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Examining the Impact of Community-level Factors on HIV Risk Behaviors among African American Women in Atlanta, Georgia

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ABSTRACT

Examining the Impact of Community-Level Factors on HIV Risk Behaviors among African American Women in Atlanta, Georgia

By

Aundrea B. Collins

May 15, 2017

Introduction: According to Paxton et. Al (2013), HIV/AIDS continues to be a health crisis for African Americans, with a significant impact on women. In 2010 in the United States, African American women made up only 13% of the U.S. female population, but were 64% of the estimated 9,500 new infections in U.S. women (Ivy, 2014). Although there are factors at each level of the socioecological model that have an impact on African American women's performance of HIV risk behaviors, it is important to address the major influences of community-level factors on health behaviors. The focus of this study is to identify, examine, and discuss community and neighborhood influences that promote HIV risk behaviors in African American women living in metro Atlanta, Georgia.

Methods: In the Sojourner Syndrome Study conducted by Dr. Sarita Davis, an exploratory qualitative method using in-depth interviews was used to gather information from participants. Twenty-three interviews from the Sojourner Syndrome Study were used for this study. The participants were African American women, ages 18 and up, and were living in Atlanta, Georgia.

Results: The results of this study indicate that the socioeconomic disadvantages due to lack of access to healthcare, drug-infested communities, exposure to different types of violence, stress, abuse (physical and sexual), and poverty all increase African American women's risk of HIV.

Conclusion: Community organizations should focus on providing effective and culturally-tailored programs and interventions that seek to address individual, family-specific, and community-specific behaviors around HIV risk and making healthy life and sexual choices.

Key Words: *socioecological model, community, family, households, Human Immunodeficiency Virus (HIV), community violence, domestic violence, intimate partner violence, physical abuse, sexual abuse, drug abuse, alcohol use, poverty, healthcare*

Examining the Impact of Community-Level Factors on HIV Risk Behaviors among African
American Women in Atlanta, Georgia

By

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B.S, Florida Agricultural & Mechanical University

A Thesis Submitted to the Graduate Faculty
Of Georgia State University in Partial Fulfillment
of the
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APPROVAL PAGE

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Author's Statement Page

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Aundrea B. Collins

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Introduction

HIV, which stands for Human Immunodeficiency Virus, is a virus that is spread through certain bodily fluids that attacks the body's immune system, specifically the T cells (Centers for Disease Control and Prevention, 2017). Once HIV destroys most of the T cells in the body, the body is unable to fight off infections and disease that begin to invade the body. HIV can be transmitted through sexual behaviors and injection drug use. Bodily fluids such as blood, pre-seminal fluids, semen, vaginal fluids, rectal fluids, and breast milk can transmit HIV. Sharing needles for drug use and tattoos are also ways that HIV can be transmitted. In the United States, HIV is spread mainly by having anal or vaginal sex with someone who has HIV without using a condom or sharing needles and syringes (CDC, 2017). According to the CDC (2017), African Americans are disproportionately affected by HIV compared to other racial and ethnic groups.

The CDC (2017) suggests that these statistics can be attributed to a multitude of factors. In all communities, the lack of awareness of HIV status contributes to an increased HIV risk (CDC, 2017). In African American communities throughout the United States, many people are unaware of their HIV status which increases the HIV risk of everyone within these communities (CDC, 2017). Other factors in the community that significantly increase an African American's risk of contracting HIV include poverty, lack of access to healthcare, lack of quality and affordable healthcare, domestic and intimate partner violence, drug use, sexual concurrency, lack of education, and shortages of resources. African American women in these communities in Atlanta are faced with these factors that increase their risk of HIV on a daily basis. The positive news in recent years show that the number of HIV diagnoses in African American

women has decreased in the past few years. Recent data indicate that, as with women overall, new HIV infections among Black women are on the decline, decreasing by 21% between 2008 and 2010 (Kaiser Family Foundation, 2014). Although HIV infections among black women are on the decline, it is necessary that research focuses on the reasons behind why African American women are still leading in the number of new HIV diagnoses among all women in the United States. It is also important to investigate and identify how African American communities influence these risk factors that increase the HIV risk of those living within these communities. The purpose of this study is to examine the role of community-level factors on HIV risk behaviors in African American women living in Atlanta, Georgia. The research questions for this study are:

1. What factors and stressors in Atlanta communities contribute to African American women performing risky sexual behaviors that increase their risk for HIV?
2. Do African American communities reinforce or promote these risky health behaviors?
3. How can African American women become more prominent figures in their communities in regards to HIV prevention, awareness, and education?
4. What specific type of interventions will cater to African American women in Atlanta communities who are at an increased risk for HIV?

The Sojourner Syndrome Study, conducted by Dr. Sarita Davis, examined how race, class, and gender influence black women's HIV risk in a poor minority community in Atlanta, Georgia. The study suggested that these three factors give important information regarding the disproportionate HIV rates among the black women living in poor minority communities.

Utilizing the twenty-three interviews from the Sojourner Syndrome Study, this study analyzes

the data from the interviews by identifying the most influential community-level factors in Atlanta communities that increase or decrease black women's HIV risk and in what ways are African American women in these communities taking care of their health or putting their health at risk. The data will also aid in determining what specific prevention methods and programs are needed in these communities.

Literature Review

In reality, African Americans are the most disproportionately affected by the virus. While only making up 12% of the United States' population, African Americans accounted for 45% of HIV diagnoses in 2015 (CDC, 2017). The group also have higher proportions of new HIV diagnoses, those living with HIV, and those ever diagnosed with AIDS in comparison to other racial and ethnic groups (CDC, 2017). This, in essence, provides a clear understanding of how African American communities throughout the United States are either infected or affected by the virus. With regard to African American women, the number of HIV diagnoses among the group fell 42% (CDC, 2017), but is still relatively high compared to women belonging to other racial and ethnic groups in the United States. For example, in 2015, 4,524 African American women were diagnosed with HIV, while only 1,131 Hispanic/Latino women and 1,431 white women were diagnosed with HIV (CDC, 2017). African American communities continue to bear the health effects of the virus at greater costs, being that they are also more likely to die of complications from the virus.

A study, referred to as the HPTN 064 Women's HIV Sero-incidence Study found that the HIV rate was 0.24 percent for the 2,099 African American women in its cohort, which happens to be five times higher than the rate estimated for African American women by the Centers for

Disease Control and Prevention (Patel, 2012). According to a CDC Projection Analysis in 2010, one in 48 African American women would be diagnosed with HIV during their lifetimes (CDC, 2016). Young African American women between the ages of 25 to 34 years old have seen a steady increase in the rates of HIV infection in the last decade. In 2010, black women accounted for 13% of all new HIV infections and 64% of all new infections among women overall (CDC, 2016). The HIV epidemic in the African American community surpasses the rates of HIV rates among other racial and ethnic groups and there are multiple factors that contribute to African Americans elevated risk of HIV.

African Americans and HIV Prevalence in Atlanta, Georgia

HIV is no stranger to Atlanta, Georgia. In recent years, the HIV rates have skyrocketed as public health professionals now compare the city's HIV prevalence to developing countries around the world. In an online article by Essence Magazine (Davis, 2016), Dr. Carlos Del Rio, co-director of the Emory University Center for AIDS Research stated that "Downtown Atlanta is as bad as Zimbabwe". Dr. Carlos Del Rio also stated that "the largest group now affected by the disease is actually African Americans with little to no access to healthcare (Davis, 2016).

According to AIDSvu (2017), 69% of people living with diagnosed HIV in 2013 were black and 75% of people living with diagnosed HIV between 2010 and 2014 were black. In 2013, the rate of black females living with an HIV diagnosis in Atlanta was 14.5 times that of white females (AIDSvu, 2017). In addition, there are specific zip codes in Atlanta that represent where many of HIV cases are located. Some of these zip codes include 30318, 30310, 30315, 30316, 30317, 30308, 30324, 30326, 30329, 30319, 30342, 30033, 30303, 30030, and 30305. These zip codes all have over 3,500 people living with diagnosed HIV per 100,000 people (AIDSvu, 2017). In

many of the same zip codes such as 30318, 30314, 30310, 30315, and 30316, females make up at least 1,300 people out of every 100,00 people that are living with diagnosed HIV and most of these females are black (AIDSVu, 2017).

The Sociological Model: The Community Level

Although there are factors at each level of the Socioecological Model that influence HIV risk, the community level of the Socioecological Model plays a greater, more personal role in the elevation of HIV risk of African American women. The community level of the Socioecological Model examines the role of workplaces, schools, and neighborhoods in which social relationships develop and it also identifies the characteristics of these settings that are associated with certain health behaviors, in this case, HIV risk behaviors. The level looks at factors that shape community norms, beliefs, attitudes, and values. In this study, the community level of the Socioecological Model will be used to investigate what community influences have a significant impact on HIV risk behaviors among African American women in Atlanta, Georgia.

In a study conducted by Duvall et. al (2013), it is suggested that strong family and community relationships are well-acknowledged in their importance within African American culture and have been linked to better health outcomes. However, HIV remains a prominent health issue in the African American community. The community and its norms and values are detrimental to reducing HIV risk among African American women in Atlanta. Norms and values such as having positive attitudes about taking care of one's health, getting tested regularly, using condoms and other protective barriers, and using clean needles are important to preventing HIV in African American communities. Paxton et. al (2013) conducted a study on relationship

factors that promote unprotected sex within African American communities and found that participants had conflicting feelings about the relationships and sexual behaviors that they have experienced or participated in within their communities. The participants reported that their families, church, and friends had an effect on their sexual behaviors, signifying that community norms, attitudes, beliefs, and values play major roles in health behaviors among members of the community.

There are other key community factors that influence HIV risk behaviors in this particular population. Drugs, community violence, lack of healthcare and education, and poverty all play a role in the HIV epidemic in the African American community and among African American women. Hixson (2011) suggested that factors such as poverty, unemployment, inadequate access to healthcare, and socio-cultural issues may contribute to the HIV phenomenon. Frew et. al (2016) also identified community-level factors that were associated with HIV risk to be poverty, unemployment, inadequate access to healthcare, the sociocultural environment, and generalized mistrust in the healthcare system. These factors along with housing, social isolation, political disempowerment, and racial/gender discrimination are suggested to contribute to the racial disparity in HIV/ AIDS diagnoses among women and have been linked to increased HIV vulnerability and susceptibility.

In Frew's study (2016), it is stated that these community factors are associated with community and social network issues such as greater sexual concurrency among people living in communities with gender imbalances. For example, in predominantly Black/African American communities, the impact of disproportionate incarceration of Black/African American men and

the associated mortality from community violence creates an imbalanced female-to-male ratio (Frew et. al, 2016).

Cultural, socioeconomic, relationship-specific and gender-specific factors are crucial to addressing HIV risk among women, and among black women in particular (Newman et. al, 2008). Taking into account socioeconomic disadvantages and racial health disparities allows interventions to provide a foundation that aids in considering gender and cultural norms of the population. Newman et. al's (2008) study found that opportunities for HIV prevention tailored to the needs of urban black women should include strategies focused on community survival in hostile social and institutional environments, rather than HIV per se. Basing HIV prevention services on community survival builds the relationship between members of the community and it allows everyone to have responsibility in maintaining the health and well-being of the community.

In a major study conducted by Blackstock et. al (2015), the perceptions of community HIV/STI risk among U.S. women living in areas with high poverty and HIV prevalence rates were examined. The study discussed optimistic bias and how black women believed their individual behaviors will protect them from HIV/STIs, although there are community-level factors that may increase their risk. Four themes arose from Blackstock's study. The lack of access to healthcare, education and information, close proximity to others, and more people with high-risk behaviors in the communities were the four major themes that related to community HIV/STI risk. The study increased the limited amount of research on community-level HIV/STI risk and it suggested that HIV prevention communication should shift focus from individual-risk behaviors to community-level risk behaviors.

Methods

The name of the study and dataset that was used to conduct this study is entitled "The Sojourner Syndrome: An Interpretive Framework for Understanding Poor Black Women's HIV Risk". Permission from the author of the The Sojourner Syndrome study was obtained to be able to use the data in this study. The Sojourner Syndrome study was conducted in "The Bluff" community located in metro Atlanta. "The Bluff" community is known to be a low-income, poverty-stricken, high-risk area for drugs and crime. The Sojourner Syndrome study utilized an exploratory qualitative approach to examine the impact of race, class, and gender on poor black women's HIV risk living in the Bluff. The target population for the Sojourner Syndrome study were individuals who identified as black women and were 18 years and older. The participants were recruited from a larger parent study called The Geography Project (GP). This study focused on examining the differences in HIV and substance abuse in high and low burden communities.

The Geography Project's street ethnography team assisted the principal investigator in finding participants who fit the criteria for being participants in the study. The street ethnography team assisted by contacting prospective participants using their phone numbers or addresses on the screening forms of the Geography Project. If potential participants agreed to participate in the study, the principal investigator scheduled them for individual interviews at locations that were most comfortable and convenient for them. The recruitment process began in June of 2009 and ended in September of 2010. Although over 452 participants met the criteria for the study, only 50 participants were recruited and interviewed. The Georgia State University Institutional Review Board approved the study and the participants of the study gave

individual written consent acknowledging their willingness to be participants in the study. As an incentive for being in the study, participants received \$20 compensation and materials and information on health and counseling services in their area.

The participants of the Sojourner Syndrome study were asked five different questions in their interviews. The questions were:

1. What is like to live in your community?
2. What things in your community hurt your and other women's health?
3. How have your sexual choices been influenced by where you live?
4. How has living in your community affected your use of alcohol or drugs?
5. Are there things in your community that help your health and that reminds you to take care of yourself?

Once the data from these interviews were analyzed, main themes were identified.

For this study, the interview transcripts from the Sojourner Syndrome study are used to address the research questions of this study. The transcripts are used to identify major themes and community-level factors that drive HIV risk behaviors among these black women in Atlanta, determine if African American communities promote or encourage risky health behaviors, seek ways in which African American women can become more prominent figures in HIV awareness and prevention, and to determine what type of interventions are specifically needed for African American women in Atlanta who are at an increased or high risk for HIV.

Data Analysis

A general inductive approach was utilized for data analysis to identify and discuss the community-level factors that have an impact on HIV risk behaviors among black women living in

Atlanta, Georgia. The researcher read through twenty-three interview transcripts thoroughly and identified common themes and factors that affect HIV risk behaviors at the community level. The themes were open-coded via highlighting. For each of the remaining research questions, the themes and concepts were open-coded and highlighted as well.

To determine the credibility of the data, the process of triangulation was used. A classmate and I examined the data so that the data could be examined from multiple perspectives. As a result, I was confident in the research study's findings. To determine the dependability of the data and the results, the code-recode procedure was used. The same results were presented after the second round of coding.

Results

Participant Characteristics

Of the twenty-three interviews used, all twenty-three participants were black women ages 18 and older and living in metro Atlanta, Georgia.

There were themes that emerged from each of the four research questions of this study.

Research Question 1: What factors and stressors in Atlanta communities contribute to African American women performing risky sexual behaviors that increase their risk of HIV?

Majority of the participants reported that living in their community involved witnessing a heavy presence of guns. The participants reported seeing women sell their bodies on the street and seeing drugs nearly everywhere in their communities. Many of the participants had family members in the household or neighbors that sold or used drugs. Community violence was also mentioned by all of the participants, although one participant mentioned that she "grew up in a loving environment with lots of friends and that living in her community was not

challenging at all". Participant #002 described her community as a "good community with bad people living within it". This participant also reported witnessing young women dating drug boys and allowing them to take over the communities. High crime, robberies, rape/molestation, and homicides were also reported by the participants.

Participants described drugs such as heroin and crack as things that hurt their and other women's health. Many of the participants witnessed their moms and dads sell or use drugs which, in turn, caused them to sell or use drugs as well. Participant #002 suggested that people were fearful of knowledge stating that "They have resources, there are things within arm's reach, but very few will take advantage of it". However, most participants reported a lack of healthcare resources in their communities. Lack of knowledge also plays a significant role in how communities hurt women's health. Participant #003 mentions how lack of education is one of the reasons why people in her community do drugs and catch sexually transmitted diseases. She says "I didn't really know about HIV because I didn't go to school". Majority of the participants had experienced or witnessed some type of abuse whether it was domestic violence, intimate partner violence, community violence, gun violence or sexual abuse. Participant #012 reported on the influence of music on the increase of violence in Atlanta communities stating "In 1996, they started coming out with songs that were disrespectful to women and violence was all they were singing about". One participant, participant #008 discussed her relationship with her boyfriend who, at the time, was incarcerated. Dating partners who are incarcerated have many effects on the health outcomes of black women. Also, participant #013 reported that she had found out that her ex-boyfriend was sleeping with men.

A common theme throughout most of the interview transcripts was that the lack of income led to many women participating in sex work (prostitution). Not all of the participants engaged in sex work, but many of the reported being witness to other women in their communities being engaged in sex work. Participating in sex work would aid these women in providing for their families or supporting their drug or alcohol addictions. Participant #001 says "To get drugs, I sleep with people I know to survive". Half of the participants reported that they did not date within their communities because they understood the risk that they would be taking and they were fearful of sexually transmitted diseases, specifically HIV/AIDS. Participant #012 stated "I've had some friends that I've watched die from AIDS and I've seen girls that they have found behind buildings behind them not caring who they sleep with and stuff". The participants reported that many of the men in their communities had sexual relationships with multiple partners and that made them fearful of making unhealthy sexual choices. One participant, Participant #013 reported that she did not trust men anymore because she had just got out of a relationship with a man who she found out was sleeping with both men and women. Peer pressure was reported as being an influence on some of the women's sexual choices as participant #008 described how her friend in her community liked to have sex with a lot of boys so that she could be popular in the community. Hanging around people making unhealthy sexual choices tended to rub on off some of the participants' choices and the choices of other women in their communities that they knew.

Peer pressure and "following the crowd" played a major role in why majority of the participants took part in drinking alcohol and/or using drugs. Many of the participants used drugs or drunk alcohol because their group of friends used drugs or drunk alcohol. Participant

#003 described her experience with following her friends' behaviors. She says "I kept seeing friends use drugs and alcohol and decided that I wanted to try it".

A history of family substance abuse was reported by all of the participants. Many of the women reported having parents who had a drug or alcohol addiction which played a part in why they began using drugs and drinking alcohol. Participant #001 described drug and alcohol addiction as the "the devil coming knocking on the door". Several participants used drugs or drunk alcohol to escape reality and the stress of their lives. For example, participant #009 stated that she smoked weed everyday and that it was just to clear her mind. She stated that she held so much inside and she would just hit her a blunt. One sub-theme that stood out was the idea of idle time and not having anything to do besides drink alcohol and use drugs. Participant #012 reported that idle time (being unemployed) led to her using drugs and drinking alcohol for the first time. She described idle time as being her "trigger" for drug and alcohol use.

Research Question 2: Do African American communities reinforce or promote these risky health behaviors?

There was not enough evidence to determine if Atlanta communities promoted risky health behaviors that increased HIV risk among African American women. The evidence from the transcripts showed that the risky health behaviors were indirectly reinforced. For example, many of the participants described participating in sex work (prostitution) or witnessing women in their communities sell their bodies for money to provide for their families or money to support their drug and/or alcohol habits. Because selling their bodies gave them opportunities to have an income, these women continued to sell their bodies to continue earning a decent

living or to support their drug and/or alcohol habits. For these African American women participating in the study and the women that they witnessed in their communities, earning the money was the reinforcement behind their willingness to sell their bodies.

Research Question 3: How can African American women become more prominent figures in their communities in regards to HIV awareness, prevention, and education?

Many of the participants mentioned how women in their communities did not utilize the resources that were placed in the communities signifying that African American women can first become more involved and aware of the fight against HIV. African American women can lead by example by getting tested and having regular health check-ups. One participant stated “guide me in the right way and tell me what I am supposed to do” showing the detrimental need for mentors, advocates, and support groups in these communities. Majority of the participants identified church as a significant figure in their communities and in their lives, stating that the church, along with prayer, helped them to grow spiritually. African American women can be more involved in spreading HIV prevention information within the church because it plays such a vital role in the survival and resilience of the African American woman. Utilizing the church will allow African American women to seek health information from a place from which they instill their spiritual faith, hopes, and beliefs in, making it more likely for them to be cautious in regards to putting their health at risk.

Research Question 4: What specific type of interventions will cater to African American women in Atlanta communities who are at an increased risk for HIV?

Many of the participants grew up in family dynamics that were different from the typical “mother, father, and children” type of household. Many grew up in single mother households

or were raised by their grandmothers or a female relative. There should be interventions that implement HIV prevention curriculums based on family structure and dynamics. Some participants mentioned how either their schools lacked sex education classes or they simply chose not to attend their school's sex education classes. This illustrates the need for better, modern, and required sex education classes in our schools at earlier grade levels. From most of the participants' responses, it can be concluded that African American women in these Atlanta communities need low-cost and safer community childcare facilities, community-specific health days, community home-based support groups as safe spaces, and more church involvement in HIV awareness, education, and prevention. Because many of the participants described the lack of transportation as a factor in not being able to take care of themselves, mobile health units are vital to improving the health and preventing HIV among African American women in Atlanta communities

Discussion

Although this study does not provide a true representation of the African American woman community's HIV risk in the United States, it does provide a solid foundation that explains how and why African American women are more disproportionately affected by HIV than women among other racial groups. In regards to health outcomes, African American women's struggles and experiences are unique and different in comparison to the experiences and struggles of women in other racial groups

From the research questions, six main themes were identified. The themes identified were violence, lack of resources/healthcare, stress, abuse (physical and sexual), and poverty. As mentioned in the results section, all of these women had experienced or witnessed some form

of violence and had experienced or witnessed some form of abuse. Different types of violence such as domestic violence, community violence, intimate partner violence, and gun violence were mentioned in the interviews. Specifically, experiencing intimate partner violence puts a person at greater risk of contracting HIV. Experiencing community, gun, or domestic violence increases stress within the home and the community which, in result, led to many of the participants turning to alcohol or drugs to escape their realities of daily life. Drugs and alcohol puts African American women at a greater risk of making unhealthy sexual choices, increasing their HIV risk. Under the influence of alcohol and drugs, these women were more likely to have sex with multiple partners, not use protection, and refrain from getting tested regularly.

Many of the women had been abused in some way. Rape and molestation in the women's communities was heavily discussed throughout the interviews. Several of the women reported being sexually abused by their fathers and uncles and several of the women discussed being physically abused by their fathers and partners. Sexual abuse increases a woman's chance of contracting HIV if the abuser is having sex with other people and not getting tested for HIV or the abuser has HIV and is careless in his choice of sexual behaviors. Physical abuse often led to the women using drugs and alcohol to escape their pain, resulting in the increase of unhealthy sexual choices.

All of women's responses helped to shed light on the lack of healthcare resources in Atlanta communities when it concerns the health and well-being of African American women. Many were in agreement that there were not enough health clinics in the community, transportation was not accessible, and that the only things that were truly accessible in the communities were drugs and guns. If there are no health clinics in the community and there is

not reliable transportation to get to health clinics in other places, it is extremely difficult for these and other women to access condoms, HIV testing sites, and other heavily-needed health services.

Poverty plays an important role in identifying the HIV risk of black women living in Atlanta. Living in poverty usually means that these women have no health insurance, no transportation, no childcare for their children, no adequate and safe housing, and no food. Many of the women interviewed discussed how living in poverty led to them selling their bodies for money to support their families or support their drug/alcohol addiction. All of these factors increases HIV risk. Living in poverty also increases stress levels in the home and in communities, sometimes encouraging women to unhealthily relieve their stress through sex. When all of these factors are examined, it is without a doubt that the majority of the women interviewed in the Sojourner Syndrome study are at an increased risk of HIV simply because of the communities that they live in.

Limitations

The findings of this study has several limitations. First, all of participants' behaviors and experiences are self-reported which increases the risk of recall bias. Many of the participants were recalling experiences and behaviors that happened over the course of their life span and that could present the problem of whether or not they are remembering events as they truly happened.

Secondly, many of the participants spoke slang or nonstandard English which made understanding some of the statements and phrases quite difficult. Some of the interview questions asked were not directly answered by the participants. For example, when asked

“How have your sexual choices been influenced by where you live?”, many of the participants did not answer the question in relation to themselves, but in relation to other women that they knew or that they had observed.

Thirdly, there were different sexual orientations among the women in this study. Depending on the sexual orientation, responses may not provide an accurate overall representation of the experiences and HIV risk for someone of a different sexual orientation.

Last, but not least, the participants' knowledge, self-perceived risk, and understanding of HIV was not assessed in the primary study's data, so it is possible that the participants may not know how to protect themselves from HIV.

Implications

To add to the findings of this study, future research should focus on African American women injection drug users in Atlanta to examine their experiences, sexual behaviors, and knowledge of HIV. Public health professionals should also do a similar study investigating community-level factors that influence HIV risk of transgendered women in Atlanta. Because the women in this study were ages 18 and older, it would be beneficial to conduct a study to examine how community factors influence the HIV risk of African American girls under the age of 18 in these same Atlanta communities.

The lack of responses on how being healthy can relate to the mental state of a community illustrates how vital it is that we address mental health issues that are often times neglected in African American communities. Because the role of mental health issues in the African American community was rarely mentioned in this study, it is imperative that a study be

conducted to examine the role of mental health issues in the Atlanta African American women population and how they affect performance of positive health behaviors that prevent HIV.

Conclusion

This study has aided in the identification of important community-level factors that impact and influence the HIV risk of African American women living in Atlanta. Because the HIV prevalence rate among African Americans in Atlanta are extremely high, it is important that we create and develop community organizations, programs, and interventions that tailor to addressing the six themes found in this study (violence, lack of healthcare resources, drug/alcohol use, stress, physical and sexual abuse, and poverty). Because all of the participants in the study are over the age of 18 and did not have many programs to teach them about sex and making healthy sexual choices at younger ages, it seems of extreme importance to implement interventions at earlier stages in the life span before it is too late for these girls/women to feel as if they cannot turn their lives around. As a result of this study, community organizations should focus on providing effective and culturally-tailored programs and interventions that seek to address individual and family-specific, and community-specific behaviors around HIV risk and making healthy life and sexual choices among African American women.

In regard to this study's research questions, the study found that violence, lack of healthcare resources, drug/alcohol use, stress, physical and sexual abuse, and poverty all contribute to an increased risk of African American women in Atlanta performing risky sexual behaviors that may lead to HIV. There was not enough information to determine whether or not Atlanta communities promote the risky sexual behaviors among African American women,

but the communities indirectly reinforce the risky sexual behaviors. The women interviewed did not find it appealing and necessary to encourage or promote these unhealthy sexual behaviors because they knew that the behaviors were wrong and unhealthy. The environments of these communities and the socioeconomic status of these women just made it easier to become involved in risky sexual or health behaviors. As a result, these behaviors tend to be reinforced especially when many of the women prostitute themselves for money to care for themselves and their families.

Last, African American women can become more prominent figures in their community's fight for HIV prevention and education by leading by example. Advocating for accessible, quality, and affordable healthcare services in low-income minority communities in Atlanta will bring attention to the fight against HIV in Atlanta. For African American women in Atlanta who do have access to these services, they can make sure they use condoms, get tested regularly, make sure their partners are tested regularly, and make sure that their fellow sister who do not have access to these services are taken care of as well. That is the mere importance and definition of what a community is and does. A community takes care of each and every one of its members and that is what Atlanta low-income African American communities seem to be lacking today. African American women can advocate for young African American girls in Atlanta communities by becoming mentors and educators and fighting for better sex education classes in Atlanta's school systems. As a result of this study, it is evident that HIV prevention, HIV education and healthy sexual decision-making begins in the household and in the community.

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