Pouget, Kershaw, Niccolai, Ickovics, & Blankenship, 2010) report that these females are more at risk for HIV, especially females residing in high HIV prevalence areas, due to the fact they may compromise their moral integrity to keep a male partner satisfied.

Because of this imbalanced sex ratio among African Americans, females may experience competition amongst themselves just to keep a male partner happy, and in doing so, they may compromise their values and, integrity, and abandon safe-sex practices just to please their partner. Paxton et al. (2013) reports that many females are pressured into unprotected sex believing they must compete with each other just to keep their male partner. Some African American females find the competition amongst other females so great that many may permit their male partner to have concurrent partners. Such phenomenon is shown in Bontempi, Eng & Quinn's (2008) qualitative study of twenty-four young African American females residing in rural North Carolina portraying the effects imbalanced sex ratios has on their sexual health behaviors and decision-making capacity. Bontempi, Eng & Quinn's (2008) participants report the impact that fewer

available male partners have on the African American females in their community. Participants report that merely having a male partner can translate into upward mobility and a "ticket out" of the projects. Unfortunately, though, some males realize their desperation and may take advantage of African American females, abusing them physically and/or emotionally. And because these African American females have an intrinsic desire to be loved, cared for, and protected by a man, sometimes they may settle, compromise their standards, and modify their behaviors just "to keep" their male partner in their lives, even to the extent of engaging in unprotected sex (Bontempi et al., 2008). Some African American females go to the extent of providing housing, transportation, and sexual conquests – yet in return, their partners may reciprocate with physical abuse, infidelity, concurrent partnerships with other African American females, increasing their risk for HIV infection (Bontempi et al., 2008).

As African American females outnumber males within their communities, participants also report that African American females may maintain a high tolerance level of abuse and infidelity from their male partners due to the fact they do not want to be single or alone (Bontempi et al., 2008). Sharpe et al. (2012) confirms the evidence that the unbalanced male-female ratio within African American communities enables males to cherry-pick their females and thus lowers the incentives for females to demand males use condoms. In all, unbalanced gender ratios within the African American communities translates into more power relinquished to males to the extent that females may tolerate males engaging in concurrent relationships, infidelity, and acts of physical violence (Sharpe et al. 2012).

Participants in Nunn et al.'s (2012) qualitative analysis of 19 African American women in Philadelphia who engage in concurrent relationships of their own, adds another layer to this phenomenon. These participants report having attempted to do things the right way in order to prevent the spread of HIV. That is, they previously had consulted with their male partner regarding having an exclusive monogamous relationship; however, when their male partner disagreed to engage in an exclusive monogamous relationship, these females engaged in concurrent relationships of their own due to the lack of trust they had in their main partner (Nunn et al., 2012).

Not only imbalanced sex ratios pose as risk factors for HIV acquisition/transmission among African American females relationship, power dynamics between genders appears to be a risk factor as well. Evidence suggests that heterosexual African American males have considerable authority over how condoms are used not only because of the imbalanced sex ratios that exist in some communities but also because of socio-cultural factors pertaining to control, trust, and masculinity. The latter factor appears to yield African American males more power to controlling condom utilization in relationships; Paxton et al. (2013) reports such a phenomenon. Evidence shows males have more control over condom utilization at the expense of their female partner(s) having no or little power to negotiate safe-sex measures (Paxton et al., 2013). Young Georgian African American female participants in Sales, DiClemente, Davis, & Sullivan's (2012) qualitative study agree that relationship dynamics is a factor in why they did not change their condom use behavior even after exposure to an HIV/STI prevention intervention. A participant reports that since her sexual partner was significantly older than she was, he

determined their use of condoms and safe-sex practice merely due to the fact that she is "his girl, his property" (Sales et al., 2012).

The power dynamics between the genders may be so great that fear may hinder African American females from trying to negotiate condom utilization with their partners. Sharpe et al. (2012) report that many African American females fear facing rejection or even retaliation from their male partner if they request them to use condoms during sex. Such a phenomenon is confirmed in Sales et al.'s (2012) qualitative study, as one participant in the study reports she "was scared to bring that conversation to [her boyfriend] to talk about [using condoms]" (Sales et al. 2012). Monroe (2006) also reports how one African American female got infected with HIV due to fear and differences in relationship power between the genders. She states the following:

> "He told me that he didn't like condoms, and he wasn't going to wear them and [told me] not to ask him. When I found out I was infected, I was upset and ashamed and [was] angry at him. But I was mad at myself because I should have known better. I should have known better to protect myself. I knew how HIV was transmitted, but I still didn't think it could happen to me because I am a heterosexual Black woman and not a drug user" (Monroe, 2006).

With regard to trust being a factor for HIV acquisition among African American females in relationships, evidence shows that males may persuade females to not use condoms with the argument that by asking the male to use a condom, the female is demonstrating her lack of trust in him. Sale et al. (2012) report that some African American females may not use condoms due to the fact that their male partner's rebuttal that she

should trust, first and foremost, that he is safe and HIV negative. If the female had engaged in unprotected sex with her partner in the past but later desires to introduce safe-sex practices into their relationship, some males retaliate accusing her of "flipping the script" and/or infidelity with other males as the reason for now wanting to use condoms (Sale et al. 2012).

However, not all African American relationships are dominated by the male gender. Conflicting evidence in Harvey & Bird's (2004) two-phase qualitative/quantitative exploratory study of 22 young Oregon African American couples and 40 African American females shows there is some equality between the genders in terms of safe-sex practices. Although several participants in the study confirmed males have more control in determining sexual practices because "a [male] has more power because he's a man," half the female participants report their sexual practices are a joint effort, and a majority of the females report that condom use is also a joint effort with their male partners (Harvey & Bird, 2004).

2.8 High-Risk partners: incarcerated males

Evidence shows that one in twenty-one African American males is currently behind bars; it is estimated that nearly one in three African American males will be incarcerated at some point during their lifetime (Harawa & Adimora, 2008). Males who have been incarcerated are classified as high-risk sexual partners for African American females (CDC, 2009). Since most African American females prefer to partner with African American males, for whom incarceration rates are higher than for other racial/ethnic

groups, this socio-cultural factor places African American females more at risk for infection (CDC, 2009; Ivy et al., 2013; Mays et al., 2012).

The nation's penitentiary system serves as an HIV incubator in part because of the activities in which inmates may engage while incarcerated – IV drug use, tattooing, body piercing, and sexual activity with other inmates. Such high-risk behaviors in a prison environment make it easy for the infection to spread among inmates (Mays et al., 2012; Roanoke Times, 2004). Evidence suggests that incarcerated individuals are more likely to be associated with lower socioeconomic status (SES), have exchanged sex for drugs/money, have had multiple sex partners, have used illicit drugs, and/or have higher rates of STDs, increasing their partner's risk for HIV infection. Compared to all racial/ethnic and gender groups, African American males (especially those between the ages of 18-34) by far experience higher incarceration rates, which places African American females at greater risk for HIV infection (May et al., 2012; Roanoke Times, 2004). Furthermore, evidence shows that the Southern region of the United States has a higher incidence of incarceration compared to the national rate – 540 per 100,000 versus 479 per 100,000 people, respectively – and that in regions burdened by higher incarceration rates there is a correlation with higher prevalence rates of STDs/AIDS (Mays et al., 2012). This phenomenon may explain why African American females residing in Southern states, like South Carolina, are affected more by the epidemic compared to African American women living in other regions.

Although imprisoned HIV-positive males most likely have acquired the virus prior to entering the penitentiary system, some African American males may acquire HIV while in prison or jail due to engaging in high-risk behaviors while incarcerated (Mays et al.,

2012). Unfortunately, prisons, jails, and other penitentiary facilities cannot control all the HIV infections that occur within their walls. Therefore, some African American males released from the system may carry back into the community whatever STDs, including HIV, they may have acquired while incarcerated (Mays et al., 2012). And because nationwide HIV screening is not routinely required for inmates when they exit the system, those African American males who got infected while in the system leave these facilities unware of their positive seroconversion. Wohl (2004) reports, "many inmates who have been locked up for a while want two things when they come out. One of them is a Big Mac. The other is sex" (Roanoke Times, 2004).

Once inmates are released back into the community setting, African American females may be at risk for HIV infection due to the fact of not knowing their partner's positive HIV seroconversion status while being incarcerated. This phenomenon was demonstrated when disproportionate rates of HIV among African American females started to occur when African American male inmates' jail sentences were shorten by policy makers (Mays et al., 2012). When their sentences were shortened, a significant rise of HIV infection rates among African American females was observed due to large numbers of inmates released back into the community (May et al., 2012; Roanoke Times, 2004).

2.9 High-Risk heterosexual partners: Black men on the DL

In the past it has often been assumed that Black men *on the DL* are the cause for disproportionate HIV rates seen among African American females. The term *on the DL* is a colloquial concept pertaining to males who claim to be heterosexual but engage in homosexual activities in secret. During the late 1990s and early 2000s, many media outlets

reported the "*Black men on the DL*" phenomenon as it related to the HIV epidemic in African American females (Anderson, 2010). The concern that Black men *on the DL* were causing disproportionate HIV rates among African American females became so alarming within the media that an episode entitled "A Secret World of Sex: Living on the Down Low" was produced on the Oprah Winfrey Show to report the secretive high-risk sexual behaviors bisexual African American males engaged in that placed African American females at risk for HIV infection (Sandfort, 2008). Featured guest King (2004) reported that married/heterosexual African American males; who engage in secretive sexual relations with other males; are a contributing factor for HIV infection currently seen in African American females (Whyte, Whyte, & Cormier, 2008). Media attention generated by programs such as this ignited sparks of contention within the African American community via placing resentment and blame on bisexual African American males for being the bridge to the homosexual community and, consequently, the reason for the disproportionately high HIV rates seen in African American females (Anderson, 2010).

However, in spite of the propaganda, there is little evidence to substantiate that Black men *on the DL* infect African American females with HIV to the extent reported (Anderson, 2010). Never-the-less, evidence shows that a significant number of African American females believe that having a partner *on the DL* will increase their risk for HIV infection and that these types of male partners are responsible for the disproportionate HIV rates seen among African American females (Anderson, 2010; Brydum, 2013). In their qualitative exploratory study of females age 49 to 67 years old, Whyte et al., (2008) report the first-hand experiences and cultural perspectives of African American females who acquired HIV infection after being in stable long-term monogamous relationships (of 10

years or longer) with Black male partners *on the DL*. He reports that African American males, who are *on the DL,* conceal their behavior in part because homosexuality is culturally taboo, and that lifestyle is frowned upon within the African American community. So Black men *on the DL* may not be forthcoming with their female partners regarding their homosexual tendencies; instead, they engage in high-risk sexual behavior with other males and return to their female partners and have unprotected sex with them (Whyte et al., 2008). Participants in the study reported being completely unaware of their male partner's DL activities. Because they were unaware of such behavior, they perceived themselves to be at no or low risk for HIV acquisition. And because these females had perceived themselves to be at no or low risk for HIV infection, they did not use sex-safe methods with their long-term partners and subsequently were infected with HIV (Whyte et al., 2008).

Payne (2008) reports that many African American females may neglect taking the proper precautions to become well informed of their partner's sexual history – to know whether they have had multiple partners or have been *on the DL*. Evidence suggests that African American females in committed relationships cannot be completely confident that their partner is monogamous, and the lack of knowing their partner's sexual history may place them at risk for HIV infection (Payne, 2008). However, not all African American females are naïve or hesitant to inquire about their partner's sexual history or the possibility he may engage in DL activities. Focusing on high HIV-prevalent areas such as Washington D.C., Goparaju & Warren-Jeanpiere's (2012) observational study of 36 African American females aged 25 to 60 years old, half of whom were infected by HIV, reports the female perspective of Black men *on the DL* as it relates to their risk for HIV infection. Because

most participants were familiar with the DL phenomenon via watching movies, talk shows, or reading literature, they report having a heightened index of suspicion towards any prospective male partner in light of the disproportionate HIV rates in the Washington D.C. area. Participants were informed about the importance of inquiring about a male partner's HIV status and/or sexual orientation as it pertains to the risk for HIV infection. However, African American females have to ask their partner questions in a peculiar manner to obtain the information needed to determine if he is involved in DL activities. For example, a participant says that "a lot of times when we ask these questions to our Black men that [it's] not the right question. …we not supposed to [ask] are you gay, it's have you slept with a man or a woman [because] if you ask somebody [are] you gay, you might get no, but if you say, do you sleep with other men, you might get [a] yes" (Goparaju & Warren-Jeanpiere, 2012, p. 887). However, McCree (2013) reports "what [African American] women need to know is not what a man calls himself, what label he likes and what he doesn't but what he has done and how" (Ross, 2013). McCree (2013) finds that African American females experience an internal debate whether to continue sexual relations when learning her partner engages in sexual activity with other men *on the DL* and considers the associated risk for HIV infection or re-infection with a different HIV strain (Ross, 2013).

Despite mainstream media information, previous research, and cultural beliefs that assume Black men *on the DL* are the prime risk factor for the HIV epidemic affecting African American females, the evidence suggesting this is significant to the extent reported is conflicting (Anderson, 2010; Ross, 2013). Leading authorities Kevin Fenton, director of the National Center for HIV/AIDS, viral hepatitis, STD and TB Prevention at the CDC,

and Greg Millet, top AIDS advisor to the Obama White House, report such evidence. Millet reports:

> "Black men on the down low have been considered prime agents of HIV transmission in the Black community despite little empirical evidence. We assessed the relationship between down-low identification and sexual risk outcomes among 1151 Black [men who have sex with men]. Down-low identification was not associated with unprotected anal or vaginal sex with male or female partners" (Wright, 2010).

Fenton reports that it is heterosexual African American males with multiple sex partners, and not Black men *on the DL*, who are responsible for the disproportionate HIV infection rates observed in African American females. Fenton reports that the proportion of HIV infections transmitted to African American females from male partners who are *on the DL* are found to be relatively few compared to male partners who have multiple female partners and/or do IV drugs (Curry, 2009). In all, leading experts confirm that Black men *on the DL* are not a significant HIV risk factor for African American females to the extent previously reported.

2.10 Concurrent relationships

Some African American females engage in their own high-risk behaviors, such as having multiple sexual partners, which increase their risk for HIV infection. Evidence shows that multiple sexual partners, also known as concurrent partners, and having a higher number of total lifetime sexual partners increases one's risk for HIV infection. Tuan (2006)

reports that having multiple sexual partners is indeed the number one factor for HIV transmission. She states the following:

> "[multiple sexual partners] increase the spread of infection exponentially: one infected person infects another; the two people infect others; these infect as many more, etc. When relationships overlap and one concurrent partner acquires an infection, transmission to all the other concurrent partners can occur in a relatively short period of time. Having concurrent sex partners, even among a very few people, has dramatic consequences for the spread and persistence of [HIV] infection within a community" (Tuan, 2006, p. 4).

Compared to other all racial/ethnic young females, evidence shows African American females have more lifetime sex partners than Latino and White females (Tuan, 2006). However, reasons why African American females have more lifetime sexual partners are varied. It appears that social circumstances may play a factor beyond that of just personal gratification. Some African American females face social circumstances in that limited financial resources (having to trade sex for money, food, and/or shelter) or experiencing abusive relationships (subjected to survival sex) causes them to have more lifetime or concurrent partners (Tuan, 2006). Other African American females may lack opportunity for upward mobility and network (sexually) with males in the community for stability (Tuan, 2006).

As previously mentioned, high incarceration rates among African American males is problematic in that it creates a social situation for some females to have concurrent relationships. High incarceration rates among male partners is problematic for females

because it creates two problems: (1) it changes the sex ratio within the community where African American females settle for less (compromise safe-sex practices) and it (2) increases female STD/HIV infection risk (Mays et al., 2012; Nunn et al. 2012). Evidence shows that incarceration among African American males disrupts relationship continuity which inadvertently causes females to seek new partner(s) to fulfill their needs, whether for sexual gratification, companionship, and/or financial stability. The qualitative study performed by Nunn et al. (2012) of 19 African American Philadelphian females confirms this. Participants shared their experiences engaging in concurrent relationships when their main partners went to prison, jail, or other correctional facilities. They state that their partner's incarceration resulted in their having concurrent partners to fulfill sexual needs, which put them at risk for HIV infection. One participant reported that her partner "went away to prison for 10 months ... slept with someone else and came back with an STI, which was trichomonas" (Nunn et al., 2012, p. 293). And when her partner was released from prison, she maintained sexual relations with both male partners simultaneously. Incarceration of African American males is a common occurrence, causing some females to have concurrent partnerships and place themselves at increased risk for HIV infection.

On the other hand, some African American females engage in concurrent partnerships for their own pleasure or personal needs, which increase their risk for HIV infection. Nunn et al. (2012) reports that most African American females prefer to be in mutually monogamous relationships, but social situations or factors may encourage them to have concurrent partnerships. Participants report the following reasons why they have engaged in concurrent partnerships: (1) they expected their male partner to have other female sex partners so they subsequently had their own "reactive" concurrent relationships,

(2) they continued sexual relations with their child's father despite having ended the relationship, (3) there was substance abuse/alcohol use, or because (4) non-main partner(s) fulfilled other purposes (Nunn et al., 2012).

Evidence shows that African American females who have multiple partners may stratify concurrent relationships into main and non-main sexual partners. Both main and non-main partners serve different purposes for African American females: sexual pleasure, emotional connection, or other needs (Nunn et al., 2012). Another participant reports that it is the lack of emotional connection with her main partner that caused her to seek out another partner who could fulfill unmet needs while she maintained a relationship with her main partner. She reports:

> "I went out and had sex with another man because my boyfriend at home wasn't paying me any attention… he wasn't giving me sex when I wanted it. A couple days after that, I had sex with another guy that I met on the bus, I had sex with him for, like 3 or 4 months" (Nunn et al., 2012, p. 291).

The reasons why some females seek concurrent partners may vary, but the reason for condom utilization between main versus non-main partners is similar among African American females. That is, many African American females may utilize condoms with non-main partners with whom they are less familiar (e.g. sexual history or STD/HIV status), while engaging in unprotected sex with their main sexual partner whom they trust more. Evidence suggests that many African American females understand the associated risk for HIV infection due to having multiple sex partners and the risk of HIV transmission without using a condom (Nunn et al. 2012; Sale et al. 2012). However, the utilization of

condoms is variable depending upon whether the female is with her main or non-main partner. One participant reports, "sometimes [I use condoms]. I'm not going to say all the time…If it was a regular [partner], probably not. That's one of the times I caught something; [it] was when it was a regular guy that I was with" (Nunn et al., 2012). Such attitudes and behaviors are common among many African American females who have main and non-main partners and do not utilize condoms consistently with main partners for various reasons (e.g. trust, steady long-term relationship, etc.) placing them at increased risk for HIV infection (Nunn et al., 2013).

2.11 Substance abuse and alcohol

Evidence shows that substance abuse and alcohol use are significant risk factors for HIV infection among African American females. Early in course of the HIV epidemic, IV drug use (crack cocaine being the drug of choice) in African American females was the most significant high-risk behavior that increased their risk for HIV infection. Once crack cocaine was tried, females became almost instantaneously addicted to it to the extent that many traded sex (which was usually unprotected) with many male partners for the drugs. They also traded sex for money in order to buy more illicit substances to support their drug habits. Fortunately, IV drug use behavior/HIV infection within African American females has declined over the course of the epidemic via help from implementing needle exchange programs (Fauci, 2010). However, IV drug use and alcohol use still are high risk behaviors that increase the risk for HIV infection among African American females. In 2004, IV drug use was the second leading associated cause for HIV infection for African American females (Trzynka & Erlen, 2004). The CDC (2008) estimates that 1 in 5 new HIV cases among females are acquired through IV drug use. Evidence shows that both casual and

chronic substance use has been and continues to be an HIV risk factor because illicit substance usage influences high-risk drug-seeking behavior in that unprotected sex is practiced at whatever cost in order to acquire the drugs (CDC, 2008).

Substance abuse and alcohol use are risk factors for HIV infection in African American females due to their psychedelic effects. Being under the influence of drugs and alcohol alters their mood to the capacity they may engage in unprotected sex, which inadvertently increases their risk for HIV infection. Sales et al. (2012) demonstrate this in their qualitative study of 50 Georgian African American females who had previously participated in a randomized controlled trial measuring the effectiveness of an STI/HIV prevention intervention. One participant reports how being under the influence of drugs/alcohol impeded her ability to practice safe sex:

> "I used to smoke and drink and stuff like that. Well, [you're] judgment is not there at all. So, I think that's probably one of the main reasons why I got pregnant twice, from drinking … if you're high and out of it, your decision making is not there. So you're just going to go with anything" (Sales et al., 2012, p 1098).

Another participant reports the foolish high-risk behavior she and her male partner engaged in while under the influence of alcohol. She states, "one day we were like intoxicated, and we decided that we was gonna have a baby. And then after that, we just kept doing it. And it's like once my period didn't come on time, he wasn't really feeling the fact that oh, she might be pregnant, like basically, he just was like, I don't think I can do this" (Sale et al., 2012, p. 1097). This evidence shows the typical effects drugs and/or

alcohol have, causing many people to make poor decisions during sexual encounters. Such attitude and behaviors put African American females at risk for HIV infection.

2.12 HIV interventions targeting African American females

There are currently 11 HIV interventions that target African American females that have been approved by the CDC or Diffusion of Effective Behavioral Interventions (DEBI) project that provide the best and most promising evidence effective of their efficacy HIV prevention (DeCarlo & Reznick, 2009). Mays et al. (2012) report that conventional HIV interventions targeting African American females, however, have placed more emphasis on individual risk behaviors highlighting the responsibility of females to use condoms with their male partners, an approach that has been shown to have limitations with the existence of the current HIV/AIDS epidemic. It is thought that HIV intervention efforts targeting African American females should evolve from focusing on individual risk behaviors and shift towards population-based strategies to address this population's HIV vulnerabilities within the community (Mays et al. 2012). Implementing population-based HIV prevention may be more adventitious to African American females as their communities appear to be tightly woven in terms of social norm ideologies; a population approach may enable females to negotiate safer-sex with male partners more effectively, increase female's self-esteem/confidence and facilitate health information social support—a support system that African Americans females need (Mays et al., 2012). In addition, it is recommended that leadership among various branches of U.S. government, like the Department of Health and Human Services, pioneer population-based HIV interventions in African American females because they have preexisting structural frameworks to use in implementing change in a broader context and capacity. In doing so, this may not only meet the target

needs of African American females but also exceed the goals President Obama set according to the National HIV/AIDS Strategy (NHAS) agenda (Mays et al., 2012).

Regardless of the scale or scope of the HIV intervention methodology, evidence supports that it is imperative that HIV interventions targeting African American females be culturally congruent. Evidence suggests there is a pervasive lack of cultural competency in HIV interventions for African American females addressing the peculiar social factors of the epidemic in the Southern region of the country (May et al., 2012). McNair & Prather (2004) report that HIV interventions targeting African American females, which consider the effects of culture and race the social factors they face, are more efficacious and may have more impact on participants compared to generic HIV interventions that do not consider these implications in the equation. Freeman (2007) confirms that in order for HIV interventions to be effective among African American females, it is essential that the intervention incorporate cultural-sensitive factors relevant to the psychosocial, educational, and generational elements they face. HIV interventions that include cultural and social aspects enable African American females to acquire an increased skill set and self-confidence, since the context of the intervention is contextually realistic, relevant, and tangible regarding their unique circumstances (McNair & Prather, 2004).

Although current HIV interventions appear to show the best and most promising evidence effective in reducing HIV within this population, retrieving HIV prevention information has historically been a low-priority concern for many African American females, secondary to the social issues many face—struggling to secure jobs, food, housing, childcare, etc. (DeCarlo & Reznick, 2009). Furthermore, since most of the HIV/AIDS cases reported in African American females occur among those living in lower

socioeconomic areas, communities where trading sex for money/shelter may be a social norm and where women may be dependent on males for financial support, use substances or experience violence, hindering their access to HIV intervention information needed (DeCarlo & Reznick, 2009). Despite intervention efforts targeting African American females, social barriers that impede them from obtaining the information they need should be taken into consideration regardless of the depth, breath and scope (individual versus population-based) on HIV intervention since social circumstances play a key role in access to preventative information.

2.13 HIV in heterosexual African American males

It is well documented that HIV disproportionately affects the African American population versus other racial/ethnic groups, yet rates in heterosexual African American males have been poorly documented. As in all African American subpopulations, HIV is a serious social problem, but there has been limited research or HIV prevention strategies done to target those who self-identify as heterosexual or "straight." (Bowleg et al., 2013). Evidence shows that heterosexual African American males are "the forgotten population" in terms of HIV research and HIV prevention program, even though the limited evidence that does exist among this population shows that HIV/AIDS rates are on the rise among them (Baker et al., 2012; Bowleg, Mingo, & Massie, 2013).

Among heterosexual African American males infected with HIV, former National Basketball Association (NBA) Lakers player Earvin "Magic" Johnson is one of the most famous heterosexual African American males diagnosed and living with HIV. His infamous public announcement regarding his positive HIV status shed light on the fact that

the virus not only affects those who engage in homosexual activity or IV drug use but also those who engage in heterosexual activity. The significance of Magic Johnson's public announcement showed that heterosexual African American males are just as vulnerable to acquiring HIV infection as other populations. Although his public announcement initially promoted significant awareness about heterosexual African American males' vulnerability to HIV, this attention quickly dissipated in the years to come with few research efforts enacted to better control the infection within the heterosexual African American male community (Baker et al., 2012). This lack of attention has been shown to have significant negative consequences over time. In 1993, two years after Magic Johnson's announcement, evidence showed that heterosexual African American males accounted for only 8% of all HIV infections in the United States, compared to 69% by 2009 (Bowleg, Mingo, & Massie, 2013).

2.14 HIV epidemiology in heterosexual African American males

Evidence shows that African American males account for 31% of all new HIV infections in the United States, and they represent nearly 50% of all HIV diagnoses among the male population across the nation. Among males in the United States, African American males account for 63% of all HIV transmissions via high-risk heterosexual contact, compared to 13% White males and 21% Hispanic/Latino males (Henny et al., 2012). The primary mode for HIV transmission among African American males includes homosexual contact (68%), followed by high-risk heterosexual activities (20%) and IV drug use (9%). In 2009, it was estimated that the rate of HIV infection among African American males was more than eight times greater than the HIV rate compared to White males, and approximately three times the rate compared to Hispanics/Latinos (Baker et al.,

2012). By age group, African American males aged 13 to 24 years old had the highest rates of HIV infection during the years of 2006 to 2009. Furthermore, of the near twenty-thousand teen/young adult males across the nation living with HIV/AIDS, the majority (64%) were African American males (Baker et al., 2012).

Compared to their White and Hispanic/Latino male counterparts, African American males appear to engage in more HIV risk-related sexual behaviors (Baker et al., 2012). Evidence shows that African American males have the highest rate of sexual intercourse during their high school years. In addition, evidence suggests that African American male students are more likely than Whites and Hispanic/Latinos to have initiated sexual activity prior to the age of thirteen. The National census shows that 14% of all adolescents have had four or more lifetime sexual partners. But for African American males, evidence shows that nearly 40% of male teens have had four or more lifetime partners—more than triple the national average. Furthermore, among African American male teens, 21% report they have used illicit drugs or have been under the influence of alcohol during their last sexual encounter (Baker et al., 2012).

While evidence shows that the number one risk factor for HIV infection among African American females is via heterosexual contact, knowing the other piece of the puzzle (e.g. like African American male's risk behaviors), is thought to be beneficial in controlling the epidemic within the population (Baker et al., 2012). Indeed, heterosexual African American males have factors that increase their risk for HIV acquisition which enables the infection to propagate throughout the African American community. According to the literature, factors that place heterosexual African American males at risk for HIV infection include the following: (1) concurrent or multiple partners, (2)

unprotected sexual activity, (3) higher rates of STD/STIs among them, (4) social-cultural contextual ramifications revolving around masculinity/machismo, (5) structural challenges, and (6) substance abuse/alcohol.

2.15 Multiple sexual partners among heterosexual males

Sexual partner concurrency – having sex with more than one individual over an overlapping period of time, is a common activity within the African American male community that places heterosexual males at risk for HIV infection. According to the evidence, among African Americans who have acquired HIV infection via heterosexual transmission, 53% of African American males engaged in concurrent sexual relationships (Baker et al., 2012).

Baker et al. (2012) report in their qualitative study factors that place their Philadelphian heterosexual African American males at risk for HIV infection. Participants report how having concurrent or multiple sex partners increases their risk for HIV infection. Participants state that having multiple female sexual partners is a social norm for African American males aged 18 to 24 to the extent that 70 to 90% of males in their communities have multiple female partners – anywhere from 2-28 sexual partners over a 3-month time span (Baker et al. 2012). The contextual ramifications for having multiple sexual partners among African American males are varied, however. Participants report that "the temptation" of having multiple female sexual partners can be irresistible because "it's easy," and many African American females readily offer them sex. Beyond not having the will-power to resist multiple sexual solicitations, some African American males obtain "sexual favors" from another female(s), apart from their main partner, due to the fact their

main partner may be unwilling to provide specific sexual acts (e.g. oral sex) he may desire (Baker et al., 2012).

Baker et al. (2012) also report that some African American males appear to enjoy the chase and thrill in pursing another female partner because there is "always somebody who looks better than your [own] girl" (Baker et al. 2012, p. 375). In addition, some males hold the perspective that they should indeed have sex with several African American females even to the extent of having a variety of sexually uninhibited partners. Moreover, participants say that having only one female sex partner is "boring" and that males "don't get the wide [sexual] experience" they should have during their youth (Baker et al. 2012, p. 375). Despite knowing the associated risk for HIV infection secondarily to having multiple female sexual partners, participants acknowledge the social shame and disapproval of this type of behavior from referential females like girlfriends, mothers, and grandmothers (Baker et al., 2012).

Twenty-eight African American male participants, majority of whom were unemployed and had been previously incarcerated, in Bowleg et al. (2013) qualitative study, report similar problems. Participants say that they know that having multiple sexual partners increases their risk for HIV infection, but they explain that monogamy, or reducing the number of concurrent sexual partners, is challenging. The participants express that they and other heterosexual males in the community like the "free-balling" or "thrill-of-the-chase" experience one gets from having concurrent/multiple sex partners. Such excitement makes it difficult for males to reduce the number of female partners they have (Bowleg et al., 2013). Moreover, some heterosexual African American males may view having

concurrent/multiple sexual partners as a social norm during the 20 to 30 age range because they are in their so-called "sexual prime" years.

Evidence shows that the imbalanced sex ratio between the genders creates an atmosphere conducive to males engaging in relationships with concurrent female sexual partners. The participants in the study conducted by Bowleg et al. (2013) report how imbalanced sex ratios between the genders create an environment conducive for males to have multiple female partners. One participant reports that high incarceration rates among males creates situations where there are more sexually available females for males to cherry-pick and choose. Being in an environment where there is a surplus of females available creates irresistible sexual enticement in which many African American males find it difficult to restrict themselves to a mutually monogamous relationship. The participant informs that "it's the temptation of just, it's like 10 [females] to one [dude] really. You got so many males locked up and gone it's like, it's really probably 15 [females]" (Bowleg et al. 2013, p. 36S). This imbalanced gender ratio makes monogamy difficult for some African American males to practice.

African American males also report that it is not difficult to find an African American female with whom to have sex. A participant reports "[there are just] so many girls out there…there's too many out there that's willing to give it up…even when you got somebody that you can get [sex] from on a consistent basis" (Bowleg et al. 2013, p. 36). The combination of an African American female surplus along with sexually enticing females also makes it difficult for some males to limit themselves to one partner. Although fully aware that having more than one sexual partner increases their risk for HIV infection,

participants acknowledge that limiting oneself to one female partner is difficult when females out number them and are sexually readily available to them (Bowleg et al., 2013).

2.16 Masculinity factor in heterosexual males

Evidence suggests there is a link between ideologies of masculinity to high-risk sexual behavior (Bowleg et al., 2011). Expectations of traditional masculine behavior within the African American male community may include expressing dominance over females via being sexually assertive, controlling relationships, and avoid displaying emotional vulnerability (Corneille, Fife, Belgrave, & Sims, 2012). Henny et al. (2012) reports that machismo (which will be used interchangeably with masculinity), like masculinity, is the ideological and socio-cultural contextual factor present within the African American community that encourages the perpetual dominance and authority males have over females via exerting sexual prowess over females who are supposed to be subordinate and submissive to males. And since traditional perspectives of masculinity encourage promiscuity with many female partners, heterosexual African American males with this ideology are more at risk for HIV infection.

Heterosexual African American males who practice traditional ideologies of masculinity tend to exuberate a tough image, strive for status, and have a peculiar characteristic of avoiding femininity via having multiple female sexual partners (Corneille et al., 2012). Evidence suggests that heterosexual African American men may condone peers with multiple female partners, have negative attitudes towards condoms, practice inconsistent condom use, and place responsibility on females to prevent pregnancy (Corneille et al., 2012; Henny et al., 2012). Bowleg et al. (2012) report that if males

continue to adhere to these traditional masculine ideologies the HIV epidemic may continue to rise among heterosexual African American males since "some African American males feel that their manhood is defined by partner concurrency and that partner concurrency is [a social] norm" (Bowleg et al., 2012, p. 369).

Masculinity, or machismo, presents with other manifestations which also may increase heterosexual African American males risk for HIV infection. Traditional masculinity discourages male emotionality, restricts affectionate behavior between males, encourages sexual conquests, and may promote physical/sexual violence and substance abuse/alcohol use behaviors (Baker et al., 2012). These attributes may explain their disproportionate HIV infection rates in that Heterosexual African American males may be stoic or feel inhibited to express concerns they have regarding their vulnerability to HIV (e.g. their struggles with sexual addictions, substance abuse, homosexual tendencies) and inadvertently fail seeing a healthcare professional who can provide them health promotion/disease prevention information (Baker et al., 2012). Participants in Kalmuss & Austrian's (2010) exploratory study, nearly half whom were New York Black males, reported delays in seeking a healthcare provider when they speculated having an STD even when being symptomatic; their traditional masculine mannerism contributed to delays in seeing a healthcare provider. However, in heterosexual African American males who reject tradition ideologies of masculinity evidence shows these males have health promotion/disease prevention attitudes and behaviors associated with health and wellness (Kalmuss & Austrian, 2010). In all, socio-cultural ramification of masculinity/machismo facilitate heterosexual African American males to not seek healthcare to the capacity they

should yet practice greater high risk behaviors which facilitates HIV infection among them (Baker et al., 2012).

Bowleg et al. (2011) reports the intricacies of how African American males' ideologies of masculinity is associated with HIV infection. They report that masculinity is correlated to higher sexual risk behaviors that may increase African American male's risk for HIV infection. Participants report that there are two main ideologies of masculinity in the African American community in that "Black men should have sex with multiple women, often concurrently; and that Black men should not be gay or bisexual" (Bowleg et al. 2011, p. 4). For example, one participant reported:

> "Black men feel like you're not a man unless you have a whole lot of partners, multiple partners, and [that if you do not] have as many so-called freaky [sexually uninhibited] experiences as possible, you're not a man. That's society's expectations on us, and we of course [have] bought into those similar stereotypes" (Bowleg et al. 2011, p.4).

This ideology is agreed by many to the extent that many African American males may even admire those who have multiple female sex partners. Many endorse the view that having sex with as many females is intrinsic merely just by being a heterosexual African American male. Participants in Bowleg et al. (2011) study inform that real masculinity confers to obtaining "all the pussy [you] can get" and the desire to get "[sex] in a heartbeat" whenever possible is a socio-cultural norm. Masculinity is personified as having multiple female partners as evident by a participant informing that "most men that I know that are real men be like, 'Damn, that's what's up! He gets a lot of jawns.' Because real men don't

hate. … Real men look up to [that] dude and give them their props [respect]" (Bowleg et al. 2011, p 5.).

The socio-cultural context of masculinity extends to the notion that some heterosexual African American males also believe that it is the responsibility of females to practice safe-sex measures. Relying on African American females to practice safe-sex measures is problematic and may increase their risk for HIV infection. Beyond placing responsibility on females, some males manipulate the situation and blame females for the lack of condom utilization. Participants in Bowleg et al.'s (2011) study report such phenomenon. African American males report that they do not use condoms simply because females fail to mention anything about using one during a sexual act and that females do not appear to care about HIV/STDs, even though infections run rampant in the community (Bowleg et al., 2011). In addition, heterosexual African American males view that because pregnancy rates among African American females is high, this indicates that the females should take responsibility in carrying condoms on their person if they are concerned about pregnancy prevention, let alone STD/HIV prevention. One male reports:

> "No, we don't talk about condoms much [with casual partners]. Not me. I never raise it. Before we had sex it's like [she says], "Yo, take off the condom," or "You ain't gonna use the condom." It's like, rarely do I have ever have a girl that say, "Here you go [use this condom]" before we even get down [start having sex]" (Bowleg et al. 2011, p.7).

The socio-cultural norm of masculinity/machismo is a factor that places African American males at risk for HIV infection. Heterosexual African American males who are

socialized in this context are more at risk for HIV than those who embrace modern perspectives of masculinity (Bowleg et al., 2011).

2.17 Unprotected sex among heterosexual males

A condom is one of the most effective ways to prevent HIV infection. Even when equipped with this knowledge, many heterosexual African American males do not practice safe-sex via condom utilization. The ideology and motivation for not using condoms, either consistently or altogether, can be contingent upon whether drugs and/or alcohol is involved or if the person is with his main or causal female sexual partner.

Despite having the best intentions to practice safe-sex, evidence shows that some heterosexual African-African males engage in unprotected sex because of "heat-of-the-moment" situations. Such situations increase their risk for HIV infection. Bowleg et al. (2011) report it is a common occurrence for African American males to be caught in tempting sexual situations and not have the will-power to resist the sexual opportunities presented. Males in the study reported that two of the most powerful things on earth are women and their vaginas and that heterosexual desire can be so intense and overpowering at times that some males do not have the will-power to resist the sexual opportunities presented (Bowleg et al., 2011). The temptation/urge to have sex may be so strong that males engage in sexual acts without protection, even if a particular female is known to be a high-risk partner for HIV or an STD. Such heat-of-the-moments encounters place heterosexual African American males at risk for HIV. A participant reports:

> "Like, you could plan to use a Trojan. Like you could have a Trojan anything, or she could have one. … You [get] …heated you know…and y'all kissing and

whatever…like grinding, whatever the situation is. And stuff…clothes start coming off, like—but your intention was to strap up [put on a condom] but you got heated! Like, shit happens" (Bowleg et al. 2011, p.7).

When drugs and/or alcohol are involved during a sexual situation, practicing safe-sex can be difficult which place heterosexual African American males at risk for HIV infection. Baker et al. (2012) report drugs and alcohol have psychedelic effects that may compromise the decision making capacity of some males to utilize condoms during sexual encounters. Participants report that they engaged in unprotected sex while being under the influence of drugs and/or alcohol. Participants share their personal experience having sex while under the influence of drugs/alcohol and say that even though they might have had intentions to practice safe-sex, drugs/alcohol make it harder for males to negotiate safe-sex and/or use condoms correctly because "you're not in your right mind" (Baker et al., 2012).

Practicing safe-sex methods via the utilization of condoms can also be contingent upon whether African American males are having sex with a main partner versus a casual partner. Participants in Baker et al.'s (2012) qualitative study report that only one to six out of every 10 young African American males utilizes condoms on a consistent basis. Although heterosexual African American males theoretically know and understand the importance of using condoms, practicing safe-sex consistently can be tricky or variable based upon whether the encounter is with a main steady female partner or a causal partner.

Heterosexual African American males engaging in sexual encounters with casual partners appear to practice safe-sex methods more frequently than when having sexual encounters with main female partners. Participants say that males tend to practice safe-sex

with causal partners more frequently than with main partners because (1) "…you can't take anything home," (2) to prevent pregnancy or STD "slip-ups," or (3) their causal partners have "other side jawns [partners] and were sleeping with other people" (Baker et al. 2012, p. 373, p. 375). Heterosexual African American males acknowledge that causal partners increases their likelihood of acquiring HIV more than their having other male sex partners on the side, reporting that "…you need a condom with your side jawn [partner] because you don't want to get caught up with your main chick, bringing something [like an STD] home" (Baker et al. 2012, p. 373). Participants report that having sex with a causal partner sometimes is done to fulfill spontaneous momentary sexual needs. Utilizing condoms in moments to fulfill instant sexual gratification needs is less of a challenge, especially when African American males are not "really sexually attracted to [the female]" (Baker et. al. 2012, p. 375). On the flip side, when having a causal partner who is highly sexually attractive, negotiating or utilizing condoms is more problematic for heterosexual African American males, since they would prefer to experience the female's body completely without a barrier in the way, even though doing so can increase their risk for HIV infection.

On the other hand, heterosexual African American males tend not to utilize condoms with main female sexual partners mostly due to issues regarding the ramifications of trust and loyalty. In fact, females will lose trust if their male partner practices safe-sex and become suspicious that their male partner is cheating or sleeping with other people if he decides to use a condom. A participant also reports that your partner might "think you're doing something because you hadn't been using [a condom before], she might think you have something (e.g. an STD or HIV)" (Baker et al. 2012, p373). However, instead of utilizing condoms to prevent HIV infection with their main partner(s), heterosexual African

American males' primary motivating force for condom utilization with main female partners is to prevent pregnancy instead. Such an approach increases their risk for HIV infection.

2.18 Structural challenges

Although heterosexual African American males may exhibit high-risk behaviors that place themselves at risk for HIV infection according to their own personal risk behaviors/characteristics, some elements, such as structural challenges, place these males at risk for HIV which is beyond their control. Such structural challenges include poverty, unstable housing, incarceration, substance abuse, and disparities within the health care system (Henny et al., 2012). It is well documented that African Americans are disproportionately affected by high rates of poverty which manifest itself with other social issues such as unstable housing, lower education attainment, unstable jobs, and also ignorance or stigma towards HIV/AIDs (Henne et al., 2012; Heeren & Jemmott, 2011). Their higher rates of poverty also correlates with underinsurance or no insurance in that they have less access to the healthcare system where they can be given health promotion/disease prevention information and strategies. Their lack of access to the healthcare system is a risk for HIV infection (Henny et al., 2012).

Another structural barrier includes imprisonment. Incarceration rates are disproportionately high within the African American male community compared to other racial/ethnic groups. High incarceration rates among heterosexual African American males increase their risk for HIV infection in part because it promotes one to revolve around a vicious cycle of poverty; poverty in turn disenfranchises these males from accessing

needed healthcare services. Structural challenges African American males face pose as barriers to community resources and healthcare professionals which in part explains why heterosexual males are more likely than White males to receive delayed health information and diagnose/treatment for disease and illnesses like the HIV infection (Henny et al., 2012).

Although some heterosexual males have basic knowledge on HIV preventive measures (e.g. using condoms), Bowleg et al. (2013) report that the structural challenges heterosexual African American males face compromises their ability to practice safe-sex. As previously mentioned, having been imprisoned increases an African American male's risk for HIV infection. However, the post-incarceration period also increases a male's risk for HIV infection as some live in halfway houses following their imprisonment and have limited freedom even though they are supposedly free citizens. Bowleg et al.'s (2013) participants report that after being incarcerated his risk for HIV increased secondarily due to the lack of access to condoms while living in a halfway house which aims to help former inmates get back on their feet and to be productive in society. While the study was being conducted, the participant shared his current experience living in halfway house:

> "I'm at a halfway house right now and my man [the supervisor] came in the door—you know how much a box of Magnums [brand of condoms] cost? And they took the condoms. They took the condoms from me. Now, my whole thing is, we are men just coming home from prison so one of the most important things on our mind is going out and having sex…" (Bowleg et al., 2013, p 35S).

Furthermore, disproportionate rates of HIV and STDs in low-income, rural, urban, and predominately African American communities also drive the HIV epidemic among

heterosexual African American males and for the entire African American community as a whole (Raj and Bowleg, 2011). In totality, structural challenges African American males face like poverty, substance use, and high incarceration rates correspond to unstable housing and unsteady employment where males are vulnerable to engage in unprotected sex, trade sex for money/drugs or have multiple/concurrent sexual partners. Such social challenges heterosexual African American males face increase their risk for HIV infection (Raj & Bowleg, 2012).

2.19 Higher rates of STDs

Evidence shows that individuals who are infected with STDs are two to five times more likely than uninfected individuals to acquire HIV infection when exposed to the virus via sexual activity (CDC, 2010). High rates of STDs among heterosexual African American males pose as a significant risk factor for HIV infection. However, what is perplexing about this phenomenon is that from a physiologic perspective females are more vulnerable to acquiring HIV infection from males given that their reproductive organs consists of more mucosal surface area to acquire the infection (Raj & Bowleg, 2012). STDs may also increase the likelihood of HIV acquisition in males in that HIV positive females with STDs may shed higher concentration of the virus in their genital secretions compared to females infected with HIV alone (Raj & Bowleg, 2012). Males having STDs engaging in high-risk HIV sexual behaviors among a population pool whose rates of STDs and HIV that is already higher than other racial/ethnic communities make heterosexual African American males more vulnerable to HIV infection (CDC, 2010).

Evidence shows that the incidence and prevalence of STDs appear to be higher among African American males compared to all other racial/ethnic males. Among males residing in inner-city areas, data shows that rates of syphilis and gonorrhea are disproportionately higher in African American males than other racial/ethnic groups. Nationally, the rate of Chlamydia was twelve times higher among African American males than Whites; in 2008, the rate of syphilis in African American males 15 to 19 years old was twenty-two times higher than that the rate of White males. The rates of gonorrhea are significantly higher among African American males than other ethnic/racial groups as well (Baker et al. 2012). In all, heterosexual African American males who have STDs have a higher risk for HIV acquisition (at a rate 2 to 5 fold), compared to those who do not have STDs, and because African American males have high rates of STDs place them at increased risk for HIV infection (Raj & Bowleg, 2012).

2.20 Prevention needs

Heterosexual African American males have been a neglected population in terms of HIV research develop having evidence-based interventions that specially target them and their specific characteristics that make these males vulnerable to HIV infection (Raj & Bowleg, 2012). Reasons for this relate to an ongoing long-held assumption, both within the lay community, the media, and even some scientific communities, that African American males acquire HIV primarily via same-sex behavior. The assumption is that, being *on the DL* is the chief factor why heterosexual African American males acquire HIV and serve as vectors for HIV transmission among the heterosexual African American community (Bowleg et al., 2011; Raj & Bowleg, 2012) Now that more evidence is suggesting that it is not heterosexual African American males *on the DL* causing

disproportionate rates of HIV within the African American community to the extent reported, notably African American females, more attention needs to be refocused on how to prevent the spread of HIV within this population (Bowleg et al., 2011).

Only recently concerted HIV prevention efforts have been formulated and implemented targeting heterosexual African Americans males despite their growing national HIV epidemic and accounting for 13% of all HIV cases in South Carolina (Raj & Bowleg et al., 2011; DHEC 2013). According to president Obama's National HIV/AIDS Strategy – a policy and document recognizing HIV prevention efforts that need to specifically target African American females, youth and African American MSM, little is in the document focused on HIV prevention needs of heterosexual African American males (Raj & Bowleg et al., 2011). However, the NHAS acknowledges that culturally congruent community-level HIV prevention efforts need implemented that targets heterosexual African American males in order to decrease rising HIV rates among this population (Raj & Bowleg et al., 2011).

Retrieving HIV information via quick doctor office visits, commercials on television (e.g. on BET –Black Entertainment Television), jails/prisons, and word-of-mouth have been tradition methods many heterosexual African American males have acquired HIV information. Evidence suggests that HIV education alone is insufficient and less likely to reduce HIV risk behaviors among African Americans (Baker et al., 2012). Research has shown that disseminating fliers and pamphlets about HIV/AIDS are nearly worthless in terms of preventing HIV infection among heterosexual African American males (Baker et al., 2012). Evidence shows that heterosexual African American males desire more information and education about HIV/AIDS particularly in settings that

facilitates and encourages interpersonal dialogue about HIV risk prevention (Bowleg et al. 2013). Data suggests that HIV prevention information/education is best presented to heterosexual African American males in an information-motivation-behavioral skills (IMB) format in that IMB may facilitate HIV protective behaviors among them.

Evidence suggests that culturally congruent settings enable heterosexual African American males to be comfortable receiving HIV information they are familiar in and can help facilitate the discussion and dissemination of HIV information within groups (Baker et al., 2012). Open-ended HIV prevention discussion forums between peers appear to be promising activities for high-risk behavioral reduction strategies among heterosexual African American males because it enables them to "get a better outlook of [HIV acquisition/transmission by being] around a group of dudes…" and may empower males to practice safer-sex behaviors (Baker et al., 2012; Bowleg et al. 2013, p. 38). Baker et al. (2012) research findings illustrate that Community-Based Organizations (CBOs), like Black Churches for example, can be instrumental in reducing HIV risk behaviors among heterosexual African American males. Evidence suggests that it would be efficacious for CBOs to employ heterosexual African American male professionals, who preferable live in the same community as participants, to provide HIV intervention strategies, counseling, HIV testing, and linkage to care. Doing so will help heterosexual African American males to receive information from a source they perceive credible and trustworthy while having a mentor and role model figure to look up to (Raj & Bowleg, 2012).

Evidence shows that not all heterosexual African American males are equipped with basic HIV knowledge and that there are inconsistencies regarding their understanding of how to properly use condoms to reduce their risk for HIV infection. Despite the

variability, evidence shows that heterosexual African American males need, and even desire, sexual negotiation skills and behavior modification tools to reduce their risk for HIV infection. Evidence also demonstrates that heterosexual African American males experience barriers to effectively requesting that they and their female partner(s) test for HIV together. Bowleg et al. (2013) report that heterosexual African American males have an eagerness to test for HIV but have difficulty asking their partners to test with them without their partner getting offended from the suggestion or getting suspicious that they themselves are living a promiscuous lifestyle. In addition, the literature also shows that they need skills on how to use condoms especially when they experience temptation moments when they feel not to do so.

The literature shows that heterosexual African American males may experience fumbling around with condom wrappers or not wanting to disrupt the "heat-of-the-moment" sexual situation via purchasing condoms which can prevent them from safe-sex practices. HIV interventions need to help heterosexual African American males learn how to "use your big head [brain] over your little head [penis];" this philosophical approach used by HIV facilitators/clinicians can motivate these males to reduce their high-risk behaviors to reduce the spread of HIV (Bowleg et al., 2013, p. 37). In addition, findings in Bowleg et al. (2013) study show three major concepts that heterosexual males need to acquire in order to reduce their risk for HIV infection. The concepts include the following: (1) how to appropriately ask a female partner to test for HIV, (2) strategies how to use condoms when tempted not to do so, and (3) for clinicians/community agencies to provide more opportunities for heterosexual African American males to be educated about HIV/AIDS via interactive classes (Bowleg et al., 2013).

2.21 Black Men who have Sex with men and HIV

By race/ethnicity, African Americans are the most severely affected by HIV but young African American MSM bear the brunt of disproportionate rates. Recent estimates show that half of the estimated 56,000 annual new HIV infections in the United States occur among men who have sex with other men (MSM) with African American MSM being the most at risk for HIV. In 2010, African American MSM represented nearly 75% of new infections among all African American males. Within the African American MSM population, young African American MSM accounted for 45% of new HIV infections. Compared to other young ethnic MSM with HIV, 55% of new HIV infections are among young African American MSM (CDC, 2012). Recent CDC findings show a 93% increase in the number of HIV/AIDS cases among African American MSM aged 13-24 years old between 2001 to 2006 (Radcliffe et al., 2010). Overall, in the United States African American MSM are experiencing epidemic HIV infection rates now rivaling that of developing counties (Peterson & Jones, 2009). African American MSM currently have a 25% chance of contracting HIV by the time they reach 25 years old and a 60% chance of acquiring HIV by the time they reach 40 years old (Mays et al., 2012). Alarming statistics such as these highlight the dire need for effective HIV/AIDS prevention efforts targeting young African American MSM (Radcliffe et al., 2010).

HIV is the sixth leading cause of death for African American males aged 20-24 and the fifth leading cause of death among African American males aged 25-34 (CDC, 2012). In 2009, young African American MSM aged 13-29 accounted for 69% of all new HIV cases nationally. Data currently show that young African American MSM aged 13-29 now have the highest HIV incidence rates compared to any MSM population and the general

HIV population. In fact, HIV infection rates among minority young African American MSM increased 48% from 2006 to 2009 with no signs of slowing down (CDC, 2012). Unfortunately, there is little evidence to explain this phenomenon. Evidence suggests that young African American MSM may face a unique set of socio-cultural contextual factors that has not been thoroughly addressed by the medical community needing to be explored so that community-level HIV-intervention programs can be tailored specially for them in the near future (Peterson, 2009).

Significant research has been done attempting to explain the relationship between high-risk behavior and HIV acquisition among MSM, but what baffles health officials today is the lack of an etiological explanation for disproportionately high HIV rates among young African American MSM. Recent information has suggested African American MSM sexual risk behavioral factors alone does not fully account for their high HIV rates (CDC, 2012). According to the CDC, there are factors that may put young African American MSM at risk for HIV. Such factors may include the following: (1) lack of knowledge of HIV status, (2) use of alcohol and illegal drugs during sexual activity, (3) complacency about HIV risk (4) young AAMSM having sex with older AAMSM and their internalized (5) stigma/fear associated to living an alternative lifestyle.

There are gaps in the literature explaining the etiology for high HIV resurgence rates in young African American MSM as well gaps related to the failure of proven methods used to halt this HIV epidemic. This is partly due to the lack of research focused on minority men within the general MSM population (Peterson & Kenneth, 2009). Young African American MSM may face a different set of socio-cultural issues, compared to the general MSM population, which has not been fully addressed or significantly explored by

the medical community. According to Peterson and Kenneth (2009), socio-cultural contextual factors – or cultural-specific barriers, that may place young African American MSM at risk for HIV acquisition and transmission may include:

(1) racial and sexual prejudice,
(2) disenfranchisement by religious institutions related to alternative lifestyle behavior
(3) possessing a higher keen sense of internalized intra-racial homophobia
(4) engaging with sexual partners with higher incarceration rates compared to other ethnic MSM
(5) exchanging sex for drugs.

2.22 Barriers – masculinity, the DL, and steady partners

Masculinity is a valued characteristic the young African American MSM community overwhelmingly prefers in their sex partners. They use masculinity to gauge their partner's HIV risk (Fields, Bogart, Smith, Malebranche, Ellen, & Schuster, 2012). Masculine males are associated with not being openly homosexual (on the DL), being "straight-acting," may identify as heterosexual (having a wife, girlfriend or fiancé), being strong or aggressive, being the insertive (top) partner and less likely to be or become HIV infected (Malebranche, Fields, Bryant & Harper, 2009). In contrast, young African American MSM perceive effeminate males to be a receptive partner (the bottom), thought to be more promiscuous than masculine MSM and less proactive about condom use, and are believed to be at greater risk for acquiring HIV. Gauging one's masculinity for HIV risk is a misconception that place young African American MSM at risk for HIV.

Young African American MSM also have the misconceived notion that those who identify as *on the DL* are a lower HIV risk MSM group. African American MSM *on the DL* are thought to be safer sex partners due to having fewer ties to the homosexual community where HIV rates are more prevalent than heterosexual communities (Wolitski, Jones, Wasserman & Smith, 2006). Young African American MSM also perceive those *on the DL* to be a protective factor since non-gay identifying MSM would not want to risk transmitting the infection to their female partners (Wolitshi et al., 2006).

Having a steady sexual partner in which unprotected anal intercourse (UAI) is perceived as safe is also a misconception young African American MSM may have fueling the HIV epidemic. Young African American MSM may have a consistent sex partner(s) in which trust mutually builds between the individual(s) where one believes the other partner will protect them from the virus (e.g. use condoms with others or inform their partner if they contracted an STD or HIV). Since trust builds up between steady partners, young African American MSM may engage in unprotected sex (Sandfort & Dodge, 2008). This increases their risk for acquiring HIV.

2.23 Barriers – racism

Racism towards African American MSM is highly prevalent throughout the gay community (Berry, Raymond, & McFarland, 2007; Malebranche et al., 2009; Raymond & McFarland, 2009). African American MSM are the least preferred sexual partners by other ethnic MSM due to African Americans being perceived as being a high risk group for acquiring HIV (Berry et al., 2007; Malebranche et al., 2009; Raymond & McFarland, 2009). Evidence shows that young African American MSM are less catered to amongst

public social venues, are less counted for among the friendships of other MSM and ranked the least easy to meet by other MSM. Therefore, African American MSM tend to sexually pair with one another in a pool already having higher rates of STDs. Because they are socially isolated from other ethnic MSM, young African American MSM also are more likely to partner with older African American MSM (10 or more years older) compared to other ethnic MSM which increases their risk for acquiring HIV (Berry et al., 2007). Young African American MSM sexual networks tend to be small. Same ethnicity partnering may create close interconnected sexual networks, such that once HIV enters the network it spreads quickly through it (Berry et al., 2007).

2.24 Barriers – the medical community

The Hippocratic Oath and the Florence Nightingale Pledge inform physicians/nurses (health care providers) to do no harm to patients. However, healthcare providers are doing harm to young African American MSM patients when they allow their professional duties/obligations to collide with personal beliefs; their personal beliefs hinder them from providing optimal care tailored to the specific needs of YBMSM. On the other hand, evidence illustrates that some young African American MSM, whether *on the DL* or are open with their sexuality, trust medical providers with health information. However, like society's philosophical approach towards same-sex relations the medical community values heterosexism and has placed social stigma on homosexuality, and homophobic attitudes towards young African American MSM. African American MSM may be dually marginalized by healthcare providers – as African American, and as MSM. Healthcare providers may have tensions between their professional duties and their own personal beliefs towards African American MSM that may hinder them from providing young

African American MSM the care they need (Saleh et al., 2011). The medical community needs to be more informed about young African American MSM's socio-cultural issues while being able to better serve this population without personal beliefs or barriers getting in their way.

2.25 Interventions for Black men who have sex with men

Appreciating variances in socio-cultural contextual factors young African American MSM face, compared to the boarder MSM population, will be necessary in order to tackle the HIV epidemic that disproportionately affects them. As to date, more than fifty types of generic MSM HIV prevention programs/interventions have been studied and implemented for the overall MSM population, yet only two of these interventions has focused specifically on African American MSM with that being Many Men Many Voices (3MV) and Defend Yourself (d-up) (Young & McLeod, 2013). Although, there are no current HIV interventions that demonstrate a high efficacy to reduce HIV acquisition/transmission rates among African American MSM, the evidence suggests it is urgent to appraise the socio-cultural contextual factors young African American MSM face, compared to other ethnic MSM, where effective community-level risk-reduction interventions can be implemented for them (Patterson & Jones, 2009).

2.26 HIV in the state of South Carolina

The HIV/AIDS epidemic in the state of South Carolina is real, very significant, and quite alarming. Evidence shows that South Carolina is a leading state in terms of HIV and STD rates (South Carolina DHEC, 2013). In 2011, South Carolina had the tenth highest HIV diagnosis rate and the seventh highest AIDS diagnosis rate in the United States (CDC,

2013). South Carolina's capital city, Columbia, was among the 15 metropolitan statistical areas (MSA) with a population 500,000 or greater having the highest HIV diagnosis rates in the United States between 2008 to 2011 (Reif, Wilson, Sullivan, Safley, Whetten, 2013; CDC, 2008, CDC, 2009, CDC 2010, CDC 2011, CDC 2012). South Carolinian demographical data and characteristics pertaining to HIV/STDs are provided in the illustrations (see **Table 2.1 – Table 2.2**) on the following pages.

South Carolina, or the *Palmetto State*, is a constituent among the "*Bible Belt*" states located in the Deep South. Consisting of a population of 4,625,360 people, nearly 28% of the state of South Carolina identify as African American (see South Carolina Demographic Data by County **Table 2.1**) (Bureau, n.d.). The state's median age is 37.9 years old; females slightly outnumber males (51.4% female versus 48.6% male) (Bureau, n.d.). Nearly 65% of males and over 70% of females in the state of South Carolina are currently or have been married (see South Carolina Demographic Data by County **Table 2.2**) (Bureau, n.d.). And compared to the United States population, South Carolina's population are a more religious population (see Religious Characteristics **Table 2.3**). Eighty-six percent of the South Carolinian population believes in God, 70% claim that religion is very important in their lives, 54% attend church services at least once per week, and 45% of South Carolinians identify as evangelical protestant (Street, NW, Washington, & Inquiries, n.d.).

Evidence shows that South Carolina is a leading state within the United States in terms of high HIV/AIDS and STD prevalence rates. In 2011, the *Palmetto State* ranked eighth in the nation for HIV/AIDS among children, adolescents, and adults (SC DHEC, 2013).

Table 2.1 South Carolina Demographic Data By County								
	United States	**South Carolina**	**Columbia**	**West Columbia**	**Orangeburg**	**Richland County**	**Lexington County**	**Orangeburg County**
Population (2010 est.)	308,747,716	4,625,360	130,038	14, 988	13,964	384,507	262,391	92,501
White population (2010)	223,553,265 or 72%	3,060,000 or 66.2%	66,777 or 51.7%	10,184 or 68%	2,977 or 21.3%	181,974 or 47.3%	208,023 or 79.3%	31,770 or 34.3%
African American (2010)	38,929,319 or 12.6%	1,290,684 or 27.9%	54,537 or 42.2%	2, 769 or 18.5%	10,479 or 75%	176,538 or 45.9%	37,522 or 14.3%	57,535 or 65.2%
Age distribution In total population (2010):								

15-19	22,040,343 (7.1%)	328,989 (7.1%)	15,120	770	1,715	33,358 (8.7%)	17,581 (6.7%)	7,490 (8.1%)
20-24	21,585,999 (7.0%)	332,494 (7.2%)	(11.7%)	(5.1%	(12.3	40,822 (10.6%)	16,313 (6.2%)	7,784 (8.4%)
25-29	21,101,849 (6.8%)	304,378 (6.6%)	22,404	)	%)	31,273 (8.1%)	17,570 (6.7%)	5,574 (6.0%)
30-34	19,962,099 (6.5%)	287,678 (6.2%)	(17.3%)	1,516	2,276	26,705 (6.9%)	16,750 (6.4%)	4,841 (5.2%)
35-39	20,890,964 (6.8%)	296,682	13,368	(10%)	(16.3	25,395 (6.6%)	18,023 (6.9%)	4,973 (5.3%)
		(6.4%)	(10.3%)	1,392	%)			
			9,227	(9.3%	959			
			(7.1%)	)	(6.9%			
Median age	37.2 yrs. old	37.9 yrs. old	7,430	1,025	)	32.6 yrs. old	37.9 yrs. old	38.1 yrs. old
			(5.7%)	(6.8%	713			
				)	(5.1%			
				881	)			
				(5.9%	612			
			28.1 yrs.	)	(4.4%			
			old		)			
				37.4				
				yrs.				
				Old				
					28.8			
					yrs.			
					old			

Gender distribution (2010):								
Males	**49.2%**	**48.6%**	**51.5%**	**48.9%**	**45.9%**	**48.7%**	**48.8%**	**47.0%**
Females	**50.8%**	**51.4%**	**48.5%**	**51.1%**	**54.1%**	**51.3%**	**51.2%**	**53.0%**

Table 2.2 South Carolina Demographic Data by County								
	United States	**South Carolina**	**Columbia**	**West Columbia**	**Orangeburg**	**Lexington County**	**Richland County**	**Orangeburg County**
Marital Status: 15 years and older, never married: Males Females (2013 American Community Survey 1-year est.)	 36.3% 30.0%	 35.2% 29.4%	 58.0% 52.0%	 NA NA	 NA NA	 NA NA	 46.4% 40.2%	 NA NA

Educational Attainment: Population High school graduate or higher	**85.7%**	**84.0%**	**86.4%**	**83.7%**	**83.9%**	**88.2%**	**89.6%**	**79.3%**
Population Bachelor's degree or higher (2008 – 2012 American Community Survey 5-Year est.)	**28.5%**	**24.6%**	**39.3%**	**32.3%**	**28.7%**	**27.9%**	**36.2%**	**18.6%**
\ Institutionalized (2010): Males Females	0.9% 0.4%	1.0% 0.4%	4.8% 1.2%	0.1% 0.5%	2.6% 1.3%	0.4% 0.4%	1.9% 0.6%	0.5% 0.3%

Income and Benefits:								
Median household income	**$53,046**	**$44,623**	**$40,550**	**$43,970**	**$32,645**	**$53,644**	**$48,420**	**$42,038**
Median nonfamily income	**$31,796**	**$26,377**	**$29,998**	**$31,637**	**$23,935**	**$32,447**	**$31,191**	**$19,349**
Per Capita Income	**$28,051**	**$23,906**	**$24,837**	**$26,395**	**$15,862**	**$26,774**	**$26,149**	**$17,687**
Persons below poverty level	**14.9%**	**17.6%**	**23.4%**	**16.5%**	**31%**	**12.4%**	**16.4%**	**23.7%**
(2012 inflation-adjusted dollars)								

Health Insurance Coverage:								
Insurance coverage	**85.1%**	**83.1%**	**85.8%**	**77.2%**	**78.8%**	**85.6%**	**86.5%**	**79.9%**
No insurance coverage	**14.9%**	**16.%**	**14.2%**	**22.8%**	**21.2%**	**14.4%**	**13.5%**	**20.1%**
(2008-2012 American Community Survey 5-Year Est.)								

Source: U.S. Census Bureau, 2008 – 2012 American Community Survey.

Table 2.3 Religious Characteristics		
	United States	South Carolina
Identify as evangelical protestant tradition	26%	45%
Believes in God with absolute certainty	71%	86%
Attend religious services at least once per week	39%	54%
Importance of religion in one's life	56% "*very important*"	70% *"very important"*
	26% "*somewhat important*"	20% *"somewhat important"*
	16% "*not too important/not at all important"*	9% *"not too important/not at all important"*

Data Source: Pew Research. Religion & Public Life Project (2014).

Table 2.4: HIV/AIDS Cases in South Carolina by population	
Cases by population % of total cases w/risks identified (1,122 total) (2011-2012)	African American MSM 49%
	African American heterosexual females 13%
	African American heterosexual males 8%
People Living with HIV/AIDS (PLHA) by population % of total cases w/risks identified (11,971 total) (2012)	African American MSM 30%
	African American heterosexual females 19%
	African American heterosexual males 10%
HIV/AIDS cases by Gender	77% of the new HIV/AIDS cases occur in males
	23% of the new HIV/AIDS cases occur in females
HIV/AIDS cases by Age	44%, of the new HIV/AIDS cases are among persons are 25 - 44 years old 30% were among people age 24 and under 26% were among people 45(+)
	30% of the new HIV/AIDS cases are among persons 24 years and older
	26% of the new HIV/AIDS cases are among persons 45 years and older
HIV/AIDS cases by race	73% African American
	20% White

Data Source: SC DHEC, STD/HIV Division (2013).

During 2011 to 2012, 73% of HIV/AIDS cases reported in South Carolina were within the African American population; 77% of all new HIV/AIDS cases were reported among males (see HIV/AIDS Cases in South Carolina by population **Table 2.4**). South Carolinians aged 25 to 44 years old are affected most by the virus followed by persons 24 years old and younger among which African American MSM account for the highest rates

of associated high-risk behaviors and those living with HIV/AIDS in South Carolina (see HIV/AIDS Cases in South Carolina by population **Table 2.4**) (SC DHEC, 2013).

At the county level, Richland County has the highest rates of gonorrhea, chlamydia, syphilis, and HIV versus any other county in the *Palmetto State* (see HIV/AIDS Diagnosis Rate in Richland County **Table 2.5**). Consistent with the overall state, more males are affected by the virus in Richland county; significantly more African Americans are infected with HIV in Richland county than Whites (see HIV/AIDS Diagnosis Rate in Richland County **Table 2.5**). Columbia of Richland County ranks sixth in the nation among large metropolitan areas in terms of the number of new AIDS diagnoses (ABFSC, 2014).

2.27 City of Columbia

Evidence shows that at the community level, the residents of Columbia have slightly different characteristics then those at the county, state, and national level. The city of Columbia is a relatively young, more educated, and slightly more male dominated population (see South Carolina Demographic Data by County **Table 2.1 and Table 2.2**). The median age of this population is 28.1 years old which is younger than those at the county, state, and national level (see South Carolina Demographic Data by County **Table 2.1**); 86.4% aged 25 years old and older have earned a high school diploma or higher and 39.3% of those 25 years old and older have attained a bachelor's degree or higher in which this population is more educated than those at the state and national level (see South Carolina Demographic Data by County **Table 2.2**) (Bureau, n.d.).

Columbia is a slightly more male dominated city with nearly 52% of its residents being male. More people are single in Columbia than those at the state and national level

with 58% of males and 52% of females 15 years old and older report never been married (Bureau, n.d.). The Columbia unemployment rate exceeds the national unemployment rate, residents of Columbia make less money than those at a national level, and the poverty rate exceeds that of both the state and national level (see **Table 2.2**) (Bureau, n.d.). And slightly more people in Columbia have health insurance than those at the state and national level. In addition, evidence shows that Columbia is a community pocket for higher rates of institutionalization. Rates show that nearly 5% of males and 1.2% of females are institutionalized which is higher than both the state and national level (see **Table 2.2**) (Bureau, n.d.).

2.28 City of West Columbia

HIV/STD rates in West Columbia of Lexington County, which is adjacent to Richland Country, are not as disproportionate as Columbia of Richland County. Data shows that West Columbia is predominately White, slightly older than the national median age, has higher rates of employment and lower rates of male incarceration versus the national average (U.S. Census Bureau, n.d.). Although the rates of HIV and STDs are lower in West Columbia compared to Columbia, the distribution of HIV in West Columbia of Lexington County is disproportionate. Evidence also shows that HIV/AIDS is more prevalent in the African American population than in Whites and that more males are affected by the virus than females (see HIV/AIDS Diagnosis Rate in Lexington County **Table 2.6**) (Lopez-De Fede, Stewart, Hardin, Mayfield-Smith, & Sudduth, 2011).

2.29 City of Orangeburg

The city Orangeburg of Orangeburg County, South Carolina is a community, in the Midlands, having disproportionate rates of HIV and STDs (see HIV/AIDS Diagnosis Rate in Orangeburg County **Table 2.7**). This predominately African American city consists of lower socioeconomic standards that are congruent with the literature in terms of having characteristics that contributes to high rates of HIV/STD infections. Compared to the national average, Orangeburg has higher rates of incarceration, more persons living below the poverty level, more people earning less than the national per capita income, fewer people who have obtained a high school degree, and less people who have access to healthcare (Bureau, n.d.; Lopez-De Fede et. al, 2011). The median age of Orangeburg residents is 28.8 (which is lower than the national average age) and more females out number males, 54.1% versus 45.9%, respectively. Being a socioeconomically disadvantaged city with high rates of unemployment, poverty, and social deprivation contributes to Orangeburg being a breeding ground for HIV and STDs to propagate (Lopez-De Fede et al., 2011). More than 44 per 100,000 African Americans are HIV infected in Orangeburg compared to less than 11 per 100,000 Whites. Males have the highest rates of infection (Lopez-De Fede et al., 2011).

Table 2.5: HIV/AIDS Diagnosis Rate in Richland County, South Carolina

Diagnosis rate **(Cases per 100,000 population)**	**Entire Population** 23.0 – 44.0	
	Gender Males: >/= 44.1 Females: >/=14.0 – 22.9	
	Race African American: >/= 44.1 White: 11.0 – 13.9	
Richland County HIV/STD diagnosis rate range **(cases per 100,000 population)**	**Chlamydia** (205.5 to 1,393.6)	High
	Gonorrhea (54.2 to 429.5)	High
	Syphilis (2.0 to 36.7)	High
	HIV/AIDS (4.8 to 44.0)	High

Data Source: Lopez-De Fede, Stewart, Hardin, Mayfield-Smith, & Sudduth, 2011.

Table 2.6: HIV/AIDS Diagnosis Rate in Lexington County, South Carolina

Diagnosis rate **(Cases per 100,000 population)**	**Entire Population** 11.0 – 13.9	
	Gender Males: >/= 14.0 – 22.9 Females: < 11.0	
	Race African American: >/= 23.0 – 44.0 White: <11.0	
Lexington County HIV/STD diagnosis rate range **(Cases per 100,000)**	**Chlamydia** (205.5 to 1,393.6)	Low
	Gonorrhea (54.2 to 429.5)	Low
	Syphilis (2.0 to 36.7)	Medium Low
	HIV/AIDS (4.8 to 44.0)	Medium Low

Data Source: (Lopez-De Fede et al., 2011).

Table 2.7: HIV/AIDS Diagnosis Rate in Orangeburg County, South Carolina		
Diagnosis rate (Cases per 100,000 population)	**Entire Population** 23.0 – 44.0	
	Gender Males: >/= 44.1 Females: 14.0-22.9	
	Race African American: >/= 44.1 White: <11.0	
Orangeburg County HIV/STD diagnosis rate range (cases per 100,000)	**Chlamydia** (205.5 to 1,393.6)	High
	Gonorrhea (54.2 to 429.5)	High
	Syphilis (2.0 to 36.7)	Medium High
	HIV/AIDS (4.8 to 44.0)	High

Data Source: (Lopez-De Fede et al., 2011).

2.30 HIV among African Americans in South Carolina

Evidence shows that South Carolina's HIV epidemic is more disproportionate among African Americans than Whites. AIDSVu (2015) reports that for the year 2010, South Carolinian African American males were infected with HIV at a rate 6.2 times more than their White male counterparts. HIV rates were even more disproportionate for South Carolinian African American females. In 2010, South Carolinian African American females had an HIV diagnosis rate 12.1 times than that of their White female counterparts (AIDSVu, 2015).

The evidence also shows that HIV infection is not evenly distributed among age groups within the African American population. It appears that some age groups within the African American population are infected with HIV more so than others. HIV rates among youth/young adult African Americans appears most problematic. Compared to all youth/young adults during 2010, African American males aged 13-24 year old residing in Columbia, South Carolina had the highest HIV diagnoses rate in the nation. Meanwhile African American females aged 13-24 residing in Columbia, South Carolina ranked ninth highest for those infected with HIV (CDC, 2013; Reif et. al, 2013). South Carolina DHEC (2012) reports that by age, the majority of new HIV cases are among persons aged 25 to 44 years old. Persons aged 24 and under are the next group with the highest rates of new HIV cases.

2.31 HIV Stigma and the African American community

HIV-stigma is the "prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV/AIDS, particularly homosexual males and IV drug users" (Lindley, Coleman, Gaddist, & White, 2010, p.13). HIV-related stigma is thought to be a key factor why the epidemic is disproportionate to the capacity that it is reported within the African American community because the shame associated how the infection is acquired keeps many silent. This silence has been demonstrated in different ways. HIV-related stigma keeps many African Americans from getting tested for HIV, it keeps individuals from disclosing their HIV status to a partner, and it acts as a barrier for those living with HIV to either seek healthcare, stay linked in care, or adhere to therapeutic modalities (Lindley, Coleman, Gaddist, & White, 2010).

Parker, Aggleton, Attawell, Pulerwitz and Brown (2002) report that HIV-related stigma is associated with negative connotations due to it being intertwined in concepts of sexuality, gender, race and class. HIV-related stigma is related to sexual stigma since the infection is primarily transmitted by sexual activity. HIV-related stigma is reinforced by sexual stigma as STDs, practicing homosexuality, engaging in promiscuity, and trading sex for drugs or money are elements considered to be sexual deviant from the main population (Parker et al. 2002). HIV-related stigma, as it is related to sexual stigma, explains why many African Americans may believe HIV is a "gay plague" having no desire to be associated with the illness (Parker et al. 2002).

HIV-related stigma is linked to gender-related stigma. In regards to the high HIV rates documented among African American females, some members within the community hold females accountable and blame them for their own problem because, in their view,

female promiscuity is considered socially unacceptable (especially compared to males) (Parker et al., 2012). Their promiscuity is considered non-normative gender behavior which, at the mercy of their lifestyle, place male partner(s) at risk for HIV. Conversely is the case in heterosexual males. It is the assumption that when a heterosexual male contracts HIV that it was his sexually deviant practices (e.g. lust for multiple sexual partners) which are to blame for HIV infection (Parker et al. 2002). HIV-related stigma, as it relates to gender stigma, is in-part the reason why the African American community believe that HIV was brought on by "White men" and have no desire to be associated with the infection (Parker et al. 2002).

HIV-related stigma is also related to race/ethnicity stigma in that the epidemic has racialized African sexuality. Radicalizing African sexuality has marginalized African Americans to an extent that this population is vulnerable for the infection (Parker et al. 2002). And since the HIV epidemic began during a period when there was polarization between the rich and the poor, HIV-stigma is linked to class/socioeconomic status (SES). Individuals facing social inequalities and limited resources, who are poor, homeless, or jobless, are more stigmatized which can make them more vulnerable to HIV infection (Parker et al. 2002). In the current era of the epidemic some African Americans still perceive HIV to being a "disease of the poor" and may have the misconception that middle class/upper class individuals have no or lower-risk as sexual partners. This misconception – rooted in stigma, places African Americans at risk for HIV infection today (Parker et al. 2002).

The CDC (2014) notes that HIV-stigma hinders people from taking actions (e.g. seeking HIV testing, disclosing HIV status, and seeking HIV treatment) needed to protect

themselves and others from the disease. The United Nations Secretary General confirms that HIV-related stigma is a barrier to the current HIV epidemic stating that:

> "[HIV-related] stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. [HIV-related] Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world" (Avert, 2014).

The delay in HIV testing in people at-risk is one of the most serious consequences resulting from HIV-stigma. Evidence shows that 36-66% of homosexual and bisexual males report that the fear of being stigmatized by HIV is a major barrier to them getting tested (Clark et al., 2003). And it is the fear of being stigmatized that has hindered people from not only getting tested for HIV but is a barrier to disclosing their HIV status to their sexual partner and seeking treatment (Schleider, n.d.). HIV-related stigma has perpetuated testing/health-seeking behavior avoidance and misinformation about the virus about how the infection spreads. Common misinformation includes inaccurate beliefs on how the virus may be acquired and transmitted. For example, misconceptions about HIV may include the belief that HIV can be acquired and transmitted through casual contact like sharing food utensils, via coughing or sneezing, or that it may even be transmitted between two non-infected individuals (Scheider, n.d.).

As a community disproportionately affected by the HIV/AIDS epidemic, African Americans have the additional burden of dealing with the negative effects associated with

HIV-related stigma (Galvan, Davis, Banks and Bing, 2008). According to the evidence, individuals within the African American community are conscientious of the stigma and discrimination associated with HIV infection (Berkley-Patton et al., 2013). As a result, many may be unwilling to actually screen for HIV secondarily to the fear of (1) being seen publically testing for the infection and/or (2) in the event having tested positive for the infection they will face exacerbated societal discrimination and stigma (Clark et al. 2003; Foster 2007).

HIV-stigma is pronounced in the African American community and more pronounced in certain pockets of the country like the Deep South (where most of the African American population reside) (Foster, 2007; Health Resources and Services Administration, n.d; ABFSC, 2014; SASI, 2014). It is thought that HIV-stigma poses more-so of a barrier within the Deep South because homophobia, medical distrust, and social conservatism is more prevalent (Foster, 2007). The close-nit nature of rural communities within the South perpetuates HIV-stigma in that fear and shame associated with the infection encourage individuals not to disclose their HIV status. It also hinders individuals from receiving HIV education in public settings (Foster, 2007).

Because HIV-related stigma is a significant barrier to controlling the HIV epidemic within the African American community, president Obama's National HIV/AIDS Strategy (NHAS) agenda includes tackling such HIV-related stigma that flourishes so deeply within this community. According to the NHAS, combating HIV related-stigma is critical to preventing the further spread of HIV within African American communities (CDC, 2014; NHAS, 2010). The NHAS document reports that the initial steps the Federal Government

will take to combat the HIV epidemic is to tackle the prevalent attitudes of HIV-stigma (NHAS, 2010).

The CDC, as per the NHAS, believes that the broader community – like the Black Church, has a significant role in HIV education/prevention efforts in order to reduce HIV-related stigma to break the silence about HIV within the African American community (Lindley et al., 2010; NHAS, 2010). Evidence shows that the Black Church is in a great position to meet the demands of addressing HIV-related stigma that pervades the African American community (Berkley-Patton et al., 2013). According to the literature, the Black Church is a long-standing powerful institution that has the capability to mobilize large numbers of African Americans; this entity can play a powerful role in reducing HIV-related stigma as it already addresses health-related challenges the community currently faces (Lindley et al., 2010; Schleicher, n.d.).

2.32 The Black Church: its significance to African Americans and role in HIV

As a conglomerate, the African American community is highly interactive with religious organizations, such as the Black Church, which serves as an important social aspect of the culture. The Black Church is an essential thread in the fabric of African American people's culture and a commonly shared traditional influential experience (Wilson, Wittlin, Munoz-Laboy, and Parker, 2011). Evidence suggests that African Americans cling to the religiosity of the Black Church, especially those residing in the Deep South "Bible Belt" region of the country who attend church services and church sponsored events at higher rates compared to other people residing in other regions in the United States (Foster, Cooper, Parton, and Meeks, 2011; Wilson et al. 2011). Compared

to other racial/ethnic groups, African Americans are more likely to report being affiliated with a religious organization, and 85% identify themselves as Christian (Wilson et al. 2011). Nunn, Cornwall, et al. (2012) report that nearly 80% of African Americans believe that spirituality plays an important role in their lives versus 56% of all U.S. adults. Indeed, more than 50% of African Americans report they attend religious services more than once a week, more than 75% pray on a daily basis, and nearly 90% of all African Americans state that they are certain God exists (Nunn, Cornwall, et al., 2012). Among African Americans who are not associated with a religious organization, 3 in 4 people believe religion is either somewhat or very important in their lives (Wilson et al., 2011). Moreover, they are more likely than other religious groups to engage in some type of activity with their religious affiliation/community and express having a high degree of comfort with supporting political notions and social affairs when their religious institution approves (Nunn, Cornwall, et al., 2012).

The Black Church plays a significant role in the lives of many within the African American community (Wilson, Wittlin, Munoz-Laboy, and Parker, 2011). The Black Church has been the cornerstone and bedrock to the African American community since the days of slavery and continues to have relevance today as it addresses many current social issues, like poverty, high unemployment rates, and high incarceration rates that presently impede or infringe on the advancement of peoples within the African American community. It was the Black Church that served as a place African Americans could meet to discuss their oppressive circumstances; it served as the meeting ground where African Americans first learned how to read and write, especially during Sunday school (Moore et al., 2012). It was the Black Church that first helped the African American community

establish financial institutions, housing, and schools (Moore et al., 2012). It was the Black Church that groomed historical figures into leadership roles and provided the African American community the motivation to be politically savvy.

The institution of the Black Church was utilized to orchestrate the Civil Rights Movement of the 1950s and 1960s to move the African American community forward, empowering African Americans to overcome oppression and social injustice (Moore et al., 2012). And it is the Black Church today that continues to serve the African American community by providing shelter to the homeless, food and clothing to the unfortunate, transportation, social and emotional support, and child care and elderly care to families and persons in need (Baker, 1999).

One of the most trusted institutions within the African American community, the Black Church today is the place where many African Americans seek information because they have great confidence in the fact that the church provides honest, authentic, and relevant information (Smith, Simmons and Mayer, 2005; Wilson et al., 2011). Under the leadership of the pastor and the ministerial staff, the Black Church presents a platform for teaching the community, preaching the gospel of the good news, politically motivating and, more recently, inspiring change for health promotion and disease prevention within the African American community (Francis & Liverpool, 2009).

In recent times, the Black Church has taken an active role in addressing various medical problems and social determinants of health that devastate the African American community. In fact, the Black Church is now the unofficial place most African Americans get their health information (Moore et al., 2012). It is well documented that compared to

other racial or ethnic groups, African Americans suffer higher incidence/prevalence rates of heart disease, diabetes and obesity, all of which negatively impact their quality of life. In addition, African Americans face more severe disease manifestations and worse health outcomes for breast cancer, prostate cancer, and colorectal cancer (American Cancer Society Cancer Action Network, 2009). The Black Church has been instrumental in disseminating information and resources promoting health promotion/disease prevention programs to inform and empower the African American community about the health conditions and infirmities that plague their parishioners (Foster et al. 2011; (Lindley et al., 2010). In effect, Nunn et al. (2013) report "dozens of successful health prevention and promotion interventions have been developed and implemented in Black Churches to include weight loss, diabetes control, cardiovascular health and nutrition programs" as well as programs screening for both breast and prostate cancers, which all have been beneficial to the African American community in combating such illnesses.

Just as the institution has helped its people triumph over social obstacles in the past, current evidence suggests that the HIV/AIDS epidemic now devastating the African American community is a social injustice the Black Church should address. Compared to other establishments, the Black Church is highly revered amongst most African Americans. Therefore, the institution of the Black Church is uniquely poised to handle the HIV/AIDS epidemic currently plaguing the African American community (Nunn et al., 2013). Since the Black Church has taken an active role in addressing other health disparities that impact the African American community, it stands on a great platform to address the HIV/AIDS epidemic that is now devastating the lives of many parishioners (Moore et al., 2012).

However, the Black Church has had a lukewarm response to addressing the HIV/AIDS epidemic due to the fact that HIV has been closely linked to homosexuality and immoral behavior (Nunn et al., 2012). According to the literature, the Black Church struggles to address the HIV/AIDS epidemic due to the social ramifications of the illness: stigma, shame, denial, homophobia, variations in human sexuality expression, pre-marital and extramarital sex, substance use and/or drug abuse (Nunn et al., 2013). Although the Black Church collectively faces barriers in their desire to combat the HIV/AIDS epidemic, few churches have initiated the formation of HIV/AIDS ministries sponsored by healthcare professionals, and a growing body of Black Churches are willing to embrace a faith-based approach to initiate HIV prevention in order to reduce the spread of HIV/AIDS within the African American community (Moore et al., 2012).

2.33 Barriers the Black Church faces in addressing HIV

The Black Church is poised with a great opportunity to counteract the current HIV/AIDS epidemic occurring within the African American community, but the pre-existing barriers within the Black Church hinder this powerful institution from reaching out to its parishioners to its full extent... The most common reasons why the Black Church has had a sluggish response to addressing the HIV/AIDS epidemic include, but are not limited to: (1) HIV/AIDS relationship to sexuality and drug abuse, (2) the leadership's fear that addressing the epidemic will compromise their ministry, (3) the leadership's lack of HIV/AIDS knowledge, (4) stigma, homophobia, and heterosexist values within the Black Church and the (5) lack of resources available to provide HIV/AIDS prevention services to the African American community (Foster et al. 2011; Lindley et al., 2010 ; Nunn et al. 2012; Wilson et al. 2011).

2.34 Leadership

The Black Church serves the African American community by being a place to obtain an array of information, including general information pertaining to health matters. At the forefront of the Black Church are elders, deacons, ministers, church mothers and other persons with leadership roles whom parishioners and lay members of the African American community view as reliable sources for authentic information (Smith, Simmons and Mayer, 2005). Central to all leaders within the Black Church is the pastor, also known as the reverend, who holds great admiration and respect. In recent times, pastors wear a myriad of hats—such as teacher, preacher, politician, change agent for health, and focal point—for which progress may be initiated within the African American community (Francis & Liverpool, 2008).

In order for HIV/AIDS information to be provided within the Black Church, those in leadership roles, such as the pastor, need to know basic facts about the illness. Not knowing information about HIV/AIDS and merely basing one's ideas on personal conviction or convoluted theology tainted with social stigma appears to be a reason why some pastors have not wholeheartedly embraced addressing the epidemic within the Black Church. This close-mindedness has consequences - the manifestation of the illness today within the African American community (AIDS Alert, 2007). In addition, having to keep up with the demands of the church, community responsibilities, family obligations, and being up-to-date on culturally acceptable topics may hinder an African American pastor's ability to address the HIV/AIDS epidemic within the African American community to the extent the social problem should be handled (AIDS Alert 2007). Foster et al.'s 2011 mixed method exploratory study finds such congruencies. That is, reasons why African American

pastors in the rural Deep South may not be involved in HIV/AIDS prevention within their local churches can be rooted in (1) fear of not knowing about the disease, (2) fear of HIV/AIDS due to stigma, (3) not knowing someone personally affected by HIV/AIDS, and (4) their personal lack of access to accurate and culturally congruent HIV/AIDS preventative services. Nunn et al.'s 2012 qualitative study of 38 influential African American church pastors/leaders residing in a highly concentrated HIV/AIDS affected area illustrated that their lack of knowledge about HIV/AIDS prevents some pastors from being forthcoming with the life-saving health information their local congregations and community needs. One participant summarized "many pastors may not want to address HIV/AIDS because they may feel like they don't want anyone to know that they don't know," with another participant acknowledging that "the more educated we [pastors] get about [HIV/AIDS], the more comfortable we become with it" (Foster et al. 2011, p. 325).

Pastors who lack knowledge about the illness are a barrier that may ultimately cripple the Black Church and prevent it from addressing the African American HIV/AIDS epidemic. However, some pastors may possess basic HIV/AIDS knowledge, yet feel inadequate or unqualified to reach out to parishioners and the African American community to address the social epidemic (Smith, Simmons and Mayer, 2005). Paradoxically, some pastors may even understand the basic fundamentals of HIV/AIDS, such as disease transmission and acquisition, yet not be attuned to the devastating impact HIV/AIDS is having on their own communities (Nunn et al. 2012). Such leadership issues hinder the Black Church's effective handling of the HIV/AIDS crisis within the African American community.

HIV/AIDS stigma may also prevent some pastors and those in leadership positions within the Black Church from handling the epidemic to the extent it needs to be addressed. It is not a new fact that HIV/AIDS possesses a stigma within the African American community. Because of HIV/AIDS stigma, pastors themselves may ignore the harsh realities of the epidemic's impact on African American women, men and youth in their own communities. In doing so, HIV/AIDS may infiltrate further into the African American community with little leadership to block such effects (Nunn et al., 2012). However, not all pastors and those in leadership within the Black Church are paralyzed due to stigma. Instead, some are moved to compassion and address the risk factors and parishioner's and lay community member's health needs related to HIV/AIDS transmission (AIDS Alert, 2007).

However, sometimes personal compassion and conviction is not enough for some pastors to address the epidemic in their very own communities. Parishioners' attitudes towards HIV/AIDS may prevail despite pastors wanting to make a difference within their community. As one participant reports, "[pastors] are afraid to address HIV/AIDS because it may put a dark cloud over your ministry…people will gossip and say, what they talking about that for, they must have a member who is infected" (Foster et al. 2011, p. 325). And since parishioners and the broader African American community have the economic power and resources to control the viability of a church, some pastors avoid mentioning the topic of HIV/AIDS to avoid the risk of losing important financial donations via tithes and offerings.

Lastly, the age, experience, and reputation of the pastor, as well as other church leaders in the African American community may present barriers within the Black Church

to responding to the HIV/AIDS epidemic. Although young pastors and leaders within the Black Church may be knowledgeable, compassionate, and enthusiastic about HIV/AIDS prevention outreach, their eagerness to help may be hindered by their youth and inexperience. Pastoral experience, reputation, and age impact a minister's eagerness to address HIV/AIDS, the same qualities on which so much of their leadership and respect within the Black Church depend (Nunn et al. 2012).

2.35 Sexuality

Addressing issues concerning sexuality has been and continues to be a sensitive topic for both clergy and parishioners within the Black Church. Francis and Liver (2009) find that many Black Churches struggle with addressing the HIV/AIDS epidemic because of the immorality with which the illness is associated – drug seeking behaviors and lascivious sexual activity outside of marriage, both of which are too culturally taboo to allow open and candid dialogue. Since the institution has a set of social issues it has not fully dealt with, they cannot uniformly embrace the epidemic wholeheartedly with grace, compassion, mercy, and love (Nunn et al 2012; Wilson et al., 2011).

An African American minister, in Nunn et al.'s 2012 qualitative study of 28 African American ministers residing in one of America's most concentrated HIV/AIDS infected areas, confirms the struggle the Black Church faces in addressing an epidemic so closely linked to human sexuality. The participant stated: "I find that talking about sexuality at church is a very tricky thing, not even just with homosexuality but heterosexual sexuality [also]. It's difficult to talk about HIV at church because we have defined what we will accept as the proper language, the proper subject, and the proper issues to talk about. Sex

and HIV are subjects that make many [parishioners] uncomfortable" (Nunn et al. 2012 p. 3). Another minister pointed out that "some of the church teachings steer away from realistic aspects of ministry…even though we know members of our congregation are having sex, we don't want to deal with that…if we did we would be including prevention from sexual encounters [too] as well as abstinence" (Foster et al. p. 325). Discussing HIV/AIDS means addressing issues of homosexuality in a public setting, and homosexuality is deeply rooted in stigma and shame for both the Black Church and African American community. Nunn et al., (2012) report that homophobia and fear of being perceived as homosexual prevent many ministers from discussing HIV/AIDS within the Black Church. A pastor in their study explains:

> "people are afraid they'll be thought of as gay…it's the biggest thing with African American men. If AIDS weren't a disease that first attacked the gay community, African American men would probably have less a problem with it. But African American men do not want anybody to think that they are gay. Let me [mention] about stigma for a moment. The big elephant in the room that created major problems and stigma for religious groups across the board is the belief that HIV/AIDS is a gay disease. That creates the fear that any man who comes forth will be labeled as gay, whether he has a family or not. Being gay is looked down on and frowned upon. There are a lot of other myths mixed in for women, such as being perceived as sexually promiscuous [like jezebel in the Bible]. The sexual aspect of this disease is big for the theological and biblical community" (Nunn et al., 2012, p 3-4).

And because the main mantra of secular HIV/AIDS prevention methodologies is the utilization of condoms, dental dams, sexual partner reduction and/or the use of bleach kits to clean dirty needles, this further complicates the Black Church's relevance and approach to HIV/AIDS interventions as it may contradict their theological principles (Francisco & Liverpool, 2009). Balancing sexual education with theology in the Black Church is a fine line to tread as some ministers are unwilling to discuss sensitive topics. Some parishioners may prefer HIV/AIDS prevention messages that emphasize abstinence versus comprehensive sex education while others may outright leave rather than be taught secular prevention methodologies. For example, a participant in Nunn et al.'s (2012) study reports that:

> "one time [the] pastor spoke to young people about sex, mentioning using protection. I was sitting in the clergy row; you could feel the heat! I was surprised he said that. Comments from the clergy highlighted they were opposed to that. It's a tight rope walk" (Nunn et al. 2012, p 5).

Furthermore, since the Black Church is rooted on the foundation of abstinence and preserving sex until marriage, promoting the utilization of using condoms, dental dams, and reducing the number of sex partners to prevent the acquisition of HIV/AIDS poses a conflict of interest and/or drastic paradigm shift which does not sit well with some parishioners. Another participant in Nunn et al.'s (2012) study illustrates:

> "In the faith community, we've taken positions promoting abstinence for so long that we don't want to mention condoms because people may think we're saying 'you should be having promiscuous sex.' I think it's a very real issue, one that at

some point the clergy has to deal with: the reality that people are having sex whether you tell them to abstain or not. I've had this debate over and over again with our youth leadership. Half of them want to tell kids to put a condom on, to protect themselves. But some of them say 'if you're telling them to protect themselves, then [you're] telling them it's okay to have sex'" (Nunn et al. 2012, p. 5).

Overall, the Black Church faces a dilemma to dealing with sensitive issues revolving around sexuality. As the Black Church struggles with how to embrace these sensitive issues, without condoning various lifestyles or compromising their own theological beliefs, health professionals, such as nurses, can act as neutral agents to deliver HIV/AIDS prevention interventions within their facilities, all while presenting factual HIV/AIDS information within a cultural-congruent acceptable fashion (Baker, 1999; Lindley et al., 2010).

2.36 Financial constraints

Although the literature shows that the Black Church has great potential as a forum for addressing the HIV/AIDS epidemic within the African American community, evidence suggests that the Black Church may face financial barriers reaching out to its parishioners and lay African American community members in its attempt to counteract the booming epidemic happening within their communities (AIDS ALERT, 2007). According to Nunn et al. (2012), addressing the HIV/AIDS epidemic may create a financial barrier for the Black Church, since generating more revenue or additional resources to startup an HIV/AIDS ministry may become an additional church expense.

Some parishioners may feel uncertain about investing in faith-based organizations that support or would like to initiate support for HIV/AIDS outreach. Such fickle attitudes may manifest in how parishioners donate their money to the Black Church running such outreach support services. A participant in Nunn et al.'s (2012) study explains that "if you talk about HIV, congregants may say 'that ain't got nothing to do with me.' That's not actually going to inspire people, to come to church or to give their tithes and offering" (Nunn et al., 2012, p. 5). Another African American minister in the study confirms this situation, stating that "one of the things preventing [the Black Church] from getting involved is not so much attitudes, but just time and resources. The problem of HIV/AIDS [is that it] cannot be solved unless there's money. Money is the acid test" (Nunn et al., 2012, p.5). Financial resources may be needed on a continuous basis for the viability of an on-going HIV/AIDS church program, something a Black Church may not have. Therefore, some African American ministers may consciously choose not to mention anything about that HIV/AIDS epidemic, so that the Black Church does not suffer financial losses.

2.37 Black Church response to HIV

The HIV/AIDS crisis is running rampant within the African American community, and the Black Church has great potential to confront and control this social issue. As stated previously, the stigma associated with HIV/AIDS makes this particular social problem too controversial for many Black Churches to confront (AIDS Alert, 2007). According to Fulton (2011), "deciding how to respond becomes complex because the predominate modes of infection—unprotected sex, promiscuity, homosexual relations, intravenous drug use, which often violate church teachings." During times of crisis, the African American community has relied on the Black Church as a source of leadership, answers, social

support, and empowerment. The current HIV/AIDS epidemic devastating many African American communities is an important issue to which Black Churches have shown mixed reactions – most have remained unresponsive with very few actively addressing the crisis (Folton, 2011).

The Black Church's response to the current HIV/AIDS epidemic within the African American community has been lukewarm and quite reluctant (McCree, Jones, and O'leary, 2010). CBS News (2008) even reports that "the Black Church, traditionally a loud voice for social change, has been silent on the crisis of AIDS in the African American community, and some say, even negligent." During the beginning of the epidemic and even now, the Black Church has had difficulty discussing the associated risk behaviors that increase one's susceptibility and vulnerability to HIV acquisition and transmission (Moore et al., 2012). Having been at the forefront of many social injustices that once disenfranchised the African American community, it is clear that the Black Church has not responded to the HIV/AIDS epidemic to the capacity it has historically shown itself to be capable of (Smith, Simmons and Mayor, 2005).

When the HIV/AIDS epidemic has been addressed, the Black Church has done so in various capacities. Some individuals within Black Churches have offered basic services to those suffering with the illness, such as food, clothing, and shelter. Other Black Churches have acted out with hostility and, indifference, and many have remained silent (AIDS Alert, 2007). However, there have only been a handful of Black Churches that have fully embraced tackling the HIV/AIDS epidemic by launching formally designated "HIV/AIDS health ministries" or having their pre-established auxiliaries (e.g. nurses' guild, health ministry) provide comprehensive HIV/AIDS prevention information,

disseminate condoms, function as HIV screening testing sites, and/or have bridged HIV positive persons to other community resources (McCree et al., 2010). In spite of the small number of churches that have embraced addressing the epidemic, as more and more of the African American population gets infected with the illness, leadership within the Black Church can no longer stand back and remain silent, complacent, or indifferent to the calamity unfolding around them (Francis & Liverpool, 2009; McCree el al., 2010).

As more and more African Americans get infected with the illness, it is imperative that leadership within the Black Church embraces tackling the HIV epidemic and informing the community about how to further prevent the spread of the virus (McCree et al., 2010). Fortunately, Black Churches are in a great position to address the HIV/AIDS epidemic, as many African Americans view faith leaders with high esteem and respect. Faith-based organizations, such as the Black Church, have access to a wide and diverse audience, including youth and adults, all of whom could benefit from HIV/AIDS prevention information (Francis & Liverpool, 2009). According to the National Association for the Advancement of Colored People (NAACP) (2014), there are 21,000 Black Churches in the U.S., and 53% of the African American community report they attend church services weekly. The Black Church has the potential to reach 20 million parishioners who can help facilitate an AIDS-free generation. The Black Church has the power to help stop the spread of HIV within the African American community (NAACP, 2014). And because the Black Church is a highly trusted establishment within the community, faith leaders are in a good position to engage African Americans with life-saving, accurate information. Although being "preached at" may be unpleasant, getting

health information from the Black Church, versus a medical establishment, may be received with love (McCree, 2010).

In order for the Black Church to be equipped and empowered to address the HIV epidemic within the African American community, evidence recommends that there should be communication between both the Black Church and health professionals (McCree et al. 2007). In doing so, this may culminate in the "sharing of information and highlight the many ways in which HIV/AIDS presents challenges to the doctrine and practice of the Black Church" (McCree et al. 2010, p.63). Such communication between these two entities may help the Black Church to reconcile its distorted evil perception of HIV/AIDS, embrace a positive perspective of human sexuality, function in a greater capacity to reach out to the sick via being more inclusive, and eliminate attitudes of stigma associated with HIV/AIDS (McCree et al. 2007). In addition, leaders within the Black Church should be provided ongoing HIV/AIDS education and training by healthcare professionals. Evidence suggests that leaders within the Black Church should be provided with ongoing workshop training that include information on (1) how HIV is transmitted, (2) associated risk factors, (3) HIV prevention and treatment, and (4) HIV testing, counseling and referral services (McCree et al. 2007). Evidence also suggests that Black Church leaders and health professionals should work together in a concerted effort to develop techniques and skills for incorporating HIV/AIDS topics or activities into different church programs, functions, and/or auxiliaries, and also network with other external entities within the community to provide a comprehensive approach to addressing HIV/AIDS among parishioners and the broader African American community (McCree et al., 2010).

2.38 Nursing in Faith-Based Organizations

Nursing's connection to the church goes back to the 1800s when nurses worked through the church to care for the sick and the poor, and unmarried pregnant women (Newsome, 1994). The role of nursing within Black Churches remains relevant today. Some Black Churches have enlisted nurses within their organization into a group formally known as the Nursing Guild while others have designated a Health Ministry, operated by a team of nurses (from lay nurses, licensed practical nurses, professional nurses to advanced practice nurses), to care for parishioners and disseminate health information to the congregation (Newsome, 1994; Payne et al., 2011). Regardless of the classification or operational title, nurses play an integral role within Black Churches. Some of these roles include, but are not limited to, the following:

1) assist children, the elderly, or anyone who has an infirmity,
2) care for infants and children during church services,
3) assist individuals with limited mobility,
4) provide emergency nursing care if needed,
5) chaperone emergency patients to the hospital if needed, and
6) perform duties with a prayerful, sincere, and Christian-like manner

(Newsome, 1994).

Nurses have been and continue to be leaders within the Black Church in regards to providing health promotion/disease prevention information to the African American population. Parishioners in the Black Church are familiar with nurses providing health workshops pertaining to breast cancer, heart disease, diabetes, obesity, and nutrition. With

the current HIV epidemic impacting African Americans, evidence shows that nurses can also be instrumental in educating the African American community about HIV/AIDS, as well as conducting HIV/AIDS prevention activities in the Black Church setting (Payne et al., 2011).

Although nurses have great potential to be instrumental in educating parishioners about HIV/AIDS in the Black Church, evidence shows there is a severe lack of nurse-led HIV preventative activities being done in this setting (Baker, 1999). Baker (1999) reports that "initiating awareness about HIV prevention is just one type of program that is sorely needed, and it is one in which nurses can get involved" (Baker, p.72, 1999). Furthermore, evidence shows there is a gap in the literature concerning the role nurses have in planning, implementing, and evaluating Black Church-based HIV/AIDS prevention programs (Baker, 1999). Since many African American people may not feel comfortable visiting a healthcare provider (due to historical racial barriers, cultural barriers, health illiteracy etc.), nurses working within the Black Church are in a great position to provide both personal and sensitive HIV health information. Because nurses are well-educated in health promotion/disease prevention and usually are trusted and held in high admiration within the Black Church/African American community, implementing HIV prevention workshops within a familiar setting, such as the Black Church, may have a great impact on preventing the further spread of HIV within the African American community (Baker, 1999; Payne et al., 2011).

2.39 Project Intervention Description – V.O.I.C.E.S. HIV Prevention Program

Evidence suggests that HIV prevention interventions targeting African Americans should consider the socio-cultural aspects unique to this population that make them vulnerable to HIV acquisition and transmission (Williams, Wyatt & Wingood, 2010). Interventions that are culture specific and consider cultural aspects may have better outcomes, in terms of effectiveness, versus generic HIV prevention interventions (Crepaz et al., 2009). Video Opportunities for Innovative Condom Education and Safer Sex, or V.O.I.C.E.S., is an HIV/STD prevention intervention that specifically targets both African American males and females. According to the Health and Human Development Programs Education Development Center (HHD) (2009), V.O.I.C.E.S. is a single-session video-based HIV/STD prevention workshop, targeting persons aged 18 years and older, designed to encourage condom utilization and improve condom negotiation skills among African American males and females who are at high-risk for acquiring or transmitting HIV. A health educator, such as a nurse, convenes a group of four to eight persons in a private room conducive for discussion to dialogue about culturally appropriate HIV prevention strategies. HHD (2009) reports that VOICE/VOCES is a "research-based intervention identified by the Diffusion of Effective Behavioral Interventions Project (DEBI), a project initiated by the Centers for Disease Control and Prevention (CDC) to help bridge the gap between HIV/STD prevention research and practice" (HHD, 2009, p.2).

Based on the theory of reasoned action and the Health Belief Model, V.O.I.C.E.S. is a 45-minute HIV prevention program that consists of first viewing a brief video followed by a small-group discussion. Participants view a culturally-relevant soap opera-like video featuring African American actors in different types of encounters – primary and non-

primary sexual relationships, discussing sexual matters; the actors in the video scenarios present information on HIV/STD risk behaviors and model condom utilization and safe-sex negotiation. Following the video scenarios, a small-group discussion is conducted to converse about the situations presented in the scenarios, educate participants about the various features on condoms, role-play safe-sex negotiation skills, and demonstrate how to apply a condom on an anatomical male model (HHD, 2009). In addition, a condom poster is presented which displays the various features and name brands of condoms. At the conclusion of the HIV prevention intervention program, participants are provided three samples of condoms participants identify as best suiting their personal needs (HHD, 2009).

There are four core elements that define and prove the efficacy of the V.O.I.C.E.S. HIV prevention program. Core elements are research-based intervention components that define the intervention, must be adhered to, and cannot be altered in any form or fashion (HHD, 2009). The four components, or core elements, of V.O.I.C.E.S. are the following:

> "(1) viewing of culturally-specific videos
>
> (2) small-group skill-building sessions
>
> (3) condom featured education
>
> (4) distribution of sample condoms" (HHD, p 7, 2009).

The video serves the purpose to quickly disseminate accurate HIV/STD prevention information, model safer-sex behaviors, and function as an "ice breaker" for the small-group to discuss sexually explicit content viewed while also provoking a robust discussion for participants to share their own personal experiences and perspectives they may have

encountered (HHD, 2009). One of the "take home" messages that the cultural specific video provides is that it is okay for persons to discuss condom use and safer-sex practices with their partner (HHD, 2009).

The second core element, the small-group skill-building session, follows the culture specific video and serves as the heart of the V.O.I.C.E.S. intervention (HHD, 2009). During this part of the program, the facilitator leads a discussion asking the 4 to 8 participants scripted questions pertaining to the actors presented in the video. In addition, the facilitator encourages the participants to reflect and share how the video scenarios relate to their own lives. The beauty of the small-group skill-building discussion session is that it provides an opportunity for participants, amongst their peers, to open-up and share, within a safe private confidential and non-judgmental environment, experiences they may have encountered trying to practice safer-sex behaviors. Participants learn not only from the video presentation but also through fellowship and listening to their peers' experiences how to overcome barriers to practicing safer-sex measures (HHD, 2009).

The third core element of the V.O.I.C.E.S. program includes providing condom specific education. This part of the program augments the small-group skill-building session as it provides participants with information about the various types of condoms, and their features, available on the market for them and their partner to choose which best suit their needs. Used as a visual aid, an elaborate poster board is presented displaying roughly 20 of the most frequently purchased condoms so that participants become familiarized with various types of condom packages; this facilitates readable recognition of condoms in stores (HHD, 2009). In addition, this part of the program provides participants the opportunity to learn the psychomotor skills necessary to apply condoms

correctly on an anatomical male model. Lastly, at the conclusion of the program, participants are given a sample distribution of condoms that they identify will suit their needs; this fulfills the fourth core element of the program (HHD, 2009).

According to the literature, V.O.I.C.E.S. is based on research the Education Development Center (EDC) conducted to illustrate the efficacy of single-session, video-based HIV/STD behavioral interventions in promoting safer sex practices via consistent utilization of condoms. The original V.O.I.C.E.S. intervention was conducted over a 12-month period during the early 1990s in which 3,348 South Bronx African American and Hispanic male and female STD clinic patients were included in the study. Patients enrolled in the study were randomized into either of three groups: (1) control, (2) video only, and (3) video plus interactive session (O'Donnell et al., 1995, p. 818). The control group received typical STD information in the clinic as per ordinary routine office visits. African American participants randomized to the video-only session viewed a 20-minute audiovisual presentation titles "*Let's Do Something Different.*" African American participants randomized to video plus interactive session viewed "*Let's Do something Different*" followed by a small group (three to eight members each matched by same gender) peer discussion guided by a gender-matched trained facilitator (O'Donnell et al., 1995, p.818). The video plus interactive session participants had the opportunity not only to discuss with their peers what they thought about the video presentation but also exchange ideas regarding the social norms of condom utilization while the facilitator, through a semi-structured protocol which allowed fluidity between different cohorts, guided the 45-minute intervention and clarified any misconceptions regarding HIV infection, condom skills, and negotiation techniques. The goal of the study was for participants to increase their intent to

utilize condoms and actual utilize condoms during sexual encounters. Results showed that for participants in the experimental group, compared to the control, had a significantly higher rate of obtaining condoms in comparison to the participants in the control group (27.6% versus 21.2 % with $P < 0.0001$) (O'Donnell et al., 1995, p. 819).

The V.O.I.C.E.S. intervention was more recently tested in Neumann, O'Donnell, Doval, Schillinger, Blank, Ortiz-Rios, Garcia, and O'Donnell's (2011) replicated study in New York City (mostly African American participants) and San Juan, Pueto Rico (mostly Hispanic participants) to assess its efficacy in the "real world" under less research-controlled environment. They used the same tools originally used reporting an alpha = 0.77 for the 15-items scale regarding correct condom use, positive condom attitudes, and perceived self-efficacy to introduce condom use and an alpha = 0.62 for the 8-item survey on STD knowledge. A total of 1,771 participants were in the New York City STD clinic site among which 76.2% identified as African American while 52.6% and 47.4% were male and female, respectively (Neumann et al., 2011, p.135). Fifty percent of the participants experienced the intervention (V.O.I.C.E.S.) and the other 50% were control (regular clinic services). Compared to the original study, the V.O.I.C.E.S. intervention in Neumann et al.'s (2011) was delivered by trained staff (rather than researchers) and 65.3% of the intervention groups consisted of mixed genders. Findings of the replicated study are consistent with the original V.O.I.C.E.S. study in which the intervention group showed the following: (1) lower incidence of STDs reported to surveillance system, (2) scoring higher on scales of STD knowledge, (3) higher condom knowledge, attitudes, and future plan to use condoms, and (4) redeeming condom vouchers at local pharmacy (Neumann et al., 2011, p. 133). Overall, Neumann et al. (2011) demonstrate that the V.O.I.C.E.S. is

efficacious, it is realistic and cost-effective, and similar results can be achieved even when done in mixed-gendered audiences.

The V.O.I.C.E.S. HIV prevention workshop is a good fit for this evidence-based practice quality improvement project due to a number of things. First, this HIV prevention workshop specifically targets African Americans and is sensitive to the unique sociocultural factors African Americans face having relevancy to capture this audience's attention regarding HIV/STDs within the community. Second, it is a cost-effective and time efficient in that it will not burden the FBO, facilitator(s), or participants in terms of operation, labor intensity, and time/scheduling commitment. Third, V.O.I.C.E.S. is one of the very few HIV prevention interventions that can be used in mixed gendered audiences; having an HIV prevention intervention workshop with this type of adaptability is more appropriate for young adult African Americans (my target population) to the extent parishioners will not have to feel secluded from their peers in the church setting. Lastly, this HIV prevention intervention workshop goes beyond merely disseminating HIV prevention information to an audience but also affords an exchange of ideas between peers/facilitator(s) where we can learn from each other, address social issues, and formulate participant specific strategies to reduce high-risk behavior.

Overall, this workshop can be highly effective in reducing the acquisition and transmission of HIV among African Americans because it is culturally-relevant and succinct as it provides HIV risk behaviors/condom use information delivered in an engaging manner –a video format of characters to whom they can relate and facilitated thought-provoking group discussion with a condom visual-aid poster-board featuring various condom brands that informs and captures the audience's attention (HHD, 2009).

2.40 Theoretical framework

The V.O.I.C.E.S. HIV program is based on two theoretical frameworks – the Health Belief Model and Theory of Reason Action. The Health Belief Model (HBM) provides V.O.I.C.E.S. the framework to explain that African American males and females will seek HIV preventative measures and will practice safe-sex methods if the individual feels they are at risk for the infection. It is used to explain that if an individual perceives HIV to be an infection that is life-altering and serious enough, then the individual fill find it will be worthwhile to gather information on strategies to prevent the infection. Kabiru, Beguy, Crichton, & Zulu (2011) illustrate the HBM's concepts in the following diagram:

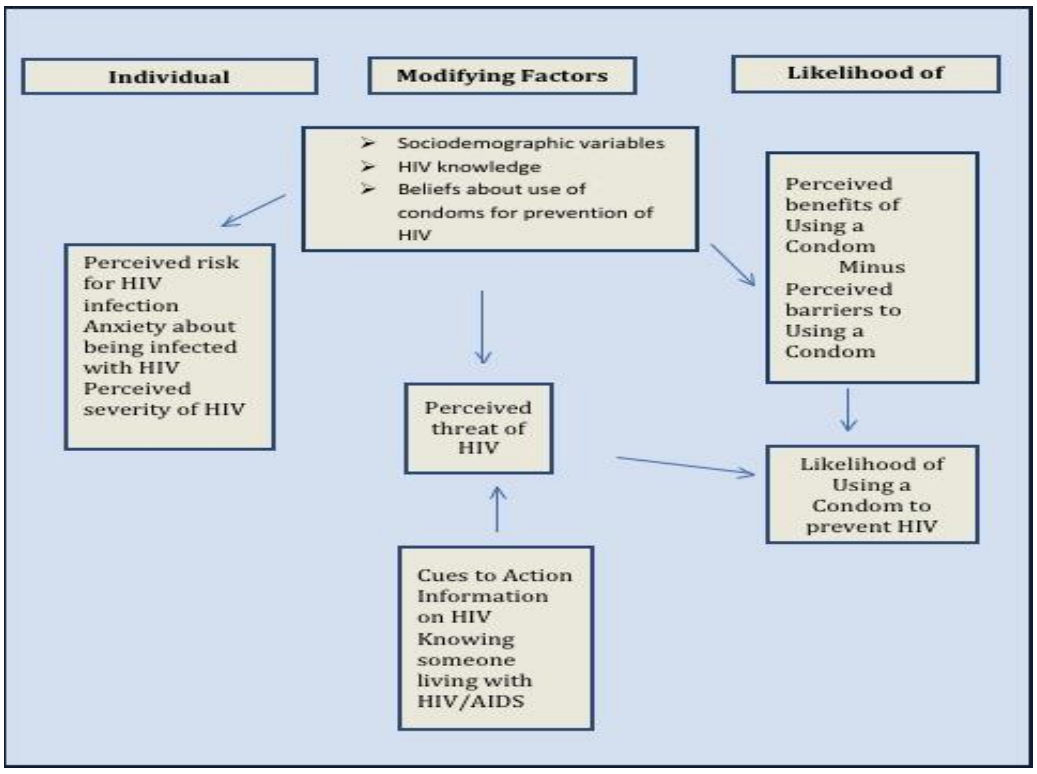

Figure 2.1: Health Belief Model Diagram

In essence, the HBM explains that health seeking behaviors – or the lack thereof, is based upon an individual's perception of an illness linked to the individual's

susceptibility to acquiring the illness (AIDSMap, 2014). This theoretical framework also explains that an individual, who recognizes his or herself to be susceptible to HIV, must perceive that their high-risk behavior(s) which make them susceptible and that behavioral modification is necessary to prevent the infection. In doing so, they must feel they are capable of successfully practicing the behavioral modification and that a cue-to-action, which is a reminder source (e.g. poster board, health care provider, friend/loved one) may be necessary to practice the health promotion/disease preventative behavior (AIDSMap, 2014). So if an individual feels that HIV is a very serious life-altering condition for which they are at risk for, then the individual will seek HIV prevention information and practice safer-sex behaviors – abstinence, use condoms, reduce the number of sex partners, to prevent the acquisition of HIV.

The Theory of Reasoned Action is the second theoretical framework that provides scientific underpinnings to the V.O.I.C.E.S. HIV intervention program. The Theory of Reasoned Action (TRA) explains that individuals carry out behaviors based on their volition, intention, and the social norms (HHD, 2006). That is, the TRA explains that African American males and females engage in observable behaviors that are based upon one's attitude towards a behavior (e.g. safer-sex via using condoms) and acknowledging how their peers or friends/family think they should behave in a given situation (AIDSMap, 2014; HHD, 2006). The model suggests that intentional behaviors may also be an expression resulting from convictions based on previous personal experiences of a given situation (HHD, 2006). Because HIV risk reduction entail elements of behavioral modification, three constructs in the TRA – (1) attitude toward the specific behavior, (2) subjective norms about a behavior, and (3) perceived behavioral control, are emphasized

in the V.O.I.C.E.S. HIV intervention so that individuals will intend to adopt health promoting/disease prevention behaviors (HHD, 2006). Hale, Householder, & Greene (2002) illustrate the original TRA model by the following diagram:

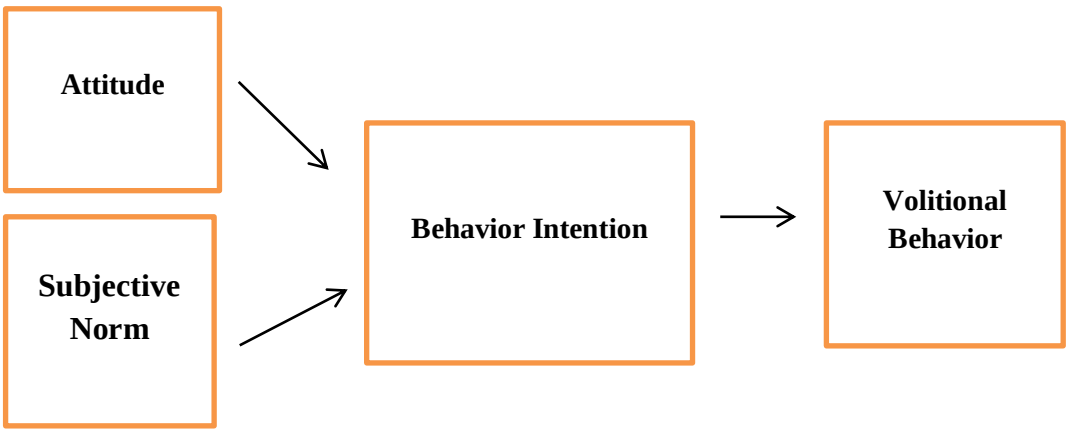

Figure 2.2: Theory of Reasoned Action Diagram

For the basis of this project, the HBM will be emphasized more because of its simplicity. In addition, since the V.O.I.C.E.S. HIV prevention program aims to modify participant behaviors, something of which will not be done in this evidence-based practice quality improvement project, the TRA theoretical framework will merely serve as minor scientific underpinnings.

2.41 Potential barriers for adoption of the practice innovation

There is significant evidence that shows the collaborative and leadership role nursing has working in partnership with the Black Church to deliver HIV preventive intervention information to members within the African American community. Nurses providing HIV information within the Black Church may halt the further infiltration and progression of the current HIV epidemic that is devastating the lives of many African Americans. Potential barriers for the adoption of this innovative practice – the Black

Church embracing professional nurses into its four walls to deliver comprehensive HIV preventive intervention information to African Americans, may include: (1) gaining entry into the church, (2) issues revolving around sexuality, and (3) stigma of HIV.

If the Black Church is to be used as a venue for the delivery of an HIV prevention intervention program and the professional nurse(s) is not a member of a particular Black Church, gaining entry to deliver such HIV prevention information may be a challenge (Cornelius, Moneyham & LeGrand, 2008). In order to overcome this barrier, collaborating with church leaders (e.g. the pastor, first lady, elders, deacons, church mothers, etc.) and establishing a working relationship of trust may help professional nurses gain entry into the Black Church; community volunteer work and participating in church ministries may also help professional nurses gain entry into the Black Church and acceptance by the overall African American community (Cornelius, Moneyham & LeGrand, 2008).

Many Black Churches may not allow condoms to be brought on church grounds, even if they are displayed in conjunction with an HIV prevention program during a health fair (AIDS Alert, 2007). This may pose as a practice innovation barrier because nurses need to provide/demonstrate condom utilization techniques in order to deliver safer-sex information, so parishioners can be equipped with the know-how tools to prevent the spread of HIV within the African American community. Therefore, nurses may need to collaborate and receive permission from church leaders to discuss with parishioners about the ramifications of engaging in oral, anal and vaginal sex. Doing so, nurses should highlight the implications of how condoms can be used to prevent the spread of HIV within the African American community prior to merely offering an HIV prevention intervention workshop within the Black Church (Cornelius, Moneyham, and LeGrad, 2008).

Since HIV prevention involves issues around sexuality which may violate church teachings (e.g. premarital sex, adultery, multiple sex partners, homosexuality), barriers to implementing this innovation may include Black Church leaders who (1) are unwilling to let nurses discuss sensitive sexual topics, (2) may want nurses to emphasize abstinence versus comprehensive sex education, (3) may not perceive their parishioners and/or surrounding community to be at risk for HIV, and (4) may not want the topic of HIV to be discussed in their church (Francis & Liverpool, 2008). In order to circumvent this potential practice barrier, the professional nurse(s) and Black Church leadership may have to compromise over what the nurse may discuss within the church building while being able to deliver essential components of an HIV workshop without significantly altering the core fundamentals of HIV prevention (Francis & Liverpool, 2008).

Stigma surrounding HIV and "immoral" behaviors associated with HIV acquisition/transmission have historically hindered the Black Church community from embracing and responding to the HIV/AIDS crisis to the extent it is capable of (Wilson, Wittlin, Munoz-Laboy, and Parker, 2011). Because HIV-related stigma is prevalent within the African American community, with the Black Church having played a key role in perpetrating HIV-related stigma within the African American community, the sociobehavioral aspects of this project may hinder high parishioner participation rates, which may pose as a barrier to nursing intervention. Thus, HIV-related stigma can have an impact on how leadership and parishioners embrace, or fail to respond, to any innovative HIV prevention interventions led by nurses (Foster et al., 2011; Wilson et al. 2011, Wittlin, Munoz-Laboy, and Parker, 2011).

2.42 Potential supports for adoption of the nursing intervention

Increasingly more Black Churches and faith leaders in the South are becoming receptive to and involved in tackling the HIV epidemic that is devastating the lives of many within the African American community (Foster, Cooper, Parton, and Meeks, 2011; Isler, Eng, Maman, Adimora, and Weiner, 2014). Their support and willingness to work with health professionals, such as nurses, may be critical in order to accurately disseminate culturally relevant and medically accurate HIV information to the African American community (Aaron, Yates and Criniti, 2011). Evidence suggests Black Churches that have pre-existing health-related ministries within their organization, such as a Nurses' Guild, HIV/AIDS Ministry, and/or Health Awareness Team, may be advocates that will bolster support for the adoption of nursing interventions (Foster et al. 2011). The Black Church, in general, has multiple strengths that can potentially support the adoption of this intervention: (1) they have parishioners who are willing to participant in church-sponsored events and (2) they are perceived as credible sources of information within the African American community and parishioners tend to support endeavors when leadership supports an initiative (Aaron, Yates & Criniti, 2011; Isler, Eng et al., 2014; Washington, 2008). Therefore, strong commitment from the pastor, key church leaders, and parishioners who have a commitment to decreasing the incidence of HIV within the community are key stake holders for the support and success of this nursing intervention (Aaron, Yates & Criniti, 2011; Francis & Liverpool, 2009).

CHAPTER 3

METHODOLOGY

This chapter provides details of the methodology used in this evidence-based practice (EBP) quality improvement (QI) project. The following methodology elements are described in this chapter: research design, unit of analysis, participant sample, recruitment techniques, setting, outcomes measured, and the theoretical framework underpinning this EBP QI's intervention. I will describe how this EBP QI project will be implemented as well as explain the strategies used to reduce barriers/increase supports. In addition, I will describe the surveys that will be utilized in this EBP QI, discuss the intervention procedures, and detail how the data will be analyzed.

3.1 Design & Data Analysis

This evidence-based practice quality improvement project will consist of a mixed methods research design as the V.O.I.C.E.S. HIV prevention workshop will be presented to four leadership focus groups assessing their level of HIV Stigma, HIV knowledge and Willingness to adopt the tool. A mixed method is being chosen because of the synergy that will be created since participants will not only be providing input, in the form of a survey, but also have opportunity to verbally interact and hear other participant's ideas regarding the workshop. A note-taker will be present at each church site to assist the PI in recording participant's comments and capture emerging themes that may develop during the

workshop. In addition, qualitative data will also be captured by describing the experiences the PI has with each church site.

In regards to quantitative methods of this evidence-based practice quality improvement project, descriptive statistics will be utilized to describe the characteristics of the sample in terms of leadership role, gender, marital status, race/ethnicity, education, and frequency of church attendance. It will also be employed to assess central tendency (the mean), measure of spread (standard deviation and range), and frequency distribution among the variables (HIV Stigma, HIV Knowledge, and Willingness). The survey instrument Likert-scales will be coded, entered into Excel, and analyzed in SAS; t-tests will be conducted to compare results between the churches and access whether there are any differences between leadership groups regarding their acceptability of the V.O.I.C.E.S. tool. The internal consistency will be examined by using the alpha coefficient.

3.2 HIV Stigma Survey

The authors of instrument number one – HIV Stigma Survey, granted the PI permission to utilize the tool in this evidence-based practice quality improvement project. The HIV Stigma survey assesses both HIV stigma and HIV knowledge; the survey was originally developed for and tested in South Carolinian Black Churches surveying parishioners, pastors, and care team members at Project Fostering AIDS Initiatives That Heal, or Project F.A.I.T.H. The items presented in the Project FAITH survey were drawn from the National Health interview Survey of AIDS Knowledge and Attitudes, the AIDS Attitude Scale, and other research studies measuring HIV-related knowledge and stigma

(Lindley, Coleman, Gaddist & White, 2010, p. 13). The authors augmented the instrument by adding knowledge items regarding mother-to-child vertical transmission and IV drug use using literature drawn from CDC fact sheets (Lindley et al., 2010, p.13). The Cronbach's alpha they report are derived from the instrument they utilized in their study.

Instrument number one is categorized into six sections, in which the first four sections will be used to collect statistical data from leadership participants. The first section of the instrument collects demographic information. The second section assesses knowledge of HIV transmission – behaviors associated with HIV acquisition/transmission. The Cronbach's alpha for the HIV transmission knowledge section was 0.789 (Lindley et al., 2010, p. 14). The third section assesses basic HIV/AIDS knowledge; it has a Kuder-Richardson alpha of 0.756. Both HIV knowledge sections combine to consist of 32 items. According to the authors, a correct response = 1 point; incorrect responses = 0 points. The possible range for HIV/AIDS knowledge score is 0-32. The higher the score indicates that the leadership participant has greater HIV/AIDS knowledge (Lindley et al., 2010, p.14). The fourth section of the instrument assesses participant's stigmatizing attitudes towards PLWHA or those at risk for HIV/AIDS; the Cronbach's alpha for this section is 0.753. In this section, a composite stigma score from the 6-items are calculated point values such as the following: agree = 2 points, don't know = 1 point, and disagree = 0 points. For the sixth item in this section, the final item is reversed in value and calculated as: disagree = 2 points, don't know = 1 point; and agree = 0 points (Lindley et al., 2010, p. 14). A total of 12 points is assigned in this section; a low score means that the leadership participant has less HIV-related stigma (Lindley et al., 2010, p. 14).

3.3 Leadership Willingness

The second instrument – Leadership Willingness, was created by the PI. It is based upon the 4 core elements of the V.O.I.C.E.S. HIV prevention intervention workshop. Because it was created by the PI, it has not undergone rigorous scientific analysis to assess its validity.

However, the 7-items administered in section two (of this instrument) will enable the PI to assess willingness among leadership participants. The assumption of the second instrument is that the more participants agree with the responses means the more likely they will adopt the V.O.I.C.E.S. tool in its original form and higher the overall numeric score on the Leadership Survey. Numeric assignment will be paired to the first 6-item responses as follows: strongly agree = 5, agree = 4, neutral = 3, disagree = 2, and strongly disagree = 1. Numeric assignment on the seventh item response will be as follows: yes = 3, no = 2, and needs to be modified = 1. Total score possible is 33. A high score indicates greater acceptability of the V.O.I.C.E.S. tool to be used in its original form.

3.4 Unit of analysis

Because evidence shows that HIV infection rates are highly disproportionate among young adult African Americans in South Carolina and that the Black Church is a locale where many African Americans congregate, the sample will be taken from the Black Church. The unit of analysis for this project will include a sample of leaders from four different South Carolinian Black Churches. Leaders within the Black Church hold some sort of formal title (e.g. bishop, pastor, elder, deacon, mother, or minister) or serve in a specific leadership role within the Faith-Based Organization (FBO) – choir director,

HIV/AIDS director, usher, etc. In all, a total of 32 leaders will be recruited from four South Carolinian Black Churches in this project. More specific, the leaders we be representative of four Black Churches located in the South Carolina Midlands.

This evidence-based practice quality improvement project will be conducted at four Black Churches in South Carolina located in three cities in the Midlands – Columbia, West Columbia, and Orangeburg. The first two Black Churches, or "Church A" and "Church C," is located in Columbia, South Carolina of Richland County. The third Black Church, or "Church B," is located in West Columbia, South Carolina of Lexington County. The fourth Black Church, or "Church D," is located in Orangeburg, South Carolina of Orangeburg County. These locations were chosen because they reside in high HIV prevalence areas and/or their ability to reach the target population.

Participants included in this evidence-based practice quality improvement project consists of leadership representing one of four different Black Churches in South Carolina – Church A, Church B, Church C, and Church D. Church A is located in Columbia of Richland County and was established in the 1960s. Church A (see Black Church A **Table 3.1**) is a Baptist church that consists of nearly 14,000 parishioners among whom, per executive secretary, young adults ages 18 to 35 years old are its largest population. Church A's social presence is well-established in the community; it has 40 active ministries, and provides many outreach services to the residents of Columbia, South Carolina. The church deacon informed the PI that Church A once had an HIV/AIDS Ministry, but lack of support, resistance, and associated stigma caused the demise of the HIV/AIDS Ministry. Church A has a Health Professions Ministry, which is similar to a Nurses' Guild, that provides nursing services to parishioners during church services as well as provide health

information during church fairs and certain months of the year (e.g. breast awareness month, domestic violence and abuse month, veteran's month).

Table 3.1: Black Church Site A	
Black Church Site A	Established 1963
	13,847 parishioners (2014)
	age 18 – 35 largest parishioner population
	86 clergy and 80 deacons
	40 active ministries
	94 employees

Data Source: Church website & Pastor's Secretary.

Church B (see Black Church B **Table 3.2**) is a Baptist church that resides in West Columbia of Lexington County. Church B also has a church located in Columbia; however, the West Columbia location was selected because of its larger parishioner population, its location being in a different county which broadens the radius of this project, and is where its headquarters resides. Church B was established in 1902 and is well known to the residents of West Columbia, Lexington County, South Carolina, and even the nation. Its current membership consists of 8,053 parishioners. Its leadership staff consists of 4 clergy leaders and 120 deacons/deaconesses. This church has over 60 active ministries one of which includes an HIV/AIDS Ministry. Although the HIV/AIDS Ministry is currently active, it faces challenges. Per executive secretary, who is the leader over this ministry, the HIV/AIDS Ministry's biggest challenge it faces is HIV stigma – parishioners do not want to have an open conversation about it. The lack of support and stigma towards HIV/AIDS hinders this ministry from thriving within the church. Many resources, time, and energy

have been devoted to the HIV/AIDS Ministry to provide outreach services to the parishioners and residents of West Columbia with only very little community participation in return.

Table 3.2: Black Church Site B	
Black Church Site B	Established 1902
	8,053 (2015)
	age 40 – 60 largest parishioner population
	4 clergy and 120 deacons/deaconess
	>60 active ministries
	160 employees

Data Source: Church Website & Pastor's Executive Secretary

Church C (see Black Church C **Table 3.3**) is a Baptist church located in the heart of downtown Columbia, South Carolina of Richland County. Established in 1877, this Black Church is also well known to the community as it provides a myriad of community outreach services to the Greater Columbia community. It has over 40 active ministries consisting of community outreach, health & wellness, and leadership development. Community outreach services include, but not limited to, providing financial assistance to persons experiencing financial distress, offering food to the homeless and others in need, and visiting individuals who are incarcerated. Church C has a gamut of ministries to enrich parishioners with health information. Such ministries include the following: (1) Cancer Support Ministry, (2) Health Care Ministry, (3) HIV/AIDS Prevention and Outreach Ministry, and the (4) Wellness Ministry. Although Church C has a functioning HIV/AIDS Ministry that can equip African Americans parishioners with HIV information, per

HIV/AIDS director, this ministry faces challenges, which threatens its viability. HIV stigma among African American parishioners, including those in leadership, is a major factor that keeps the HIV/AIDS Prevention and Outreach Ministry functioning to the fullest extent it is capable of.

Table 3.3 Black Church Site C	
Black Church Site C	Established in 1871
	>5000 total parishioners
	age 18 – 35 largest parishioner population
	70 clergy and 80 deacons
	>40 active ministries
	20 employees

Data Source: Church Website & HIV/AIDS Director/Church Deacon

Church D is located in Orangeburg, South Carolina of Orangeburg County. Established in 1984, Church D is a Pentecostal church that has over 300 parishioners, 13 active ministries, and 20 employees who help run this faith-based organization (see Black Church D **Table 3.4**). Currently, this church has an HIV/AIDS Ministry and it even has an entity conducting HIV research on its premises. The leader of Church D has a deep commitment for HIV prevention at the church and surrounding community and is a policy maker and community advocate for decreasing the spread of HIV within the African American community.

Table 3.4: Black Church Site D	
Black Church Site D	Established 1984
	>300 total parishioners
	age 18 – 35 largest parishioner population
	13 clergy and 13 deacons
	13 active ministries
	20 employees

Data Source: Church Website & Church Evangelist

3.5 Cultural Congruence

The PI who facilitated the intervention is as an experienced African American male registered nurse who is well-known at Church A. In order to properly conduct this project, the PI retrieved the CDC's V.O.I.C.E.S. training kit, read the instructions, and completed the 8-hour V.O.I.C.E.S. online training modules. In addition, the PI received extracurricular HIV/STD training sponsored South Carolina's DHEC STD/HIV Division Training center. Both the extracurricular training and the V.O.I.C.E.S. training modules prepared the PI to do this HIV prevention workshop before leadership participants in the Black Church.

3.6 Sample

There will be 32 leadership participants included in this evidence-based practice quality improvement project. Participants will consist of males and females who serve in leadership roles in four South Carolinian Black Churches from the Midlands. The leadership titles participants will hold include the following: bishop, pastor, minister,

deacon, elder, youth leader, HIV/AIDS director, and/or church secretary. Prior to enrolling in this EBP QI project, participants will be asked to meet certain eligibility criteria: (1) willing to participate in a survey via group dialog and written feedback on survey, (2) have an ability to speak and understand both written and verbal English, (3) have no cognitive or psychiatric difficulties that will impede one's ability to participate, (4) currently live in the state of South Carolina, (5) hold a formal leadership role, title, or position within the Black Church where the survey is conducted, (6) self-report as African American or Black, (7) be willing to view the V.O.I.C.E.S. video, (8) consent to view condom demonstration, and (9) view the V.O.I.C.E.S. condom feature poster board. A specific leadership role or extensive leadership experience are not criteria to participate, neither is age or gender.

3.7 Recruitment

Participants from each church will be recruited in different ways. For Church A – the PI's home church, the PI contacted the executive secretary, who has agreed to help the PI move this EBP QI project forward. To move the PI's project forward at Church A, the executive secretary collaborated with the senior pastor in which the senior pastor permitted the PI's information to be forwarded to the senior associate pastor. Once the senior associate pastor retrieved the PI's information of intent to introduce the V.O.I.C.E.S. HIV prevention workshop to leadership within the church, the senior associate pastor contacted the PI providing a list of 8 potential leaders to recruit. Upon retrieving this information, the PI informed the senior associate pastor's secretary of the 8 potential leadership participants that the senior associate pastor wanted the PI to recruit into this project. The secretary emailed the 8 pre-selected leadership participants notifying them the PI's request. In

addition, the secretary informed the PI that she will also email blast other (assistant) pastors, senior elders, elders, church mothers, and ministers to recruit as many leaders possible into the PI's EBP QI project. Doing so, the secretary will inform potential leadership participants the nature of this project, request their participation, and convey the date/time when to meet on the church campus.

While the senior associate pastor assisted the PI in recruiting 8 leader participants in Church A, the PI simultaneously collaborated with the senior deacon at Church A. The senior deacon was made aware that the PI was trying to extend this project to Church B but had no personal contact with that FBO. The senior deacon provided contact information to talk with the Director of Operations Officer (DOO) at Church B. Once the DOO received clearance for the PI to conduct the project at Church B, the DOO contacted the pastor's executive secretary to act as the liaison with the PI to recruit 8 persons in leadership roles. The executive secretary, who is also the director over the HIV/AIDS Ministry, recruited the 8 leader participants. In addition to that, the executive secretary arranged the time and location to conduct the project among leadership.

The former HIV/AIDS director at church A informed the PI to contact Church C's HIV/AIDS director due to the fact that Church C may be interested in this project. The PI contacted Church C's HIV/AIDS director explaining who he is, current project he was undertaking, and requested permission to do this project at the church. The HIV/AIDS director stated she would relay this information to the pastor requesting permission for the PI to implement the project among leadership. With assistance from the HIV/AIDS director, the HIV/AIDS director stated she would try to recruit 8 leadership personnel on behalf for the PI to participate in this EBP QI project.

In regards to Church D, the PI was informed that this FBO would possibly be interested in participating in this evidence-based practice quality improvement project. The PI contacted the church office in order to collaborate with the bishop – leader over Church D. The PI was first referred to the community project coordinator, who is incidentally conducting HIV research at this church; the community project coordinator subsequently referred the PI to the church evangelist. Both the community project coordinator and evangelist served as a liaison to get the PI in touch with the bishop. Once the bishop granted permission for the PI to do the intervention, the church evangelist planned to recruit 8 leaders, on behalf for the PI, to participate in this project.

3.8 Setting

This evidence-based practice quality improvement project will be presented at each of the four selected church campuses, mentioned prior, in this study. The PI will meet leadership participants in a private board room at their local church. The private board room will be large enough to accommodate the leadership committee but small enough to facilitate a cozy environment where a dialogue can take place, ideas can be developed, and confidentiality secured.

3.9 Outcomes to be measured

Outcomes to be measured include HIV stigma, knowledge about HIV/STDs, and feasibility of doing the V.O.I.C.E.S. intervention within the Black Church. To measure the outcomes, two instruments will be utilized. The first instrument will be the *HIV Stigma Survey*, which was originated and designed by Lindley, Coleman, Gaddist, and White's

(2010) HIV stigma study that measures HIV stigma within South Carolina Black churches. The *HIV Stigma Survey* will enable the PI to measure HIV stigma and HIV knowledge among Black Church leaders (see HIV Stigma Survey in **Appendix i**). The second instrument, which was designed by the PI, reflects the 4 core elements of the V.O.I.C.E.S. intervention and will be used to assess Black Church leadership perspective of the feasibility of conducting this intervention within the Black Church on young adult parishioners aged 18-35 (see Leadership Survey in **Appendix ii**). The following table (see Project Instruments **Table 3.5**) shows the instruments that will be utilized in this EBP QI project and their reported validity:

Table 3.5: Project Instruments

HIV Stigma Survey (Instrument No. 1)	**HIV Stigma**	**6-items**	**Alpha = 0.753**
	HIV knowledge (Basic Information)	**20-items**	**Alpha = 0.756**
	HIV Knowledge (How HIV is Transmitted)	**12-items**	**Alpha = 0.789**
Leadership Survey (Instrument No. 2)	**Willingness**	**7-items**	**Alpha = NA**

Utilizing the Black Church as a platform to provide HIV prevention appears promising to equip African Americans with the tools of knowledge to protect them from the infection. In general, the PI hopes this HIV prevention intervention workshop will enlighten Black Church leaders of the potential V.O.I.C.E.S. could have on young adult African American parishioners. The PI hopes that Black Church leaders realize that the V.O.I.C.E.S. workshop can be an effective tool to empower young adult African American parishioners with life-saving information, strategies, and tools to prevent HIV acquisition/transmission not only among young adult parishioners but for other African Americans, in their community, who are sexually active or at risk for HIV acquisition/ transmission. Furthermore, the PI hopes that Black Church leaders report that the V.O.I.C.E.S. workshop can be used to suit their church's need within the church setting and that it has the potential to reduce HIV incidence in young adult parishioners, reduce HIV stigma, and increase awareness about HIV, and future plans to use condoms or practice abstinence.

3.10 Instruments

Two instruments will be utilized in this evidence-based practice quality improvement project. The two instruments – the *V.O.I.C.E.S. Leadership Survey* and an *HIV Stigma Survey*, will be administered to leadership participants in this EBP project which will be used to answer the question: in the Black Church, is leadership more willing to permit adoption of the V.O.I.C.E.S. program to increase knowledge of HIV, reduce HIV stigma, increase the use of condoms and/or promote abstinence among parishioners ages 18-35 in its original form or in a modified form.

The *V.O.I.C.E.S. Leadership Survey* was developed by the PI. The PI's survey is based upon the V.O.I.C.E.S. HIV intervention's science and the 4 core elements. The *V.O.I.C.E.S. Leadership Survey* consists of three parts. The first part assesses demographical data – such a gender, leadership role, age, and race/ethnicity; the second part consists of 7 Likert-scale items, and the third part consists of free style writing space to provide feedback and comments. The 7 Likert-scale items consists of feasibility questions that pertain to the leadership participant's level of agreement (to specific elements of the V.O.I.C.E.S. intervention) that they would allow or not allow at their church. The 7 Likert-scale items consists of the following statements:

(1) "I would allow the V.O.I.C.E.S. video that demonstrates "safe sex" negotiation skills to be presented to young adults, age 18-35, at my church,

(2) I would allow a nurse to demonstrate to young adults, age 18-35, how to properly apply a condom on an anatomical male model,

(3) HIV prevention information is something young adults, age 18-35, at my church need to be informed of,

(4) After watching the V.O.I.C.E.S. video, I would allow a nurse to facilitate a 20 minute discussion with young adults, age 18-35, to: (1) talk about the video, (2) assess their risk for HIV, and (3) provide strategies how to overcome barriers to condom use,

(5) The church is an appropriate place for young adults, age 18-35, to learn information about HIV,

(6) I would allow a nurse to distribute condoms to young adults, age 18-35, at an HIV workshop, like V.O.I.C.E.S. at my church, and

(7) Overall, the V.O.I.C.E.S. intervention is appropriate in the church setting. Nothing needs to be modified."

The leadership participants will answer the 7 Likert-scale items based on their level of agreement; answer options for the first six questions included "strongly agree," "agree," "neutral," "disagree," and "strongly disagree." The seventh question's answer option included "Yes," "No," and "Needs to be modified." The third part of the *V.O.I.C.E.S Leadership Survey* consists of a free style writing section where participants can share comments or make suggestions, if they choose to do so.

3.11 HIV Stigma Survey

Leadership participants will be given the *HIV Stigma Survey*. This instrument will be administered twice via pre- / post- intervention to assess HIV stigma and HIV knowledge within the model. Developed by Lindley, Coleman, Gaddist, & White (2010), the HIV Stigma instrument utilized in this study was designed and constructed assessing HIV stigma and HIV knowledge among African American parishioners in South Carolina. The original scale was used on 1,445 parishioners, 61 pastors/ministers, and 109 care team members from a total of 9 Black Churches in South Carolina (Lindley et al., 2010). All participants were aged 18 years or older, predominately African American, and 71.9% female. Lindley et al.'s (2010) instrument consists of Likert scales which are subdivided into four categorical sections as following: demographics, knowledge of HIV transmission, basic knowledge about HIV/AIDS, and stigmatizing attitudes towards people living with or at risk for HIV/AIDS.

3.12 Demographics

Section one – or demographics, obtains information such as the participant's: date of survey collection, zip code of residence, house of worship name, sex, marital status, race, education, and religious characteristics.

3.13 Knowledge of HIV Transmission

Section two – or knowledge of HIV transmission, consists of a 12-item scale (with "very likely," "somewhat likely," or "unlikely" response options) that assess participant's knowledge how they believe a person could acquire HIV infection. The statements in this section include but are not are limited to the following: (1) "sharing plates, forks, or glasses with someone who has HIV," (2) "using public toilets," (3) "being bitten by mosquitoes or other insects," (4) "being kissed on the check by someone who has HIV," (5) "being coughed or sneezed on by someone who has HIV," (7) "donating or giving blood," and (8) "getting tested for HIV." Cronbach's alpha for this section is 0.789 (Lindley et al., 2010).

3.14 Basic HIV/AIDS Knowledge

Section three – or basic HIV/AIDS knowledge, is a 20-item true/false scale (with "true," "false," "don't know" response options) that assesses the participant's HIV/AIDS knowledge. Statements in this section include but are not limited to the following: (1) "birth control pills protect against HIV (the virus that causes AIDS)," (2) "there is no cure for HIV/AIDS at present," (3) "a person can be infected with HIV and not have the disease AIDS," (4) "most people who have HIV look sick," (5) "if having sex, the best way for a person to reduce his or her risk of getting HIV is to use a condom every time," and (6) "it

can take ten or more years for someone with HIV to test positive." Kuder-Richardson alpha for this section is 0.756 (Lindley et al., 2010).

3.15 Attitudes

Section four – or attitudes, is a 6-item scale (with "agree," "disagree," or "not sure" response options) that assesses whether participants have stigmatizing attitudes towards people living with or at risk for HIV/AIDS. Statements in this section include the following: (1) "AIDS is a punishment from God for sin," (2) "I think people who inject drugs deserve to get AIDS," (3) "I think homosexuals deserve to get AIDS," (4) "most people who have the AIDS virus only have themselves to blame," (5) "I have little sympathy for people who get the AIDS virus from sexual promiscuity," and (6) "I think people with the AIDS virus should be treated with the same respect as anyone else." Cronbach's alpha for this section is 0.753 (Lindley et al., 2010).

In all, the PI's *V.O.I.C.E.S. Leadership Survey* will be used to measure the degree upon which leadership think various elements of intervention is permissible (or should be done) within the Black Church. The PI's *V.O.I.C.E.S. Leadership Survey* will enable the PI to answer which parts of the intervention need to be modified in order for it to be accepted in the Black Church arena. In addition, the *V.O.I.C.E.S. Leadership Survey* will help determine if there are any discrepancies within leadership on what should or should not be done. Because HIV stigma can be a factor in how leadership may perceive HIV prevention, the *HIV Stigma Survey* tool will be used to verify their level of stigma.

3.16 Description of intervention: Procedure

The PI submitted the project proposal to the University of South Carolina's Institutional Review Board (USC IRB) for approval. Simultaneously, the PI was networking in the community, establishing relationships for when the project began. A letter determining the study was exempt was obtained from the USC IRB. The leadership participants were recruited at each church with help from a member at each church site who served as a liaison between the PI and potential participants. The PI explicitly explained to liaison personnel the inclusion criteria persons in leadership roles had to meet in order to be recruited. Once the liaison personnel understood this, they recruited participants on behalf of the PI since they were familiar with their church leaders and could expedite the recruitment process.

At Church A, both the senior associate pastor and his secretary plan to recruit leadership participants via email blasts to the entire clergy of the church. At Church B, the executive church secretary plans to recruit leadership participants in-person during church services and at church events. At Church C, the HIV/AIDS director plans to recruit leadership participants via collaborating with the leadership committee at the church. At Church D, the church evangelist plans to recruit leadership participants by sending emails to as well as direct face-to-face contact.

Eligible leadership participants will be provided the time, date, and location where to meet on each church's campus. For each of the four QI presentation sessions, the PI will use PowerPoint slides so that there will not be significant variation in content delivery between each Black Church site.

3.17 Procedure

The PI will meet with leadership participants in a private board room on the church campus. The private board room will be large enough to accommodate the leadership committee but small enough to facilitate a cozy environment where a dialogue of exchanging information and ideas could be done. The private board room will have appropriate resources the PI needs to conduct the intervention (e.g. computer, DVD, lighting, table, chairs). Prior to starting the presentation, light refreshments will be served so that leadership participants can get comfortable, decompress from their busy day, and personally meet and greet the PI.

After serving light refreshments, the PI will begin the leadership workshop by immediately administering a pre-intervention HIV Stigma survey – instrument number one. Administering the pre-intervention HIV Stigma survey before information is given to leadership will enable the PI to measure their baseline HIV knowledge and HIV stigma and assess the impact of the intervention after information is disseminated. After the pre-intervention HIV Stigma survey is completed by leadership participants, the PI will start the workshop by showing a PowerPoint presentation. Using the PowerPoint, the PI will inform the participants who he is, prior nursing experience, future nursing plans, and the nature of the EBP QI project. The PI will provide brief information about the current HIV epidemic in young adult African Americans, the significance of the Black Church to African Americans, and how nurses can utilize the Black Church as a platform to provide HIV preventative information to young adult African American parishioners. During the introductory process, the PI will self-disclosed his personal convictions and articulate that he was not trying to promote sexual activities within the church or "push condoms." The

PI will inform the leadership participants that V.O.I.C.E.S. HIV prevention workshop can equip young adult parishioners to teach others, who are not practicing the Christian lifestyle (abstinence), safe-sex methods to protect them from this deadly disease until "they get it right with the Lord." The PI will also convey that this 60-minute workshop can help young adult parishioners, who attend church but struggle to adhere to abstinence, to be equipped with information to prevent the acquisition and spread of HIV.

Starting this evidence-based practice quality improvement via the PowerPoint presentation serves several purposes. First, it enables the PI to formally introduce himself to the leadership participants so that Black Church leaders can understand (and perhaps be comforted) that the PI is "an insider" by faith. Second, it will organize the intervention where the participants will know what to anticipate for the next 60 minutes. Third, it will enable the leadership participants to take notes on the information presented, if desired. Fourth, the PowerPoint presentation will aid the PI to stay on task while providing uniformity so that each church site can receive the same information.

Following the introduction, the PI will introduce the leadership participants to the V.O.I.C.E.S. intervention. The PI will explain the V.O.I.C.E.S. acronym, history, and the 4 core elements. Then the PI will explain his intent to "walk them through" each step of the intervention's four core elements. Prior to walking them through each step, the PI will forewarn participants that a condom demonstration will be done on a Styrofoam penile model and that anyone is welcome to leave the room during that time if they do not feel comfortable viewing.

Next the PI will provide an overview of each of the four elements of the V.O.I.C.E.S. HIV prevention workshop: (1) view soap opera style video, (2) post video

discussion about the characters and their personal risk for HIV, (3) condom demonstration, and (4) condom board presentation. After briefly explaining the four elements of the intervention, the PI will introduce each element of the V.O.I.C.E.S. intervention to the leadership participants. First, using a laptop, the PI will present the 20-minute V.O.I.C.E.S. video titled "Do it Right." After the video is presented, the PI will briefly expound to the leaders about the post video discussion that would ordinarily occur with the parishioners. The PI will mention that a nurse-facilitator would inquire about the young adult parishioner's perspective of the characters in the video, discuss parishioner's risk for HIV, and strategize ways for parishioner's to overcome barriers of not utilizing condoms. Second, the PI will demonstrate how to correctly apply a condom on a male anatomical penile model. Prior to doing so, the PI will explain that the V.O.I.C.E.S. HIV workshop values empowering African Americans how to properly use condoms as the evidence shows that condoms are one of the most efficacious mechanisms to use in order to prevent HIV infection. The PI will also mention that it is not only important for young adult parishioners to know that condoms are effective in preventing HIV acquisition/transmission but also know how to properly apply a condom in order to receive their benefits.

Third, the PI will present the V.O.I.C.E.S. condom poster board to the leadership participants. The PI will inform them that it is important for young adult parishioners to know the following: (1) there are different types of condoms commercially available to suit people's needs, (2) one size does not fit all, and (3) that condoms can be appealing to utilize (due to the variety available) to the extent of persuading people to use them. The PI will mention this to leadership participants because this is a sales-pitch the V.O.I.C.E.S.

workshop uses. Fourth, the PI will dispense survey number two – the *V.O.I.C.E.S. Leadership Survey*. The PI will mention that providing feedback/comments would be helpful. That is done to encourage leadership participants to answer all questions and provide their insight or constructive criticism. Lastly, once the leadership participants complete the second survey, the PI will thank them for their participation and open the floor up for group comments, questions, and/or dialog. The PI will do this in order to obtain any possible anecdotal evidence to this study.

CHAPTER 4

RESULTS

The purpose of this evidence-based practice quality improvement project is to assess Black Church leadership's opinion whether the CDC's approved HIV prevention intervention V.O.I.C.E.S. can be implemented among young adult African American ages 18-35 in the church setting in its original or does it need to be modified. This chapter will depict the sample's characteristics, analysis of the research questions, and provide a general conclusion of the results obtained. Black Churches who failed to participate in this EBP QI project will also be described.

4.1 Description of Sample

Only two Black Churches participated in the V.O.I.C.E.S. HIV prevention leadership workshop – Church B (or Church one) and Church E (or Church two, a newly recruited church described below). Total sample size was 12. Among the 12 participants, 50% of the sample was male, 58% were married, 33% were single, and 8% had been divorced. All participants described themselves as Black/African American. Forty-two percent of the sample participants were high school graduates, 17% had some college or technical school training, 25% were college graduates, and 17% had earned a graduate degree. Nearly all participants reported that they attend church at least once a week. Participants held the following leadership roles: (one) assistant/associate pastor, (two)

elder, (one) choir president, (one) deacon, (three) minister, (one) trustee, and (three) "other." Participants who identified as "other" specified that they were either a member, an usher/minister-in-training, or "non-specified." Sample age range was between ages 18 to 75.

4.2 Church One

Among the 12 sampled Black Church leaders who participated in this evidence-based practice quality improvement project, Church One's leadership made up 50% of the sampled participants. Among the 6 participants, 50% were male, 50% were married, and 50% were single. All participants described themselves as Black/African American. Sixteen percent of the sample participants were high school graduates, 16% had some college or technical school training, 33% were college graduates, and 33% had earned a graduate degree. Eight-three percent of participants reported that they attend church at least once a week. Participants held the following leadership roles: (one) elder, (one) deacon, and (four) "others." Participants who identified as "other" specified that they were either a choir president, trustee, member, or "non-specified." Sample age range was 36-65. Sixteen percent of the sample was aged 36-45, 66% were aged 46-55, and 16% were aged 56-65 (see Frequency Distribution Demographics **Table 4.1**).

Table 4.1: Frequency Distribution for Demographic Variables by Church

Variables		Church 1		Church 2	
		N	%	n	%
Gender	*Male*	3	50	3	50
	Female	3	50	3	50
Marital Status	*Married*	3	50	4	66
	Single	3	50	1	16
	Divorced	0	0	1	16
Age Ranges	*18-24*	0	0	1	16
	25-30	0	0	1	16
	31-35	0	0	0	0
	36-45	1	16	3	50
	46-55	4	66	0	0
	56-65	1	16	0	0

	66-75	**0**	**0**	**1**	**16**
Leadership role	*Asst./Assoc. Pastor*	0	0	1	16
	Elder	1	16	1	16
	Deacon	1	16	0	0
	Minister	0	0	3	50
	Other	4	66	1	16
Education Attainment	*High School Graduate*	1	16	4	66
	Some College/Technical School Training	1	16	1	16
	College Graduate	2	33	1	16
	Graduate Degree	2	33	0	0

4.3 HIV knowledge

Results from the pre-intervention HIV Stigma Survey shows that most leadership participants at Church One were very knowledgeable about behaviors conducive to HIV transmission. Overall, the pre-intervention HIV Stigma Survey showed that leadership participants answered 10 of the 12 HIV transmission knowledge questions – section two, correctly. Results show that 50% on the sample incorrectly perceived that an individual is "very likely" to acquire HIV by donating or giving blood and 50% reported that they believe an individual is "very likely" to acquire HIV by having unprotected oral sex with someone who has HIV. However, all participants correctly identified that an individual is

"very likely" to acquire HIV by having unprotected anal/vaginal sex and sharing needles for drug use with someone who has HIV.

Regarding the basic HIV/AIDS knowledge assessment questions on the pre-intervention HIV Stigma Survey, overall, Church One leadership participants answered 16 of the 20 questions correctly having an overall mean composite score of 26 for the HIV Knowledge section. All leadership participants at Church One correctly identified that if having sex, the best way for a person to reduce his/her risk of getting HIV is to use a condom every time, any person with HIV can pass it on to someone else through oral, vaginal, or anal sex, and that someone can get HIV by having unprotected sex with an infected sex partner. They were less knowledgeable that HIV can be transmitted from mother to baby by breast milk, that bleach can be used to clean dirty needles for injecting drugs to reduce the risk for getting HIV, and that having an STD increases one's risk for HIV acquisition.

The post-intervention HIV Sigma Survey results showed that Church One leadership participant's HIV knowledge remained relatively the same. Although their post-intervention total mean composite score for the HIV Sigma Survey HIV Knowledge section remained 26, participants indicate that they increased in HIV knowledge among certain assessment questions. For example, in the section pertaining to HIV transmission knowledge there was a greater frequency of participants reporting that HIV is not transmitted by sharing plates, forks, or glasses with someone who has HIV, by using public toilets, nor by donating/giving blood. They also demonstrated knowledge acquisition in the basic HIV/AIDS knowledge section as well. In this section, more leadership correctly reported that there is no cure for HIV/AIDS at present, it is possible, but unlikely, to get

HIV from an HIV test, and that people who have unprotected oral, anal, or vaginal sex should get tested for HIV regularly. This knowledge acquisition is likely attributed by the PI providing brief facts about HIV in his PowerPoint presentation and by information presented in the V.O.I.C.E.S. audio-visual presentation.

4.4 HIV stigma

In regards to comfort and stigmatizing attitudes towards people living with or at risk for HIV/AIDS (PLWHA), the pre-intervention Comfort and Attitude section shows that Church One's leadership is "very comfortable" with HIV/AIDS. Their mean score for the pre-intervention HIV Stigma Survey Comfort section was 1.66 which indicates this group is very comfortable with HIV/AIDS. Findings from the pre-intervention HIV Stigma Survey Comfort section reveals that 83% reported they are "very comfortable" sitting next to a person with AIDS in church, 83% are "very comfortable" hugging a person with AIDS, and 83% reported feeling "very comfortable" shaking hands with a person who has AIDS. Sixty-six percent reported they were "somewhat" comfortable having a child with AIDS in the church nursery; however, 50% reported they were "not very comfortable" using a toilet after someone who has AIDS. After the V.O.I.C.E.S. HIV prevention leadership workshop was provided, their mean score for the Comfort section reduced to 1.62 indicating (although not very significant) which demonstrates they had increased in comfort and were still very comfortable with HIV (see HIV Stigma Survey Mean of Churches **Table 4.4**).

The pre-intervention HIV Stigma Attitude section shows that Church One's leadership was comfortable with people living with or at risk for HIV/AIDS. The mean

score for this section was 4.0 indicating that leadership participants are comfortable with HIV/AIDS. The pre-intervention HIV Stigma Survey Attitude section reveals that all leadership participants "disagree" that AIDS is a punishment from God for sin; all "disagree" that people who inject drugs deserve to get AIDS; all "disagree" that homosexuals deserve to get AIDS. In addition, they all "disagree" that they have little sympathy for people who get the AIDS virus from sexual promiscuity and that HIV/AIDS is a form of genocide against African Americans. All reported that they "agree" people with AIDS virus should be treated with the same respect as anyone else. Their post-intervention mean score stayed relatively the same (4.4) indicating no significant change in their attitude towards PLWHA (see HIV Stigma Survey Mean of Churches **Table 4.4**).

4.5 Leadership survey

In general, Church One's leadership was very receptive of the V.O.I.C.E.S. intervention. All leadership participants at Church One reported that HIV prevention information is something young adults, age 18-35, at their church need to be informed of. With regards to V.O.I.C.E.S's four core elements, 100% "strongly agree" that the V.O.I.C.E.S. video should be presented to young adults at their church; 83% "strongly agree" (17% were neutral) that they would allow a nurse to facilitate a 20-minute discussion with young adults to talk about the video, assess their risk for HIV, and provide strategies how to overcome barriers to condom use; 83% "strongly agree" they would allow a nurse to do a condom demonstration before the young adults; 83% "strongly agree" they would allow a nurse to distribute condoms to young adults. All, or 83%, but one participant reported "yes" that the overall V.O.I.C.E.S. intervention is appropriate to do in the church

setting and that nothing needs to be modified (see V.O.IC.E.S. Leadership Survey Response by Church **Table 4.2**).

Table 4.2: V.O.I.C.E.S. Leadership Survey Response by Church

Do you agree with the following statement?		Church 1		Church 2	
		n	%	n	%
I would allow the V.O.I.C.E.S. video that demonstrates "*safe sex*" negotiation skills to be presented to young adults, age 18-35, at my church.	*Strongly Agree*	6	100	0	0
	Agree	0	0	4	66
	Neutral	0	0	1	16
	Disagree	0	0	1	16
	Strongly Disagree			0	0
I would allow a nurse to demonstrate to young adults, age 18-35, how to properly apply a condom on an anatomical male model.	*Strongly Agree*	5	83	0	0
	Agree	1	16	4	66
	Neutral	0	0	0	0
	Disagree	0	0	1	16
	Strongly Disagree	0	0	1	16

HIV prevention information is something young adults, age 18-35, at my church need to be informed of.	***Strongly Agree***	**5**	**83**	**3**	**50**
	Agree	1	16	3	50
	Neutral	0	0	0	0
	Disagree	0	0	0	0
	Strongly Disagree	0	0	0	0
After watching the V.O.I.C.E.S. video, I would allow a nurse to facilitate a 20-minute discussion with young adults, age 18-35, to: (1) talk about the video, (2) assess their risk for HIV, and (3) provide strategies how to overcome barriers to condom use.	*Strongly Agree*	5	83	0	0
	Agree	0	0	3	50
	Neutral	1	16	2	33
	Disagree	0	0	1	16
	Strongly Disagree	0	0	0	0
The church is an appropriate place for young adults, age 18-35, to learn information about HIV.	*Strongly Agree*	5	83	2	33
	Agree	1	16	4	66
	Neutral	0	0	0	0
	Disagree	0	0	0	0
	Strongly Disagree	0	0	0	0

I would allow a nurse to distribute condoms to young adults, age 18-35, at an HIV workshop, like V.O.I.C.E.S. at my church. Overall, the V.O.I.C.E.S. intervention is appropriate in the church setting. Nothing needs to be modified.	***Strongly Agree***	**5**	**83**	**0**	**0**	
	Agree	1	16	3	50	
	Neutral	0	0	1	16	
	Disagree	0	0	1	16	
	Strongly Disagree	0	0	1	16	
	Yes	5	83	4	66	
	No	0	0	0	0	
	Needs to be modified	1	16	2		33

4.6 Church Two

Church Two is the second Black Church whose leadership participated in this study. Church Two's pastor learned about the study from a mutual colleague and contacted the PI informing that he wanted his leadership staff to participant in the study. Located in Northeast Columbia, South Carolina, Church Two is a non-denominational church established in 2002 and currently has a membership of 250 parishioners, 10 clergy/3 deacons, 1 (paid) employee, and 14 active ministries. Parishioners between the ages 19 to 50 make up the largest age group at Church Two. Their demographics are described in the following figure (see Black Church E **Table 4.3**):

Table 4.3: Black Church E	
Black Church Site E	Established 2002
	250 parishioners (2015)
	age 19 – 50 largest parishioner population
	10 clergy and 3 deacons
	14 active ministries
	1 paid employee (others are volunteers)

Data Source: Church Administrator

Among the total 12 sample participants, Church Two's leadership made up 50% of the sample in this study. Among the 6 participants, 50% were male, 66% were married, 16% were single, and 16% were divorced. All participants described themselves as Black/African American. Sixty-six percent of the sample participants were high school graduates, 16% had some college or technical school training, and 16% were college graduates. All participants reported that they attend church at least once a week. Participants held the following leadership roles: (one) assistant/associate pastor, (one) elder, (three) minister, and (one) "other." Participant who identified as "other" specified that they were an usher/minister-in-training. Sample age range was 18-75. Sixteen percent of the sample was between the ages 18-24, 16% were between the ages 25-30, 50% were between the ages 36-45, and 16% were between the ages 66-75 (see Frequency Distribution for Demographic Variables by Church **Table 4.1** above).

4.7 HIV Knowledge

Results from the pre-intervention HIV Stigma Survey shows that Church Two leadership participants, as a group, were not quite knowledgeable about behaviors conducive to HIV transmission. Overall, Church Two's leadership participants correctly answered 6 of the 12 HIV transmission knowledge questions on the pre-intervention HIV Stigma Survey. Most leadership participants incorrectly reported that a person can acquire HIV by mosquitoes or other insects, donating or giving blood, and by having unprotected oral sex with someone who has HIV. Fifty percent believed that a person is "somewhat likely" to become infected with HIV by sharing plates, forks, or glasses with someone who has HIV or by using public toilets. However, all participants correctly reported that an individual is "very likely" to acquire HIV by having unprotected anal/vaginal sex and sharing needles for drug use with someone who has HIV.

With regards to their basic knowledge about HIV/AIDS, overall, Church Two's leadership answered 16 of the 20 pre-intervention HIV Stigma Survey basic HIV Knowledge questions correctly for a total composite score of 22 for HIV Knowledge. All leadership participants correctly reported that birth control pills do not protect against HIV, there is no cure for HIV/AIDS at present, and that a person can be infected with HIV and not have the disease AIDS. In addition, they all correctly reported that in order to prevent getting HIV people who inject drugs should never reuse or "share" needles, any person with HIV can pass it on to someone else through oral, vaginal, or anal sex, and that someone can get HIV by having unprotected sex with an infected sex partner. However, only 66% reported that if having sex, the best way for a person to reduce his or her risk of getting HIV is to use a condom every time.

The post-intervention HIV Sigma Survey showed that Church Two leadership participant's HIV knowledge increased slightly. For example, in the Knowledge section pertaining to HIV transmission, participants demonstrated knowledge acquisition in the post-intervention by correctly reporting that HIV is "unlikely" to be transmitted by sharing plates, forks, or glasses with someone who has HIV, by using public toilets, or by donating/giving blood. They demonstrated that their basic HIV/AIDS knowledge increased as well. In the basic HIV/AIDS Knowledge section, more leadership reported that there is no cure for HIV/AIDS at present, it is possible, but unlikely, to get HIV from an HIV test, and that people who have unprotected oral, anal, or vaginal sex should get tested for HIV regularly. This is likely to be attributed by the PI providing facts about HIV in the PowerPoint presentation and the information presented in the V.O.I.C.E.S. audio-visual presentation.

4.8 Leadership Survey

More than half of Church Two's leadership participants were receptive of the V.O.I.C.E.S. intervention; however, there were leadership participants that reported reservations about certain elements of the V.O.I.C.E.S. intervention. Results show that all participants agree that HIV prevention information is something young adults, age 18-35, at their church need to be informed of. All reported that the church is an appropriate place for young adults to learn information about HIV. Regarding the acceptability of V.O.I.C.E.S's four core elements, 66% agree (17% were neutral and 17% disagree) that the V.O.I.C.E.S. video should be presented to young adults at their church; 50% agree (33% were neutral and 17% disagree) that they would allow a nurse to facilitate a 20-minute discussion with young adults to talk about the video, assess their risk for HIV, and

provide strategies how to overcome barriers to condom use; 66% agree they would allow a nurse to demonstration how to properly apply a condom on an anatomical male model to young adults; 50% agree (17% disagree and 17% strongly disagree) they would allow a nurse to distribute condoms to young adults. Most, or 66%, reported "yes" that the overall V.O.I.C.E.S. intervention is appropriate in the church setting and that nothing needs to be modified (see V.O.IC.E.S. Leadership Survey Response by Church **Table 4.2**).

4.9 Church One versus Church Two

As a group, the 12 leadership participants were fairly knowledgeable about basic HIV facts and how the virus can be acquired and/or transmitted and were fairly comfortable with PLWHA. However, there were differences between the two Black Churches. Overall, the pre-intervention showed that 12 leadership participants answered 8 of the 12 HIV knowledge questions in first part of the Knowledge section correctly. The pre-intervention reveals that all 12 participants correctly reported that it is "very likely" an individual can acquire HIV by having unprotected anal or vaginal sex with someone who has HIV and by sharing needles for drug use with someone who has HIV. Only 75% correctly reported that an individual can acquire HIV by having sex with multiple sex partners. Interestingly, 75% of the sample incorrectly reported that it is "very likely" a person can acquire HIV by having unprotected oral sex with someone who has HIV and that a person is "very likely" to acquire HIV by donating or giving blood. In the second part of the Knowledge section, which pertains to basic HIV/AIDS knowledge, overall the participants scored 16 out of 20 for a total composite score of 24 for HIV knowledge. All 12 leadership participants correctly identified that birth control pills do not protect against HIV, a person can be

infected with HIV and not have the disease AIDS, most people who have HIV do not look sick, any person with HIV can pass it on to someone else through oral, vaginal, or anal sex, and that someone can get HIV by having unprotected or sex with an infected sex partner. The pre-intervention revealed that only 83% of the sample correctly reported that it is "true" that if having sex, the best way for a person to reduce his or her risk of getting HIV is to use a condom every time.

The post-intervention reveals that the sample's HIV knowledge scores stayed relatively the same. Overall, the post-intervention reveals that the sample scored an 8 out of 12 in part one of the Knowledge section and 16 out of 20 in the second section for a combined total score of 24. Although the HIV knowledge post-score stayed relatively the same, there were subtle differences in the post-intervention HIV Stigma Survey responses. For example, there was a decline in knowledge among all participants in that 91% (compared to 100% in pre-intervention) reported that someone is "very likely" to acquire HIV by having unprotected anal or vaginal sex with someone who has HIV or by sharing needles for drug use with someone who has HIV. It is uncertain why there was a slight decrease regarding this matter, especially since the PI taught leadership participants about modes of HIV transmission in a brief PowerPoint lecture. On the other hand, there was a slight increase, from 75% to 82%, in the number of participants who reported "very likely" that a person can acquire HIV by having sex with multiple sex partners. In addition, there was an increase, from 83% to 100%, among participants that reported "true" that if having sex, the best way for a person to reduce his or her risk of getting HIV is to use a condom every time. This is a significant response; it is most likely attributable due to exposure to the V.O.I.C.E.S. intervention and by the PI teaching leadership that condoms are the best

tool currently available to prevention the spread of HIV. Interestingly, increasingly more (pre- 75% versus post-82%) participants incorrectly reported in the post-intervention Knowledge section that it is "very likely" to acquire HIV by having unprotected oral sex with someone who has HIV. Although no information given to participants during the HIV workshop pertained specifically to HIV transmission rates via oral sexual activity, it is plausible that the participants may perceive the oral cavity to be a sensitive body region and therefore more vulnerable to HIV acquisition/transmission.

Overall, Church One's leadership scored higher in the pre- post- HIV Knowledge section. However, Church Two's leadership participants demonstrated a slight increase on the post-intervention HIV Knowledge section whereas Church One had a slight decrease. When comparing Church One to Church Two's HIV knowledge, Church One's leadership knew more about how people become infected with HIV. For example, more of Church One's leadership participants initially knew that HIV is unlikely transmitted by sharing utensils with an HIV-positive person, by using public toilets, or by mosquitoes or other insects. The pre-intervention HIV Stigma Survey also revealed that they knew that a person is more at risk for acquiring HIV by having multiple sex partners. It is likely that Church One's leadership initially knew more about HIV simply due to the fact that their church has an active HIV/AIDS Ministry. When comparing pre- to post- HIV knowledge acquisition between leadership, Church Two's leadership demonstrated that their HIV knowledge increased more after the HIV leadership workshop was presented to them. This effect is demonstrated by quantitative statistics. When using t-tests to compare the churches, results show that Church One's leadership HIV knowledge slightly decreased whereas Church Two leadership's HIV knowledge slightly increased (see HIV Stigma

Survey Mean of Churches **Table 4.4**). This effect is significant having p-values of 0.0457 and 0.0785 regarding HIV knowledge (12-items) and total HIV knowledge (32-items), respectively. This slight increase in HIV knowledge among Church Two's leadership is likely due to the fact that the PI provided basic facts about HIV in his PowerPoint lecture and by the information provided in the V.O.I.C.E.S. audiovisual presentation.

Table 4.4: HIV Stigma Survey Mean of Churches

	Church 1 (n=6)				Church 2 (n=6)			
Label	**Mean**	**Std**	**Min**	**Max**	**Mean**	**Std**	**Min**	**Max**
HIV Knowledge: 12-items (pre)	9.83	1.47	8.00	12.00	5.50	1.05	4.00	7.00
Comfort (pre)	11.67	3.20	7.00	15.00	14.17	2.48	11.00	18.00
Attitude (pre)	4.00	1.26	2.00	6.00	5.17	2.40	2.00	8.00
Basic HIV Know: 20-items	16.17	2.32	14.00	19.00	15.67	1.21	14.00	17.00
(pre)	26.00	3.46	22.00	31.00	21.17	2.04	19.00	24.00
Total HIV Know: 32-items (pre)	9.40	2.19	6.00	12.00	6.50	1.64	4.00	9.00
HIV knowledge: 12- items	11.40	4.83	7.00	17.00	14.50	2.17	12.00	18.00
(post)	16.60	2.07	14.00	19.00	16.00	1.67	13.00	18.00
Comfort (post)	4.40	0.89	4.00	6.00	5.50	2.26	2.00	8.00
Basic HIV: 20-items (post)	26.00	3.94	20.00	30.00	22.50	2.35	20.00	26.00
Attitude (post)	-0.80*	1.30	-3.00	0.00	1.00*	1.26	-1.00	2.00
Total HIV Know: 32-items	0.00	0.00	0.00	0.00	0.33	1.51	-1.00	3.00
(post)	0.20	1.79	-2.00	2.00	0.33	1.37	-2.00	2.00
Diff. total Knowledge: 12-items	0.00	0.71	-1.00	1.00	0.33	1.51	-1.00	3.00
(post - pre)*	-0.80*	1.48	-3.00	1.00	1.33*	2.07	-1.00	5.00
Diff. total Attitude								
Diff. total Comfort (post – pre)								
Diff. total HIV (post – pre)								
Total Knowledge: 32 items post								
- pre 32 items *								

There was a significance in total knowledge (post-pre) between the churches, p-value 0.0457.
There was a significance in total stigma (post-pre) between the churches, p-value 0.0785.

In addition, there were differences noted between the two churches in terms of their comfort and attitudes towards people living with HIV/AIDS (PLWHA). Overall, Church

One's leadership was more comfortable with HIV/AIDS and had less stigmatizing attitudes towards PLWHA then Church Two's leadership. Church One's leadership pre- and post- scores in the Comfort section was 1.66 and 1.62, respectively, which indicates they were "very comfortable" with HIV and were slightly more comfortable after the intervention was presented to them. On the other hand, Church Two's leadership pre- and post- scores in the Comfort section was 2.02 and 2.07, respectively, which indicates they were "somewhat comfortable" with HIV. One of the key factors that differentiate Church Two's comfort from Church One's comfort is due to the fact that most leadership at Church Two is "not at all comfortable" using a restaurant drinking glass once used by a person with AIDS whereas most leadership at Church One reported to be much more comfortable in a scenario like this.

In regards to attitudes towards people living with HIV/AIDS, Church One's leadership reported having less HIV/AIDS stigmatizing attitudes then Church Two's leadership. In the Attitude section, Church One leadership's pre- post- scores were 4.00 and 4.40, respectively, indicating that they had low levels HIV stigma. Whereas Church Two leadership's pre- post- scores were 5.2 and 5.5, respectively, revealing that they had slightly higher HIV stigmatizing attitudes towards PLWHA. Although the difference between the pre- and post- intervention's effect on attitude scores are not statistically significant among the Black Churches, the level of HIV/AIDS stigma between the Black Churches are. Attitudes that differentiate Church Two's leadership from Church One's leadership is that more of Church Two's leadership agree that AIDS is a punishment from God for sin, more agree that most people who have the AIDS virus only have themselves to blame, and that fewer disagree that homosexuals do not deserve to get AIDS. According

to the literature, persons who know less about HIV tend to be less comfortable with the disease and have more stigmatizing attitudes towards PLWHA. That appears to be the phenomenon here. It is plausible that because Church Two's leadership knows less about HIV is the reason why they are less comfortable and have more stigmatizing attitudes towards PLWHA compared to Church One's leadership.

4.10 Analysis of additional research inquires

In regards to the inquiry *"Are HIV knowledgeable Black Church leaders more willing to adopt V.O.I.C.E.S. in its original form,"* it appears that leaders who are more knowledgeable about HIV are more willing to accept this intervention, in its original form, in the church setting. In general, Church One's leadership was more educated than those at Church Two. That is, Church One's leadership acquired more formal education (e.g. some college, college graduate, graduate degree) than Church Two's leadership. Because Church One's leadership acquired more education and has an active HIV/AIDS Ministry, it is plausible these factors made them more knowledgeable about HIV then Church Two's leadership. Moreover, since Church One was more knowledgeable about the HIV phenomenon this may have caused them to be more receptive to the concepts/ideologies of the V.O.I.C.E.S. intervention making them more willing to adopt this tool in its original form versus Church Two. Conversely, Church Two's leadership was less educated and less knowledgeable about the HIV phenomenon. Their limited education and HIV knowledge may have translated into them being more apathetic to be willing to adopt this intervention (in its original form) in the church setting (see Willingness to Adopt V.O.I.C.E.S. in its Original Form **Table 4.5**). In all, there appears to be a relationship between HIV

knowledgeable leaders and willingness to adopt the V.O.I.C.E.S. intervention within the church setting.

Table 4.5: Willingness to Adopt V.O.I.C.E.S. in its Original by Church

		Church 1 (n=6)		Church 2 (n=6)	
		N	%	N	%
Overall	Yes	5	83	4	66
	No	0	0	0	0
	Needs to be Modified	1	16	2	33

In regards to the inquiry *"Will lower levels of HIV stigma among leadership correlate to increased acceptance of V.O.I.C.E.S.in its original form,"* it appears that leadership who demonstrate lower levels of HIV stigma are more willing to accept the intervention in its original form versus leadership who have higher levels of HIV stigma. Church One's leadership were "very comfortable" with HIV and therefore demonstrated lower levels of HIV stigma and reported they were more willing to accept the V.O.I.C.E.S. intervention in its original form then Church One. On the other hand, Church Two's leadership had higher levels of HIV stigma then Church One's leadership. Church Two were less comfortable with matters pertaining to HIV/AIDS, they demonstrated higher stigmatizing attitudes towards PLWHA, and had lower levels of accepting the V.O.I.C.E.S. intervention in its original form.

4.11 V.O.I.C.E.S. acceptability by leadership

The PICO question driving this evidence-based practice quality improvement project is the following: "*in the Black Church, is leadership more willing to permit adoption of the V.O.I.C.E.S. program to increase knowledge of HIV, reduce HIV stigma, increase the use of condoms and/or promote abstinence among parishioners ages 18-35 in its original form or in a modified form?*" Results from the V.O.I.C.E.S. HIV prevention leadership survey reveals that among the 12 sampled leadership participants 75% of the participants agree "yes" that the V.O.I.C.E.S. intervention is should be presented to young adults in its original form in the church setting. Among the 12 leadership participants, 25% reported that the intervention "needs to be modified." However, no one in the sample reported "no" that the V.O.I.C.E.S. intervention in not appropriate in the church setting. Results show that there were differences between the two Black Churches regarding their level of acceptability and opinion about the V.O.I.C.E.S. intervention being implemented in the church setting. Overall, 83% of Church One's leadership participants agreed "yes" to the V.O.I.C.E.S. intervention being implemented in its original form to young adults in the church setting versus 66% of leadership participants at Church Two. Also, more participants at Church Two reported that the V.O.I.C.E.S. intervention needs to be modified in the church setting.

Leadership expressed varied opinions during the discussion phase of the intervention; themes that emerged varied based upon the Black Church intervention site. At Church One, all of the participants agreed that the V.O.I.C.E.S. intervention is appropriate for young adults in the church; however, one participant –a deacon, suggested that abstinence should be emphasized more in the church setting. Common themes that

emerged at Church One is that HIV prevention has taken the "back seat" by leadership in the Black Church despite the social significance the virus is having on the African American community. One participant – an elder, stated the following:

> "y'all may not agree with me, but we need an intervention like this for our young people. The church is ignoring this social problem as if HIV doesn't exist. We're acting like ostriches just hiding our heads in the ground pretending that this problem will go away on its own. We need to be real. Young people are having sex, despite what we're teaching them from the pulpit. We need to be practical and give them the education they need to prevent the further spread of HIV."

Most participants had nodded their heads in agreement. One participant added, "the church is okay with talking about cancer with no problem, but not [HIV]. My question is why only focus just on young adults 18-35? We need to also talk to our younger teens nowadays. We tried something like this years ago, but it did not go over well and parents did not approve of it. I think [V.O.I.C.E.S.] is needed now more than back then years ago. We should try to develop future sessions [like this] at events in our youth church…maybe on youth recreational night." Another participant stated, "I know a couple whose husband gave her AIDS and them blamed her for giving it to him. So HIV prevention is even appropriate for those who are married…" One participant brought up the notion that V.O.I.C.E.S. would be a great intervention to present to young adults because it addresses "safe sex" measures and has the potential to correct the misconception about oral sex. A participant informed the group stating, "oh, and young people get it twisted that oral sex is safe sex. I'm getting wind that oral sex is a high risk sexual activity going down at the church because our young people want to keep their virginity until marriage… but what's happenin' is that a lot of

'em are catchin' oral cancers." One participant, a deacon, agreed with the comments that were made by other leadership participants but suggested that more emphasis be placed on abstinence. He stated the following:

> "Now, I'm hearing what you all are saying, but, as a deacon, I have to stand on the principle of abstinence. Yes, I know that a lot of our youth are having pre-marital sex but we still have to teach what the Bible says about abstaining. But I do have to admit that I have a 19 year old son. Not too long ago, we went school shopping to buy supplies since he was moving into the dorms on campus. When we had finished all of our shopping I asked him 'son, do you now have anything you need' he replied, 'no dad. I need a box of condoms.'"

During the conclusion of the V.O.I.C.E.S. HIV prevention leadership workshop, consensus was reached that V.O.I.C.E.S. is an appropriate intervention to do at church for young adults 18-35. In fact, they requested the PI to return to their church again to introduce other leadership to the V.O.I.C.E.S. intervention and also conduct the intervention on their young adults. Overall, leadership participants were comfortable having all 4 core elements of the V.O.I.C.E.S. intervention presented in the church setting. Participants commended the PI's efforts and insight choosing to target Black Church leadership to get involved with HIV prevention in the church setting. A participant at Church One made concluding remarks stating "without leadership's approval nothing can be implemented…it starts with leadership. We have to get [more of] them on board [with HIV prevention]."

On the other hand, leadership participants at Church Two had mixed opinions about the V.O.I.C.E.S. intervention in the church setting. Although most, or 66%, of the

leadership participants agreed "yes" that the overall V.O.I.C.E.S. intervention is appropriate to do in the church setting, Church Two's leadership did not agree as strongly as Church One's leadership. In addition, more participants (33%) suggested that V.O.I.C.E.S. intervention needs to be modified for the church setting and that not all 4 core elements of the intervention are appropriate to be presented or talked about in the church setting. Common themes that emerged from the discussion phase of this study is that abstinence should be emphasized more than "safe sex" in the church setting or that there should be a balance between abstinence and "safe sex." One participant – a deacon, stated the following:

> "I appreciate all what you're doing and I understand that you're coming from a medical perspective. However, because this is a church I think we should focus on abstinence. I totally disagree with condom demonstrations on church premises or handing out condoms to the young adults; if we teach them how to put on condoms and pass out condoms we would be condoning them having sex. Instead, I think the church could provide [young adults] basic information about HIV and maybe show pictures of STDS –show them the consequences you could get if you have sex outside of marriage, and that might scare them to practice abstinence. If they would like to learn more about safe sex, the church can act like a liaison and bridge them to the health department or other community services where they can learn more about how to use condoms and get condoms, if needed. However, I don't agree that everything that this intervention entails should be included in the church setting, because this is a church, after-all, and we just shouldn't have condoms and penis models on church property."

Another participant – a minister, agreed with the previous comment saying "this is a church. We need to teach our young adults what is right [abstinence]. If we teach them 'safe sex' we would be promoting them to have sex." However, another participant who is an elder in the church, disagreed stating "I'm an old man and all my kids are over the age of forty. Years ago when they were young, I taught them abstinence. That worked for then. But nowadays, abstinence ain't effective. Young people are having sex and we need to be realistic that they are having sex. I think we should show something like this with our young people because there are so many diseases out there these days. Something like V.O.I.C.E.S. can help our young people protect themselves from so much that's out there." The associate pastor added, "I think we should show something like this with our youth. If I don't teach my youth about HIV prevention, the world will. Kids are eventually going to go out there and get this information somewhere else. I'd rather have them learn this type-of-stuff in the church first…learn it the right way, in the right environment." A minister augmented to the associate pastor's commented saying "as a parent, I want to be the first to teach my child about sex. There's so much stuff running rampant in the community today versus how it was when I was going up; they need to be equipped with this information. I think we should have well-informed young people; a workshop like this would be good. I do think there should be a balance, even in the church. We need to be practical and teach reality to, not just spirituality."

4.12 Black Churches that failed to participate

Church A's leadership did not participate in this evidence-based practice quality improvement project. In all, it took Church A 10 months to report that they will not be able to participate. Church A failed to participate in the V.O.I.C.E.S. HIV prevention

leadership workshop due to the V.O.I.C.E.S. video being problematic to present within their church setting. The following is a description of the sequence of events that led to Church A's withdrawal from this evidence-based practice quality improvement project.

During the recruitment phase only one Black Church leader – a female senior elder, responded to the email blast sent by the senior associate pastor's secretary. Two leadership personnel personally contacted the PI during worship services acknowledging that they saw the email and would like to participate; however, they did not respond to the secretary's email. Another leadership personnel informed that she would like to participate; she informed the PI that she did not see the email blast and stated that the email sent to leadership staff may have gotten lost in their inbox due to multiple emails being sent to them during that time period. Therefore, the PI contacted the senior associate pastor's secretary to inquire if another email blast could be sent to church leadership. The secretary informed the PI that "since only one leader responded to the email blast, we have done what we could do to help. I was told that our office is no longer going to be involved helping you on this project." After that phone conversation, the PI called the senior associate pastor regarding the matter to verify what the secretary informed him. The senior associate pastor told the PI that the church still plans to work with him regarding HIV prevention. The PI informed the senior associate pastor that there were 4 leaders who would like to participate in the V.O.I.C.E.S. HIV prevention leadership workshop and requested if he could face-to-face recruit 4 more leadership participants into the study. Initially, the senior associate pastor granted the PI approval to do so during the phone conversation, but later recanted stating that he would reach out to the Young Adult Ministry youth leaders instead. In concluding the phone conversation, the senior associate pastor apologized for

the delay in recruitment and stated he would do his absolute best to expedite the process so that the PI can implement the V.O.I.C.E.S. HIV prevention leadership workshop.

A few weeks later, the PI informed the senior associate pastor that materials of this study were going through Institutional Review Board (IRB) processing. Therefore, the PI requested written consent from the senior associate pastor, on the church's behalf, stating Church A has granted the PI permission to implement the V.O.I.C.E.S. HIV prevention workshop to their leadership. In return, the senior associate pastor requested that the PI email his secretary a formal letter explaining the objectives of the study and submit a copy of the HIV Stigma Survey and Leadership Survey in order to verify the documents. Per his request, the PI emailed the associate senior pastor's secretary providing such documents. Two days later, the senior associate pastor replied to the PI providing the following statement, "thanks for sending this information to us. After reviewing the surveys, I think that we should not show [the] video to the participants and not include some parts of the workshop that include condom demonstrations. Let me know if the committee is ok with this and I will have [my secretary] send [the head] deacon a copy of this email to offer his opinion. Thanks so much."

The PI informed the senior associate pastor that the V.O.I.C.E.S's audio-visual presentation is a critical element and that it cannot be omitted from the leadership workshop. The PI explained that omitting the condom demonstration is feasible, but without being able to present the V.O.I.C.E.S's video the church will not be able to participate in the study. The senior associate pastor responded stating, "I really would like to have [our church] do something related to HIV prevention. Please let me know what we can do." When the PI questioned the associate pastor about what was problematic about

the V.O.I.C.E.S's video, he stated "I think that [because of] the condom demonstration and because the church teaches abstinence. We do realize that many youth will not abstain, [but] personally, I would support preventive methods."

When the PI became fully aware that presenting the V.O.I.C.E.S. HIV prevention leadership workshop at Church A was no longer possible, the PI requested to retrieve the V.O.I.C.E.S.'s videos back from the senior associate pastor. However, there was considerable confusion regarding who had the V.O.I.C.E.S's videos. Ultimately, the videos were never found and the senior associate pastor told the PI that "I think that I mistakenly shredded your DVD's. I am so sorry and I will pay for the cost. Please forgive me and I really do want us to work with you on HIV prevention."

Church C's leadership also did not participate in this evidence-based practice quality improvement project due to the fact that the HIV/AIDS Ministry director and co-director were unsuccessful in recruiting leadership participants. However, they failed to periodically touch basis with the PI to inform him whether they were actively recruiting leadership participants and/or trying to coordinate the PI with key stakeholders within their church. Their limited cooperation and communication with the PI made the PI focus on recruiting Black Church leadership at other sites. The following description is the sequence of events that occurred depicting the experience why the PI was unable to present the V.O.I.C.E.S. HIV prevention leadership workshop to participants at this site.

During the recruitment phase of the study, the HIV/AIDS Ministry director became ill and was unable to be reached for nearly two months. When the PI was finally able to reach the HIV/AIDS Ministry director, she informed him that she had been hospitalized

for a week stating "my pulmonary hypertension got out of control and I was sick as a dog." She informed the PI that her suffering from pulmonary hypertension causes many leaders/parishioners within the church to inquire if she is actually HIV-positive as if she was falsely names another medical condition merely to conceal a HIV-positive serostatus. She reported that "because I've been severely sick with my pulmonary hypertension so much lately, many people within the church (especially the youth) ask me do I have HIV and question my motives for leading the HIV/AIDS Ministry."

The HIV/AIDS Ministry director told the PI that she would still attempt to recruit leadership participants for the workshop. She informed the PI that getting leadership on-board will be a difficult task to do "due to HIV-stigma" and that her pastor definitely will not participate in the workshop. She reported, "I know my pastor very well and what he thinks about HIV. He will allow you to provide the workshop, but he ain't gonna want to participate." Furthermore, the HIV/AIDS Ministry director informed the PI that leadership who does participate in the V.O.I.C.E.S. HIV prevention leadership workshop will most likely be those apart of their HIV/AIDS Ministry or familiar with HIV prevention activities.

After the proceeding conversation with the HIV/AIDS Ministry director, 3 more weeks expired and the PI did not hear back from the HIV/AIDS Ministry director. The PI attempted to call her, but only received her voicemail. The PI then called the church's office. The PI talked with the church secretary, explained who he is, and requested to be connected with the HIV/AIDS Ministry. The church secretary informed the PI that the HIV/AIDS Ministry director had been sick but she would notify the director or co-director to return the phone call. Two weeks expired after the PI talked with the church secretary. Then the PI reached out to Church A's former HIV/AIDS Ministry director – a current

deacon, informing him of the delay being experience at Church C. The deacon stated he knew Church C's HIV/AIDS Ministry co-director, who is also a church deacon. The deacon called the co-director and requested if the PI could contact him. After the co-director granted permission, the PI called the co-director via his personal cellular phone.

The PI contacted Church C's HIV/AIDS Ministry co-director via cellular phone communication. The co-director informed the PI that the HIV/AIDS Ministry director fell ill again and that he would assist the PI in recruiting participants. However, the co-director informed the PI that recruiting leadership participants will not be easy and not to get one's hope up. The HIV/AIDS Ministry's co-director briefed the PI with the following statement:

> "Black people don't really wanna come to the conclusion that HIV is problematic in our community. Ministers don't wanna talk about HIV! Leadership act like HIV ain't happening in the church. They only deal with the problem until it affects them personally – a family member, their son, their daughter, or their whoever. Think about this. Back in the day, people who had Alzheimer's disease were thought to be crazy; Black people frowned upon those types of people. And Black people who had family members suffering from Alzheimer's disease were put away into crazy houses versus how we treat them today. Just how Black people stigmatized Alzheimer's then is just how they stigmatize HIV today. HIV-stigma is real and leadership act real funny about HIV. People judge me thinking that 'oh, he must be gay or be HIV-positive since he's working within the HIV/AIDS Ministry.' I've been fighting this battle with leadership since 1996; I'm tired. It's not a gay problem as a lot of church people think... We just can't get our leadership to come on board.

They will not participate in HIV prevention activities; they are resistant! Good luck if you can do anything; this just won't happen."

At the conclusion of the conversation, the co-director instructed the PI to write a formal letter to the pastor and HIV/AIDS Ministry since the Church C needed written documentation before they submit consent to the University of South Carolina's IRB. The PI submitted the letters to the church secretary (the same generic later that was submitted to all church sites). In addition, the PI called the pastor twice leaving voicemail messages requesting to return his call. The pastor never returned the PI's call nor responded to the letter (see Church Letter **Appendix v**). The PI verified that the HIV/AIDS Ministry leaders received their letters. The PI text messaged the co-director six weeks later to verify if he had recruited any leadership participants. He replied, "no, we haven't." After that, the PI did not contact them again.

Church D did not participate in this evidence-based practice quality improvement project as well. Ultimately, the bishop's schedule was hectic and the PI did not get the opportunity to conference with him (as planned per church evangelist) to initiate the process of recruiting leadership representatives. The following description is the sequence of events that occurred depicting the experience why the PI was unsuccessful to present the V.O.I.C.E.S. HIV prevention leadership workshop to participants at Church D.

The church evangelist instructed the PI to drive to Orangeburg, South Carolina to experience their worship service and meet the bishop afterwards. The PI did just such. The PI attended their Wednesday night Bible study service and participated in their praise & worship services. Following the service, the church evangelist introduced the PI to the head

deacon whom had been previously made aware that the PI had plans to present an HIV prevention leadership workshop. In the presence of the deacon, the church evangelist told the PI "make sure you get his contact information because from tonight forward you'll have to contact him. I've done all the coordinating that I could do." After meeting the head deacon, the church evangelist introduced the PI to the bishop. The evangelist explained to the bishop who the PI is. The bishop embraced the PI and stated "it's nice to meet you. I look forward to talking with you soon on this."

The next day, the PI called the church office and talked with the church evangelist. The PI asked the church evangelist when the bishop would be available to meet regarding the EBP QI project. The evangelist stated, "I will notify bishop's secretary to set up an appointment for you. If you don't hear from her continue to wait until you do. Bishop's schedule has been hectic with providing pre-marital counseling, working for the school board, maintaining his new marriage while maintaining his duties at the church. I've done what I could do on my end, so just wait until you hear from Sister [M]." Two weeks expired and the PI did not hear from the bishop's secretary. The PI called the church office and spoke with the church evangelist notifying her that he never heard from the bishop's secretary. The church evangelist replied she would reach out to her again. However, the PI never heard from the bishop's secretary.

Because Church A, Church C, and Church D failed to participate in the V.O.I.C.E.S. HIV prevention leadership workshop, the PI recruited more Black Churches. The PI contacted seven additional Black Churches; two resided in Orangeburg, South Carolina, one resided in Rock Hill, South Carolina, and the other four resided in Columbia, South Carolina. Among the seven Black Churches recruited, only two pastors (one from

Orangeburg, South Carolina the other from Columbia, South Carolina) responded to the PI's request. Between the two pastors, only one made provision allowing his leadership to participate (see **Church E or Church 2 above**).

A pastor in Orangeburg, South Carolina initially consented to the PI presenting the V.O.I.C.E.S. HIV prevention leadership workshop to his leadership committee. In fact, the pastor stated "I would love for you to come and visit our church sometime and meet our young people. Our youth need to see other young adult African American men doing positive things in the community. I will get you in contact with the head deacon who is head over our Health Professions Ministry." The PI informed the pastor of the logistics of the V.O.I.C.E.S. HIV prevention intervention. To be noted, the more detailed information the PI provided about the V.O.I.C.E.S. workshop (e.g. condom demonstration, condom poster board presentation, etc.) the worse the pastor's speech impediment became. This was an interesting phenomenon to be noted because talking about sexual matters appeared to make the pastor uncomfortable to the extent the PI was skeptical if the pastor would actually allow his leadership to participate in the study. At the conclusion of the conversation, the PI informed the pastor written consent from the church needs to be provided to the IRB in order to move forward. The pastor had the PI contact the church secretary in order to retrieve the church's email address so that the PI could send written documentation (see Church Letter in **Appendix v**) explicitly explaining what the PI's V.O.I.C.E.S. HIV prevention leadership workshop entailed. The PI called the church office three days later to confirm that the pastor received the email. However, no one answered the phone. The PI made numerous attempts calling the church office, but failed to reach anyone. Therefore, this church did not participate in this study.

4.13 Conclusion

The HIV epidemic among young adult African Americans is serious and quite alarming in the state of South Carolina and Black Churches can play a significant role to counteract this healthcare crisis. Black Church leadership who are more knowledgeable about HIV appears to understand the implications and social significance of the HIV epidemic, thus are more likely to adopt the V.O.I.C.E.S. intervention in its original form. HIV stigma may play role to the extent how well Black Church leadership embrace the V.O.I.C.E.S. intervention being presented in the church setting; however, HIV knowledge appears to be a greater factor how well the V.O.I.C.E.S. intervention is approved by leadership.

In summary, Church One's leadership was more willing to adopt the V.O.I.C.E.S. intervention than Church Two. There may be factors why Church One's leadership accepted the V.O.I.C.E.S. intervention in its original form while Church Two was less receptive. First, housed within Church One is an active HIV/AIDS Ministry. Having an active HIV/AIDS Ministry within their church may be the reason why Church One was more knowledgeable about HIV, were more comfortable with HIV, and had lower stigmatizing attitudes towards PLWHA. Because of these elements, this is the likely reason why Church One's leadership was more receptive to adopting V.O.I.C.E.S. in its original form versus Church Two. Second, church denomination may play role to V.O.I.C.E.S. acceptability in the church setting. Church One is a Baptist church whereas Church Two is a Non-Denominational church. Differences in denomination and religious philosophical doctrine may be a contributing factor how Black Church leadership's response and preference to addressing HIV prevention among young adults. Because the V.O.I.C.E.S.

intervention places heavy emphasis on the concept of "safe sex," certain Black Church denominations may not agree with providing comprehensive sexual health information that includes condom utilization, even if they realize their parishioners are engaging in sexual activities outside the confinement of marriage.

In conclusion, there are no CDC-approved evidence-based HIV prevention interventions available that is specific to implement among young adult parishioners in the Black Church setting. Because of this, current CDC-approved interventions may need to modified to be acceptable by Black Church leadership for the church setting. This study has shown that the community-based CDC-approved V.O.I.C.E.S. HIV prevention intervention can be applicable in the Black Church setting and that leadership are willing (to some degree) to allow nursing to conduct this intervention among young adult African American parishioners 18-35. Implications from this inquiry suggest that nursing should partner with Black Church leadership to curtail evidence-based HIV prevention interventions to be applicable to their parishioners while adhering to church doctrine.

CHAPTER 5

DISCUSSION

Results of this evidence-based practice quality improvement inquiry show that there are South Carolinian Black Church leaders willing to permit HIV prevention/education services targeting young adult parishioners within the church setting. And there are Black Church leaders who are eager to collaborate with nursing about HIV prevention and willing to permit V.O.I.C.E.S to be implemented among young adults ages 18-35. Results of this inquiry also show that HIV knowledgeable Black Church leaders have lower levels of HIV stigma and appear to be more willing to adopt the V.O.I.C.E.S.'s tool in its original form than leaders less knowledgeable about the virus. This was an expected finding because it confirms the evidence that HIV knowledgeable leaders tend to be more progressive than those less knowledgeable about HIV and/or have higher stigma levels towards PLWHA.

As more and more young African Americans adults aged 18-35 get infected with HIV, it is imperative that nursing use non-traditional locals, like the Black Church, to meet them where they are to better address the healthcare crisis they are facing. Evidence shows that the Black Church may be a feasible setting nursing can use as a platform to provide HIV prevention/education services to young adult African Americans. The V.O.I.C.E.S. HIV prevention intervention appears to be a practical culturally relevant community-based intervention nursing can utilize to adapt it for the Black Church setting. In this chapter, I

will provide my recommendations for nursing practice, research, and education as it pertains to the advancement of HIV prevention in the Black Church. I will discuss this evidence-based practice quality improvement project's limitations as well as provide a general conclusion.

5.1 Recommendations for Practice

The Black Church is a local where many young adult African Americans congregate, so it has the power to influence and reach many African Americans. It recent times, the Black Church has taken on the role in providing health information, like HIV prevention, to its congregants and the broader African American community. Therefore, the Black Church can certainly play a critical role in providing HIV prevention/education to African Americans and can be used to promote the delivery of accurate information about the disease. Because nursing education place heavy emphasis on health promotion and disease prevention, providing HIV prevention education services within the Black Church setting can be an opportune local nursing can have a significant positive impact. I recommend that nursing practice utilize the Black Church as a platform to provide HIV prevention and education in order to prevent the further spread of the infection within the African American population.

There are many implications nursing practice has within the Black Church. First, nursing practice should focus on counteracting the effects of HIV stigma which pervades so deeply within the African American community. Nursing practice should work with Black Church leadership to begin the discussion about HIV and educate leadership about common myths and facts regarding the disease. To this effect, nursing practice can also

do so with parishioners. Second, nursing practice should partner with Black Churches to create a culture that can stimulate the development, implementation, and maintenance of an HIV/AIDS Ministry. Having nursing practice manage or co-manage HIV/AIDS Ministries within Black Churches appears promising because the well-respected and trusted personification of the profession may help FBOs tackle sensitive topics (e.g. variations in human sexuality and drug abuse) that have once been difficult to address within this setting. Third, nursing practice should function as liaison between the medical world and the religious world to bridge the two entities whereby African Americans can obtain comprehensive coordinated health services (pertaining to HIV) in a manner that is culturally congruent and acceptable among the biopsychosocial religious continuum.

5.2 Recommendations for Research

To date, Baker's (1999) qualitative study is the only inquiry that specifically illustrates a model how nursing can gain entry into the Black Church to provide HIV prevention/education to African American parishioners. Her research shows that nurses can play a significant role in providing HIV prevention/education within Black Churches. There is a significant gap in the literature that demonstrates how nursing can collaborate/negotiate with leadership regarding how to utilize the Black Church as a platform to provide evidence-based HIV prevention to young adult African Americans in a fashion that is congruent to the church's doctrine. Therefore, I recommend that more research be done that illustrates how nursing can (1) gain-entry into Black Churches, (2) collaborate/negotiate with Black Church leaders regarding how to adapt current CDC-approved evidence-based HIV prevention interventions in this setting, and (3) implement HIV prevention services to young adult African Americans in the Black Church setting. It

is important that more HIV prevention interventions be developed since current evidence-based interventions are not tailored to the church setting or are culturally specific for dissemination within religious institutions. Since there are no evidence-based HIV prevention interventions specific to the African Americans in the Black Church setting, I also recommend that more research be generated focusing on this phenomenon.

5.3 Recommendation for Education

There are many socio-cultural factors that place African Americans at risk for HIV and hence the current HIV epidemic among them. It is important that nursing practice educate its members to be well-informed on African American culture and their folk characteristics; and ensuring the profession has a working knowledge about common diseases, like HIV/AIDS, that are problematic within this population, have an understanding of their healthcare seeking behaviors, and possess a knowledge base how they utilize healthcare systems. I recommend that nursing practice be competent to work with these ethnic minorities in terms of providing pertinent HIV prevention information in a fashion that is culturally congruent to them.

5.4 Limitations

A sample of 32 Black Church leadership participants was originally recruited into this study; however, only 12 leadership personnel participated in the study. Therefore, one limitation of this study is its small sample size. Also, because the sampled participants were limited to two Black Churches residing in the Midlands of South Carolina, this study may not be reflective of the viewpoints of all leadership in the *Palmetto State* or be generalizable to other regions across the nation. In addition, this study is limited to the perspective of

Black Church leadership from Baptist and Non-denominational religious perspectives. Religious denomination may have an impact how leadership view the current HIV epidemic and the extent upon which Black Church leaders feel obligated to get involved in the fight against HIV. Black Church leaders from Baptist and Non-denominational congregations may have different perceptions about what their level of involvement in HIV prevention should be versus those of other church denominations. Thus, this study may not be reflective or generalizable to the leadership viewpoints of other Black Church denominations (e.g., African Methodist Episcopal, Church of God In Christ, and Presbyterian). Despite these limitations, results obtained from this inquiry are valuable for a number of reasons. First, it illustrates the processes it takes to gain-entry into Black Churches and can serve as an exemplar of the barriers to overcome when working with communities of faith. Second, it sheds light how a community-based HIV prevention intervention can be adapted into a religious setting. Third, it provides a framework for future church-based interventions to be tailored by in terms of orchestrating and implementing an HIV prevention interventions in Black Churches.

5.5 Conclusion

South Carolina is a leader among the United States in terms of high incidence of morbidity & mortality rates of chronic disease, high ranking in HIV/AIDS rates, and poor health outcomes. The current HIV epidemic in the state of South Carolina is alarming, exquisitely complex to address, and very problematic, especially within the African American population. This is rightfully so because of HIV stigma, which pervades so deeply within the African American community, as well as the socio-political powers that be governing this state.

HIV stigma is a significant contributing factor to the current HIV epidemic within the African American community. Unlike other medical conditions and diseases, it is difficult for many within the African American community (including Black Church leaders) to talk about HIV in part because of the social implications HIV acquisition/transmission entails – homosexuality, promiscuous lifestyles, drug use, and drug abuse. These social implications are socially and culturally taboo to talk about and keep many silent. Despite the difficulty to talk about HIV acquisition/transmission among friends, family, public forums, and larger social entities, this does not negate the fact that many are still engaging in various lifestyles "*on the hush*" while HIV disseminates rapidly through the African American community. Breaking the silence about HIV is imperative to counteract HIV stigma in the fight against HIV. As health educators and trusted members within the African American community, nurses can play a significant role in breaking the silence about HIV and moving the discussion forward. It is imperative, however, that nurses be culturally competent and comfortable with matters regarding sexual health, variations in human sexuality, and substance abuse.

Although HIV stigma plays a role to the HIV epidemic among African Americans, current policies keep South Carolinian African Americans vulnerable to the continuation of disproportionately high HIV/AIDS rates. Because South Carolina's political leaders value the practice of abstinence until marriage, South Carolinian African American youth are not acquiring the comprehensive sexual health education needed in secondary education in order to make "safer sex" decisions if they chose to engage in sexual activities prior to marriage. Knowledge is power and, unfortunately, African American youth are not being equipped with sexual health education that can empower them to protect themselves

from HIV. This may explain why African American youth 13-24 are leaders among the nation in terms of having the highest rates of HIV for any metropolitan statistical area. If South Carolina's leaders would invest more into African American youth's sexual health education, perhaps their high rates of HIV and STDs may decrease which can potentially save the *Palmetto State* millions of dollars overtime due to less youth requiring HIV therapeutic modalities.

Moreover, evidence shows that institutionalized settings are a breeding ground for HIV transmission and disproportionately more African American males are incarcerated and confined to institutionalized settings in South Carolina. Unfortunately, South Carolinian political leaders are oblivious to the fact that some inmates are engaging in sexual activities while incarcerated. This is expressed by political leaders not permitting condoms to be purchased or distributed to inmates, their action changing the law to desegregate HIV-positive from HIV-negative inmate living spaces, and not requiring a "test-out" procedure to screen inmates for HIV once they leave correctional facilities. These policies don't help to counteract the disproportionate HIV rates among African American males. In fact, these policies help facilitate the propagation of HIV/AIDS among African American male inmates and may place the broader South Carolinian African American population at risk for HIV once inmates are released into the community. There are significant implications to work with legislators to reverse these policies to counteract the effects HIV/AIDS is having on the African American community.

Despite the existing institutionalized barriers that exist which prevent South Carolinian African Americans from acquiring HIV prevention health information/tools, the institution of the Black Church has so much potential to address the current HIV epidemic

that is burdening the African American community. In recent times, the Black Church has taken on the role of addressing many of the health disparities, including HIV/AIDS to some extent, currently burdening the African American community. Although the Black Church has great potential to counteract the HIV/AIDS epidemic among its people, HIV stigma plays a huge factor that hinders its potential. My experience working with Black Churches in the Midlands taught me that HIV stigma is real, it still exists, and it can be a barrier to gaining access into this setting. Even though some Black Churches advertise that they have HIV/AIDS Ministries, the implementation phase of this evidence-based practice project inquiry taught me that some Black Churches have storefront HIV/AIDS Ministries that appear to be alive (or active) on the outside but are actually dead, or dormant, within their church walls. HIV/AIDS Ministries are dead in part because many persons within leadership are ashamed to congregate and talk about matters pertaining to HIV (e.g. prevention, education, acquisition, transmission, etc.). It is my impression that many within leadership may not want to start the dialogue about HIV because they are in denial about the significance of the disease or that it may in fact take some leadership personnel "back down memory's lane" reminding them of the promiscuous lifestyles they may have once practiced before converting to living the Christian lifestyle. It is also my impression that many within leadership do not want to address HIV to the extent it should be addressed in part because they worry about what others think; some leaders aim to be politically correct and do not want to rustle feathers by challenging rudimentary old mindsets of other leadership personnel or their congregants.

Although prevalence of HIV-stigma abounds in many Black Churches, there are some Black Churches who embrace educating their parishioners about the disease. Black

Churches that provide HIV/AIDS prevention/education can serve as models for other churches to follow. In order for HIV prevention education to be delivered within Black Churches, it is imported nursing collaborate with leadership to assess and adhere to their preferred way of teaching HIV/AIDS to their congregants. Nursing can be instrumental by providing culturally relevant educational resources to Black Churches to increase congregants' knowledge/awareness about the disease while decreasing associated stigma.

My experience doing this evidence-based practice quality improvement project taught me that there are Black Church leaders who are willing to collaborate with nursing about HIV prevention and are willing to allow HIV prevention interventions to be implemented within their church setting. Never-the-less, it is imperative that nurses know their audience and be cognizant that some topics/concepts pertaining to HIV prevention can be very sensitive and may not acceptable to present among some Black Church leaders. For example, the V.O.I.C.E.S. intervention includes doing a condom demonstration and distributing condom products to participants may be very problematic for some church leaders. Doing a condom demonstration before some Black Church leaders may also be problematic. So it is imperative to collaborate with pastors regarding sensitive issues like this prior to presenting HIV prevention/education to their leadership staff.

As the Black Church starts to take an active role in addressing various medical problems and social determinants of health burdening the African American community nursing should partner with Black Churches in effort to provide HIV prevention/education to young adult congregants. This evidence-based practice quality improvement project shows that nurses can utilize the well-known community-based HIV prevention intervention V.O.I.C.E.S. and adapt it to the Black Church setting. Although some

elements of the V.O.I.C.E.S. intervention, like condom demonstration, may need to be modified for the Black Church setting, most leadership personnel may find this intervention relative and pertinent to present to young adults ages 18-35. Nurses inquiring to employ evidence-based practice HIV prevention interventions within the Black Church setting should consider implementing the V.O.I.C.E.S. HIV prevention intervention.

REFERENCES

Abenaa, A. (2011). Economic and social barriers to HIV/AIDS testing in African American college men. *The University of Maryland McNair Scholars Undergraduate Research Journal*, Vol. 3, p 11-24.

Adimora, A., Schoenbach, V. & Doherty, I. (2006). HIV and African Americans in the Southern United States: Sexual networks and social context. *Sexually Transmitted Disease*, Vol. 33, No. 7, p.39-45.

AIDS Benefit Foundation of South Carolina (2014). HIV & AIDS statistics. Retrieved 10/20/14 from http://abfsc.org/SideBar_A.htm

AIDS.gov (2015). U.S. statistics. Retrieved 11/1/15 from https://www.aids.gov/hiv-aids-basics/hiv-aids-101/statistics/

AIDSMap, (2014). HIV & AIDS: sharing knowledge, changing lives. Retrieved May 31, 2014 from http://www.aidsmap.com/Reasoned-action-model/page/1768410/

AIDSVU (2015). Retrieved 1/8/15 from http://aidsvu.org/state/south-carolina/

American Cancer Society Cancer Action Network. (2009). Cancer disparities: a chart book. Retrieved 3/17/2014 from http://action.acscan.org/site/DocServer/cancer-disparities-chartbook.pdf?docID=15341

American Sociological Association. (2005). Rack, ethnicity and the health of Americans. ASA Syndney S. Spivack program; American Sociological Association series on how race and ethnicity matter.

Anderson, T. (2010). HIV in Black women: it's not about men on the down low. Black AIDS Institute. The Body: the complete HIV/AIDS resource. http://www.thebody.com/content/art55695.html?ic=2004 retrieved 12/16/13

Augustin and Bridges (2008). How social and cultural forces lead to unequal risk for African Americans/Black. Advocates for Youth. Retrieved 12/2/13 from http://www.advocatesforyouth.org/publications/524-understanding-disparities-in-the-hiv-epidemic-?tmpl=component&print=1&page=

Avert (2013). HIV & AIDS among African Americans. Retrieved10/7/13 from Avert.org website http://www.avert.org/hiv-aids-among-African Americans.htm

Avert (2014). HIV & AIDS stigma and discrimination. Retrieved 4/25/14 from http://www.avert.org/hiv-aids-stigma-and-discrimination.htm

Avert (2015). HIV & AIDS in the United States of America (USA). Retrieved 11/5/15 from http://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa

Baker, S. (1999). HIV/AIDS, nurses, and the Black church: A case study. *Journal of the Association of Nurses in AIDS Care*, Vol. 10, No. 5, September/October 1999, p. 71-79.

Baker, J. L., Brawner, B., Cederbaum, J. A., White, S., Davis, Z. M., Brawner, W., & Jemmott, L. S. (2012). Barbershops as Venues to Assess and Intervene in HIV/STI Risk Among Young, Heterosexual African American Men. *American Journal of Men's Health*, *6*(5), 368–382. DOI: 10.1177/1557988312437239

Beadnell, B., Baker, S., Gillmore, R., Morrison, D., Huang, B. and Stielstra, S. (2008). The theory of reasoned action and the role of external factors on heterosexual men's monogamy and condom use. *Journal of Applied Social Psychology*. Vol. 38, No. 1, pp. 97-134. Blackwell Publishing, Inc.

Beatty, L., Wheeler, D. & Gaiter, J. (2004). HIV prevention research for African Americans: Current and future direction. Retrieved 10/7/13 from http://www.hawaii.edu/hivandaids/HIV_Prevention_Research_for_African_Americans__Current_and_Future_Directions.pdf

Berkley-Patton, J. Y., Moore, E., Berman, M., Simon, S. D., Thompson, C. B., Schleicher, T., & Hawes, S. M. (2013). Assessment of HIV-related stigma in a US faith-based HIV education and testing intervention. *Journal of the International AIDS Society*, *16*(3(Suppl 2)). doi:10.7448/IAS.16.3.18644

Berry, M., Raymond, H. F., & McFarland, W. (2007). Same race and older partner selection may explain higher HIV prevalence among black men who have sex with men. *AIDS (London, England)*, *21*(17), 2349–2350. doi:10.1097/QAD.0b013e3282f12f41

Bond, L., Wheeler, D. P., Millett, G. A., LaPollo, A. B., Carson, L. F., & Liau, A. (2009). Black men who have sex with men and the association of down-low identity with HIV risk behavior. *American Journal of Public Health*, *99*(Suppl 1), S92–S95. doi:10.2105/AJPH.2007.127217

Bontempi, J. M. B., Eng, E., & Quinn, S. C. (2008). Our Men Are Grinding Out: A Qualitative Examination of Sex Ratio Imbalances, Relationship Power, and Low-

Income African American Women's Health. *Women & Health, 48*(1), 63–81. DOI: 10.1080/03630240802132005

Bowleg, L., Mingo, M., & Massie, J. S. (2013). "The Skill Is Using Your Big Head Over Your Little Head" What Black Heterosexual Men Say They Know, Want, and Need to Prevent HIV. *American Journal of Men's Health*, *7*(4 suppl), 31S–42S. DOI: 10.1177/1557988313483305

Bowleg, L., Teti, M., Massie, J. S., Patel, A., Malebranche, D. J., & Tschann, J. M. (2011). "What does it take to be a man? What is a real man?": ideologies of masculinity and HIV sexual risk among Black heterosexual men. *Culture, Health & Sexuality*, *13*(5), 545–559. doi:10.1080/13691058.2011.556201

Boston University School of Public Health (2013). The health belief model. Retrieved 5/23/14 from http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-Models/SB721-Models2.html

Boston University School of Public Health (2013). Theory of planned behavior. Retrieved 5/26/14 from http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-Models/SB721-Models3.html

Braithwaite, R. & Arriola, K. (2008). Male prisoners and HIV prevention: a call for action ignored. *American Journal of Public Health Association.* Volume 98 (Suppl 1): S145-S149.

Campinha-Bacote, J. (2009). A culturally competent model of care for African Americans.

CDC (2007). A heightened national response to the HIV/AIDS crisis among African Americans. Retrieved 9/14/13 from

http://www.huffingtonpost.com/2013/02/07/national-black-hiv-aids-day_n_2641287.html

CDC (2015). HIV among African American gay and bisexual men. Retrieved November 1, 2015, from http://www.cdc.gov/hiv/group/msm/bmsm.html

CDC (2008). HIV/AIDS among women. Retrieved November 15, 2013, from http://www.cdc.gov/hiv/topics/women/resources/factsheets/pdf/women.pdf

CDC (2015). HIV among women. Retrieved November 1, 2015, from http://www.cdc.gov/hiv/pdf/risk_women.pdf

CDC (2010). HIV – Human Immunodeficiency Virus and Acquired Immunodeficiency Virus (AIDS). Retrieved 10/7/13 from http://www.cdc.gov/breastfeeding/disease/hiv.htm CDC (2012). HIV in Correctional Settings. Retrieved 10/7/13 from http://www.cdc.gov/hiv/topics/correctional/

CDC (2015). HIV in the United States: at a glance. Retrieved 10/27/15 from http://www.cdc.gov/hiv/statistics/basics/ataglance.html

CDC (2013). HIV testing in the United States. Retrieved 9/28/13 from http://www.cdc.gov/nchhstp/newsroom/docs/HIV-Testing-US-508.pdf

CDC (2013). Leading causes of death in males United States. Retrieved 11/5/15 from http://www.cdc.gov/men/lcod/

CDC (2013). Leading causes of death by age Group, Black females-United States. Retrieved 11/5/15 from http://www.cdc.gov/women/lcod/2013/WomenBlack_2013.pdf

CDC (2013). 30 years of HIV in African American communities: A timeline. Retrieved 9/15/13from http://www.cdc.gov/nchhstp/newsroom/docs/timeline-30years-hiv african american-community-508.pdf

CDC (2010). The role of STD detection and treatment in HIV prevention. Retrieved 9/14/13 from http://www.cdc.gov/std/hiv/stdfact-std-hiv.htm.

ChoiceHIV (2014). California HIV options: interventions, collaboration, and everything. Retrieved 10/12/13 from http://choicehiv.org/interventions/interventions.php?action=intervention_details&intervention_id=68&render=html

Choi, K., Yep, G. and Kumekawa, E. (1998). HIV prevention among Asian and Pacific Islander American men who have sex with men: a critical review of theoretical models and directions for future research. *AIDS Education and Prevention*, 10, Supplement A, 19-30.

Cohen, J (1988). Statistical power analysis for the Behavioral Sciences. Department of Psychology. New York University. Lawrence Erlbaum Associates, Hillsdale New Jersey.

C-Span (n.d.). African American men: video clip Retrieved 2/5/14 from http://colorlines.com/archives/2010/07/the_truth_about_the_down_low_and_hiv.html

Culture and Diversity Issues. *Society of Urologic Nurses and Associates, Urologic Nursing*. Vol. 29, No. 1.

Dean, H. D., & Fenton, K. A. (2010). Addressing Social Determinants of Health in the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections, and Tuberculosis. *Public Health Reports*, *125*(Suppl 4), 1–5.

De Fede, Stewart, Hardin, Mayfield-Smith, Sudduth (2011). Spatial visualization of multivariate datasets: an analysis of STD and HIV/AIDS diagnosis rates and socioeconomic context using ring maps. *Association of Schools of Public Health*. Public Health Reports, Supplement 3, Vol. 126, p 115 -126.

DHEC (2012). An epidemiologic profile of HIV and AIDS in South Carolina 2012. Retrieved 8/31/14 from http://www.scdhec.gov/health/docs/pp_2012_SC_HIV_EpiProfile.pdf

DHEC (2013). National Black HIV/AIDS Awareness Day events scheduled. Retrieved 10/7/13 from http://www.scdhec.gov/administration/news/2013/nr20130204-01.htm

DHEC (2012). South Carolina 2012 Ryan White HIV/AIDS statewide coordinated statement of need and comprehensive plan. STD/HIV Division South Carolina DHEC. Retrieved 9/24/13 from http://www.scdhec.gov/health/disease/stdhiv/docs/2012%20SouthCarolinaSCSNandCompPlan.pdf

Edberg, M. (2006). Essentials of health behavior: Social and behavioral theory in public health. Health Belief Model. Chapter 4. Jones & Bartlett Learning, LLC.

Estabrooks P., Nelson, C., Xu, S., King, D., Bayliss, E., Gaglio, B., Nutting, P. and Glasgow, R. (2005). The frequency and behavioral outcomes of goal choices in the self-management of

diabetes. *Diabetes Educator, 31*(3), 391-400. Retrieved 9/7/13 from http://abfsc.org/SideBar_A.htm

Fertman, C. & Allensworth, D. (2010). Health promotion programs from theory to practice. *Society for Public Health Education*. John Wiley & Sons. ISBN 978-0-470-24155-4.

Fauci, A. (2010). National Black HIV/AIDS awareness day February 7, 2010. *States News Service*. Retrieved from http://www.highbeam.com/doc/1G1-218201382.html

Fields, E. L., Bogart, L. M., Smith, K. C., Malebranche, D. J., Ellen, J., & Schuster, M. A. (2012). HIV risk and perceptions of masculinity among young Black men who have sex with men. *Journal of Adolescent Health, 50*(3), 296–303. doi:10.1016/j.jadohealth.2011.07.007

Frew, P., Archibald, M., Martinez, N., Rio, C., and Mulligan, M. (2007). Promoting HIV vaccine research in African American communities: Does the theory of reasoned action explain potential outcomes of involvement. Challenge (Atlanta Ga). Vol. 13, No. 2, p. 61-97.

Goparaju, L., & Warren-Jeanpiere, L. (2012). African American women's perspectives on "down low/DL" men: implications for HIV prevention. *Culture, Health & Sexuality, 14*(8), 879–893. doi:10.1080/13691058.2012.703328

Harvey, S. M., & Bird, S. T. (2004). What makes women feel powerful? An exploratory study of relationship power and sexual decision-making with African Americans at risk for HIV/STDs. *Women & Health, 39*(3), 1–18. DOI: 10.1300/J013v39n03_01

Health and Human Development Programs Education Development Center (2009). Effective bilingual HIV/STD prevention intervention with demonstrated effectiveness in: STD clinics. Education Development Center, Inc. Retrieved August 22, 2014 from https://www.effectiveinterventions.org/Files/09-1029_Admin_Preview_Guide-VOICES.pdf

Healthy People 2020 (2013). Healthy people 2020 HIV objectives. Retrieved 9/17/13 from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=22

Heeren, G. A., & Jemmott, J. B., 3rd. (2011). Health Promotion: Results of focus groups with African American men. *Journal of Men's Health*, *8*(1), 50–55. doi:10.1016/j.jomh.2010.11.002

Henny, K. D., Crepaz, N., Lyles, C. M., Marshall, K. J., Aupont, L. W., Jacobs, E. D., … Charania, M. R. (2012). Efficacy of HIV/STI behavioral interventions for heterosexual African American men in the United States: a meta-analysis. *AIDS and Behavior*, *16*(5), 1092–1114. DOI: 10.1007/s10461-011-0100-2

Hodder, S. L., Justman, J., Haley, D. F., Adimora, A. A., Fogel, C. I., Golin, C. E., O'Leary, Soto-Torres, Wingood, El-Sadr, (2010). HIV Prevention Trials Network Domestic Prevention in Women Working Group. (2010). Challenges of a hidden epidemic: HIV prevention among women in the United States. *Journal of Acquired Immune Deficiency Syndromes (1999)*, *55 Suppl 2*, S69–73. doi:10.1097/QAI.0b013e3181fbbdf9

Ivy, W., Miles, I., Le, B., & Paz-Bailey, G. (2013). Correlates of HIV infection among African American women from 20 cities in the United States. *AIDS and Behavior*. DOI: 10.1007/s10461-013-0614-x

Jeffreys, M. (2006). Teaching cultural competence in nursing and health care: Inquiry, action and innovation.

Kabiru, C. W., Beguy, D., Crichton, J., & Zulu, E. M. (2011). HIV/AIDS among youth in urban informal (slum) settlements in Kenya: What are the correlates of and motivations for HIV testing? *BMC Public Health*, *11*, 685. DOI: 10.1186/1471-2458-11-685

Kaiser Family Foundation (2014). Black Americans and HIV/AIDS. Retrieved 8/2015 from http://kff.org/hivaids/fact-sheet/black-americans-and-hiv-aids/

Kaiser Family Foundation (2013). The Kaiser commission on Medicaid and the uninsured. Retrieved 9/23/13 from http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8460-health-coverage-for-the-black-population-today.pdf

Kaiser Family Foundation. (2013). Women and HIV/AIDS in the United States. Retrieved November 14, 2013, from http://kff.org/hivaids/fact-sheet/women-and-hivaids-in-the-united-states/

Kalmuss, D., & Austrian, K. (2010). Real Men Do…Real Men Don't: Young Latino and African American Men's Discourses Regarding Sexual Health Care Utilization. *American Journal of Men's Health*, *4*(3), 218–230. DOI: 10.1177/1557988309331797

Kanu, A. (1997). Behavior intention and use of condoms for HIV/AIDS prevention among rural African American students. *The Health Education Monograph Series*. Vol 15. No. 2.

Lindley, L. L., Coleman, J. D., Gaddist, B. W., & White, J. (2010). Informing faith-based HIV/AIDS interventions: HIV-related knowledge and stigmatizing attitudes at project F.A.I.T.H. churches in South Carolina. *Public Health Reports, 125*(Suppl 1), 12–20.

Laurencin, C., Christensen, D. & Taylor, E. (2008). HIV/AIDS and the African American community: A state of emergency. *Journal of National Medical Association*; 100:35-43.

McNair, L. D., & Prather, C. M. (2004). African American women and AIDS: factors influencing risk and reaction to HIV disease. *Journal of Black Psychology, 30*(1), 106–123. DOI: 10.1177/0095798403261414

NAACP (2015). Criminal justice fact sheet. Retrieved 11/5/2015 from http://www.naacp.org/pages/criminal-justice-fact-sheet#

NAACP (2013). Health care fact sheet: Health disparities. Retrieved 10/7/13 from http://www.naacp.org/pages/health-care-fact-

NAACP (2013). The Black church & HIV: the social justice imperative. Retrieved 9/25/13 from http://www.theblackchurchandhiv.org/

NASTAD. (2010). Black Women and HIV/AIDS: Finding for Southeast Regional Consumer and Provider Focus Group Interviews. Retrieved November 14, 2013, from http://www.nastad.org/Docs/highlight/201038_NASTAD%20final.pdf

Neumann, O'Donnell, Doval, Schillinger, Blank, Ortiz-Rios, Garcia, and O'Donnell, 2011. Effectiveness of the VOICES/VOCES sexually transmitted disease/human immunodeficiency virus intervention when administered by health department staff: does it work in the "real world"? *Sexually Transmitted Diseases*. Volume 38, number 2, p 133-139. DOI: 10.1097/OLQ.0b013e3181f0c051.

Nunn, A., Cornwall, A., Chute, N., Sanders, J., Thomas, G., James, G., … Flanigan, T. (2012). Keeping the faith: African American faith leaders' perspectives and recommendations for reducing racial disparities in HIV/AIDS infection. *PLoS ONE, 7*(5). DOI: 10.1371/journal.pone.0036172

Nunn, A., Cornwall, A., Thomas, G., Callahan, L., Waller, A., Friend, R., Broadnax, J. & Flanigan, T. (2013). What's God got to do with it: Engaging African American faith-based institutions in HIV prevention. *Global Public Health*, Vol. 8, No. 3, p 258-269.

Nunn, A., Cornwall, A., Thomas, G., Waller, P. A., Friend, R., Broadnax, P. J., & Flanigan, T. (2013). What's God got to do with it? Engaging African American faith-based institutions in HIV prevention. *Global Public Health*, *8*(3), 258–269. doi:10.1080/17441692.2012.759608

Nunn, A., Dickman, S., Cornwall, A., Kwakwa, H., Mayer, K. H., Rana, A., & Rosengard, C. (2012). Concurrent sexual partnerships among African American women in

Philadelphia: results from a qualitative study. *Sexual Health, 9*(3), 288–296. DOI: 10.1071/SH11099

O'Donnell, Doval, Duran, and O'Donnell (1995). Video based sexually transmitted disease patient education: its impact on condom acquisition. American Journal of Public Health, 85:817-822.

Palmetto AIDS Life Support Services. Retrieved 10/2/13 from http://www.palss.org/

Parker, R., Aggleton, P., Attawell, K., Pulerwitz, J. and Brown, L. (2002). HIV/AIDS-related stigma and discrimination: A conceptual framework and an agenda for action. The Population Council Inc. Retrieved 10/21/14 from http://www.popcouncil.org/uploads/pdfs/horizons/sdcncptlfrmwrk.pdf

Paxton, K., Villarreal, B. and Hall, N. (2013). Increasing knowledge of HIV transmission: An important ingredient in HIV risk reduction among African American women attending community college. *Journal of HIV/AIDS & Infectious Diseases*. Vol (2): 101, p. 1-8.

Payne, J. W. (2008). The black woman's burden: an epidemic of HIV. The AIDS virus weighs heavily on straight African American women, not just gay men. *U.S. News & World Report*, *145*(8), 64, 66.

Peterson, J. and Jones, K. (2009). HIV prevention for black men who have sex with men in the United States. *American Journal of Public Health*, *99*(6), 976–80. doi:10.2105/AJPH.2008.143214

Petri, L. (2010). Concept analysis of interdisciplinary collaboration. Nursing Forum, April-June, Vol 45, No. 2. Wiley Periodicals, Inc.

Pew Research Center (2014). Religion & public life project: religious landscape survey. Retrieved 10/19/14 from http://religions.pewforum.org/maps

Pittiglio, L., Jackson, F., & Florio, A. (2012). The relationship of self-esteem and risky sexual behaviors in young African American women. *Journal of National Black Nurses' Association: JNBNA*, *23*(1), 16–20.

Pouget, E. R., Kershaw, T. S., Niccolai, L. M., Ickovics, J. R., & Blankenship, K. M. (2010). Associations of sex ratios and male incarceration rates with multiple opposite-sex partners: potential social determinants of HIV/STI transmission. *Public Health Reports*, *125*(Suppl 4), 70–80.

Poundstone, K., Strathedee, S. and Celentano, D. (2004). The social epidemiology of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome. *Public Health & Epidemiology*, Vol.26, issue 1, p 22-35.

Prejean, J., Irene Hall H & Tang, T. (2012). HIV diagnoses and prevalence in the southern region of the United States, 2007-2010. *Journal of Community Health* 38:414-426. DOI: 10.1007/s10900-012-9633-1

Pryor, C., Siu, V., Guilbault, D., and Ofuatey-Kodjoe, N. (2009). Why us? Left behind and dying. Retrieved 9/7/13 from http://www.cultureunplugged.com/documentary/watch-online/play/10847/Why Us--Left-Behind-and-Dying

Raymond, H. & McFarland, W. (2009). Racial mixing and HIV risk among men who have

sex with men. *AIDS Behavior*, vol. 13, p 630-637. Springer Science + Business Media, LLC.

Rosenstock, I., Strecher, V. and Becker, M. (1994). The health belief model and HIV risk behavior change. In R.J. DiClemente and J.L. Peterson (Eds.), Preventing AIDS: Theories and methods of behavioral interventions (pp. 5-24). New York: Plenum Press.

Radcliffe, J., Doty, N., Hawkins, L. A., Gaskins, C. S., Beidas, R., & Rudy, B. J. (2010). Stigma and sexual health risk in HIV-positive African American young men who have sex with men. *AIDS Patient Care and STDs*, *24*(8), 493–499. doi:10.1089/apc.2010.0020

Raj, A., & Bowleg, L. (2012). Heterosexual risk for HIV among black men in the United States: a call to action against a neglected crisis in black communities. *American Journal of Men's Health*, *6*(3), 178–181. DOI: 10.1177/1557988311416496

Reif, S., Pence, B., Hall, I., Hu, X., Whetten, K., & Wilson, E. (2014). HIV diagnoses, prevalence and outcomes in nine Southern states. *Journal of Community Health.* DOI 10.1007/s10900-014-9979-7

Reif, S., Whetten, K., & Wilson, E. (n.d.). HIV/AIDS Epidemic in the South Reaches Crisis Proportions in Last Decade. Retrieved November 14, 2013, from http://www.indyweek.com/images/blogimages/2011/12/08/1323374055-research_report_final_with_cover.pdf

Reif, Wilson, Sullivan, Safley, & Whetten (2013). HIV/AIDS in metropolitan statistical areas: 9 southern states. Retrieved 6/7/2014 from http://southernaidsstrategy.org/research/

Sales, J. M., DiClemente, R. J., Davis, T. P., & Sullivan, S. (2012). Exploring why young African American women do not change condom-use behavior following participation in an STI/HIV prevention intervention. *Health Education Research*, *27*(6), 1091–1101. doi:10.1093/her/cys059

Sandfort, T. G. M., & Dodge, B. (2008). "...And then there was the down low": introduction to Black and Latino male bisexualities. *Archives of Sexual Behavior*, *37*(5), 675–682. DOI: 10.1007/s10508-008-9359-4

SC DHEC. (2013). HIV/AIDS among African American women in South Carolina. Retrieved November 14, 2013, from http://www.scdhec.gov/health/disease/stdhiv/docs/AfricanAmericanWomenHIV_SC_FactSheet2013.pdf

Sharma & Romas (2012). Theoretical foundations of health education and health promotion. Second Edition. Jones & Bartlett Learning. ISBN 978-0-7637-9611-2

Sharpe, T. T., Voûte, C., Rose, M. A., Cleveland, J., Dean, H. D., & Fenton, K. (2012). Social determinants of HIV/AIDS and sexually transmitted diseases among black women: implications for health equity. *Journal of Women's Health*. *Supplement 21*(3), 249–254. doi:10.1089/jwh.2011.3350

Sitzman, K. & Eichelberger, L. (2003). Understanding the work of nurse theorist: A creative beginning. Jones & Bartlett Learning. ISBN 10: 0763747661

South Carolina DHEC (2013). Housing opportunities for people with AIDS: Grantee and community profile. Retrieved 9/24/13 from http://www.scdhec.gov/health/disease/stdhiv/hopwa.htm

South Carolina HIV/AIDS Council. Retrieved 10/2/13 from http://www.palss.org/

South Carolina DHEC (2013). 2013 HIV/AIDS summary: South Carolina. Retrieved 10/20/14 https://www.scdhec.gov/health/docs/stdhiv/2013Epi-FS-SC.pdf

South Carolina DHEC (2013). South Carolina's STD/HIV/AIDS data. Retrieved 10/20/14 from http://www.scdhec.gov/Health/docs/Surveillance%20Report%202013.pdf

Stampley, C. D., Mallory, C., & Gabrielson, M. (2005). HIV/AIDS among midlife African American women: an integrated review of literature. *Research in Nursing & Health, 28*(4), 295–305. doi:10.1002/nur.20083

Sterk, C. E., Klein, H., & Elifson, K. W. (2005). Self-Esteem and "at risk" women: determinants and relevance to sexual and HIV-related risk behaviors. *Women & Health, 40*(4), 75–92. DOI: 10.1300/J013v40n04_05

Sylla, Harawa, & Reznick (2010). The first condom machine in a US jail: the challenge of harm reduction in a law and order environment. *American Journal of Public Health.* 100(6) 982-985. DOI: 10.2105/AJPH.2009.172452

Trzynka, S. L., & Erlen, J. A. (2004). HIV disease susceptibility in women and the barriers to adherence. (Clinical Practice). *MedSurg Nursing*. Retrieved from http://www.highbeam.com/doc/1G1-115972328.html

United States Census Bureau (2014). Retrieved 10/16/14 from http://quickfacts.census.gov/qfd/states/45000.html

U.S. Department of Health and Human Services (2005). Theory at a glance: A guide for health promotion practice. Retrieved 6/17/14 from http://www.sbccimplementationkits.org/demandrmnch//wp-content/uploads/2014/02/Theory-at-a-Glance-%E2%80%93-A-Guide-For-Health-Promotion-Practice.pdf

University of Twente (2014). Health belief model: Explaining health behaviors. Retrieved 6/1/14 from http://www.utwente.nl/cw/theorieenoverzicht/theory%20clusters/health%20communication/health_belief_model/

Valbrun, M. (2015). Black males missing from college campuses. *America's Wire.* Maynard Media Center on Structural Inequity. Retrieved 11/5/15 from http://americaswire.org/drupal7/?q=content/black-males-missing-college-campuses

Vyavaharkar, M (2010). The relationships between depression and HIV-related stigma, disclosure of HIV-positive status, and social support among African American women with HIV disease living in the rural southeastern United States. *Journal of the Association of Nurses in AIDS Care*, 21 (2): 144 -152.

Washington, R. (2008). The relationship between African American clergy and lay leaders' beliefs, knowledge and behavioral intentions on HIV/AIDS prevention program resources. ProQuest Information and Learning Company. UMI Dissertations. ISBN: 9780549438175

WebMD (2013). HIV and AIDS in Blacks: an alarming crisis. Retrieved 9/16/13 from http://www.webmd.com/hiv-aids/hiv-aids-in-blacks-alarming-crisis

Williams, J., Ramamurthi, H., Manago, C. and Harawa, N. (2009). Learning from successful interventions: A culturally congruent HIV risk-reduction intervention for African American men who have sex with men and women. *American Journal of Public Health*. Vol. 99, No. 6.

Williams, Wyatt, and Wingood (2010). The four Cs of HIV prevention with African Americans: crisis, condoms, culture, and community. Current HIV/AIDS Reports, vol. 7, p. 185-193. DOI: 10.1007/s11904-010-0058-0

Wilson, Wittlin, Munoz-Laboy, and Parker (2011). Ideologies of Black churches in New York City and the public health crisis of HIV among Black men who have sex with men. *Global Public Health; 6*(*Suppl 2*):S227-S242. Doi:10.1080/17441692.2011.605068

Wilson, P., Wright, K., & Isbell, M. (2008). Left behind. Black America: A neglected priority in the global AIDS epidemic. Black AIDS Institute, Los Angeles, CA.

Wright (2010). The truth about the "down low" and HIV. Colorlines. Retrieved 12/6/13 from http://colorlines.com/archives/2010/07/the_truth_about_the_down_low_and_hiv.html

Wolitski, Jones, Wasserman, & Smith (2006). Self-Identification as "down low" among men who have sex with men (MSM) from 12 US cities. *AIDS Behavior*, 10, 519 529.

Young and McLeod (2013). The disproportionality of HIV transmission among Black men who have sex with men (BMSM): recommendations for an effective prevention model. *Advances in Social Work* vol.14 no.2, p 442-457.

APPENDIX A

EVIDENCE TABLE

Brief Reference	Type of study/ Quality rating	Methods	Threats to validity/ reliability	Findings	Conclusions
Aaron, E., Yates, L. & Criniti, S. (2011)	Case Reports **N=214** 3	**Three organizations – a faith-based organization (FBO), a community-based maternal health organization, and an HIV medical clinic associated with a university, formed a "Partnership" to address the HIV epidemic via using the Black Church. The researchers describe how the Partnership expanded a FBO's capacity to decrease HIV stigma, increase HIV education and**	**Limited to one Black Church in Pennsylvania; may not be generalizable to all Black Churches.**	**Results from the HIV Knowledge pre-test showed that adults had more initial knowledge about HIV than adolescents, 75.3% versus 41.9%, respectively. Both adults and adolescent's post-test HIV Knowledge scores increased, but adults continued to score higher on the HIV Knowledge than adolescents. Among the 145 parishioners and**	**Because the HIV epidemic disproportionately continues to impact the African American community and the Black Church plays a significant role in their lives, Black Churches are in a great position to implement HIV prevention programs that can alleviate the epidemic. Evidence**

		awareness in an African American community by a series of workshops/events. The Partnership secured buy-in and assistance from key stakeholders in the church community; the pastor granted full support for the Partnership to provide HIV promotion of educational sessions geared for adults and teens in the congregation. The pastor delegated selected ministry leaders to place emphasis of HIV awareness events during Sunday services; the Partnership was allowed to speak directly from the pulpit during a Sunday service to describe the goals of the Partnership.		**community members who screened for HIV, all received their results within the appropriate time period to learn their results. There were no HIV-positive results. Researchers demonstrate it is import that collaborations between consumers, health providers, FBOs, and government agencies be had in order to provide effective HIV prevention/education within the African American community. In this study, partnership and collaboration between these entities resulted in program success. Study showed that the HIV prevention project was success**	**suggests that there is a need for innovative HIV prevention programs and that collaboration between FBOs, public health, and HIV-care organizations need to be done to provide effective HIV prevention and coordination of care. Partnership between these three organizations can play a significant role in alleviating fear, HIV stigma, and discrimination which hinders the African American community in the fight against HIV.**

		The Partnership also had an article posting in the church bulletin and posted flyers around the neighborhood all of which was done to gain congregational support to do activities within the church. **The Partnership conducted formal and informal interviews with parishioners and key leaders to learn the HIV prevention/testing needs of the church and then conducted workshops to increase HIV knowledge, disease progression, and treatments. A guidebook, "*HIV/AIDS: A Manual for Faith Communities*," was adapted into lessons to meet the needs of**		**due to the following:** **(1) Strong commitment of the pastor, key leaders, and the congregation** **(2) Collaboration between a church-affiliated faith-based community organization** **(3) Involvement of the faith-based community and the target population in design, implementation, and program evaluation** **(4) Strong commitment from the Partnership to present culturally appropriate prevention messages**	

		the constituents of the congregation. A sample of 42 adults participated in six separate workshops consisting of lectures, PowerPoint presentations, group activities, role playing, and videos. An 18-item true/ false HIV Knowledge Questionnaire was administered to participants both pre- and post-intervention workshop. An HIV education and skill-building intervention for adolescents was orchestrated, on behalf of the community's request. The intervention held for the adolescents was an abbreviated version of Black Entertainment		**(Aaron, E., Yates, L. & Criniti, S., 2011, p. 154). In addition, the researchers implemented 5 key elements – tenets shown to be effective faith-based HIV prevention programs in African American communities, that have found to make a program successful:** **(a) Involving community members in program design, execution, and evaluation** **(b) Designating a church liaison with interest and experience in HIV prevention activities** **(c) Designing programs on**	

		Television's (BET) and Kaiser Family Foundation intervention titled "Rap it Up." The adolescent-specific intervention version dispelled popular myths and misconceptions, reduced stigma and discrimination, and increased HIV testing. The intervention included lessons on general HIV knowledge, risk reduction, values and self-identity, self-esteem and self-respect, negotiation skills, media messages, support networks, empowerment, and social change. The adolescent workshops included lectures, role-playing, group activities, and videos (Aaron, E., Yates, L.		**the basis of compassion and spirituality rather than fear or judgement** **(d) Using culturally competent programs and materials** **(e) Developing a sense of ownership within the faith-based organization to gain support and participation** **(Aaron, E., Yates, L. & Criniti, S., 2011, p. 154).**	

		& Criniti, 2011, p. 153). A total of 27 adolescents (aged 12 to 21) participated in at least one of the four sessions; 16 completed all four lessons. **In addition to the workshops Partnership provided to the congregants, an HIV testing an education event was implemented at the church during National Black HIV/AIDS Awareness Day after a church service. At this event, 12 HIV counselors and nurses were recruited from 6 community-based organizations to perform HIV testing. A total of 145 parishioners and community members were**			

		screen for HIV that day.			
Baker (1999).	**Non-Analytic Case Study** N=1 **4**	Researcher describes the experience of planning an HIV/AIDS education/prevention program in the Black Church setting. Researcher attended community workshops and professional seminars, conducted literature searches, reviewed current research, media publications on HIV/AIDS, and reviewed personal data from a current HIV research project. Researcher engaged in community-based HIV prevention programs serving in various capacities (e.g. educator, organizer, and social support). In addition, the researcher conducted a literature search to understand	Small sample size Study was limited to one Black Church in New York; may not be generalizable to general population	Participants consisted of head cleric, adult mentors, church leaders, and church members/parents of teenagers (in the mentoring program) at the intervention site –the researcher's personal church in New York. All participants expressed full support for an HIV/STD prevention/education program for teenage congregants. Church member participants expressed their concern regarding high AIDS rate within the African American population and the importance of having open communication with teenagers about sexuality and the	Obtaining support from church leadership is essential in order for HIV prevention/education to be implemented within the Black Church setting. In order for HIV prevention/education workshops to be implemented within the Black Church setting, it is imperative to establish collaborative relationships between clergy and nursing to move forward. As a collective body, Black Church leaders have not been deeply involved in HIV prevention and education in part because

[redacted]		the role of the Black Church in health, disease, HIV/AIDS, and social support. Researcher consulted Pernessa Seele's organization, The Balm in Gilead, health care providers, case managers, and lay/professional community leaders to obtain their experiences/views in working with Black Churches/religious communities regarding HIV/AIDS education and prevention and the challenges associated with the task. Researcher met with Black Church site's cleric committee and parents. At first meeting, researcher established credibility as a health educator within the church setting, explained her formal education as a nurse, role as a		HIV epidemic. The participants expressed they prefer teenagers to practice abstinence until marriage yet understood that some teenagers may not abstain in which risk reduction information was important to present to them.	addressing HIV risk reductive activities may violate church teachings. Nurses should view this as an opportunity to partner with leadership and have collaboration with Black Church leaders to bridge the gap in providing HIV health education in faith-based communities. Nurses working within the Black Church should be aware of the issues involved in working with churches pertaining to HIV/AIDS/STDs. Various criteria nurses involved in HIV prevention/educat ion within Black Churches should have include

		community educator, background as a research studying the HIV/AIDS epidemic among African Americans, and desire to conduct an HIV/AIDS program within the Black Church setting. During first meeting, a parent-leader participant expressed need for an HIV education and prevention program targeting teenagers in the church local. The initial meeting led the researcher to present an HIV/AIDS education /prevention program targeting teenagers in the church. Per request, the researcher subsequently designed and implemented a pilot HIV program to Black Church leadership and parental participants			some of the following: (1) "Have a genuine desire to initiate disease prevention and health education activities within the setting of the Black Church (2) Conduct a comprehensive literature review and consult with experts in the field of HIV/AIDS (3) Understand the historical role of religious institutions in the Black community (4) Understand the specific health-related topic (e.g. HIV/AIDS)

		which addressed HIV/STD definitions, modes of transmission, self-esteem and choice issues, abstinence, and discuss reduction measures such as utilizing dental dams and male/female condoms. The subsequent meeting consisted out having a meeting with head cleric, parents, program mentors, and other church leaders collaborating on teenage HIV prevention/education workshop and how to gain support from parents and church leaders.			and its impact on the Black community (5) Understand the community's health beliefs and health care practices (6) Know the community's past experiences and current perceptions about health care services and health care professionals (7) Know available health and religious resources in the community (8) Know and communicate with religious leaders in the community

					(9) Understand communication patterns in the religious community (10) Gain acceptance within the religious community by establishing credibility as an expert on the topic of interest. (11) Build collaborative relationships with community members in the religious community in order to establish support for health education programs" (Baker, 1999, p.76)
Baker, J., Brawner, B.,	**Cross-Sectional**	Researchers in this study examined the	Small convenience	A total of 35 African American males	Traditionally, heterosexual

Cederbaum, J., White, S., Davis, Z., Brawner, W. & Jemmott, L. (2012).	**Qualitative Study** N=48 **2-**	attitudes, beliefs, intentions, and sexual behaviors as it relates to HIV-risk among African American males aged 18-24 in Philadelphia. They explored the feasibility of developing an African American culturally tailored HIV prevention program to be implemented in local neighborhood barbershops. Project director networked with 13 African American barbershop owners in West Philadelphia aiming to recruit participants into study. Fifty-four percent (54%) agreed to participate and allowed researcher to post flyers in their barbershops to recruit participants. Eligible participants included those who (a) self-	sample may not be generalizable to African American males aged 18-24 across the nation Recall bias	were Questionnaire-only participants. Demographics of the questionnaire-only participants consisted of the following: (1) average participant age was 20 years old, (2) 46% attained high school education, (3) 83% never been married, (4)74% never had children, (5) 29% had been incarcerated at some point, (6) 57% were employed full-time, (7) 71% reported that a barber is a reliable/trustworthy source for health information. Forty percent (or 40%) report attending barbershop once every two weeks. A total of 13 African American males were Focus Group participants. Demographics of the	males have been a hard-to-reach population to provide HIV prevention interventions to. In order to better reach this population, meeting them where they are and in their own colloquial language may be more effective in providing them effective cultural specific HIV prevention/education versus conventional methods. Venues such as Barbershops appear to be an effective setting to reach heterosexual African American males, especially those residing in inner-city locations.

[redacted]		identified as African American, (b) heterosexual, and (c) between ages 18 to 24 years old. A total of 48 African American males were recruited. Thirty-five (35) males completed a questionnaire survey and 13 males participated in a focus group that was held at one barbershop. **Questionnaire Survey** Thirty-five participants completed an 8-page, self-administered paper/pencil questionnaire. The questionnaire assessed their (1) socio-demographics, (2) sexual experiences, (3) drug use, (4) HIV/AIDS knowledge, and (5) partner sexual communication.		these participants consisted of the following: (1) average participant age was 19 years, (2) 77% attained high school education, (3) 92% never been married, (4)85% never had children, (5) 8% had been incarcerated at some point, (6) 31% were employed full-time, (7) 85% reported that a barber is a reliable/trustworthy source for health information. Thirty-nine percent report attending barbershop once every two weeks. **Questionnaire Findings** Sixty-four percent of the participants report having tested for HIV infection over their lifetimes; none within the sample had an HIV-positive	

[redacted]		Barbershop participants answered questions such as the following: (1) length of time they had been getting their hair cut at that specific barbershop, (2) frequency of haircuts, (3) average time spent in barber's chair, (4) perception of their barber being a reliable, trustworthy source to retrieve health information. **Focus Group** Focus group (of 13 males) was facilitated by two African American males in a Southwestern Philadelphia barbershop. Elements of the Theory of Planned Behavior provided the basis to identify the group's (a) perceived outcomes, (b) relevant referent groups, (c)		result. Seventy-six percent have never had an STD; among those who have had an STD diagnoses, Chlamydia was the most common STD. Seventy-four percent of the sample answered the AIDS/STI knowledge questions correctly; among the AIDS/STI knowledge questions, 38% reported not knowing that anal intercourse increases risk of transmitting HIV/AIDS and 40% reported that STIs always have symptoms. Most participants reported positive attitudes toward condom utilization and decreasing their sex partners to one female within the next 3 months. Most reported favor	

[redacted]		facilitators and barriers, (d) characteristics and qualities, and I alternative to said action in regards to HIV-risk prevention behaviors. Sample item questions consist of the following: 1) "Do you think that HIV is something that African American men in Philadelphia should be concerned about" 2) "How can African American men prevent themselves from contracting HIV and other STIs" 3) "Would you be willing to be tested via urine samples for STIs; what are barriers to being tested via urine samples; what are some		towards utilizing condoms, believed that condom utilization can be enjoyable, and that a reverent figure would want them to utilize condoms. Seventy percent (or 70%) indicated that they plan to utilize condoms every time they have sex in the future, and 57% plan to have sex with only one partner. Results from sexual risk behavior type questions showed that 75% and 42% had vaginal sex and anal sex, respectively, with a female within the past 3 months. Only 17% reported having used a condom for every sexual encounter in the past 3 months. Thirty-five percent reported not having a main/steady partner;	

[redacted]		solutions to these barriers" 4) "What is good/bad about using condoms" 5) "What makes it easy/hard to use condoms" 6) "Why do young men have more than one partner" 7) "Which type of partner (steady, causal, or paying) is it easier/harder to use condoms with and why" 8) "If someone gave you some money to design an HIV/STD prevention and health promotion program for African American men, what would you like to make sure it included; now, think about the messages and themes; what messages and themes would you		participants had an average of 4 female partners in the previous 3 months. **Focus Group Findings** within a group, male participants shared their attitudes and beliefs regarding HIV/STIs, condom utilization, multiple female sex partners, and HIV prevention programs specific to young adult African American males aged 18 to 24 years old. Most participants agree/report that the HIV epidemic is one of the most import health issues currently affecting the African American male community. Although most understood that HIV is mainly spread by unprotected sex,	

[redacted]		want to make sure it included" (Baker, J., Brawner, B., Cederbaum, J., White, S., Davis, Z., Brawner, W. & Jemmott, L., 2012, p.372). Prior to the focus group session, participants completed self-administered paper/pencil questionnaire. Then the facilitators led the participant discussion; participants spoke on their thoughts regarding the focus group guide. The discussion was audiotaped, transcribed, analyzed, and coded. Qualitative software was used to analyze data; transcripts were coded into both general and specific themes; themes were		most participants report not utilizing condoms due to various reasons, e.g. accidents/slip ups, being with main partner, and knowing their partner's HIV/STI-negative status. Participants had various responses to the use/disuse of condoms. Participants report that condom utilization can be easy when a female reminds the male to use a condom, the male is cognizant to protect himself, and realizing the consequences of what HIV/STI positive male's experiences. Participants report that condom disuse can occur the when female partners tell them they are allergic to condoms	

[redacted]		evaluated by the project director. SPSS 17.0 was utilized to analyze the survey data; descriptive Statistics/frequency counts were utilized to describe the study sample's demographics, attitudes, beliefs, and intentions.		or simple do not want to use condoms. Males report that being under the influence of alcohol/illicit drugs diminishes their judgement to use protection. Participants report that condom utilization can be contingent based upon whether a male is with a steady or casual sex partner. Males report the necessity of condom utilization among casual partners in order to prevent them from transmitting an infection to their main female partner. However, in steady relationships pregnancy prevention was the main reported reason for condom utilization. Participants reported	

				that introducing condoms in a steady sexual relationship is difficult as females may suspect infidelity. Participants report males have multiple sexual partners for various reasons. Fifty percent of the participants believe that males their age have multiple sex partners. There are various reasons why males may have more than one female sex partner concurrently. Participants report "temptation," "it's easy," "being greedy," and "it's easily give to you" are some reasons why males have concurrent female partners. Participants report that utilizing barbershops as a venue for HIV	

				prevention can be ideal because it's a convenient local to exchange information with peers and mentors.	
Balaji, Oster, Viall, Heffelfinger, Mena, & Toledo (2012).	**Qualitative Study** N=16 **3**	Recruited sample from previous CDC quantitative study for in-depth qualitative interview. Participants in the study were asked about: (1) "General characteristics of YBMSM in the area" (2) "Personal networks/ community social groups of MSM" (3) "Relationships and ways to meet other men" (4) "Individual and community attitudes toward safe sex, HIV/AIDS" (5) "Community attitudes about homosexuality …" (6) "Access to health care"	Recruiting participants from the previous study may promote sample bias. Finding from this study may not be generalizable to YBMSM living in other communities	1. General Community perceptions of Black MSM: faith, religious teaching and faith leaders contribute to the lack of tolerance of homosexuality in the Black community. 2. Gay Community: many YBMSM identify "Gay Families" as supportive environments for acceptance 3. Religion and Faith: participants indicate that religion faith/involvement in religious institutions is important to their lives, they attend church regularly, and identified church leaders as	The findings from this study suggests: 1. The impact of stigma on risk behavior should be explored more to explicitly address and the challenge/stigma among YBMSM themselves and their communities. 2. Greater attention should be paid to the role that ideas of masculinity may play as a driver of the HIV epidemic among YBMSM and how this knowledge can be used to inform prevention efforts.

[redacted]		(7) “Experience being diagnosed with HIV” (8) “Their recommendations of improving HIV prevention” (p. 731). Inductive approach was utilized to guide identification and articulation of patterns, themes and conclusions from interviewee’s responses. Qualitative data analysis software used for thematic analysis. Coding reports were generated in EZ-Text to interpret data into four domains representing important social forces in YBMSM’s lives: (1) The general community (2) The gay community (3) Religion and faith (4) Family.		critical sources of homophobia/discrimination. 4. Family: participants either reported or implied that they were out-the-closet to their immediate families with experiencing reactions ranging from initial abandonment to support.	3. Family and religion offer potential sources of support and routes through which to deliver HIV prevention interventions. 4. Due to the significant role religion has in shaping the opinions and influencing attitudes, public health programs should partner with religious officials to improve tolerance and acceptance of YBMSM to promote HIV prevention.

Bond, Wheeler, Millett, LaPollo, Carson, & Liau (2009).	**Descriptive Correlational Study** N=1151 **3**	Recruited Black and Latino MSM examining factors associated with HIV risk behavior to HIV infection among those identified as on the DL versus non-DL identifying MSM. Statistical analysis compared demographic and sexual risks to differentiate the two groups assessing if DL identification was a higher contributing HIV behavioral risk factor.	Study population was predominately low- income located predominately in Northeast metropolitan area; may not be a true representation of the Black MSM population overall. Participant self-reporting their sexual risk behaviors may have caused underreporting due to social desirability.	1. Compared to popular press, DL-identity is not associated with engaging in greater sexual risk behavior with partners. Black MSM who identity as 'DL' (regardless of HIV status) engage in similar sexual risks similar to non-DL-MSM. 2. DL identity does not always imply having female sex partners. 3. DL identity more likely to be bi or homosexual then heterosexual; non-DL-identity are similarly likely to report being heterosexual as DL-MSM. 4. DL-MSM less likely to "bottom" with male partners and less likely to test HIV+.	Black MSM identifying as on the DL is not associated with higher sexual risk behavior and higher HIV prevalence.
Bowleg, L., Teti, M., Massie, J.,	**Exploratory Study**	Researchers recruited 41 African American	The sample population may	Analysis indicates that African	Findings add to the empirical

Patel, A., Malebranche, D. & Tschann, J. (2011).	N=41 **2-**	males, aged 19 to 51, to explore knowledge about masculine ideologies to sexual HIV risk behavior among heterosexual African American males. Researchers recruited males aged 18 years and older from stores, street corners, and various venues in Philadelphia, Pennsylvania. Prospective participants were screened by phone to determine their eligibility into the study. Eligibility criteria included that participants self-identify as African American, be at least 18 years old, and report heterosexual activity within the previous two months. Participants were divided into 6 focus groups to explore two research questions:	not be generalizable to broader heterosexual African American male population. Group level intervention may have promoted some participants to answer questions in socially acceptable manner.	American males in the study have two main ideologies about masculinity. The first ideology is that African American males should have multiple female sex partners, usually concurrently. The second ideology is that African American males should not be homosexual/bisexual . Participants in the study reveal that in order to be masculine African American males should have many female partners. Having multiple partners is an African American male social norm something of which participants believe society expects of them. Because society and the African American	evidence that African American males, like other ethnic groups, embrace the ideology that males should have sex with multiple females. Given the alarming HIV epidemic and HIV over representation among the African American male population, it is critical that heterosexual African American males reduce their number of sexual partners and utilize condoms. Findings suggest that there are several opportunities for HIV prevention among the heterosexual African American male population and that using

		(1) "What are the *explicit* (e.g., directly stated) masculine ideologies Black heterosexual men express that have implications for sexual HIV risk behaviors" (2) "What are the *implicit* (e.g. not directly stated but inferred from analysis) masculine ideologies that have implications for Black heterosexual men's sexual HIV risk" (Bowleg, L., Teti, M., Massie, J., Patel, A., Malebranche, D. & Tschann, J., 2011, p. 2). Two trained African American males facilitated each focus group session. To lead the discussion		male community endorse promiscuous heterosexual behavior, African American males praise other men who have regular uninhibited sexual conquests. On the other hand, masculinity is also defined as having a weakness to say no to sex when females solicit to them. Results also show that participants believe that African American males should only be heterosexual. African American males who engage in homosexual behavior are frowned upon and such behavior is not considered a masculine trait. Homosexual activity is not what a "real" African American male does. Although	ideologies of masculinity as a theoretical framework may be most efficacious in behavioral risk reduction. Challenging heterosexism social norms will be essential for HIV risk reduction among heterosexual African American males.

		about ideologies of masculinity, one facilitator gave each participant a piece of paper that was divided into two columns. The first column read “Black men should…” while the second column read “Black men should not…” (Bowleg, L., Teti, M., Massie, J., Patel, A., Malebranche, D. & Tschann, J., 2011, p. 3). After participants wrote answers down on paper, the facilitator requested for participants to share their responses with the whole group. Because the first four focus groups did not make the connection of masculine ideology specific to African American males clear for analysis, the researchers		having multiple female sex partners is social acceptable, it is believed that males who have sex with men and women are to blame for rising HIV rates within the Heterosexual African American male community. Results also show that females, not males, should be responsible for condom utilization. Because pregnancy outside of wedlock is very prevalent among African American females, males feel it should be a female’s prerogative to utilize birth control measures to prevent pregnancy and/or HIV/STDs.	

		conducted two additional focus groups to assess this phenomenon. The (facilitator) guide for the two additional groups implemented the same format/sequence of questions about ideologies of masculinity, but questions about sexual risk were excluded. With the new groups, the researchers included the question "is this experience specific to Black men or men in general" (Bowleg, L., Teti, M., Massie, J., Patel, A., Malebranche, D. & Tschann, J., 2011, p. 3). Focus group sessions were digitally recorded; each participant received a $50 cash incentive.			

Berry, Raymond & McFarland (2007).	**Secondary Data Analysis of a Survey Study** N=1,547 **3**	Investigators analyzed San Francisco's 2004 National HIV Behavior Surveillance data examining interracial/intergenerational partnering among MSM.	Expert opinions can be wrong, limited, biased or invalid. Author cited several sources throughout the article.	1. Black MSM were 3 times likely to sexually partner with themselves. Whereas, Latino MSM were 1.5 times likely to pare among themselves followed by whites. 2. Compared to White MSM, Black MSM were more likely to have a partner 10 or more years older. Asian MSM were more likely to have a partner within 10 years of his own age compared with white MSM.	1. The combination of interracial and intergenerational sexual mixing may explain why the prevalence of HIV initially became higher among Black MSM, and why the high prevalence has been sustained into the third decade of the epidemic. 2. Same-race/ethnicity partnering may create closely interconnected sexual networks, such that once HIV enters the network, it spreads quickly through it. 3. Same race/ethnicity partnering is risky to the network when there are

					large age gaps between partners, but protective to the network when age gaps are small.
Bontempi, J., Eng, E. & Quinn, S. (2008).	**Qualitative Study** N=24 **2-**	Twenty-four African American females residing in an Eastern, rural North Carolina living in public housing community town were recruited into study. Participant eligibility included persons who self-identify as African American, aged 18 years or older, identified as heterosexual, and lived in public housing. Two health advisors, working with an STD prevention project in the community, recruited females they personally knew (that met eligibility criteria) into the study and asked	Possible selection and participation bias. Sample is limited to rural low-income impoverished community and may not be applicable to general African American female population. A White facilitator led the group discussion; participants may not have been fully forth-coming in discussions due to racial difference.	Majority of the participants were 30 years old or older; the average participant age was 35 years old. Most of the participants were single, divorced, or separated, and had children living with them. Seven participants worked full-time, seven were unemployed, and four were pursing higher education. The African American male-to-female sex ratio in the community was .80 during the time the study was conducted. Two major themes surfaced from the focus group	African American females residing in low-income communities may be at risk for HIV in part due to imbalanced sex ratios between the genders. Females residing in these communities may feel they have to compete amongst each other just to have a male in their life. Desperation to have a male partner in their life, females may financially support males, endure maltreatment, and/or compromise their moral standards

		eligible females to ask other peers they knew to participate in the study. A total of 24 females were inducted into the study. Participants were then divided into 5 focus groups. Focus groups participated in discussions that pertained to different aspects of social contexts that may affect female's sexual health behaviors. The researchers asked participants questions about the group's sense of living in their local community and their relationships with males. Such questions consisted of the following: (1) "What is it like to be an African American woman living in "Sparksburg?"		discussion guides. The first theme pertained to the treatment by and negotiation of safe-sex practices with male partners. Most participants believe that males, in their community, hold significant power in male-female relationships. Participants report that having a male partner is a ticket out of low-income impoverished areas. However, females tend to tolerate inappropriate behaviors to keep a male partner. Some females will take care of males by providing food, shelter, transportation, while others may endure physical/emotional abuse or tolerate males having concurrent	that subsequently put them at risk for HIV. Future research needs to be done to explore African American female's sexual decision-making capacity within relationships where power imbalances play a role. Studies should have males in the sample in order to capture the phenomenon of power and sexual decision making within heterosexual relationships.

		a. "What are the racial issues?" b. "What are the economic factors?" c. "What issues affect women only?" (2) "What kinds of things make it easy or difficult to be with a man?" a. "How do men and women get along in relationships?" b. "How do men feel about using condoms?" c. "How do women feel about using condoms?" Focus groups discussed questions at length until theoretical saturation was complete and no new information emerged from the discussions.		relationships where females experience little reciprocity in return. Participants report that it is primarily a female's responsibility to utilize condoms in order to prevent HIV/STDs. Participants report that it is essential to carry condoms on person because males do not take the initiative to utilize condoms. Some participants believe that HIV infection rates reported about the African American population is not as disproportionate as the medical community claim. Some participants believe that the HIV epidemic is nothing more than a conspiracy and a modern form of	

				governmental genocide “given” to the as African American community. The second theme that surfaced from the focus group’s discussions is that welfare is a vicious cycle that keeps some African American females oppressed in low-income communities. The cycle is played out by females engaging in unhealthy relationships, become pregnant, enter into the welfare system and become locked into being financially dependent on the government. Becoming locked into the system causes females to have low self-esteem, feel powerless, and this	

				subsequently reduces their ability to prevent HIV infection.	
Coleman, J., Lindley, L., Annang, L, Saunders, R. & Gaddist, B. (2012).	**Qualitative Study** N=36 **3**	Researchers in this study aimed to develop a framework to guide South Carolinian Black Churches in the development and implementation of HIV/AIDS prevention programs within their congregations. Participants in this study included Black Churches from all regions of South Carolina (Upstate, Midlands, and Low Country); representative Black Church pastors, care teams (groups of individuals who coordinate HIV/AIDS prevention programs in their local church), faith-based technical	Study was limited to South Carolina Black Churches that were self-selected and willing to participant. Churches in the study already had preexisting ministries that addressed HIV/AIDS in varying capacities to parishioners and the African American community. Participant churches may differ in qualities and characteristics from other Black Churches that do not	All participants in this sample were African American. There were 22 participants among the care team focus groups who had a mean age of 50, range was 26 to 82 years old; 82% of care team members were female among whom the average time a participants served on the care team was 2.3 years. Pastoral participants (n=8) had a mean age of 52 years with an age range from 39 to 65 years. Most pastoral participants were male (87.5%), had an average of 25	As an institution, the Black Church has significant influence in African American communities which places this entity in a great position to provide culturally appropriate HIV information in a local most African American are familiar. However, HIV-related stigma pervades deep into the African American community which hinders Black Churches to addressing the disease to the

[redacted]		assistance providers, and project champions (persons who worked at the policy level to obtain funding for Project FAITH). Eligible participants included only churches that had participated in Project FAITH for at least 1 year. Participants were selected via utilizing a stratified purpose sampling strategy based upon the region within the state and church size (small church = 250 or fewer parishioners whereas large church = 251 or more parishioners). After stratification was done, the churches were randomly selected to be invited to participate in the study. All care teams and pastors were selected independently so that	address HIV/AIDS within their congregations. Study is limited to protestant South Carolinian Black Churches and my not be generalizable to Black Churches of different denominations or churches in other regions of the country.	years of experience, and (on average) served 12.5 years in their current churches. There were two project champion participants, one male and one female, who had in-depth interviews with the researchers. **Inputs** *The elements present within the church before an HIV/AIDS prevention program is adopted and/or implemented.* On an individual level, participants report that HIV/AIDS prevention program leaders had certain characteristics that enabled for an HIV program to take root.	extent it needs to be addressed. Findings confirm that HIV-related stigma creates barriers and challenges for Black Churches to implement HIV/AIDS prevention programs to congregants and the community. Fear of contracting HIV, fear of PLHA, and the belief that HIV is a homosexual disease make some parishioners and some leaders reluctant to using the church as a platform to fight HIV/AIDS. In addition, some leaders and

[redacted]		all churches were eligible for both a care team focus group and pastor interviews. Data was collected by the researchers via implementing semi-structured in-depth interviews and focus groups with individuals who were directly involved with Project FAITH. Six (or 6) focus groups were conducted and were stratified by care team and faith-based technical assistance providers. Researchers conducted in-depth interviews with a stratified sample of 8 pastors and 2 project champions. Interview guides were developed specific to each group of participants based on evaluation results from the first year of		This characteristics included desire to help the African American community, church commitment and the fight against HIV, and willingness to take risks. On an organizational level, participants reported there had to be buy-in, preexisting infrastructure, and actions to facilitate implementation of an HIV/AIDS program. At the community level, participants report that churches themselves have a role in that they have been a place where African Americans can go to get health information; when churches take action, change can occur.	parishioners may be apathetic of the HIV epidemic affecting their community which hinders HIV prevention programs being provided to parishioners and the community. Black Churches can be instrumental in counteracting HIV-related stigma within the African American community by disseminating accurate information about the disease; messages for Black Church pulpits along with bulletin announcements,

[redacted]		Project FAITH and extant literature. All focus groups and interviews were audiotaped and transcribed verbatim. Transcripts were coded to identify concepts and then loaded into QSR NVivo 8 for data management and further analysis. Constant comparative analysis was implemented throughout the analytic process so that themes were grounded in the data. Merging concepts were grouped by level – individual, organizational, or community. Data analysis defined the inputs, mediators, enablers and inhibitors, and output for Black Church based HIV prevention programs that were a part of Project		The presence of inputs bolstered and prepared churches to initiate and implement HIV/AIDS programs. **Enablers** *The factors that facilitated the implementation and continued success of HIV/AIDS prevention programs within the church.* Participants reported that there were characteristics that enabled HIV/AIDS programs to flourish within the church. Such characteristics included pastors taking a stance to speak-out to congregants about the disease, integration of	church flyers, and information pamphlets are necessary steps towards reduce HIV-related stigma within Black Churches and the community. In order for HIV prevention programs to be successful within Black Churches, it is important that persons who "enable" implementation of HIV programs get the support needed to run them. Factors such as mediators can also build acceptance for Black Churches to adopt HIV/AIDS

[redacted]		FAITH. Findings were used to develop a theoretical framework for faith-based HIV/AIDS prevention programs.		HIV/AIDS program into other ministries, technical assistance providing HIV training and workshops, congregant's presence at HIV-sponsored events. **Inhibitors** *Factors that posed as barriers to HIV/AIDS program implementation within the church.* Participants report that apathy towards the disease, leadership resistance, or even competing agendas/commitments within the church. Participants report that congregant hold care team members in a negative light in that they assume	prevention within the church setting. Mediators that can help churches embrace HIV prevention include providing education to leaders/parishioners what HIV is, correcting myths or discrepancies about the disease, illustrating a model how to support PLHA. Doing such may be received well by key stake holders when presented in a fashion that is culturally and theologically congruent.

				people who have compassion to address HIV/AIDS are either HIV-positive and/or homosexual (both which are culturally taboo). Other inhibitors included the lack of resources, participation or even overt church resistance. **Mediators** *Factors that influenced the delivery of the HIV/AIDS prevention program that included strategies for implementing programs and/or increasing acceptance of the program by congregants.* Participants reported	

				that providing HIV/AIDS education to congregants was an important milestone to enable these programs to move forward within the church. Educating about the disease and dispelling incorrect myths about HIV helped discredit long-held negative views about the illness which helped the church to support these prevention programs. **Outputs** *The intangible/tangible changes that occurred in churches and communities as a result from HIV/AIDS program's active*	

				and presence Participants reported that as congregants became more knowledgeable about HIV/AIDS the more positive and interested parishioners were about discussing the disease and had less fear and stigma towards PLHA. Also, the information provided to Project FAITH churches transformed communities and congregations to the extent other churches were opening-up to collaborate with churches who have HIV/AIDS prevention programs.	

				Policy and Stigma Participants reported that stigma is a hindering factor to HIV/AIDS programs. They reported that stigma manifests itself as denial, linking HIV/AIDS to homosexuality, fear of HIV or PLHA, and blaming individual for being HIV-positive.	
Cornelius, Moneyham & LeGrand (2008).	**Qualitative Study** N=30 **2-**	Participants were recruited from 3 African American Protestant (Baptist and Methodist) churches located in low-income areas of Mecklenburg County, North Carolina. Four focus group interviews were conducted among 30 African American women, aged 50 years and older, from three churches	Study results may be limited to only Baptist and Methodist church settings located in low-income counties. Small sample size may not be generalizable to larger population.	Participants were receptive to the idea of a church-based HIV prevention program. It was noted that many participants agree that church-based HIV prevention programs are needed in this setting for older African American women.	Nurses can build upon the study's recommendation to implement successful church-based HIV prevention programs for persons of all ages. Support from church leadership is paramount to any type of

[redacted]		regarding adaptation of Sisters Informing Sisters on Topics about AIDS (SISTA) curriculum for older females and its feasibility of implementing the curriculum in a church setting. Eligible participants included those who self-report as African American, speak English, age 50 years or older, and involved in heterosexual relationships. Participants engaged in 5 interactive focus group sessions led by the research team where they shared their opinions about the content of the SISTA curriculum. Participants were asked the following: (1) "What is the relevance of this activity to older African American women"		When targeting this population, facilitators need to provide age specific information and statistics to older age African American females so they will realize they are vulnerable to HIV infection. Role-play activities can help women initiate sexual discussions with health care providers and sexual partners; using videos that have age-specific information about HIV can be instrumental.	educational program being conducted within the church setting. Gaining entry to utilize the church as a plat-form for HIV prevention is challenging. In order to gain entry into the church to conduct HIV prevention programs, establishing trust precedes everything in order to work with this community. Nurses need to communicate with church leaders about the consequences of oral, anal, and vaginal sex and various sex-safe practices. Nurses

		(2) "What would you change" (3) "How would you modify this activity for older African American women" (Cornelius et al. 2008, p. 20). Participants were asked about their opinion about the utilization of the church as a venue for implementing HIV prevention programs such as SISTA in this setting.			may need to discuss the utilization of condoms (and other protective modalities) with leadership prior to working with their parishioners.
Crepaz, N., Marshall, K., Aupont, L., Jacobs, E., Mizuno, Y., Kay, L., Jones, P., McCree, D. & O'Leary, A. (2009).	**Literature Review** **3**	Researchers sought to evaluate the efficacy of HIV behavioral interventions targeting the African American female population; they identified elements that make HIV behavioral interventions effective within this population. Researchers conducted a	Most studies retrieved targeted inner-city low-income females; evidence may not be generalizable to low-income females living in rural USA or African American females of other	Thirty-seven studies were retrieved to include a total of 13,354 participants. Across all studies, characteristics of the participants consisted of a median age of 27, with an age range from 12 to 63 years old, median education was high	HIV/STD behavioral interventions are efficacious in preventing venereal infections among African American females. More research is needed to examine the potential contribution of

[redacted]		comprehensive literature review employing a standardized approach using the following 3 key words: (1) HIV, AIDS, or STIs; (2) intervention evaluation; and (3) behavior or biological outcomes. AIDSLINE, EMBASE, MEDLINE, PsycINFO, and Sociological Abstracts electronic databases were used to find pertinent literature. Researchers manually searched through 35 journals that regularly published articles on HIV/STI prevention research and scanned through the reference lists of pertinent evidence retrieved. Retrieved studies were evaluated and analyzed based on the	socioeconomic status.	school or less, low income who were unemployed or on public assistance. Most studies retrieved contained multiple intervention elements that focused on reducing the risk of HIV among heterosexuals. All interventions analyzed provided information regarding increase of HIV knowledge among participants. HIV intervention programs that focus on behavioral interventions have a significant impact on HIV-risk reduction behaviors that result in decreased incidence of STDs in	prevention strategies that attend to community-level and structural-level factors affecting HIV infection and transmission in this population. For African American females, studies show that the most effective HIV prevention interventions are those that are gender/culture-specific, focus on empowerment, and provide them condom training and safe-sex negotiation skills. HIV prevention interventions need

[redacted]		following inclusion criteria: (1) they were evaluations of US-based behavioral interventions intended to reduce the risk of HIV or STI transmissions; (2) they targeted women or stratified data by gender; (3) more than 50% of their female participants were African American, or were stratified by ethnicity; (4) they were randomized controlled trials or controlled studies that minimized systematic bias associated with non-randomization; (5) they measured at least 1 HIV-risk sex behavior (e.g., unprotected vaginal or anal intercourse, condom use), or measured clinical diagnosis or laboratory confirmation of STI;		African American females. Studies targeting African American females demonstrate that employing gender or culture-specific strategies presented by female facilitators, implementing techniques to empower participants, providing skills training in condom utilization and safe-sex negotiation, and providing role-playing to teach negotiation skills have better outcomes than those that do not take these elements into consideration.	to address the socioecological factors that place African American females at risk for HIV like sexual networks, concurrent partnerships, intimate partner violence, gender radio imbalances within the community, and socioeconomic oppression. Future research should focus on examining the relationship between medical, behavioral, community-level, and structural-level interventions in order to achieve optimal HIV-prevention

		(6) they reported at least 1 post-intervention outcome; and (7) they provided data necessary for calculation of effect size. (Crepaz, N., Marshall, K., Aupont, L., Jacobs, E., Mizuno, Y., Kay, L., Jones, P., McCree, D. & O'Leary, A., 2009, 2070). Literature retrieved included articles that were published between January 1988 to June 2007. A total of 37 articles were retrieved and analyzed in this study.			results.
Sandfort & Dodge (2008).	**Literature Review** **4**	Reviewed and condensed current theoretical perspectives known to the field sited by other investigators. Extrapolated evidence from other studies to generate	NA	6. Unprotected sex was common with steady partners than with casual partners, regardless of their sex.	Numerous research inquiries arose from this literature review. The authors suggests the following inquiries should be investigated in

		new questions for research. They specifically, reviewed MSMW, who do not identify as gay or disclose their same-sex involvement to their female partners.		This finding suggests that MSMW may serve as a bisexual bridge for HIV transmission. 2. HIV-positive MSMW are less likely to engage in unprotected sex with their main partner(s) then HIV-negative men or males who did not know their HIV status. 3. Unprotected sex without disclosure of HIV status was more prevalent among men who were more exclusively homosexual-identified. 4. There is some correlation that the	future studies: (1) Explore the development of bisexual behaviors and identities among ethnic minority populations to further understand the social aspects of ethnic minority male bisexuality in the U.S. and other territories (6) Explore the experiences and expressions of ethnic minority male bisexuality

				practice of unprotected sex may be ethnically specific.	in the U.S. and how it resembles or differs from ethnic minority males in other national cultures around the world (4) Further explore the phenomenon of denial and stigmatization of male bisexuality in ethnic minority communities; explore successful intervention elements that begin to understand the health

					implications of bisexuality beyond disease transmission and other negative consequences.
Fields, Bogart, Smith, Malebranche, Ellen, & Schuster (2012).	**Secondary Data Analysis** N= 35 **3**	Secondary data analysis was collected from three prior studies of Black MSM by semi-structured interviews. The studies were combined amplifying supplementary analysis, which extended the primary studies' questions.	Possible selection bias due to samples synthesized from two different locations. Small sample size.	1. YBMSM perceived masculine men as a socially desirable characteristic in one's partner. YBMSM use masculinity to gauge a partner's HIV risk. 2. Masculine men were associated with not being openly gay, lack any feminine characteristics, being strong or aggressive, being the "top" partner in anal intercourse and less likely to be or become HIV infected. Masculine partners were thought to be sexually safe.	YBMSM have misconceptions that may place them at risk for HIV. Within the YBMSM community, there is a high social desirability of having a masculine partner. Masculine male partners are perceived to be low-risk partners to the extent some YBMSM may not use condoms to prevention the acquisition/transmission of HIV. Power dynamics and sexual role between YBMSM and masculine males or older

[redacted]				3. Effeminate men were perceived to be the receptive "bottom" partner and thought to be more promiscuous than masculine MSM. Bottoms are thought to be high risk because they were less proactive about condom use. 4. Based on sexual role, tops are low HIV risk while bottoms are perceived as high HIV risk. 5. Intergenerational, older Black partners were perceived to be more masculine than younger partners in whom the older partner controls safe-sex measures. 6. Partners can be trusted to be safe if they are known for a long time; if one knows his partner well and trusts him, then condom use	MSM may influence condom decision-making in that a masculine male partner or an older MSM may determine whether condoms are utilized. Power dynamics and age differences may influence condom utilization which may contribute to HIV acquisition/transmission among YBMSM from an insertive partner to a receptive partner all my coalesce to create considerable potential risk for HIV transmission.

				need not to be a priority because a trusted partner keeps the participant safe. Participants reported that monogamous partners are presumably safe.	
Foster, P. (2007).	**Expert Opinion** **4**	The researcher reports that HIV/AIDS has evolved over the last 25 years to become more feminine and more ethnic impacting the lives of many within the African American population. Compared to the beginning of the epidemic, HIV/AIDS is becoming more concentrated in the South and in small rural communities. Some places, like Alabama, are booming with alarmingly high rates of HIV/AIDS. In order to counteract this, the researcher	NA	The Alabama Black Belt HIV/AIDS Tour activities were advertised within the community by poster leaflets, radio advertisements, and by nationally/locally known persons and entertainers. However, attendance to some of the events was uneventful. **Stigma** HIV-stigma is thought to be a barrier to receiving HIV/AIDS education and information. Because rural areas tend to be tight-knit communities where private information	There are several factors fueling the HIV/AIDS epidemic among African Americans, particularly those residing in rural Alabama. These factors include the following: (1) ineffective risk reduction activities like condom utilization and needle exchange programs, (2) missed diagnosis through early HIV testing, (3) unequal access to early and consistent treatment. In

		sought to increase HIV/AIDS awareness in rural Alabama settings. The researcher conducted a multicity HIV/AIDS outreach educational tour targeting Alabama's Black Belt counties. The researcher implemented a 3-level prevention intervention to Alabamian African American residents in 5 cities located either in the Black Belt or near targeted Black Belt counties. The researcher provided the following: (1) Primary education aimed at youth, college administrators, faculty, staff, and community persons through town hall meetings, press conferences, high schools and		disseminates rapidly through it, HIV stigma perpetuates people to be silent about their personal sexual activities, risk behaviors, and HIV status. The researcher learned that people in rural communities will seek HIV testing and treatment outside their local hometowns or state so that their personal information will not be the talk of the town. Many African Americans recall the first images of HIV. Many believe it pertains primarily to homosexual White males. Because if this, African Americans do not want to be associated with HIV or perceive to be susceptible to it. **Fear**	addition, distrust towards the predominant White medical established community, genocide (e.g. Tuskegee syphilis study), and HIV conspiracy theory among rural African Americans. Stigma, fear, and denial appear to be barriers and drivers that fuel the HIV/AIDS epidemic in Black belt counties of Alabama. Providing community-based culturally competent HIV prevention may increase community awareness about the disease and promote social action for locals to talk about

		universities, a detention center, and a special health and wellness gospel concert, (2) Secondary prevention aimed at early detection of HIV through HIV screening at several events (3) Tertiary prevention aimed at encouraging those who are HIV infected to lead health lifestyles through healthy eating, physical activity, adequate sleep, and compliance with antiretroviral medications (Foster, P., 2007, p. 319). The researcher produced multimedia presentation to disseminate health and prevention messages to Black		The reason for fear of HIV/AIDS among African Americans is not well defined. The researcher reports that fear may be a driving force to HIV/AIDS stigma. Fear may manifest itself in rural communities by HIV-positive persons be afraid of other residents knowing about their HIV-positive status and their risk behaviors. The researcher reports that some of their attendees avoid attending public HIV/AIDS forums due to fear of being seen by others and/or being perceived as HIV-positive. In small towns, people avoid HIV prevention activities in fear that confidentiality regarding their	HIV/AIDS and ultimately reduce the spread and eliminate this health disparity.

		Belt residents. Multimedia presentations included radio announcements, disseminations of palm cards, video clip production by the Tuskegee University president used for town hall meeting, and videotapes/DVDs. The researcher explored the phenomenon of Stigma, Fear, and Denial (SFD) that may hinder rural African Americans from seeking HIV/AIDS prevention; doing so, a theoretical framework is developed to address barriers using community-based culturally competent approaches for rural African Americans.		HIV/AIDS status may be breached. **Denial** Denial is a strong barrier to HIV/AIDS prevention in African American communities. Many people in rural African American community are in denial that some of its people practice same-sex behaviors, do IV-drugs, or engage in promiscuous life-styles. In order to join the fight against HIV/AIDS, it is essential they begin dialog about these activities to tackle behaviors that place rural African Americans at risk for the infection. **Prevention: use of a SFD framework to decrease HIV/AIDS**	

				in rural African Americans To reduce Stigma, Fear, and Denial, the researcher suggests the following: (1) Eliminate misinformation, myths, and distrust associated with HIV/AIDS in rural African American communities (2) Implement community-based/community-empowerment events where key African American leaders are recruited to inform rural Alabamians about HIV/AIDS barriers in their community (3) Provide peer training and train-the-trainer to provide	

				HIV/AIDS prevention educational components to address stigma, fear, and denial among African Americans (e.g. conspiracy theories, alternative lifestyles, homophobia, and HIV testing) (4) Recruit key clergy in the community to recruit other clergy to begin the address these issues in a more holistic/comprehensive manner (5) Provide culturally sensitive primary, secondary, and tertiary care by health care providers, educators, and community	

				leaders who work with rural African Americans (Foster, P., 2007, p. 323-324).	
Foster, P., Cooper, K., Parton, J. & Meeks, J. (2011).	**Exploratory Study** N=50 **2-**	Researchers gathered information from rural Baptist ministers, in the Deep South, about their interest in HIV prevention within their churches and motivating factors to participate/initiate HIV prevention activated based on their geographic location (urban vs. rural). Consisting of a mixed qualitative and quantitative approach using both interviews and surveys, African American pastors, who are members of the Alabama New Era Progressive Baptist Conference, were recruited by the project's ministerial	Small sample size Sample consisted of most pastors of Baptist denomination; findings may not be generalizable to Black Churches of other denominations.	For Phase 1 of the study, 8 pastor participants completed the in-depth interviews. Demographics of this sample included the following: 100% male, all African Americans, and Baptist denomination affiliation. Most (87%) work full-time within the ministry; most have dual occupations (e.g., funeral director, mechanic, supervisory and management occupations). Collectively, the 8 pastor participants report there are several reasons why some pastors are not	Finding from this study show that African American pastors in the rural Deep South are receptive to providing HIV/AIDS education and testing in the church setting. However, HIV stigma is a barrier that can keep many pastors, who are willing to address/provide HIV services, silent and inactive from speaking on this social issue within the African American community. Evidence shows that more dialog needs to be done

[redacted]		liaison. The study was conducted in two phases – phase 1 and phase 2. In Phase 1 of the study, demographic information was collected from participants. Researches collected data by from participants by implementing in-depth interviews. The interview questions are as follows: (1) "Do you know anything about HIV/AIDS" (yes or no) (2) "How would you rate your knowledge compared to other Black Church leaders" (better than average, good, about average, less than average) (3) "Where did you receive your		involved in HIV/AIDS prevention: (1) fear of HIV/AIDS due to stigma or fear due to lack of HIV/AIDS knowledge, (2) not knowing someone personally affected by the disease, (3) conflict of how HIV/AIDS fits into the church's mission; (4) the lack of access to accurate and culturally competent prevention services (Foster, P., Cooper, K., Parton, J. & Meeks, J., 2011, p. 325). In addition, pastors may not address HIV/AIDS because they fear how parishioners may negatively respond. Pastor participants report that there are certain reasons why they became interested in	with Black Church leadership regarding HIV prevention. Talking with Black Church leadership may develop trust between HIV/AIDS professional and pastors which may encourage more Black Church leaders to get more involved in HIV prevention within their churches. Minority health care providers, who serve minority populations, can be instrumental to the Black Church in the fight against HIV. Minority health professionals can collaborate with Black Church leaders, build

[redacted]		information about HIV/AIDS" (4) "What are your feelings about how HIV/AIDS is currently being addressed in the African American community" (5) "What role do you think the Black Church could play in addressing HIV/AIDS in the African American community" (6) "Have you ever taken a HIV/AIDS test, under what circumstances" (7) "Have any HIV/AIDS prevention services been conducted at or by your church; if yes, what were they" (8) "Why do you think some Black pastors may not		HIV/AIDS prevention at their local church. These reasons include: (1) being a health care provider or having a spouse who is, (2) having moved back to the South from another part of the country, (3) whether their church had a pre-existing health-related ministry, or (4) if they knew someone infected with HIV/AIDS (Foster, P., Cooper, K., Parton, J. & Meeks, J., 2011, p. 325). For Phase 2 of the study, a total of 56 pastors and lay church leader participants completed the study. All participants reported being African American, 51.9% were female, majority (94.6%) were Baptist	their trust and be instrumental in providing HIV health information within faith-based settings.

[redacted]		be educated about HIV/AIDS" (9) "Why do you think some Black pastor may not want to have their church participate in HIV/AIDS prevention activities" (10) "Are there any other leadership roles or positions in the Black Church that might be influential in convincing pastors to conduct HIV/AIDS prevention activities." (11) "Do you have any suggestions about how to influence Black pastors to conduct more HIV/AIDS prevention activities" (Foster, P., Cooper, K., Parton, J. & Meeks, J., 2011, p. 324) Interview questions were audiotaped, transcribed, and analyzed. Open		denomination, and most (53.6%) of the participants were between ages 41-60 years old; participants came from Alabama representing both urban and rural congregations. Most of the participants in Phase 2 were interested in having HIV/AIDS prevention services within their congregations. Those who were not interested (5 participants) reported so because (a) not being a pastor, (b) were retired, (c) had already been tested, and/or (d) currently participating in another ministry providing HIV/AIDS (Foster, P., Cooper, K., Parton, J. & Meeks, J., 2011, p. 325).	

[redacted]		coding was then utilized to identify concepts and categories for summarization and analysis of the data. During Phase 2 of the study, the researchers administered a written survey and demographic profile to pastoral participants, layperson personnel attending a regional conference, and a sample of members from two rural congregations that were pastored by the ministerial liaison. The survey was created by the principal investigator and research assistant and was reviewed by the ministerial liaison. The survey questions are as follows: (1) "Are you interested in receiving		Regarding the findings in both Phase 1 and Phase 2 of the study, participants report both positive and negative influencing factors of HIV/AIDS prevention being done in the Black Church. Some of the positive influencers included: (1) having an HIV-positive relative or close friend or member of the congregation, (2) married to a health care provider or being a health care provider, (3) previously lived in a larger metropolitan city and relocated to a small rural area, (4) being concerned about the parishioners/community and having a desire to help, and (5) recognizing that HIV/AIDS is a problem within the	

[redacted]		HIV/AIDS education and testing for your church congregation" (yes, no, if no, explain why) (2) "If you know anything about HIV/AIDS, where did you get your information" (e.g, brochures, TV, radio, internet) (3) "What influenced you to become concerned about or interested in HIV/AIDS" (4) "Do you have a Nurses Guild, Health Awareness Team, or Health Ministry at your church" (yes, no, if yes, how long) (5) "Do you personally know anyone who is HIV positive or who has AIDS" (yes, no, if yes, what is your		African American community (Foster, P., Cooper, K., Parton, J. & Meeks, J., 2011, p. 327). In regards to negative influencers, participants report that HIV/AIDS is not addressed in their churches due to (1) not knowing parishioners who are HIV-positive or have AIDS, (2) fear that addressing this social problem will compromise the ministry due to HIV-related stigma, (3) fear that addressing HIV/AIDS will offend elderly parishioners, (4) fear of being viewed as ignorant or not knowing enough about HIV/AIDS, and (5) not knowing how to address HIV/AIDS (e.g., moral issue versus a health/societal issue)	

[redacted]		relationship with them) (6) "Have you ever made a home visit or hospital visit to a HIV positive patient or a patient with AIDS" (yes, no, if yes, what is your relationship with them) (7) "Have you ever conducted a funeral for a HIV positive person or a person with AIDS" (yes, no, if yes, what is your relationship with them) (Foster, P., Cooper, K., Parton, J. & Meeks, J., 2011, p. 325). Descriptive statistics were employed to analyze demographic data retrieved from Phase 1 and Phase 2; descriptive statistics were employed to analyze Phase 2's		(Foster, P., Cooper, K., Parton, J. & Meeks, J., 2011, p. 327).	

		survey. Frequencies and percentages were computed for both Phase 1 and Phase 2 study Participants. Cross-tabulations were utilized along with Pearson x^2 and Fisher Exact Test to show if there difference between rural and urban churches and other variable of interest for participants in Phase 2 of the study.			
Francis & Liverpool (2009).	**Literature Review** **3**	Researchers confirm the evidence that supports the notion that faith-based settings should provide HIV/AIDS prevention; there is little evidence on the different types of faith-based HIV prevention programs that are currently being implemented and/or have been implemented effectively in faith-based settings.	Literature review search is limited to two search engines to retrieve manuscripts; there may be more evidence regarding this phenomenon than they report.	Literature review obtained nearly 500 manuscripts of evidence. Faith-based HIV prevention programs that targeted African American were strategized into 3 populations: (1) faith-based leaders, (2) adult substance users, and (3) adolescents. The Churches United to Stop HIV (CUSH) program is	Evidence suggests that public health and FBO can partner and collaborate to develop HIV/AIDS prevention/education programs for African Americans. In order for collaboration to be successful between both parties, the following key

		Researchers conducted a comprehensive literature review of faith-based HIV/AIDS prevention programs in order to provide recommendations for developing partnerships with faith-based organizations to provide HIV/ADS prevention and education. Researchers utilized Medline and PsychInfo search engines to conduct literature search. Approximately five-hundred manuscripts were obtained. Key words utilized to obtain articles, briefs, and peer-reviewed data are as follows: (1) "Religion and HIV prevention" (2) "Church-based HIV programs"		a faith-based HIV prevention programs that targets church leaders aimed at training leadership how to develop HIV education programs, provide outreach and referral services, and implement support programs for persons infected/affected by the virus. The Metropolitan Community AIDS Network (Metro CAN) is a faith-based HIV prevention program that targets adult substance users addressing their HIV risk behaviors, provides substance use treatment, case management, and mental health services with integrated spirituality and cultural competency.	elements are necessary to bridge the two together to provide HIV prevention/education: (1) Involve the FBO and the target population in design, implementation, and program evaluation; (2) Recognize that the senior pastor/pastoral staff may have time constraints, requiring a liaison who is committed in HIV-related initiatives; (3) Incorporate spirituality and compassion into prevention

		(3) "Religiosity and HIV prevention" (4) "Black churches and HIV" (5) "Black churches and HIV prevention" (6) "Churches and HIV prevention" (7) "Faith-based HIV prevention" (Francis & Liverpool, 2008, p.8).		An intervention known as Teens for AIDS Prevention (TAP) is a faith-based HIV prevention programs targeting African American adolescents. This church-based program provides teens with HIV/AIDS facts and vocabulary, HIV transmission, condom information, communication skills and addresses other topics. Another church-based intervention, Project BRIDGE, targets adolescents providing them substance use and HIV/AIDS risk reduction.	efforts instead of authoritarian and judgmental opinions and attitudes, (4) Make sure the program is culturally appropriate for the target audience, (5) Create a sense of ownership by the FBO to ensure wider program distribution and participation (Francis & Liverpool, 2009, p. 12) Many FBOs struggle with the sexual immorality and drug abuse behaviors associated with the root of HIV acquisition and transmission.

					Because providing comprehensive sexual risk behavior reduction is a key component for HIV prevention/education, FBOs may not want certain elements to be presented to parishioners as it may violate church doctrine. Instances like these will take collaboration between public health and the FBO so that HIV prevention/education can be presented to parishioners in a manner that is congruent with leadership's wishes. Public health professionals need to be aware that

					churches may not want certain aspects of an intervention to be presented to parishioners. Therefore, they need to be willing to negotiate with church leaders so that both parties can reach an agreement as to what will be effective. Furthermore, it may be permissible that the two entitles can partner to the extent that abstinence can be the high-light of HIV prevention/education within the FBO and then "bridge" parishioners to community organizations for more comprehensive

					HIV prevention/education information.
Freeman, C. (2010).	**Expert Opinion** **4**	The author explains the impact of the HIV epidemic among the African American female population and describes the need for behavioral interventions specific for females who attend historically Black colleges and universities (HBCUs). Author describes behavior change interventions tailored to address the cultural and socioeconomic aspects of HIV prevention among African American females at HBCUs and the broader African American community.	There is limited knowledge related to the incidence of HIV transmission among African American females who attend historically Black colleges and universities. More HIV prevention interventions are needed to address issues related to HIV transmission among college age African American females as well as members of the larger African American community.	Population limited to African American females attending/living on HBCUs; may not be generalizable to African American females across the nation.	HIV rates are alarming among the African American female population. In order to reduce infectious rates among them, culturally appropriate public health initiatives need to be executed, community support provided, and more awareness of the factors that influence their high-risk sexual practices need to be explored. HIV/AIDS prevention programs targeting African American females need to be culturally competent and

			Evidence suggests that HBCU campus environments contain multiple factors that can promote a breeding ground for HIV acquisition/transmission among African American females. First, African American females make up a larger percentage student population than their male counterparts creating a female gender surplus. The imbalanced gender-ratio creates an environment where "man-sharing" may become		focus on the many factors affecting an individual's risk for HIV, including sociocultural factors. As the HIV epidemic continues to burden the African American female community, more information needs to be developed pertaining to the following inquires: (1) "why do females willing participate in unprotected sexual activity with males whom are suspected to be on the down-low," (2) "what should be asked of young females

			standard practice. Imbalanced gender-ratio gives males leverage to decide whether condoms will be employed during sexual activities; this makes females vulnerable to HIV infection. African American females living on HBCUs may have male partners who have sex with other males, which increase their risk for HIV. Physiologically, males are more likely to transmit HIV to females versus females-to-male because: (1) more		how have multiple sexual partners as a result of a past history of sexual abuse" (3) "what should be asked of females who possess a high level of spirituality and participant in high-risk sexual activities" (4) "what should be asked of males who engage in unprotected sexual activity with both males and females" (Freeman, C. 2010, p. 54). It is essential that advance practice nurses understand the relationship

[redacted]			exposed surface area in the female genitals than males; (2) higher levels of HIV is found in semen than in vaginal fluids; (3) more semen is exchanged during sex than vaginal fluids; (4) females often have undiagnosed STDs that makes them more vulnerable to acquire the infection. A history of sexual abuse during childhood may contribute to high-risk taking sexual behaviors that may increase a female's lifetime risk of contracting HIV.		between health-related beliefs, cultural values, disease incidence/prevalence, and develop skills to improve quality of care to diverse populations.

			Author reports that research studies have historically treated African Americans as a "one monolithic whole;" ignoring differences within the population may decrease the efficacy of HIV prevention among certain groups.		
Fulton (2011).	**Descriptive Study** N=203 **2+**	Black Churches have served as institutional hubs within the African American community and have been the forerunner for social change to addressing the challenges its people face. In light of the HIV epidemic that is disproportionately affecting the African American community, however; the Black Churches'	Small sample size; may not be generalizable to all Black Churches across the nation.	Findings show that Black Churches who are externally engaged with community affairs (e.g. collaborate with outside organizations, promote political participation, has a group which assesses community needs, seeks government funding, and has outside speakers) are more	There is a lot of variation within the Black Church community and no two Black Churches are necessarily the same. In terms of HIV/AIDS prevention and outreach, evidence suggests that a Black Church congregation's commitment to a

		ambivalent response to this social problem may signify that this institution may not be as relevant as it once was, per researcher. Per researcher, there may be two variables that may predict whether a Black Church congregation will respond to addressing HIV/AIDS within its community: (1) the congregation's liberal-conservative ideological orientation and (2) the congregation's external engagement with the community. The two hypothesis driving this research are as follows: (1) "Conservative Black congregations will be less likely to have an HIV/AIDS program,"		likely to offer an HIV/AIDS program than churches who are not involved with their local communities. A congregation's liberal-conservative theology is not a factor whether the church will offer an HIV/AIDS program. Black Churches who identify as politically conservative, report the Bible is inerrant, have no welcome statement for homosexuals, and/or forbid homosexuals to have a leadership role within the congregation were less likely than non-conservative identifying Black Churches to offer an HIV/AIDS program. Clergy's level of education and the congregation's age also showed to have	social service can function independently of its liberal-conservative disposition. Evidence suggests that Black Churches who are involved with the social affairs of their external surroundings are more likely to have an HIV/AIDS program than those who are more isolated from their community (worldly affairs). When examining whether a Black Church will respond to African American social issues, a predictor is to focus on the ongregation'sinter action with their external

[redacted]		(2) "Externally engaged Black congregations will be more likely to have an HIV/AIDS program" (Fulton, 2011, p. 619). A Black Churches' liberal-conservative ideological orientation and external engagement to sponsor an HIV/AIDS program were analyzed by using the Wave II of the National Congregations Study (NCS). Furthermore, the researcher analyzed the perspectives of parishioners who attend congregation-based social services (e.g. HIV/AIDS programs) in order to obtain qualitative data about the characteristics of the		no effect whether a Black Church has an HIV/AIDS program. However, a church's geographic region and the setting it is located in (urban, rural, in the South) is a predictor whether the congregation offers an HIV/AIDS program. Black Churches residing in the South were significantly less likely to offer an HIV/AIDS program than those located in other regions (residing in urban settings).	environment versus determining where the congregation fits along the liberal-conservative continuum.

		type of persons who attend such activities. The dependent variable in this study is *HIV/AIDS program* inquiring participant's about "does your congregation currently have any program or activity specially intended to serve persons with HIV or AIDS;" responses were coded as "yes" (1) or "no" (0). To assess the congregation's ideological orientation, 5 "dummy variables" were constructed to operationalize the congregation's liberal-conservative ideology which are the following: (1) *Theologically conservative* – "theologically speaking, would your congregation be considered			

		more on the conservative side, more on the liberal side, or right in the middle, (2) *Politically conservative* – "more on the conservative side," "more on the liberal side," or "right in the middle," (3) *Bible is inerrant* – "does your congregation consider the Bible to be the literal and inerrant word of God," (4) *No statement welcoming homosexuals* (5) *Forbids homosexual leaders* (Fulton, 2011, p.620-621). Five dichotomous variables were used to measure a congregation's			

		engagement with their external environment to predict whether a Black Church would have an HIV/AIDS program. The 5 variables are as follows: (1) [Congregation] has a group assessing community needs, (2) Collaborates with outside organizations, (3) Promotes political participation, (4) Seeks governmental funding, (5) Has outside speakers (Fulton, 2011, p. 622). The researcher also analyzed other variables that would influence a Black Churches' likelihood of having an HIV/AIDS program which are as follows:			

		congregational size, clergy graduated, congregation's ages, geographic region, and community context (urban versus nonurban). The sample consisted of 203 Black Churches of whom African Americans accounted for at least 60% of the congregants; total sample represents approximately 100,000 regularly attending adult parishioners.			
Goparaju, L. & Warren-Jeanpiere, L. (2012).	**Exploratory Qualitative Study** N=36 **2-**	Researchers examined African American female's knowledge, attitudes, beliefs, and behaviors regarding males "on the DL." Invitation letter was sent to Washington DC's Women's Interagency HIV Study (WHIS) regarding voluntary study. The topic and	Findings may not be generalizable to all African American females. HIV serostatus may have influenced participant's perception about non-disclosing males on the	The mean age of the participants was 45 years old, with a range from 25 to 60 years. Seventeen participants were HIV-negative; 19 were HIV-positive. Majority of the participants had a high school diploma, 14 reported never been married, 20 reported an annual	Females in this sample are aware of the phenomenon of males being on the DL. Because the HIV epidemic is highly prevalence in the Washington DC area, females are concerned of male partners being on the DL which

[redacted]		goals of the study were explained in detail when females expressed interest to participant in the study. Transportation, refreshments and $40 dollars cash was provided to participants for compensation for their time. Thirty-six African American female participants were recruited from Washington DC, some of whom were HIV-positive. Participants were subdivided into 6 focus groups; 3 of the groups consisted of HIV-positive participants and 3 were HIV-negative. Participants engaged in focus-group discussions which captured their responses regarding their knowledge,	DL, especially if the participant was a victim of HIV infection from a partner suspected or was on the DL.	income less than $12,000 a year. Data analysis shows that six major sub-categorical themes emerged from the focus-group discussions; no differences were found between HIV-positive or HIV-negative focus groups. Most of the participants became aware of the term "on the DL" mainly from media outlets like movies, books, or talk shows regarding the DL lifestyle. Most participants had a high index of suspicion towards potential male sex partners living in the Washington DC area. Because HIV is highly prevalent in the DC area, participants express concerns about	may increase their risk of HIV or re-infection with a different strain of HIV. Findings imply that females have an important role in facilitating an open dialog with their male partners about sexual health and safe-sex practices. It is important for females to inquire about their male partner's sexual history early during the course of their relationship in order to obtain a baseline of their partner's behavioral risk. Information they should inquire about include the following: 1) What is your HIV status

[redacted]		attitudes, beliefs, and behavior pertaining to males on the DL. The following questions served as focus group guides for participants to discuss in their focus group: (1) "Have you heard the term 'down-low' or 'DL'" (2) "How did you hear about this term" (3) "What does 'DL' mean to you" (4) "Describe how you would feel if you discovered your partner was having a sexual relationship with another woman" (5) "Describe how you would feel if you discovered your partner was having a sexual relationship with another man" (6) "Why do you believe some		engaging in sexual relationships with local males in part due to their high incarceration rates. They believe that incarcerated males are higher risk HIV partners since men tend to engage in DL sex with other inmates and not report this activity when released from jail. Participants revealed that they would have feelings of anger and hurt if they found out their male partner was having sex with other men on the DL. However, 3 of the focus groups expressed empathy towards DL African American males because they realize that homosexuality is stigmatized within the African American community which	2) Have you had any STDs in the past six months 3) How many male partners have you had since your last HIV test 4) How many female partners have you had since your last HIV test 5) Do you always use condoms with your sexual partners (Goparaju, L. & Warren-Jeanpiere, L., 2012, p.889). Study implications for health care providers who care for HIV-positive and/or at-risk females it that they can help African American females engage in

[redacted]		African American men might be on the 'DL'" (7) "When you have a new sexual partner do you ask his sexual history" (8) "Do you specifically ask your partner if he has had sex with other men" (9) "How do you ask this question" (10) "Do you always use condoms with your partner" (Goparaju, L. & Warren-Jeanpiere, L., 2012, p.883). The interview guide was modified as needed depending how the females responded to the questions. The facilitator (first author) asked additional questions, when necessary, to		marginalizes males who struggle with same-sex tendencies from reaching out to obtain the support they need. Three of the six focus groups reported that homosexuality is a sin based upon their religious convictions. With regards to sexual health communication practices with male partners, participants report varying degrees regarding their sexual health communication styles and strategies with current or potential male sex partners. Some participants report the necessity of asking direct explicit questions about their male partner's sexual orientation and/or HIV status;	direct health communication with males on the DL. Health care providers can empower females with tools how to facilitate sexual health communication with their partner(s) while encouraging them to obtain partner sex history early-on within their relationships. Health care providers should be aware of African American males who are on the DL, the cultural ramifications thereof, and assist females to become more comfortable of speaking openly with male

		facilitate emerging group discussions. Upon completion of the focus group discussions, audiotapes were transcribed verbatim. Transcripts were uploaded into NVIVO 9 qualitative data analysis software to facilitate coding processes.		others use indirect communication methods.	partners about DL behavior.
Harvey, S. & Bird, S. (2004).	**Exploratory Qualitative Study** N=84 **2-**	Study was conducted in two phases. For Phase I, the sample consisted of 22 African American couples who were recruited through the female partner. Phase II consisted of 40 African American females. Females were recruited from family planning and STD clinics, and other community areas in Portland, Oregon. In both phases, females were recruited into the	The definition of power in a relationship among participants is subjective and may not be applicable to the general African American population. Study was conducted in the West; participant's perspectives may differ than those residing	About three-quarters of Phase I participants (both males and females) report that power in a relationship means control. Some participants believe that power in a relationship means that one person has total control over the other individual or that one partner has control over the partner's actions (e.g. the leaders, has the "upper hand"). Majority of women and 50% of the	Relationship power is linked to control and decision-making. Persons who are in control within the relationship are thought to have "power over" the other individual. Sources that make females feel powerful in their relationships include education attainment, financial independence (financial

[redacted]		study (by phone or in-person) if they self-identified as African American, between ages 18-25, had a male sex partner, and engaged in unprotected vaginal or anal sex within the previous 3 months. In addition, they had to meet one or more of the following conditions: (1) More than one lifetime sex partner (2) Ever had an STD (3) Ever had sex with a man who she knew or thought has having sex with other men or women (4) Ever had sex with a man who she knew or thought was using IV drugs (5) Ever had sex with a man who she knew or thought	in other regions in the country. Power dominance in a relationship may be dependent upon confounding factors not discussed in this study (relationship length, age difference, circumstantial situations, etc.).	males report that having control in a relationship, control over their partner, independence, and being the dominant decision-maker are important components of feeling powerful for females. Females feel powerful when they are autonomous and can do things without asking her partner. Sources of feeling powerful can be when females are in charge of money, able to provide for their family, or earn more money than their male partner. Physical pulchritude and ability to control when and type of sexual acts make females feel powerful, as does objecting to sexual intercourse. Forty-six percent males and 73%	provider), and physical pulchritude. Females feel powerful in relationships when they feel close with their male partner and know that their partner is faithful to them. Lastly, Phase I participants report that sexual/reproductive decision-making is a shared activity and that both males and females share this power with their partner.

		had an STD or HIV/AIDS (Harvey, S. & Bird, S., 2004, p. 4). For Phase I, both the female and their male partner had to be willing to participate in the study and both members of the couple had to agree to participant in order to be enrolled into the study. The male partner had to be 18 years old or older but did not have to self-identify as African American. To explore the meaning of power in heterosexual relationships, the researchers asked Phase I participants the following questions: 1)"What does power in a relationship between a man and a woman mean to you" 2)"What things do you think make a		females believe that condom utilization is a joint decision with their partners.	

[redacted]		women feel powerful in a relationship with a man" (Harvey, S. & Bird, S., 2004, p. 4). Furthermore, the questions were asked in the context in the following manner: a) When to get pregnant b) Whether to use something to keep from getting pregnant c) Whether or not to use a condom d) Whether or not to have sex e) What kinds of things they do when they have sex (Harvey, S. & Bird, S., 2004, p. 6). In Phase II, female participants were assessed on their level of agreement with 26 statements regarding what makes women feel powerful in heterosexual			

		relationships. The 26 statements were derived from Phase I female participant's belief; congruencies were assessed in Phase II.			
Hodder, S., Justman, J., Haley, D., Adimora, A., Fogel, C., Golin, C., O'Leary, A., Soto-Torres, L., Wingood, G., & El-Sadr, W. (2010).	**Expert Opinion** **3**	A summary of current epidemiology of HIV/AIDS among females in the United States, researchers provide suggestions on critical components that need to be unified in order to provide cohesive plan to reduce the incidence of HIV infection among females in the United States.	NA	The incidence and prevalence of the HIV is concentrated in hot spots that vary by location, poverty rate, race/ethnicity, and mode of transmission. By 2006, approximately 1.1 million adults and teenagers had been infected with HIV. Of the 1.1 million persons infected, about 21% were unaware of their infection. The HIV epidemic among US females is concentrated in the Northeast and the South. Heterosexual activity is the major mode of HIV	Four areas must be addressed to effectively counteract the incidence of HIV within the female African American population. First, more studies need to be done to assess the characteristics of at-risk African American females. In doing so, more evidence will shed light why the incidence of HIV is rising within this population. Second, HIV behavioral interventions need to also address the male partners of

				acquisition for US females since 1995. HIV is the third most common cause of death among African American females aged 35 to 44 and the fourth most common cause of death among younger African American females aged 25-34. African American females are at risk for HIV infection due to the following: poverty, lack of access to medical care, poor knowledge about HIV/AIDS, financial dependence on male partners, low self-esteem, alcohol and drug use, and assortative mixing within the high-HIV prevalence African American community. In addition, concurrent sexual partnerships,	African American females. This will capture partner characteristics that are driving the epidemic among females. Third, expanded HIV testing and linkage to care is critical for African American females in order to reduce the spread and morbidity & mortality of the infection. Lastly, HIV prevention plans (such as the NHAS) need to continuously make implementation recommendations that are evidence-based and have proven efficacy.

				having a partner who has been incarcerated, and the imbalance gender ratio in African American communities place females at risk for infection.	
Ivy, W., Miles, I., Le, B. & Paz-Bailey, G. (2013).	**Cross Sectional Study** N=3,951 **2-**	Investigators compared individual risk factors, sex partner characteristics, and socioeconomic/demographic characteristics of HIV-positive-unaware African American females to HIV-positive infected females recruited in 20 cities in the United States. Individuals were recruited from poverty stricken areas, as defined by the U.S. Census Bureau as places where 20% or more of the residents live below the poverty	Study is limited to those living in the 20 Metropolitan Statistical Areas; may not be generalizable to African American females of higher socioeconomic status.	Among HIV-positive females, those who were previously diagnosed with HIV were similar to HIV-positive-unaware females in terms of demographic and economic variables evaluated in this study. Various demographic and socioeconomic factors are significantly associated with being HIV-positive-unaware. Such factors included: 35 years and older, low education attainment (less then high	In low-income African American females, contextual factors such as age, socioeconomic characteristics, and last sex partner characteristics are strongly associated with an HIV-positive-unaware status then individual risk factors. African American females who have exchange-for-sex partners appear to be one of the greatest risk factors to being

[redacted]		threshold. Eligible participants completed a survey and were asked to recruit 5 peers from their social network. Their peers completed the survey as well; participants who reported a low socioeconomic status and no injection drug use in the previous 12 months were asked to recruit persons from their social networks as well. Females who were recruited include those who self-report being Black or African American, consented to both the survey and HIV test, resided in the contiguous U.S., and had a positive or negative HIV test result. Variables for analysis included socioeconomic status		school diploma), homeless, Medicaid recipient, unemployed, disabled, or "other" employment classification status. Risk factors associated being HIV-positive-unaware are related to drug use and exchange sex. Characteristics of the female's sex partner are also a contributing factor to HIV-positive-unaware status. Females who suspected their last male sex partner had ever had sex with another male were more likely to be HIV-positive-unaware; also those whose partners had used illicit drugs.	HIV-positive-unaware. Because 42% of the recruited sample consisted of African American females having an HIV-positive-unaware status, not knowing one's HIV positive serostatus may be a contributing factor fueling the HIV epidemic among low-income African Americans in urban places. Socioeconomic/demographic variables along with partner risk characteristics are associated to having an HIV-positive-unaware status compared to individual risk factors alone. Living in poverty stricken areas

		& demographic data, partner risk factor, or individual risk factor.			with limited resources are a factor that, by it-self, increases African American females to be at risk for HIV infection. HIV prevention interventions that target African American females need to take into account the contextual factors that predispose this population for HIV infection rather than focusing on individual behavioral factors alone.
Malebranche, Fields, Bryant, & Harper, (2009).	**Qualitative Exploratory Study** N=29 **3**	Obtained sample from self-identified Black MSM in Atlanta, Georgia via internet, intercept method at Piedmont Park, and snowball methods. Interviewed all MSM participants via an	Interrater reliability may not have been consistent throughout study. The relationship between masculinity and sexual risk	1.Central themes captured was the physical, emotional or psychological absence of biological father's presence lacking in participants lives growing up due to early age death,	This study is one of the first to qualitatively explore masculine socialization among groups of Black MSM, so more work is needed.

[redacted]		instrument developed by the lead PI capturing the study's explorative questions. Interviews were recorded, transcribed verbatim and uploaded into Altas.TI to organize code and analyze the data.	behavior among Black MSM may be confounded by other variables. The concepts of socialized masculinity are limited to the perspectives of Black MSM in the study.	incarceration, emotionally distant or never knowing who they were. Formative Black manhood teachings emphasize hustling and making babies. All participants acknowledge that muscular physique, baggy clothes and thug-like behaviors are what defined stereotypical Black manhood today. 2. Participants view the gay lifestyle to entail: careless lifestyle, flamboyancy, promiscuity, drug usage, disjointedness and only pertaining to White men. These perceptions influenced them to distant themselves from identifying as gay or associate with the gay community. 3. Findings show that one's race has	1. A stark reality of fatherless upbringings emerged in the analysis; the impact of fatherless households may be a factor to think about among YBMSM. 2. Black racial identity has much influence on: sexual behaviors, partner selection, involvement in the gay community and sexual identification labels. 3. Attention needs to be given to the unique racial and cultural context of masculine socialization experiences that impact the lived experiences and mental health of Black MSM.

				an impact on sexual identity within the community. Being Black and identifying as gay is a social disadvantage; Whites can be open with gay sexuality due to White privilege. 4. Masculinity plays an important factor in selecting sexual partners; femininity is not desirable in male sexuality. The "top" is perceived as masculine and considered a protective component from HIV risk as they have more control of condom usage during sexual acts.	
Mallory, C. (2007).	**Descriptive Study** N=10 **2-**	The researcher conducted a descriptive study to explore the experiences of HIV-positive African American females	Study is limited to low-income African American females residing in the rural Deep South.	The participants consisted of heterosexual African American females between 30 to 64 years old, had 1 to 11 children, obtained	Majority of the females in this study acquired HIV from being in monogamous relationships with long-term male

		living in rural southeastern United States. The target population of this study consisted of rural African American females who were previously infected with HIV and were marginalized by poverty and/or drug use. To be included in this study, participants had to be at least 18 years old, residing in or located near a community with a population of 20,000 residents or fewer, be HIV-positive, and have a history of drug use and/or living at or below the poverty line, speak English, and provide informed consent. The sample population was conveniently recruited from a pool of eligible females	Study may not be applicable to African American females residing in urban cities or those who are not socioeconomically derived.	10 to 15 years of education, and had limited resources. Participants reported that their HIV exposure consisted of engaging in sexual contact with male(s), some of whom were IV drug users or had sexual contact with other men or women. However, 7 females had acquired HIV from long-term male partners such as their husband or live-in boyfriend. Three females were unsure who transmitted HIV to them secondary to them trading sex for drugs, money, or shelter. Participants were strategized into two categories. The first were those who engaged in multiple high-risk activities. The second were	partners. Most females were primarily interested in sustaining meaningful long-term relationships that enhanced their quality of life; little did they know they would be at risk for HIV infection. If condoms are introduced in monogamous relationships, this can create strife between couples because partners may suspect infidelity. Although high-risk HIV behaviors such as IV drug use, multiple sex partners, and trading sex for money, drugs, or shelter is intuitive to acquiring HIV, introducing

		who had participated in a previous study and were referred to the researcher. Recruited participants were made aware that participation was voluntary and received $20 cash for each interview. The research conducted a pre-post interview with each participant to collect qualitative data. Data collected pertained to demographic, HIV risk, and biographical information. Females were asked about the events and circumstances that led to their HIV infection. All interviews were recorded and transcribed verbatim. Transcript data were organized using a combination of work processing and qualitative data analysis software.		those unlikely to engage in high-risk taking activities. Some females acquired HIV as they traded sex for survival needs like drugs, money, food, and/or shelter. Several participants thought they were at low-risk to contracting HIV because they were in a committed romantic relationship. These HIV-positive females practice monogamy, had few lifetime sex partners, reframed from illicit street drug use, and assumed that their partner would protect them from STDs. Low-risk HIV-positive participants engaged in unprotected sex with their primary romantic partner	condoms to prevent HIV in monogamous committed relationships is troubling for many African American females. As the prevalence of HIV rises among African Americans, risks for HIV transmission from perceived monogamous male partners are increasing female's risk for HIV. Although abstinence until marriage (or a committed relationship) has been the traditional message to preventing HIV, females who are married may still need to utilize

				because of the following: (1) desired partner intimacy, (2) lacked judgement of partner's HIV-risk, (3) expected partner to be faithful, and (4) desired to become pregnant (Mallory, C., 2007, p.32). In addition, low-risk HIV-positive participants perceived that males should initiate condom utilization. Low-risk HIV-positive participants expected their male partners to be faithful and that if the male were unfaithful they assumed he would at least use a condom to protect her from HIV/STDs.	condoms to prevention the acquisition of HIV.
Moore, D., Onsomu, E., Timmons, S., Abuya, B. & Moore, C. (2010).	**Exploratory Qualitative Study** N=7	The researchers explored HIV/AIDS communication strategies among church leaders at	Small sample size limited to metropolitan North Carolina community.	Sample demographics consisted of mostly male (57%) Black Church leaders;	The Black Church is an institution that has empowered the African American

[redacted]	**3**	predominately African American Black Churches who were constituents in interfaith-based organizations which consists of different religious denominations/faith belief systems. Realizing the Black Churches are important institutions that can play role in reducing the spread of HIV/AIDS, the researchers sought to answer three main questions: (1) How do leaders in predominately African American churches, who are members of an interfaith-based organization in North Carolina, communicate HIV/AIDS information to their congregations and	Opinions and views expressed by leadership in this study may not be generalizable to Black Church leaders in other regions of the country.	most leaders were Baptist (57%), followed by Presbyterian (29%) and Catholic (14%). Seventy-two percent (or 72%) were leaders over congregations consisting of over 500 parishioners, 14% were leaders over congregations sized 251-499, and 14% were leaders over congregations 101-250 parishioners. The churches represented were among a coalition of the interfaith-based HIV/AIDS organization for more than five years. Data analysis revealed four major themes that emerged from the Black Church leadership participants. The four themes are: (1) "disseminating	community to triumph over difficult and oppressing times; it remains relevant today and can help meet the biopsychosocial emotional needs of the African American community. Evidence from this study suggests that the Black Church can be used as a platform to help reduce the spread of HIV/AIDS within the African American population. Despite its potential, only some Black Churches appear to be willing to play an active role in the fight against HIV. Although prevalence of

[redacted]		the surrounding community (2) How do leaders at predominately African American churches, who are associated with an interfaith-based organization, address HIV/AIDS stigma (3) How do leaders at predominately African American churches, who are involved with an interfaith-based organization, educate or conduct HIV/AIDS testing (Moore, D., Onsomu, E., Timmons, S., Abuya, B. & Moore, C., 2012, p.866) Researchers recruited 7 pastors/preachers from North Carolinian Black Churches who participated in semi-standardized interviews over the		information about HIV/AIDS through a combination of communication modes, (2) responsibility and obligation to create more awareness about HIV/AIDS, (3) reducing stigma by example, and (4) preaching and teaching compassion" (Moore, D., Onsomu, E., Timmons, S., Abuya, B. & Moore, C., 2010, p. 870). **First Emerging Theme: Disseminating Information about HIV/AIDS through a Combination of Communication Modes.** Participants reported disseminating HIV/AIDS in a variety of ways to congregants is	HIV-stigma abounds in many Black Churches, there are some Black Churches who embrace educating their parishioners about the disease. Black Churches that provide HIV/AIDS prevention/education can serve as models for other churches to follow. In order for HIV prevention education to be delivered within Black Churches it is imported to collaborate with leadership to learn and adhere to their preferred way of communicating HIV/AIDS to their congregants. Community health

[redacted]		telephone. The semi-standardized interviews consisted of a set of predetermined questions which allowed researchers to ask in-depth questions based on the respondents' answers. The study's instrument consisted of 18 questions in which 7 of the questions assessed background information about the participant's church. Some of the questions were the following: (1) "How do you communicate information about HIV/AIDS (sermons, workshops, speakers)" (2) "Are there any scriptures that you use to address		effective. Communicating HIV/AIDS to congregants can consists of having: (1) HIV-focused prayer breakfast, (2) hosting health professionals or people living with HIV/AIDS (PLHA) to teach about the infection, (3) and wearing HIV ribbons during certain times to remind people about disease prevalence. However, it was made aware that preaching about HIV in sermons or doing a few workshops alone is not adequate in disseminating HIV information. **Second Emerging Theme: A Sense of Responsibility and Obligation to Create More Awareness about**	organizations and partners (like HIV knowledgeable health professionals) can be instrumental by providing culturally relevant educational resources to Black Churches to increase congregants' knowledge/awareness about the disease while decreasing associated stigma.

[redacted]		HIV/AIDS or behaviors associated with HIV/AIDS such as intravenous drug use" (3) "How does your church plan to continue HIV/AIDS education" (Moore, D., Onsomu, E., Timmons, S., Abuya, B. & Moore, C., 2012, p.869). Conversations were recorded, transcribed, and analyzed. Grounded Theory was utilized to analyze the data. The researchers also used an open coding method to examine, compare, conceptual and categorize the data. The Grounded Theory enabled researchers to report the main communication approach Black Church leaders used		**HIV/AIDS.** Leadership participants expressed that the Black Church as a role and level of responsibility of raising the level of awareness about HIV/AIDS within the African American community. Participants report that the church, as an institution, should be on the forefront of making the African American community more aware about HIV and that pastors/preachers (leaders) have a duty to organize HIV/AIDS Ministries to address the epidemic affecting the community. **Third Emerging Theme: Reducing**	

[redacted]		disseminate HIV/AIDS information to African American parishioners.		**Stigma by Example.** Participants report that reducing HIV stigma within the African American community is important. Doing so, leadership report decreasing HIV-stigma by testing for HIV and encouraging parishioners to test for HIV so that people can know their status. Participants report that it is essential that leadership support and embrace people who are HIV/AIDS positive and be more open to discuss the behaviors that make African American at risk for HIV. **Fourth Emerging Theme: Preaching and Teaching Compassion**	

				Participants reported that it is essential that leadership demonstrate love and compassion towards PLHA and instruct parishioners not to judge or condemn how HIV-positive persons contracted the disease. Participants report that the Black Church should be a place for PLHA to obtain the emotional support they need while suffering with the disease.	
Newsome, J. (1994).	**Qualitative Study** N=15 **3**	Researcher conducted a qualitative study to define and delineate the role of nursing in the Black Church setting; comparisons were made between the roles of a church nurse versus a professional nurse. A sample of 15 participants, consisting of 3 types of members from 5	Recall Bias Small sample size	**History of Church Nurse** Most participants reported that church nursing existed within their congregation since the inception of their faith-based organization. Among the 5 representative churches, Nurses Guilds had an	Nursing was birthed out of the church, and its historical roots are that of being perceived as a Christian calling to serve humankind and glorify God. Because church nursing preceded professional nursing, the two

		different types of denominations within the African American religious community, was included in the study. The 5 denominations included African Methodist Episcopal, Baptist, Church of God, Nondenominational, and Pentecostal. Five participants were ministers, 5 participants were church mothers, and the other 5 participants were members of the Nurses Guild of each church. Eighty percent of the minister participants were male; this sample had an age range of 40 to 65 years. Church mother participant's age range was 60 to 80 years. The target sample, members of the Nurses Guild,		existence within them from 20 to 60 years. Participants noted that church nurses are distinguished from other leaders/members in the church by their traditional uniform—white dress, cap, hosiery, and shoes, which has remained constant over time. Consensus among the participants revealed that the definition of a church nurse is someone who: (1) professes Jesus as their savior, (2) claims to be a Christian, (3) dedicated to their calling, and is (4) knowledgeable of the Bible and nursing duties. In addition, participants identified church nurses as individuals	roles are similar to the extent of caring for individuals with acute problems or providing health promotion/disease prevention activities. The roles differ according upon where care is given; nurses working within congregations perform duties under the auspices of the church when working as a church nurse. Overall, the sample had different perspectives of a church nurse's role based on whether the participant was a minister, church mother, or nurse. Nurses in the study regarded that church nurses

		consisted of an age range of 30 to 65 years. Two of these nurses were registered nurses, one was a licensed practical nurse, and the other two were lay nurses. The researcher conducted 3 focus groups; each focus group consisted of a representative from each of the 5 church sites sampled. The focus groups served the purpose of providing qualitative information regarding church cultural patterns or themes related to the community, its history, rituals, citizens, social norms/rules, beliefs, and practices. The 3 focus groups met in a local community center. The researcher conducted all focus		who care for members who are sick, experiencing bereavement, comfort children, and care for those who cannot care for themselves, and cherishes/nurtures individuals while providing the best possible care. **Role of the Church Nurse** Participants described the duties of the church nurse as the following: (1) Assist children, the elderly or anyone who display illness or an inability to help themselves (2) Take care of infants and children during church services (3) Take care of individuals who cannot walk or need assistance in walking	attended to parishioner's medical issues during services whereas ministers and church mothers viewed church nurses as providing more than less comfort measures during church services. All participants were knowledgeable about diseases impacting the African American community and suggest that professional nurses should set-up and offer health education programs within the church setting.

[redacted]		groups. Following the focus group session, participants who were more knowledgeable were further interviewed one-on-one with the researcher in order to clarify and elaborate on experiences previously mentioned in the group sessions. Historical data and church literature were examined to add more depth to the study. After findings emerged, 3 participants from each group were asked to review overall findings of this study for accuracy. The researcher developed and used a questionnaire among participants to retrieve information such as the following: (1) The history of church nursing in		(4) Provide emergency care when needed within legal parameters and assist individuals to obtain necessary emergency medical attention (5) Accompany emergency patients to the hospital if needed (6) Call family members of individuals if needed for emergencies. (Newsome, 1994, p.136) **Significance and Importance of the Church Nurse** Participants reported that the church nurse is an important individual who is well-respected and whose services rendered to the	

		each church and internationally (2) The definition of church nursing (3) The role of the church nurse (4) The significance or importance of the church nurse to the participant and the congregation (5) Experiences involving the church nurse (Newsome, 1994, p. 135) After questionnaire completion, participants were asked to discuss and elaborate on their responses. The researcher actively engaged in the discussion via providing examples, asking more questions for clarification, and answering questions participants had		church is unique. The participants acknowledged that the services church nurses provide pastors and parishioners are very important including the Christian calling upon their lives to serve humankind and glorifying God. **Experiences** Participants reported the roles of the church nurse based upon their personal experiences. Minister, nurse, and church mother participants had slightly different perspectives of the church nurses' role. a. *Ministers*. Minister participants held the perspective that church nurses held the role of assisting them robe and	

		pertaining to the study. Content analysis was utilized into group data that was provided by participants from each of the five questionnaire inquiries.		disrobe during church services, fill their pitchers with water or juice, and/or handle parishioner emergency situations (e.g. hypoglycemic episodes). b. *Nurses*. Nurse participants reported that the church nurses' role consisted of providing health promotion and acute care services to parishioners. Acute care services include assisting parishioners who had fallen in the sanctuary, fainted, or had undergone cardiac arrest. Church nurses were described	

				as assisting bereaved families during funerals via comfort care to those crying and had fainted. Health promotion activities they performed include providing blood pressure screenings. c. *Church Mothers*. Church mother participants reported that the role of the church nurse also include assisting crying children during services, attending to parishioners who were experiencing potentially life-threatening situations (e.g.	

				syncope, hypoglycemia, etc.).	
Nunn, A., Cornwall, A., Thomas, Gladys, Callahan, Waller, A., Friend, F., Broadnax, J. & Flanigan, T. (2013).	**Exploratory Study** N=40 **3**	The HIV epidemic is disproportionate among the African American community in part due to the social and structural factors (e.g. poverty, HIV stigma, lack of access to care) that exist within African American communities. Faith-based institution may have a more significant role in controlling the African American epidemic. The researchers acknowledge that President Obama's National HIV/AIDS Strategy has great implications for faith-based institutions to prevent the further spread of HIV within the African American community. The researchers initiated a	Limited to faith-based organizations in Philadelphia, Pennsylvania; may not be generalizable to Black Churches located in other regions.	**Broad-based media approach** In order to promote HIV awareness, reduce HIV-stigma, and encourage HIV testing, a number of media messages were created and projected into the community. Billboards, posters, and transit shelter ads were created and posted in high incidence HIV zones of Philadelphia conveying people to test for HIV. Radio broadcast announcements by local pastors were done and Philadelphia's two main newspapers, "*The Philadelphia Inquirer"* and "*The Philadelphia Tribune,"* posted front-page articles	As the HIV epidemic continues to impact the African American population, it is critical that new HIV prevention approaches be developed to counteract the social and structural elements that drive the epidemic among African Americans and to accomplish the mission of President Obama's NHAS. This study shows the significance faith-based organizations can have in counteracting the HIV epidemic among African

[redacted]		citywide faith-based HIV/AIDS prevention campaign. The campaign had three primary components aims which included the following: (1) A citywide media campaign to raise awareness about HIV/AIDS in the African American community and the importance of engaging faith-based leaders (2) HIV testing and educational events at mosques and churches (3) Sermons about HIV/AIDS (Nunn et. Al, 2013, p. 260). The researchers conducted a community-based exploratory study sponsored by Brown University and Philadelphia Mayor Nutter's Office of		pertaining to HIV awareness. Finding showed that utilizing the media as a platform to spread the word of HIV had dramatic impact on faith-based prevention programs to fight HIV-stigma and increase community HIV awareness. **Enlisting clergy requires community outreach** There was widespread participations by local clergy. Many Black Churches and mosques were excited to engage in HIV/AIDS prevention program. Having high profile faith-leaders advocating for HIV prevention facilitated the recruitment of other	Americans. Black Church leaders are key stakeholders to address the epidemic within faith-based communities. This study adds to the evidence that when leadership in faith-based organizations is on-board in the fight against HIV, HIV testing and HIV/AIDS knowledge may be increased, HIV-stigma may be reduced, and better access/continuity of care may occur in African American communities. In all, engaging faith-based organizations appears to be a critical piece of the puzzle to

[redacted]		Faith-Based Initiative. Focus groups were formed and qualitative interviews were conducted to solicit faith leader's input for media outreach and HIV prevention campaigning. A total sample consisted of 40 leadership participants – who were pastors, imams, and other clergy, from various faith-based organizations representative of Philadelphia, Pennsylvania. Influential local pastors and imams were enlisted into study; their images were profiled on billboards and bulletin boards to promote HIV testing; high profile faith leaders provided HIV information during their sermons and conducted radio		clergy and promoted HIV testing in many faith-based organizations among who had never provided HIV testing evented prior and linked churches with community organizations to provide broader city wide network. **HIV education and testing events** A total of 150 people underwent HIV testing at Black Churches and mosques during the campaign. No one who tested for HIV was newly diagnosed with HIV. A large group of parishioners reported that they tested for HIV at their local Black Church/mosque after hearing support for HIV testing from their faith leaders.	controlling the HIV epidemic among African Americans. Gaining access to faith-based organizations is crucial to reduce the spread of HIV among African Americans. Because faith-based organizations may vary from one institution to the next it is important to note that HIV prevention efforts within various Black Churches/mosques my require tailoring activities/events to the individual institution versus a "one size fits all" approach to HIV prevention in church settings.

[redacted]		interviews to promote citywide HIV/AIDS awareness.		Results showed that HIV testing turnout was highest among congregations in which faith leaders encouraged parishioners to get tested during sermons. Conversely, in 3 faith-based organizations where the pastors did not preach about HIV during sermons but who offered HIV testing events only had 10 people who tested for HIV. **Costs and sustainability** The enactment of this citywide campaign research effort led to the creation of *Philly Faith in Action*, which is an alliance between Brown University Medical School's Global Health Initiative and 70 faith leaders in	HIV prevention interventions need to be developed since current evidence-based interventions are not tailored to local audiences or culturally specific for dissemination in partnership with religious institutions. More research needs to be done to further understand how community-based organizations and African American faith communities can partner to provide effective HIV prevention and how the two entities can augment each so African Americans can receive comprehension HIV health promotion/disease prevention care.

				Philadelphia. This newly formed alliance developed HIV testing and prevention curricula and programs for faith audiences. The *Philly Faith in Action* coalition has reported testing over 2000 persons in faith-based and community settings since the implementation of this citywide research campaign. **Embracing diverse approaches and HIV prevention messages** There were diverse approaches to addressing HIV in religious contexts, especially in relation to variations in human sexuality behavior, abstinence, and condom utilization. Faith leaders report that the success of the	

				citywide research campaign was in part due to tailoring evidence-based educational events for each religious institution versus using a "one size fits all" approach. Many pastors reported that they integrated information about the benefits of abstinence until marriage and the importance of avoiding multiple sex partners in their sermons. Some pastors preached about condom utilization while others avoided the topic altogether.	
Nunn, A., Cornwall, A., Chute, N., Sanders, J., Thomas, G., James, G., Lally, M., Trooskin, S. & Flanigan, T. (2012).	**Qualitative Study** N=38 **3**	Researchers examined the perspectives of Pastors and Imams on what they perceived are the barriers to addressing HIV/AIDS to their congregants;	Half of the sample had a pre-existing relationship with the Mayor's Office of Faith-Based Initiatives. Therefore, they	Sample consisted of 38 participants majority whom were male (71%) and Baptist (39%). Other denominations represented included African Methodist Episcopalian (16%),	Although faith leaders may understand that there is an HIV epidemic occurring within the African American community, they

		Recommendations were obtained for how to enhance HIV prevention programs in faith-based organizations (FBOs.) Researchers conducted in-depth interviews and focus groups with well-known African American religious leaders, located in Philadelphia, regarding their knowledge about how HIV is transmitted, Philadelphia's HIV/AIDS crisis, and their views regarding the social, behavioral, and structural drivers of HIV within the African American community. Religious leaders from Philadelphia's largest faith-based institutions were recruited along with other faith leaders known for their social	may be more progressive and willing to talk about HIV then other local FBOs not associated with the coalition. Sample is limited to Philadelphia and may not be generalizable to faith leaders across the nation.	Muslin (13%), Non-denominational (13%), Methodist (6%), Pentecostal (6%), Evangelical (3%), and Jewish (3%). Emergent finding themes were grouped into two major categories: (a) barriers/challenges engaging African American faith community in HIV/AIDS programs, and (b) opportunities and recommendations from participant faith leaders how to engage faith community in HIV prevention. **Barriers/Challenges to Engaging American-American Faith-Based Organizations in HIV Prevention**	may not be completely aware to the magnitude the infection is devastating the lives of many in their very own communities. In general, faith leaders in the study realize the importance of addressing HIV prevention, but HIV-stigma hinder some from addressing the illness within their church or Mosque. One of the biggest challenges to addressing HIV prevention within FBOs is addressing variations of human sexuality. Because the infection was originally linked to homosexual behavior, faith

[redacted]		outreach programs; recruited participants formulated 5 focus groups. Focus groups were comprised of diverse Christian and Muslim denominations so that groups would be diverse in composition and perspective. Grounded theory qualitative interviewing technique was utilized; researchers employed semi-structured interview guides to conduct and direct the group discussions. Focus group guide questions pertained to the following: (1) faith leaders' knowledge of HIV transmission and the local Philadelphia epidemic (2) factors contributing to		Common themes that emerged include the following: (1) faith leaders understand how HIV is transmitted but are unaware of the disparities and impact of the local HIV epidemic, (2) participants perceive that discussing human sexuality in a faith setting is challenging and may not be an appropriate place to do so, (3) participants fear they may be viewed as a homosexual if they discuss matters pertaining to HIV/AIDS, (4) participants report apprehension in that if they encourage condom utilization that would conflict with FBOs theological principle of "abstinence only," (5) participants think that merely	leader may be reluctant to address it in fear they may be perceived as gay and/or HIV-positive. Another challenge why faith leaders may not address HIV is that some fear congregants will stop giving financial support to their ministry which can be detrimental to a FBO. Without financial support from congregants, churches and mosques will merely have to close their doors. Pastoral age and years of experience may have an affect whether the church/mosque leader will address HIV among

[redacted]		Philadelphia's HIV/AIDS epidemic (3) existing HIV/AIDS programs in their congregations (4) challenges and opportunities for addressing HIV/AIDS in a faith-based context (5) leaders' normative suggesting for how the faith community can enhance HIV prevention in Philadelphia (Nunn, A., Cornwall, A., Chute, N., Sanders, J., Thomas, G., James, G., Lally, M., Trooskin, S. & Flanigan, T., 2012, p. 2). Group discussions lasted approximately 1.5hrs, were recorded, transcribed, coded, and analyzed to understand the barriers/opportunities for addressing racial disparities in HIV		addressing HIV would negatively impact how congregants donate via tithes and offerings, and (6) pastoral age, experience, and reputation plays role whether the individual FBO leader will embrace the fight against HIV (younger/less experienced were less confident about discussing HIV/AIDS). **Participant's recommendations for improving HIV/AIDS prevention within FBOs.** Participants report recommendations how to get leadership involved in the fight against HIV using an FBO approach. They recommend that: (1)	congregants. Younger faith leaders appear to avoid addressing HIV in fear that HIV-stigma will place a dark cloud over the ministry and hinder future growth; older well-seasoned faith leaders may have an easier time addressing the epidemic in-part due to their established presence in their communities. Faith leaders have varied opinions whether condom education should be presented within the church/mosque setting. Overall, leaders in the study suggest they have a compelling indication to work with persons affected by HIV

		infection with faith leaders.		faith leaders be educated about the local epidemic to promote widespread involvement in HIV prevention, (2) faith leaders should encourage people to test regularly for HIV, (3) faith leaders should preach about the disease from the pulpit, create HIV/AIDS Ministries, and engage the media department regarding HIV prevention/awarenes s, and that (4) faith leaders should collaborate and form coalitions in the fight against HIV within the community.	similar how Christ provided service to the poor, sick, and stigmatized populations.
Nunn, A., Dickman, S., Cornwall, A., Kwakwa, Mayer, K., Rana, A. &	**Qualitative Analysis** N=19 **3**	Researchers conducted qualitative interviews among 19 heterosexual African American female participants who had	Small sample size Participants were recruited from a specific location in	African American females report to use condoms more frequently with non-main partners versus main partners	Social, structural, and behavioral factors can influence African American female's

Rosengard, C (2012).		engaged in concurrent partnerships in Philadelphia. Participants were recruited in a high HIV incidence area. Eligibility consisted of: (1) self-identify as African American and heterosexual, report having engaged in one or more concurrent sexual partnerships within the last 6 months in their behavioral risk assessment, report only ever having has sex with males, Speak English, at least 18 years old, and provide written informed consent. Both HIV-negative and HIV-positive females were recruited. Researchers explored participant's social norms, attitudes, and practices regarding	Philadelphia so findings may not be generalizable to generable population. Recall bias.	because they trust main partner more than non-main partners. Social factors leading to partner concurrency includes that concurrency is a social norm, females lack ability to negotiate partners' concurrent partnerships, not being married, and not trusting partners. Structural factors consisted of financial dependence on male partners (and vice versa) and incarcerations interrupting partnerships. Behavioral factors consisted of alcohol and cocaine use.	engagement in concurrent partnerships. HIV interventions targeting African American females need to address the structural factors and social determinants that place this group at risk for HIV infection, beyond the traditional behavioral factors CDC HIV interventions have focused on.

		partner concurrency and the behavioral, social, and structural factors that influence concurrent sexual relationships.			
Pittiglio, L., Jackson, F. & Florio, A. (2012).	**Mixed Quantitative / Qualitative Design** N=33 **2-**	Researchers examined the lack of self-esteem as it relates to how African American females define HIV-risky sexual behavior. To be eligible to participate, inclusion criteria consisted of the following: self-identify as an African-America female and be involved in a heterosexual relationship. All socioeconomic classes were eligible. Participants were recruited from community-based organizations, churches, colleges/universities, hair and nail salons, laundromats, grocery	Selection bias	Among the 33 participants in the sample, the age range was from 25 to 43 years with a mean age of 34 years old. Thirty-three percent of the participants were married, 6% divorced, 6% separated, 9% classified themselves as a member of an unmarried couple, and majority (45%) had never been married. Participant's had an educational level ranged from high school diploma to post graduate studies. Fifty-one percent identified as Baptist and described	Having low self-esteem plays role in African American females risk for HIV. HIV prevention strategies targeting this population need to consider that low self-esteem plays role in African American female's risk for HIV. Low self-esteem should be taken into consideration when devising and/or implementing HIV prevention initiatives for this population. Future studies need to be designed to assess

		stores, and shopping centers from three metropolitan regions in Michigan. A convenience sample of 33 African American females were recruited and then divided into 3 focus group sessions. The focus groups completed a socio-demographic and interview questionnaire; a middle-aged African American professor of nursing facilitated the focus group session. The Socio-Demographic Questionnaire assessed standard information including age, race, education level, marital status, income level, religious affiliation and participation, sexual activity, current relationship duration, and		themselves as being moderate to very religious. Eighty-seven percent reported being sexually active. Sixty-five were currently in a relationship. Majority of the participants responded that they were "very confident" their male partner has been faithful. Upon analysis of the focus group transcripts, three major themes emerged as underlying causes of risky HIV behaviors among young African American females. The three themes are: (1) Negotiating condom use (2) Risk factors specific to African	the relationship between low self-esteem and risky sexual behaviors so that health-care providers can equip this vulnerable population with self-efficacy and sexual assertiveness skills needed to protect themselves from the HIV epidemic.

		confidence that the current relationship was monogamous. (Pittiglio, L., Jackson, F. & Florio, A., 2012, p.17) The Interview Questionnaire consisted of the following scales: (1) Condom use intentions (2) Attitudes toward condoms (3) Condom use self-efficacy (4) Perceived partner norms (5) Partner-specific perceived vulnerability (6) HIV information heuristics (7) Duration of relationship (8) Relationship commitment (Pittiglio, L., Jackson, F. & Florio, A., 2012, p.17) Participants also completed the Modified AIDS Risk		American women (3) A lack of self-esteem (Pittiglio, L., Jackson, F. & Florio, A., 2012, p.18) When examining the relationship between a lack of self-esteem and risky sexual behaviors, participants report that many females have low self-esteem and self-worth: "A lot of girls out there have low self-esteem" "Girls are not respecting themselves" "Black women too often have no self-love" Participants report that low self-esteem may place African American females at risk for HIV because: "they are willing to accept anything	

		Reduction Model (MAARM) tool which was a semi-structured qualitative interview guide. In order for participants to verbally respond openly during this process of the intervention, researchers worded the MAARM questions in a fashion that participants would report their observations about the general African American female population while not providing their own personal experiences, per se. The researchers fashioned the questions to suit their audience so that females would respond to questions without fear they were self-disclosing information. During the focus group session, the facilitator asked questions like,		because of low self-esteem" "they want to be in a relationship, so a lot of the time they are willing to accept and lower their standards for something that rationally they would not accept" (Pittiglio, L., Jackson, F. & Florio, A., 2012, p.18) While African American females may have low self-esteem, some may have a false sense of high self-esteem when they have male partners. Participants report: "[some females say], "I have a man and it makes them feel like they're in a relationship, it boosts them up." "Self-esteem plays a big part because you know a lot of girls nowadays have low self-esteem. They	

		for example, "Why do you think African American women participate in behaviors that could put them at risk for HIV or STDs." Self-esteem – the researchers' chief variable, in the study is conceptualized as a way an African American female views herself, whether having a positive or negative appraisal. Analysis of the focus group's transcript was used to identify underlying causes of risky HIV behaviors in African American females.		feel like if I don't do it with this guy he will no longer be around, he won't be with me. They will take whatever he gives them. As long as someone see me in his care, or they see him pull up to my house, like I have somebody." (Pittiglio, L., Jackson, F. & Florio, A., 2012, p.18) In all, lack of self-esteem leads to risky behaviors among African American females because when they have low self-esteem males can take advantage and make females have sex without utilizing condoms.	
Raj, A. & Bowleg, L. (2012).	**Expert Opinion** **4**	The authors report that heterosexual African American male HIV infection rates is on the rise in the United States, current treads show.	NA	**Research** The authors recommend for research development and evaluation of community-based	It is well documented in the literature that the HIV epidemic is problematic among African American men

[redacted]		Although the Center for Disease Control's (2009) *Heightened National Response to the HIV/AIDS Crisis Among African Americans* and the President's National HIV/AIDS Strategy's (2010) document recognizes that more HIV/AIDS prevention needs to implemented among Black MSM, females, and youth, the authors inform that these two manuscripts fail to address problems/solutions for heterosexual African American males. Authors report that there has been a significant lack of attention on heterosexual associated HIV acquisition/transmission among African American males		interventions to be done to promote HIV prevention and increased HIV testing and counseling among heterosexual African American males at risk for HIV. They recommend reaching this population in places where they commonly congregate outside of conventional clinical sites (e.g. barber shops, job training programs) with messages from credible peers whom they can relate to. Also, they recommend that community organizations provide linkages between each other (e.g. HIV counseling and testing program) in order to meet the needs of this population and navigate them	who have sex with men and injection drug users. However, there is limited research reporting the HIV epidemic among heterosexual African American males. More needs to be done in terms of increase support for research, program development, and policies that can improve HIV prevention and testing among heterosexual African American males.

[redacted]		partially because the scientific community previously viewed HIV infection acquired mostly by homosexual activity. Therefore, heterosexual African American males have been neglected regarding HIV prevention and research efforts. The authors report that disproportionate rates of HIV/STDs in low-income, urban, and mostly African American communities combined with structural challenges (e.g. poverty, unemployment, and housing) are drivers for higher HIV infection rates among heterosexual African American. The authors convey that if "researchers and practitioners fail to recognize and		through the proper channels. **Programs** The authors recommend that funds be allocated to community-based programs so that effective HIV interventions targeting heterosexual African American males can be developed, identified, and maintained. Furthermore, the authors recommend that financial support for programs should be acquired not only from governmental funds but also from public-private partnerships. **Policy** Because most HIV-infected heterosexual African American males come from urban	

[redacted]		address heterosexual risk for HIV among Black men, why should we expect Black heterosexual men to do so? And in the absence of that change, growing HIV disparities for Black men will continue and the risk for generalized epidemic in Black communities will grow" (Raj, A. & Bowleg, L., 2012, p. 3). The authors recommend that research, program, and policy be developed to address HIV risk in African American communities with increased focus on heterosexual African American males at risk for HIV infection.		impoverished communities commonly characterized by structural challenges (e.g. poverty, low-performing schools, inadequate job opportunities, high crime rates, high HIV/STD prevalence), the authors suggest that more policy efforts be done to counteract the structural elements that propitiates this vicious cycle for their failure and vulnerability for HIV acquisition/transmission. According to the authors, current policy promotes their vulnerability for HIV; reversal of policies that restrict access to housing and employment post-incarceration, for example, my	

				potentially reduce heterosexual African American males for HIV.	
Raymond & McFarland (2009).	**Cross-sectional Study** N=3,532 **2**	Researchers used a time-location sampling (TLS) method to obtain a random sample pool of multicultural MSM attending various venue-day-time (VDT) events (e.g., bars, dance clubs, gyms, churches, and street locations). Only research staff approached MSM at venues thus allowing both non-gay identified and gay identified MSM to be recruited into study.	Lack of complete information regarding participant's sexual networks or interconnection partnerships. Response bias related to racial sensitive questions.	1.Black MSM are the least preferred as sexual partners by other MSM and are perceived to be higher risk for HIV compared to other partners which may lead to men of other races avoiding Black MSM as sexual partners. Black MSM are counted less frequently among the friendships of other MSM; they are ranked as the least easy to meet by other MSM. Also, Black MSM are perceived to be less welcome in the common venues for socializing among MSM.	1. There appears to be a racial segregation phenomenon going on in the MSM community. The combination of attitudes on the part of non-Black MSM, friendships, and social networks that are less likely to include Black MSM, and the environments found in gay venues serve to separate Black MSM from other groups. 2. Gay venues cater more to White MSM than any other racial group that may perpetuate them as the most desired MSM

					group; Blacks perceived to be less welcome in common venues for socializing among MSM. 3. The combination of attitudes on the part of non-Black MSM/friendship and social networks are less likely to include Black MSM.
Saleh, Operario, Smith, Arnold, & Kegeles (2011).	**Qualitative Study** N= 42 **3**	Two focus groups (21 people total) were formed from staff working at community-based offices (CBO). A group-facilitated moderator obtained their perceptions, attitudes and "brutally honest" opinions towards Black MSMW. Twenty-one non-gay/homosexual identifying Black MSMW recruited and interviewed about:	Moderator gathered the opinions of the focus groups in an open forum; some staff members may have been reluctant to be "brutally honest" before their peers in the professional setting. This sensitive topic may have caused some participants to	Service providers can be affected by same-sex behaviors among Black men. Healthcare providers are not immune from the effects of social stigma, homophobia and society's value of heterosexism. Healthcare providers may have tensions between their professional duties and their own personal beliefs towards Black MSMW that may	Strategies and efforts need to be implemented to educate healthcare workers/ professionals about the distinctions between sexual identity and sexual behavior; Black men who identify as straight (in a heterosexual relationship or single) might also have sexual

[redacted]		(1) "Sexual behaviors with female and male partners (2) Perceptions of HIV prevention needs (3) Relationship issues (4) Identification with regard to sexual behavior and race/ethnicity (5) General issues currently in the participant's life" (Saleh, Operario, Smith, Arnold, & Kegeles, 2011, p. 542). Interviews were recorded, transcribed and analyzed by two independent coders who read each transcript, recorded memos. The coders developed a list of thematic content areas capturing salient issues.	not self-disclose their experiences and opinions to the moderator during 1-to-1 interviews. Selection biases; the study may have excluded the perspectives from male staff members who are less comfortable talking about sexuality. Social and cultural attitudes towards Black MSMW may have changed during data collection of this study.	hinder them from providing MSM the care they need.	relations with other men secretly. Thus, healthcare works and professionals need to have the skills to screen for Black MSM and provide HIV preventative care in a culturally appropriate manner. Medical workshops need to be developed/ implemented for healthcare providers to address the homophobia attitudes that persists within the medical community; therefore, Black MSM will feel safe to share their sexual health problems and providers are more sensitive to this population

					providing them the service they require and deserve.
Schleicher, T. (n.d.).	**Qualitative Study** N=538 **2-**	Researches explored the relationship between HIV stigma and HIV knowledge to the following variables: (1) religiosity, (2) HIV testing, (3) perceptions about HIV, and (4) demographics among Black Church members/community members who use church outreach services (e.g. food pantries, social services, etc.). Participants aged 18-64 were recruited from four Black Churches and their associated community outreach activities in Kansas City metropolitan area. A total of 538 persons were included in the	**Religiosity** results show there is a positive correlation between religiosity & stigma item "Truth" with Formal Practices; a negative correlation between religiosity & HIV knowledge with Formal Practices. With regards to a participant's denomination, there is no difference of HIV stigma or knowledge. However, participants who held leadership	HIV stigma is difficult to operationalize and may not have been completely captured in study. There was a lack of sexual diversity among participants; having a limited number of non-heterosexual identifying participants may limit the generalizability of this study.	The Black Church has the power to influence and reach many African Americans; the Black Church can play a critical role in providing HIV prevention/education and could be used to promote the delivery of accurate information about the disease. This study suggests that the Black Church could play a significant role in reducing HIV stigma and enhance HIV knowledge as part of a broader HIV prevention church-based HIV intervention. Church-based

[redacted]		sample; 63.8% were female, 85.1% were heterosexual, and 72.5% had some form of insurance. A third (33.3%) of the sample had only a high school education or lower, 36.1% of the participants had a college education or higher, and 18.6% made less than $1,000/month. Participants completed a survey titled "Taking it to the Pews" – an HIV education and screening intervention in Black Churches. Participants received $10 after survey completion. Researchers measured HIV-Related Stigma, HIV Knowledge, Religiosity, and HIV testing among participants. Stigma was measure by 5-	titles/roles are less afraid of HIV-positive persons than those who do not have a leadership role. **Perceptions and exposure regarding HIV issues** Results show that there were no differences in HIV stigma or knowledge whether if the participant's church did or did not talk about HIV/AIDS testing, HIV/AIDS prevention, and/or related topics. There was a significant difference regarding the perception how		HIV interventions related to HIV stigma and knowledge may need to be specifically tailored to some congregants such as males, non-heterosexuals, and older adults in order to decrease stigma and increase knowledge among them. Lastly, Black Church leaders have implications to communicate information about the disease in order to decrease HIV stigma and increase HIV knowledge to all congregants and community members.

		items adapted from national studies on HIV/AIDS stigma. HIV Knowledge was measure by 10-items regarding HIV knowledge. Religiosity was measured by participants reporting their church denomination, leadership role, and completing a 7-item version of the Religious Background and Behavior. HIV testing was measured by assessing how many times participants tested for HIV in their lifetime and how confident they were that they would re-test in the next 12 months. Correlational analysis was used on all continuous items to identify variables correlated with stigma items and	serious HIV/AIDS is and the knowledge score. Participants who did not consider HIV/AIDS to be a serious issue had lower knowledge scores versus those who perceived HIV/AIDS to be a somewhat or very serious problem. In addition, there was a significant difference regarding whether a participant's church talked about how to get HIV/AIDS and the stigma item "Concerned." Participants		

		knowledge score. ANOVA and independent t-tests were conducted with categorical variables.	who reported that their church had talked about HIV acquisition/transmission were less concerned that they would be treated differently or discriminated against versus participants whose church did not talk about HIV acquisition/transmission. There was also a significant difference regarding whether the participant's church had educated them about personal risk for HIV and the stigma item "Comfortable." Participants who report that		

			their church had talked about personal risk for HIV were less comfortable sharing a pew with an HIV-positive person than those whose church had not discussed personal risk. **Demographics** Age was negatively correlated with both the stigma item "Responsible" and "Knowledge" and positively correlated with the stigma item Afraid. Results also show that there was no significant different regarding the participant's sex		

			and the stigma item "Responsible." Significantly more male participants strongly agreed that persons infected with HIV were responsible for their illness than female participants. There was no significant stigma or knowledge differences found regarding the participant's race, relationship status, insurance, and parenthood. There was a significant finding regarding participant's education attainment and		

			the score on the stigma item "Afraid." Participants who completed only a high school education were more afraid of an HIV-positive person than participants who had some graduate training or a graduate degree. There were significant findings among the participant's sexual orientation. Those who did not disclose their sexual orientation were less comfortable with sharing a pew with an HIV-positive person than a heterosexual identify		

			participant and were more afraid of an HIV-positive individual than those who identified as homosexual or bisexual. In addition, those who identified as heterosexual were more HIV knowledgeable than those of another orientation or who chose not to disclose their orientation. A participant's income was significant to the stigma item "Afraid." Participants who made more than $3000/month were less afraid of HIV-positive persons than		

			those who made less.		
Sales, J., DiClemente, R., Davis, T. & Sullivan (2012).	**Qualitative Study** N=50 **3**	Researchers recruited 50 African American females 18-23 years old from Atlanta, Georgia. Eligible females included those who previously participated in an AFIYA who had been randomized into the intervention condition, completed the intervention workshop, and completed at least one post-intervention follow-up. A convenience sample was recruited by telephone contact or in-person after having completing their 36-month follow-up session. Participants had one-on-one interviews with the researcher in private conference rooms in two sexual health clinics or in a private space in the	Study may not be generalizable to larger population who have participated in HIV prevention programs or ones different to AFIYA. Selection bias; participants were recruited 36-months after having completed the AFIYA intervention. Participants may have had secondary gain in participating in this study.	Nearly all females reported barriers to using condoms. The most common reason why participants experienced barriers to using condoms were related to partner or relationship-related issues resulting in non-condom use after participating in AFIYA. The following reasons are why participants fail to use condoms: (1) Male partner dislikes or opposes condom utilization. (2) Male partner is controlling where female fears to express introducing condoms (3) Utilizing condoms confers	Even though there are many HIV prevention interventions for the female African American population, there will be some who participate in them that may still engage in high-risk sexual behaviors post-intervention. It is important to be able to identify barriers that differentiate African American females who fail to practice safe-sex after an HIV prevention intervention; identifying these barriers can be the first step to design new HIV prevention programs for vulnerable

[redacted]		participant's home. Participants were compensated $25 dollars upon interview completion.		relationship mistrust (4) Resistant to change believing that they cannot change. (5) Females lack confidence, self-esteem, self-respect to express what they want (6) Do not have condoms on person when sexually aroused (7) Living with male partner, or close proximity (8) Under the influence of alcohol (self and/or partner (9) Pregnant, desire pregnancy, not concerned about getting pregnant, or male partner wants a baby (10) Being on oral contraceptive pills or using	African American youth.

				other birth control methods (Sales et al., 2012, p.1096).	
Smith, J., Simmons, E. & Mayer, K. (2005).	**Qualitative Study** N=18 **3**	This is a qualitative pilot study. The researcher sampled a group of Rhode Island Black Church clergy members to assess their attitudes towards providing HIV/AIDS prevention programs in their churches in order to understand the perceived barriers clergy have in offering HIV/AIDS prevention programs in the Black Church. The researchers developed a 25-item survey for Black Church leaders to retrieve feedback regarding their congregation's demographics and whether their church provides a health and/or HIV/AIDS prevention program.	Small sample size Sample taken from Northeastern region of the U.S.; characteristics found may not be generalizable to Black Churches across the nation.	Of the 22 participants recruited into the study, a total of 18 clergy members participated. The mean age of the clergy participants was 48 years, with an age range of 34 to 62 years. Participants had an average of 20 years' experience in the ministry (range 3-55 years). Majority of the churches were Baptist (66.7%) affiliated, female dominated (94.4%). Nine Black Churches consisted of congregational size less than 100 parishioners while the other 9 Black Churches consisted of a congregational	Most clergy participants indicate that utilizing the Black Church as a platform to address HIV/AIDS is an appropriate place to help congregants and peoples of the community; it is also part of their church's mission. However, limited resources may hinder Black Churches from providing HIV/AIDS services both parishioners and people of the community need. Given that HIV is on the rise among African American females and that

		The 25-item survey instrument was developed by Tesoriero and colleagues and was adapted for the participants in this study. Prior to survey administration, the 25-item instrument was peer-reviewed. Sample participants consisted of being members of the one and only clergy organization representing African American clergy in Rhode Island. This organization is comprised of 22 clergy members who represent 22 Church churches in the region. The 25-item survey instrument acquired demographic information from clergy participants the certain characteristic of the congregation were		size of 100-499 parishioners. Majority of the sample Black Churches do not provide a generic health program or an HIV/AIDS prevention program. Only 22.2% of the Black Churches provide health education/prevention outreach services in the community. Most clergy participants believe that HIV/AIDS services are needed within their Black Church (83.3%) and neighborhoods (77.8%). However, most clergy do not feel qualified to provide HIV/AIDS education/services and most of the sampled Black Churches do not have financial power needed to provide	Black Churches are heavily populated with females, the Black Church may be an appropriate and effective place to reach this population providing them needed HIV/AIDS prevention information.

		they serve. Clergy/congregation demographics questions included the following: type of church denomination, minister's experience, minister's age, average length of stay at current Black Church, gender balance of congregation, and congregation size. Clergy participants were assessed for: (1) general health promotion programs and/or specific HIV prevention programs offered in their church and (2) reason for providing/not providing HIV/AIDS services. (Smith, J., Simmons, E. & Mayer, K., 2005, p. 1683). Participants were given coffee shop gift certificates as incentive to complete		HIV/AIDS prevention services.	

		the confidential survey instrument. The data was analyzed using SPSS 11.5 statistical package for Microsoft Windows and the Fisher's exact tests of significance and frequencies were formulated from the data retrieved.			
Stampley, C., Mallory, C. & Gabrielson (2005).	**Literature Review** **3**	A literature was conducted to synthesize the findings of preexisting research regarding HIV risk taking and prevention behaviors among African American females age 40-65. Inclusion criteria consist of studies that included African American females aged 40 and older because perimenopause/post-menopause females may have unique beliefs/behaviors related to HIV	Variation in measurements across studies on variables analyzed may confound the accuracy in result interpretation. Lack of systematic investigation regarding age, gender, culture, and ethnicity among some studies my limit how findings can be extended to the general African	Eight studies were captured and consisted mostly of descriptive correlational or descriptive comparative and cross sectional. One of the studies was a quasi-experimental design. Common variables, or concepts, analyzed in these studies included standardized socio-demographic characteristics such as the following: age, education, employment status,	Evidence shows that African American females have misconceptions about HIV; variation in HIV knowledge partially related to age and education. Evidence suggests that females 40-plus do not believe to be at risk for HIV and they have sex with males partners whom they do not their risk factors.

[redacted]		prevention and risk taking behaviors that differ from their younger female counterparts (which has been more explored in the literature). Original studies published from 1987 and current peer reviewed journals that target this population and the risk factors related to HIV prevention were reviewed. The literature review was conducted in 3 phases. First, databases such as Medline, CINAHL, EBSCO, Ovid/Ibis, PsychINFO, ERIC, Social Science Abstracts, Sociological Abstracts, Family Index Database, and Contemporary Women's index were searched utilizing key words in all	American population aged 40-plus.	marital status, living arrangement, knowledge of HIV/AIDS, perceived vulnerability, susceptibility, sexual assertiveness, and risk taking behaviors/sexual practices. Regarding age and knowledge of HIV/AIDS, the literature sites mixed finding about the effects of age on knowledge about HIV and AIDS. The relationship between age, education level, and income to knowledge about HIV transmission and practicing prevention warrants further investigation in this population. Regarding perceived vulnerability/susceptibility of HIV infection in African American females	Review of the literature shows that middle aged African American females mostly rely on monogamy as a method to protect themselves from HIV and that they do not discuss sexual matters, like condom utilization, with their male partners. Findings from the literature suggest that middle aged African American female risk taking behavior can be modified by improving their knowledge about HIV/AIDS, help them realize they are vulnerable to HIV infection, and that they need communicational skills how to negotiate safe-sex

[redacted]		combinations. Key words included "human immunodeficiency virus," "acquired immunodeficiency syndrome," "women," "midlife/middle adulthood," "midlife," and "African American." Second, the reference lists from primary articles were examined; those that met inclusion criteria were included in the review. Lastly, evidence was also found by manually searching through published journals regarding women's health and HIV/AIDS. Research studies that were attained were read and coded deductively for stated purpose of the study, sample characteristics,		40-plus, evidence is consistent that these females are less likely to be worried about acquiring HIV than females aged 30 to 39 years old. African American females aged 55-plus perceive their odds of becoming HIV infected, or already being infected, is low or no chance. In addition, older females rarely know their HIV know their HIV serostatus. Evidence suggests that older African American females are less likely to inquire about their sexual partner's risk factors for HIV. And, these females are less likely to know what their partner's HIV serostatus or purchase condoms compared to females	practices with male partners.

[redacted]		research design, concepts/variables under study, measures, findings, and study limitations. In addition, research studies were also analyzed for their adequacy in research methods, reliability and validity, and major findings.		aged 18-25. Evidence also shows that African American females 40-plus are likely to suspect partner infidelity when a male partner introduces condoms to the relations after sexual intimacy has been established. Regarding risk-taking behaviors among this population, the evidence is inconsistent. Some studies show females aged 40 or 50 years old are less likely than those under 40 or 50 to utilize condoms, yet had fewer sexual partners and were less sexually active then younger females. Other evidence shows that older females tend to practice safe-sex by	

				practicing monogamy.	
Stewart, J. & Dancy, B. (2012).	**Ethnographic Case Study** N=1 **2-**	Researchers sought to understand how a Black Church's religious culture supports the development, implementation, and maintenance of an HIV Ministry. The research inquiries include the following: (1) "What role did the religious culture have in the development of an HIV ministry within the church" (2) "What role did the religious culture have in the implementation of an HIV ministry within the church" (3) "What role did the religious culture have in the maintenance of an HIV	Study took place within a church whose denomination was open and affirmed homosexuality. May not be generalizable to all Black Churches. Small sample. Study was conducted only at one church.	The participant sample represented a large metropolitan mega-church that has a membership of 8,854 parishioners that is located in a predominately African American community which has a median income of $43,201. Seventy-two percent of the church population is female and the largest (34%) age group are those between 41-55 years old. A total of 9 interviews were conducted. Of the 9 participants interviewed, 2 participants were involved in the HIV Ministry's development, 3 were involved in the implementation, and 4 were involved in	No research has been done regarding the concept of how religious culture, such as beliefs, social norms, attitudes, and knowledge has (or may have) on the role of development, implementation, and maintenance of a Black Church HIV Ministry. Results show that "a belief in helping others, feelings of compassion toward individuals infected with HIV and an emphasis on the importance of HIV education for ministry members as well as for the general congregation" are

		ministry within the church" (Stewart, J. & Dancy, B., 2012, p. 421). Researchers recruited participants from one predominantly African American mega-church in the Midwest whose membership consisted of more than 8,000 parishioners. Participant sample consisted of 9 individuals –1 pastor, 1 pastor emeritus, 1 associate pastor, and 6 church members identified by these pastors, all whom had a role in the HIV Ministry's development, implementation, or maintenance. In addition, 50 general parishioners were recruited by convenience sampling technique.		the HIV Ministry's maintenance. Five parishioners function to coordinate the HIV Ministry's activities in which most (80%) of the HIV Ministry coordinators were African American. **HIV Ministry Development** This church's HIV Ministry was orchestrated with a mission to "comfort through support, education and training for individuals, families, and friends affected by HIV disease" (Stewart, J. & Dancy, B., 2012, p. 424). The pastor emeritus, leader over developing this ministry, reported that the church's HIV Ministry was birthed after a parishioner, who	indicators and influencers of the development, implementation, and maintenance of a Black Church HIV Ministry (Stewart, J., & Dancy, B., 2012, p. 427). In order for an HIV Ministry to thrive within the Black Church, it is essential that pastoral leadership supports and accepts the development/sustaining of an HIV Ministry and the social enigmas that are associated with the infection. Beyond pastoral leadership support, other factors that enable an HIV Ministry to thrive within the Black Church include support

[redacted]		Data was collected by varied qualitative tools: (1) nonparticipant observation summary, (2) participant observation guide, (3) document review guide, (4) ethnographic interview guide, (5) HIV ministry awareness questionnaire, and (6) a demographic questionnaire. **Nonparticipant Observation Summary** Here, the principle researcher observed relevant events/activities the church engaged. By observation, the principle researcher assessed the general culture/climate of the church noting event locations, persons involved, behaviors, direct quotes that		was abandoned by his family, was dying from AIDS. The developers of the HIV Ministry initiated this department with two major beliefs: (1) pastoral leadership and support is essential to the development of the ministry and (2) that all parishioners should be accepted, regardless of sexual orientation. In the development of the HIV Ministry, leaders over the ministry reported that educating parishioners about HIV was essential (to birth this department) in order to decrease HIV-related stigma. Doing so, founding leaders aimed for parishioners to understand the biology of the	from the following: (1) members, (2) health professionals, (3) and liaisons between health departments and the church. Church doctrine and mission are big factors whether HIV can be addressed within a Black Church; a Black Church who's parishioners have a strong commitment in the fight against HIV also help an HIV Ministry sustain over time. Indications from this study shows that health professionals (such as nursing) can work with Black Churches to create a culture that can stimulate

		related to beliefs, norms, attitudes **Participant Observation Guide** this tool was utilized when the principle researcher participated in activities during the HIV Ministry and church services. Participant observations included engaging in congregational activities like reading the Bible out loud, praying with parishioners, singing, and taking communion **Document Review Guide** this tool was utilized to evaluate documents related to the church's culture in relationship to the development, implementation, and maintenance of its HIV ministry. The		disease, the medical implications, and have information disseminated (literature and/or forums) to them. **HIV Ministry Implementation** Participants who helped implement the HIV Ministry report that they had a personal conviction to fight against HIV-stigma and help others suffering from the infection or affect by HIV. Participants who helped implement the ministry reported that merely being a Christian compels one to love others, want to serve, and meet the needs of others just how they would hope that others would do onto them.	the development, implementation, and maintenance of an HIV Ministry. Nurses can function as liaison between the medical world and the religious world to bridge the two entities whereby the Black Church can be a local where sensitive issues such as African American sexuality and HIV can be addressed – a setting where most African Americans congregate.

		documents evaluated pertained to the church's doctrines and mission statements, HIV Ministry planning agendas, HIV Ministry program curricula, books, materials, etc. **Ethnographic Interview Guide** The principle researcher interviewed participants, who played role in creating, implementing, and maintaining the HIV Ministry. In doing so, the principle researcher ascertained information on the church's beliefs, norms, and attitudes **HIV Ministry Awareness Questionnaire** Utilizing this one-item instrument, the		Implementer participants report that providing comprehensive education/training sessions to parishioners was essential for the HIV Ministry's service to the church. Such education/training sessions was provided in five 4-hour session that addressed such as HIV history, science of the infection, HIV testing, HIV prevention, and spiritual aspects of the infection. The HIV Ministry's implementation process took about 1 to 2 years. **Maintenance of the HIV Ministry** Both the church and the HIV Ministry believe that "Jesus calls all Christians to love others,	

		principle researcher asked 50 parishioners whether they had heard of the HIV Ministry at the church. This one-item instrument was used to assess parishioners' knowledge of the HIV Ministry **Demographic Questionnaire** This tool was utilized to obtain basic demographic data about the church such as the following: (1) total number of active members, (2) average parishioner socioeconomic status, (3) percentage of male and female members, (4) age ranges, (5) and ethnicity of the HIV Ministry and church (Stewart, J. & Dancy, B., 2012, p. 422). The principle researcher executed		particularly those who are generally neglected, ignored, and discriminated against" (Stewart, J. & Dancy, B., 2011, p. 426). The church's doctrine aims that all parishioners love others in action via supporting the oppressed and strive for social justice and liberation for all. (Stewart, J. & Dancy, B., 2011, p. 426). Parishioner participants report that the HIV Ministry is integral within the church as its mission is congruent with the church's values. Ninety-four percent (or 94%) of the parishioner participants reported that they were aware of the HIV Ministry's presence	

		all interviews, nonparticipant observations, participant observations, documented reviews, and administered all the questionnaire surveys among the pastors, key personnel involved in the HIV Ministry, and lay parishioners. All interviews were audiotaped and transcribed verbatim. Descriptive statistics were employed to analyze the demographic data.		within the church. The HIV Ministry makes its presence known within the church by providing HIV information in church bulletins, announcements about the ministry is alluded to from the pulpit, and the HIV Ministry conducts interactive forums targeting youth which empowers parishioners. General activities and functions provided by the HIV Ministry keeps this department thriving and made aware within the church. The HIV Ministry has been in the maintenance phase for 17 years and ongoing.	
Taylor &Valera (2011).	**Qualitative Study** N= 9	Recruited Black married MSM (BMMSM) between ages 30 and 60 identified as	Small sample size; may not be generalizable to larger population.	The analysis revealed 3 themes: (1) Participant's awareness of same-sex behaviors and	This study suggest that providers/researchers need to determine how to

[redacted]	**3**	heterosexual, is married, attends church once a week, and engaged in same-sex behaviors in past 6 months. Semi-structured interview were conducted with participants; the sample completed a demographic questionnaire regarding three main topics: (1)" Experiences with managing same-sex behavior in heterosexual marriage (2) Perceived strengths and negative experiences attending church (3) Earlier awareness of same-sex attractions" (Taylor &Valera, 2011, p.110). Live interviews were recorded, transcribed verbatim and processed via		same-sex attractions/impact of homophobia (Taylor &Valera, 2011, p. 111). They were aware of their sexual attraction toward men prior to marriage (debut from 10-38 years old). Most of them had same-sex encounters prior to marriage while one had his first encounter during marriage. Demonization about homosexuality kept them living closeted lives. (2) Hating sin but not the sinner (Taylor &Valera, 2011, p.114). The participants report that the culture of the Black church spends a great deal of time condemning gay people and enforcing	work in partnership/in collaboration with the Black Church and Black MSM to develop culturally appropriate stigma reduction/HIV prevention programs to curb the HIV epidemic in the Black community irrespective of their view around homosexuality. The Black Church is still a source for consciousness raising, community advocacy, social networking and social support for many African Americans. Since church participation in the Black church for Black MMSM may be possible,

		thematic analysis. Themes from interviews were patterned into subthemes by which the researchers evaluated the subtheme statements.		that same-sex behavior is a sin (3) Coping with same-sex behaviors and concealment (Taylor &Valera, 2011, p. 116). The informants reported using strategies to conceal same-sex attractions. One key component is maintaining separation between their heterosexually married/religious lives and their sexual relationships with men was to impose rigid guidelines for being "careful": quick encounters/keep a low profile.	findings of this study underscore the need for intensive stigma reduction and HIV prevention in the Black church.
Ward (2005).	**Expert Opinion** **4**	Analysis was developed from a variety of disciplines: sociology, psychology, history, gender studies, politics and theology. Analysis also formulated by	NA	1. The social and health issues facing many Black communities are complex and deeply interwoven. Social ills currently derive from the fallout around	1. The Black church owns a great debt to the provision of homophobia secondary due to the history of slavery and racism. Whites,

		informed conversations by 9 Black clergy, 5 Black ministers and visits at Black churches.		hypermasculinity and the homophobia that supports it within US Black communities. Homophobia and rigid constructions of masculinity are a thread of many intertwined issues including: fatherless households, incarceration, child abuse, domestic violence, and drug trafficking. 2. Homophobia among Blacks also stems from slavery/ racism as Whites hypersexualized, pathologies, demonized and mystifies Black sexuality. 3. Hypermasculinity is a living force today that drives homophobia negativity within Black community. Hypermasculinity defines what Black	during slavery, are part of the blame to this phenomenon as they originally dominated the interpretation of Biblical teachings while exploiting black male sexuality during slavery and afterwards. It is critical that Black Churches/communities begin to take responsibility for their role in producing homophobia and initiate/address concerns like sexuality, homosexuality, and homophobia in the Black Church. 2. For Black communities, religion-based homophobia/narrow constructions of

				men measure up to: patriarchy, sexism, heterosexism, 'gangster-style cool pose image, and making babies.	masculinity it supports may never be fully disentangled from the more fundamental, interlocking systems of racism, patriarchy and capitalism in the context of which they developed. De-mythologizing Black sexuality is an essential ingredient of the sexual discourse, which needs to take place in the Black community.
Wilson, P., Wittlin, N., Munoz-Laboy, M., & Parker, R. (2011).	**Qualitative Study** N=81 **2-**	Researchers explored New York City (NYC)-base churches' ideologies about sexuality, health, HIV/AIDS, and how these ideologies relate to the Black Church in responding to the HIV epidemic among Black MSM.	Overall, the sample of Black Churches in the study responded to HIV by providing support and prayer to those who are sick, provide HIV/AIDS and sex education (through	Study limited to Black Church in NYC and may not be generalizable to Black Churches across the nation. Sample size may not be large enough to make generalizations to other Black Churches. Data was not collected from Black	Researchers identified three interrelated ideologies tied to sexuality and health as the reason for the lack of a significant response of the Black Church to the HIV epidemic Black MSM are facing. The three

[redacted]		Researchers conducted interviews and focus groups in Black Churches located in predominately African American neighborhoods in NYC. Most of the churches sampled in the study participated in HIV prevention or other HIV-related efforts to some degree. Some Black Church sites had HIV/AIDS Ministries that functioned to mobilize parishioners and members of the community to respond to the HIV/AIDS epidemic. A total of 81 males and females representing 6 Baptist churches, 3 African Methodist Episcopal, 2 Catholic churches, 3 Inter/Non-denominational churches, and 1 Presbyterian church	workshops, health fairs, and pastoral counselling), and referral to prevention/treatment services in the local community. None of the churches reported to specifically respond to the HIV epidemic among Black MSM; none addresses the reality that men were having sex with other men within the context of HIV mobilization. Findings from interviews and focus groups show that the following major themes emerged which can help explain the lack of Black MSM-	MSM parishioners or gay/bisexual identifying Black Church leaders. Their perspectives may differ.	ideologies – (1) "love the sinner hate the sin," (2) "don't ask don't tell," and (3) "your body is a temple, are concepts the play role why some Black Churches have not addressed the HIV epidemic among Black MSM." In order for Black Churches to fight the HIV epidemic among the Black MSM population, it is imperative that they begin the dialogue about homosexuality and same-sex behaviors something which place them as risk for HIV acquisition/transmission. Breaking the silence about homosexuality

[redacted]		from NYC were sampled in the study. Participants were recruited several ways. Some were recruited by HIV Community-Based Organizations that were working with Black Churches to form HIV/AIDS Ministries. Some of the researchers recruited Black Church leaders from their local church; other participants were recruited by referral. Semi-structured interviews and focus groups, lasting 1-2 hours, were conducted in the churches. Interviews were recorded. Interviews and focus group topics pertained to the churches'/worship traditions' values related to sexuality, health and illness,	specific mobilization efforts: (1) Love the sinner, hate the sin – the belief that homosexual behavior can be distinguished and separated from homosexuality identity. (2) Don't ask, don't tell – the belief that homosexual identities and behaviors should be kept private (3) Your body is a temple – the belief that spiritual and physical health are		and same-sex behaviors within the church can stimulate consciousness-raising and social action within the Black Church community. The ideology that 'your body is a temple' can provide an opportunity for Black Churches to decrease HIV infection rates among Black MSM because this phenomenon can be applied to promote condom utilization or abstinence.

[redacted]		stigma, and HIV/AIDS. Interviews with pastors enabled researchers to obtain the churches' official stances and decision-making processes and pastors' internal conflicts. Focus groups consisted of 5-7 parishioners which enabled researchers to learn more about church's values with their peers while enabling researchers to gain a better understanding of the dynamics within the churches. Probes were utilized to explore issues and salient points raised during discussion. All interview/focus group sessions were recorded and transcribed were coding was produced. Multistage interactive process was applied to analyze transcripts.	interconnected (Wilson, P., Wittlin, N. & Munoz-Laboy, M., 2011, p. 5). **Love the sinner, hate the sin: behavior vs. identity** Parishioners and leaders report that they support and love Black MSM, but do not support the homosexual lifestyle. In their view, they believe the Bible condemns such behavior; therefore, they despise the sin but not the sinner. **Don't ask, don't tell: private vs.**		

[redacted]		Codes such "acceptance," "church response," "community mobilization," "discrimination," "HIV/AIDS," "homosexuality," "homophobia," "religious ideology," "sin," and "stigma" was used to identify and compare themes.	**public knowledge** Parishioner participants report that homosexuality is a personal matter that the church does not address openly. Participants report that if leadership or parishioners suspect a person engages in homosexual behaviors, they will not question the person because the church does not need to know what people do in their bedrooms. A pastoral participant reports that even though he does not approve of homosexual		

[redacted]			behavior, that has not kept him from appointing homosexuals to certain position; he only preferred for the person keep their sexual identities/behaviors private from church. **Your body is a temple: physical health and spiritual health** Participants report that one's body is the temple of God, according to the Bible, and that individuals should strive to keep it healthy and holy. Most parishioners/pastors participants reported that		

[redacted]			they do not believe HIV/AIDS is a punishment for sin or that anyone or any particular group deserved to be infected with the virus. However, some participants articulated the connection that when individuals engage in risky behaviors (sinful life styles) that predisposes them to acquiring HIV. However, some participants hold the view that for those who acquired HIV by sexual immorality are more so deserving of the infection		

			because of sinful activities, versus a person who acquired the infection by other means (e.g. in utero, blood transfusion, etc.).		
Wolitski, Jones, Wasserman, & Smith (2006).	**Comparative Study** N=455 **2-**	Researchers recruited participants from 12 major U.S. cities comparing racial identity, sexual identity and sexual practices among MSM who consider themselves to be on the DL versus MSM who did not claim to be on the DL. Statistical methods compared characteristics, sexual practices and internalized homophobia to differentiate HIV risks between the two groups.	The results may not be generalizable to all MSM especially those who claim to be on the DL since they have fewer ties to the gay community. Exclusion of Asians, Native Americans and other ethnic minority MSM groups may further limit the generalizability of study findings. Some participants may have	1. Levels of internalized homophobia here higher among DL-identified MSM compared to non-DL MSM. 2. DL-identified MSM were less likely than non-DL MSM to have had 7 or more male partners in the past 30 days. 3. DL-identified MSM were less likely than non-DL MSM to have ever been tested. 4. DL-identified MSM were significantly less likely to have read	1. It is important to recognize that the DL phenomenon is not necessary a new one; new is the use of this specific label and the recognition of HIV risk of DL MSM and their partners. 2. HIV prevention messages have reached some DL-MSM and there needs to be more maintenance of effective risk reduction strategies in this population.

			different perceptions of the term "on the DL" compared to the researcher's DL definition. The decision to include MSM unfamiliar with the term DL may pose threat to statistical analysis.	an HIV-related publication. 5. DL-identified MSM were 2.1 times more likely to have attended a safer sex workshop than were non-DL MSM. 6. DL-identified and non-DL MSM rated healthcare providers as the most trustworthy source of HIV information. 7. DL-identified MSM were less likely to report having had any involvement with the gay community and fewer linkages to the gay community versus non-DL MSM.	
Whyte, J., Whyte, M. & Cormier, E. (2008).	**Exploratory Qualitative Study** N=11 **2**	Researchers describe the experiences how older African American females became infected with HIV while in monogamous relationships with male partners who		Participants ranged from 49 to 67 years old most of whom were married; the duration of the monogamous relationships ranged from 11 to 33 years. Nearly all	

[redacted]		secretly had sex with other males. Sample was recruited from South Georgia and North Florida in clinics that provided care exclusively to HIV-infected individuals. Participant eligibility included being female at least 45 years old with a history of being in strict monogamous relations for 10 years or longer. Participants were interviewed over a 1-year period. Researchers conducted unstructured and semi-structured interview questions to collected data from participants. Interview questions were as follows: (1) "How did you respond to finding out you were infected with		participants had a high school education; most of the participants were of low-income socioeconomic status. Participants had an HIV-positive status ranging from 4 months to 3 years and learned that they had contracted the infection 7 months to 3 years prior to the study. Five major themes emerged from participant interviews. The themes are as follows: (1) "Feeling betrayed and losing trust" (2) "Reflecting on the past relationship" (3) 'Seeking positive aspects of the relationship" (4) "Feeling ashamed before God,	

[redacted]		HIV? Talk about your reason for being tested and your memories of having been told you were positive." (2) "How did you initially cope with your HIV diagnosis? What are your memories of finding out you contracted the virus from your husband/partner?" (3) "Tell me about your decision to continue or end your relationship. What kinds of things influenced your decision?" (4) "What was your relationship with your husband/partner like after you found out how you became infected?"		community, and family" (5) "Assuming the caregiver role/sharing the burden of illness." (Whyte, J., Whyte M. & Cormier, E., 2008, p. 425). All participants felt betrayed by their male partners. The combined effects of relationship betrayal, homosexual activity, and the stigma associated with the disease destroyed most of the participant's relationships with their male partners. Newly learning their HIV-positive sero-conversion made participants reflect on the quality of their relationship prior to receiving the diagnosis. Most participants report that they sustained	

[redacted]		(5) "If there was a delay in finding out that you had become infected by your husband/partner, what was your relationship like from that point forward?" (6) "What changed about your interactions with your family and/or friends after your diagnosis? How do you explain these changes?" (7) "How would you describe your experiences in gaining health care after your diagnosis? What about your husband/partner's care?" (Whyte, J., Whyte M. & Cormier, E., 2008, p. 426). Demographic information was		their relationships during difficult times, but after receiving an HIV diagnosis their relationships could not sustain afterwards. Although betrayal and anger toward their male partner was a thematic finding, participants who remained in their relationships did so because they reflected on the positive characteristics of their partners. Another theme that emerged from the study was that participants were ashamed before God, their family, and their community in part by the stigma associated with HIV in the African American community and the humiliation of	

[redacted]		obtained on all participants. Observational field notes were recorded during the entire interview process to document both the participants' observations and nonverbal behaviors.		realizing that their partner has homosexual tendencies. The final theme that emerged in the study was that participants hold a burden of the HIV infection. Participants who continued their relationships with their male partners uniformly took on a caregiver role despite suffering with their on sickness.	

APPENDIX B

SIGN SCORING SYSTEM

Scottish Intercollegiate Guideline Network Key to evidence statements and grades of recommendations	
Levels of Evidence	
1++	High quality meta-analyses, systemic reviews of RCTs, or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systemic reviews, or RCTs with a low risk of bias
1 -	Meta-analyses, systemic reviews, or RCTs with a high risk of bias
2++	High quality systematic reviews of case control, cohort, or studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

APPENDIX C

KEY SEARCH TERMS OR PHRASES

African American females

African American males

Black church

Black men who have sex with men

HIV

HIV stigma

Nursing

APPENDIX D

HIV STIGMA SURVEY

You have been asked to complete this survey on knowledge, attitudes and behaviors that relate to HIV/AIDS. All of your answers will be kept confidential – I will not share your individual answers with anyone. It is important that you answer each question honestly. Please do not write your name on this survey or share your answers with others.

Section 1:

Please tell me about yourself.

Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: □ White/Caucasian
□ Black/African American
□ Asian or Pacific Islander
□ Native American or Alaska Native
□ Other (please specify):_____.

Education (Highest grade or year in school that you completed):

□ Grades 1-5 (Elementary School)
□ Grades 6-8 (Middle School)
□ Grades 9-11 (Some High School)
□ Grade 12 or GED (High School Graduate)
□ College 1-3 years (some college or technology school)
□ College Graduate
□ Graduate School

During the last year, how often did you go to church?

□ At least once a week
□ 2-3 times a month
□ Once a month
□ A few times a year

Section 2: *Knowledge*.

Please tell me how likely it is that someone could get HIV by doing the following activities.

How likely is it that a person could become infected with HIV by:	**Check only one box per question.**
1. Sharing plates, forks or glasses with someone who has HIV.	□ Very Likely □ Somewhat Likely □ Unlikely
2. Using public toilets.	□ Very Likely □ Somewhat Likely □ Unlikely
3. Mosquitoes or other insects.	□ Very Likely □ Somewhat Likely □ Unlikely
4. Being kissed on the cheek by someone who has HIV.	□ Very Likely □ Somewhat Likely □ Unlikely
5. Being coughed or sneezed on by someone who has HIV.	□ Very Likely □ Somewhat Likely □ Unlikely
6. Donating or giving blood.	□ Very Likely □ Somewhat Likely □ Unlikely
7. Getting tested for HIV.	□ Very Likely □ Somewhat Likely □ Unlikely
8. Having unprotected oral sex with someone who has HIV.	□ Very Likely □ Somewhat Likely □ Unlikely

9. Having unprotected anal sex with someone who has HIV.	□ Very Likely □ Somewhat Likely □ Unlikely
10. Having unprotected vaginal sex with someone who has HIV.	□ Very Likely □ Somewhat Likely □ Unlikely
11. Having sex with multiple sex partners.	□ Very Likely □ Somewhat Likely □ Unlikely
12. Sharing needles for drug use with someone who has HIV.	□ Very Likely □ Somewhat Likely □ Unlikely

Please tell me if you think each statement below is true or false. "DK" means that you don't know.

HIV/AIDS Knowledge:	**Check only one box per question.**
1. Birth control pills protect against HIV (the virus that causes AIDS).	□ True □ False □ DK
2. There is no cure for HIV/AIDS at present.	□ True □ False □ DK
3. A person can be infected with HIV and not have the disease AIDS.	□ True □ False □ DK
4. Most people who have HIV look sick.	□ True □ False □ DK
5. If having sex, the best way for a person to reduce his or her risk of getting HIV is to use a condom every time.	□ True □ False □ DK

6. It can take ten or more years for someone with HIV to test positive.	□ True □ False □ DK
7. People can get HIV by sharing needles and/or syringes (to inject drugs) with someone who has HIV.	□ True □ False □ DK
8. There is a vaccine available to the public that protects a person from getting HIV.	□ True □ False □ DK
9. In order to prevent getting HIV people who inject drugs should never reuse or "share" needles.	□ True □ False □ DK
10. It is possible, but unlikely, to get HIV from an HIV test.	□ True □ False □ DK
11. Bleach can be used to clean dirty needles for injecting drugs to reduce the risk of getting HIV.	□ True □ False □ DK
12. If a person has a sexually transmitted disease, such as gonorrhea, herpes, or syphilis, he or she is more likely to get HIV.	□ True □ False □ DK
13. HIV can be transmitted through casual contact, such as shaking hands, hugging or sharing a drink with someone who has HIV/AIDS.	□ True □ False □ DK
14. If a man pulls out before orgasm, condoms don't need to be used to protect against HIV.	□ True □ False □ DK

15. There is medicine available to prevent a pregnant woman infected with HIV from passing it to her baby.	□ True □ False □ DK
16. Any person with HIV can pass it on to someone else through oral, vaginal, or anal sex.	□ True □ False □ DK
17. Someone can get HIV by having unprotected or sex with an infected sex partner.	□ True □ False □ DK
18. If a mother has HIV, the baby can get it by drinking breast milk.	□ True □ False □ DK
19. People who have unprotected oral, anal, or vaginal sex should get tested for HIV regularly.	□ True □ False □ DK
20. People who share needles should get tested for HIV regularly.	□ True □ False □ DK

Section 3: *Comfort.*

Please indicate how comfortable you would be in each of the following situations. Please check only one response for each.

How comfortable would you be…	**Check only one box per question.**
1. Sitting next to a person with AIDS in church.	□ Very Comfortable □ Somewhat Comfortable □ Not Very Comfortable □ Not At All Comfortable

2. Using a restaurant drinking glass once used by a person with AIDS.	□ Very Comfortable □ Somewhat Comfortable □ Not Very Comfortable □ Not At All Comfortable
3. Hugging a person with AIDS.	□ Very Comfortable □ Somewhat Comfortable □ Not Very Comfortable □ Not At All Comfortable
4. Shaking hands with a person who has AIDS.	□ Very Comfortable □ Somewhat Comfortable □ Not Very Comfortable □ Not At All Comfortable
5. Wearing a sweater once worn by a person with AIDS.	□ Very Comfortable □ Somewhat Comfortable □ Not Very Comfortable □ Not At All Comfortable
6. Using a toilet after someone who has AIDS.	□ Very Comfortable □ Somewhat Comfortable □ Not Very Comfortable □ Not At All Comfortable
7. Having a child with AIDS in the church nursing.	□ Very Comfortable □ Somewhat Comfortable □ Not Very Comfortable □ Not At All Comfortable

Section 4: *Attitudes.*

Please indicate if you agree or disagree with the following statement. NS means that you are "not sure". Please circle only one response.

Circle only one response for each.	**Do you agree or disagree with the following statement?**
Agree Disagree NS	1. AIDS is a punishment from God for sin.
Agree Disagree NS	2. I think people who inject drugs deserve to get AIDS.
Agree Disagree NS	3. I think homosexuals deserve to get AIDS.
Agree Disagree NS	4. Most people who have the AIDS virus only have themselves to blame.
Agree Disagree NS	5. I have little sympathy for people who get the AIDS virus from sexual promiscuity.
Agree Disagree NS	6. I think people with the AIDS virus should be treated with the same respect as anyone else.
Agree Disagree NS	7. Scientists and doctors can be trusted to tell us the truth about HIV/AIDS.
Agree Disagree NS	8. I believe the HIV/AIDS is a form of genocide again African Americans.

9. If you tested HIV positive, how concerned would you be about people discriminating against you?

□ Very concerned
□ A little concerned
□ Not concerned

10. How much do you think fear of discrimination against people with AIDS stops people from getting tested for HIV?

□ Not at all
□ A little bit
□ A great deal

Section 5: *Information.*

Where do you get most of your information about HIV/AIDS? Check all that apply.

□ Television
□ Radio
□ Friends or Acquaintances
□ Materials distributed at church
□ Health Department (DHEC)
□ Other (please specify):_____
□ Newspapers/Magazines
□ Family Members
□ Doctor/Health Care Provider
□ Internet
□ AIDS Hotline

Where can someone go to get tested for HIV?_____.

Section 6: *Behaviors.*

I realize that this information may be very personal, but it is necessary for me to understand more about what people are doing. I will keep your answers private. I ask that you be honest in your responses. "DK" means that you don't know or cannot remember.

Have you ever been tested for HIV in your lifetime?	□ Yes	□ No	□ DK
Have you been tested for HIV in the past year?	□ Yes	□ No	□ DK
Have you been diagnosed with an STD in your lifetime?	□ Yes	□ No	□ DK
Have you been diagnosed with an STD in the past year?	□ Yes	□ No	□ DK

How often do you use a condom when you have sexual intercourse?

□ Always □ Sometimes □ Never

Did you use a condom the last time you had sexual intercourse?

□ Yes □ No □ Don't know

THANK YOU FOR COMPLETING THIS SURVEY ☺

APPENDIX E

"V.O.I.C.E.S. Leadership Survey"

Part I

1) **Leadership Role:**
   - □ Bishop
   - □ Pastor
   - □ Asst. /Assoc. Pastor
   - □ Sr. Elder
   - □ Elder
   - □ Deacon
   - □ Mother
   - □ Minister
   - □ Other (please specify) _____

2) Age: □ 18-24 □ 25-30 □ 31-35 □ 36-45 □ 46-55 □ 56-65 □ 66-75 □ 76-85 □ 85+

Part II

Questions	
Do you agree with the following? I would allow the VOICES/VOCES video that demonstrates "safe sex" negotiation skills to be presented to young adults, age 18-35, at my church.	**Please Circle: Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree /** **Comments:**

Do you agree with the following? I would allow a nurse to demonstrate to young adults, age 18-35, how to properly apply a condom on an anatomical male model.	**Please Circle: Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree /** **Comments:**
Do you agree with the following statement? HIV prevention information is something young adults, age 18-35, at my church need to be informed of.	**Please Circle: Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree /** **Comments:**
Do you agree with the following statement? After watching the VOICES/VOCES video, I would allow a nurse to facilitate a 20 minute discussion with young adults, age 18-35, to: (1) talk about the video, (2) assess their risk for HIV, and (3) provide strategies how to overcome barriers to condom use.	**Please Circle: Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree /** **Comments:**
Do you agree with the following statement? The church is an appropriate place for young adults, age 18-35, to learn information about HIV.	**Please Circle: Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree /** **Comments:**

Do you agree with the following statement? I would allow a nurse to distribute condoms to young adults, age 18-35, at an HIV workshop, like VOICES/VOCES at my church.	**Please Circle: Strongly Agree / Agree / Neutral / Disagree / Strongly Disagree/** **Comments:**
Do you agree with the following? Overall, the VOICES/VOCES intervention is appropriate in the church setting. Nothing needs to be modified.	**Please Circle: Yes / No / Needs to be modified** **Comments:**

Part III

Any Comments:_____
_____
_____
_____
_____
_____
_____
_____.

Suggestions:_____
_____
_____
_____
_____
_____
_____.

APPENDIX F

CHURCH LETTER

Dear Pastor [X] and Leadership Team,

First, I send you all greetings in the name of our Lord and Savior Jesus Christ who is the head of my life. My name is Bro. Jason and I am a member at Bible Way Church of Atlas Road where I serve as a registered nurse within the Health Professions Ministry. Currently, I am a doctoral student at the University of South Carolina and I am in the mist of doing research in the college of nursing in order to complete my dissertation. My dissertation evolves the disproportionate HIV infection rates within the African American community and how nurses can utilize the African American Church as a platform to provide HIV prevention education just as we currently use the church to inform our community about diseases that affects our people the most (e.g. diabetes, hypertension, breast cancer, prostate cancer, etc.).

My dissertation involves collaborating with persons who hold leadership roles within the African American Church in regards to the Center for Disease Control's (CDC) HIV intervention titled "V.O.I.C.E.S." V.O.I.C.E.S. is the CDC approved HIV prevention workshop that is also known as "Video Opportunities for Innovative Condom Education and Safer Sex." Specifically, I would like to present the V.O.I.C.E.S. intervention to 8 leaders within your church and get fed back, in the form of a brief survey, on what components of the intervention would be permissible to do within the confinement of the African American Church setting. The intervention will take 60 minutes to complete which will include the following components:

(1) Show a 20 minute soap-opera style video of young African American couples negotiating safe-sex scenarios
(2) Nurse demonstrates to audience how to correctly apply a condom on an anatomical male silicone penile model
(3) Nurse presents a poster board displaying condoms sold in retail and educate audience about their unique characteristic features
(4) Nurse obtains survey from leadership committee

The survey will measure HIV stigma among African American Church leadership and the elements of the V.O.I.C.E.S. intervention that is approved or not approved, by leadership, within the church. This same approach will also be done at other churches and I am reaching out to your ministry in order to increase the statistical power of my study.

In conclusion, I humbly realize that addressing HIV infection within the confinement of the church is challenging, especially since it may be acquired due to engaging in sexual activities outside the Biblical principles of marriage. My conviction is to educate the body of Christ so that they can be empowered to effectively teach others, who are falling short

to the glory of God, mechanisms to "wrap it up" and protect themselves from this deadly disease that is now labeled as a Black person's disease. I look forward to hearing from you and being a willing servant.

Your Brother in Christ,

Jason Richard, RN
University of South Carolina