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Examining the Effectiveness of a Brief HIV Prevention Intervention
for Older African American Women in a Church Setting

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy
in Social Welfare

by

Megan Tiffany Ebor

2019

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ABSTRACT OF DISSERTATION

Examining the Effectiveness of a Brief HIV Prevention Intervention
for Older African American Women in a Church Setting

by

Megan Tiffany Ebor

Doctor of Philosophy in Social Welfare

University of California, Los Angeles, 2019

Professor Aurora P. Jackson, Chair

An educational group curriculum was developed whereby a controlled trial involving an HIV prevention program designed and tailored to the lives of older African American women was carried out in a church setting. The model was tested using a sample of 62 women, 29 of whom were assigned to the experimental condition and 33 to the comparison condition. Measures of HIV knowledge, stigmatizing attitudes toward people living with HIV, self-efficacy beliefs and behaviors, and psychological wellbeing were utilized to test the effect of the 4-session group intervention on change in these variables from pretest to posttest. Between-within subjects analyses of variance showed that participation in the study was associated with an increase in HIV knowledge and self-efficacy regarding taking control of one's life and circumstances, regardless of group assignment. In addition, participation in the study was associated with a significant improvement in the women's psychological wellbeing; i.e., decreased depressive symptoms. This change in depressive symptoms was due in part to the experimental condition assignment. Efficacy beliefs about condom use and stigmatizing attitudes about people living with HIV were nonsignificant. Implications for future HIV prevention interventions and research are discussed.

The dissertation of Megan Tiffany Ebor is approved.

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2019

DEDICATION

In the words of E.M. Bounds, “Prayers outlive the lives of those who utter them; outlive a generation, outlive an age, outlive the world.” In this spirit, I stand on the shoulders of countless people, yet there are two women in my life that have sustained and continue to sustain me through their prayers. To my grandmother, the late Frances Smith, and my mother, Marianne Smith-Parker, I dedicate this dissertation. These women of wisdom have taught me many things; but most importantly, they have taught me to depend and draw my strength from God, the charge of speaking truth to power, and living life on purpose according to His will. To my husband, Joe, and our three sons, Justin, Blake and Chandler, I thank you for your support and understanding throughout this journey. You each have been an inspiration, providing me with the encouragement needed to keep moving forward. Our family meetings throughout this time kept me on my toes as well as enthused.

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I would like to thank my dissertation committee of Alfreda P. Iglehart, Gail E. Wyatt and Vickie M. Mays for their support over the past two years as I moved from an idea to a complete study. This is truly one for the record books! I would also like to acknowledge the women that participated in my study and the church family that supported this effort. Over the course of my doctoral education I have had many mentors, friends and supporters that have been highly instrumental in providing guidance or a listening ear. I am fortunate to have such amazing people in my life – Thank you.

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CHAPTER 1

INTRODUCTION

1.1 Statement of the Problem

As we approach the fourth decade of the human immunodeficiency virus (HIV) epidemic in the United States (U.S.), HIV has evolved as a major public health concern that disproportionately affects older African American women (Altschuler, Katz & Tynan, 2004; Ebor, Murray, Gaul, & Sutton, 2015; Linley, Prejean, An, Chen, & Hall, 2012; Smith & Larson, 2015). Although at the onset of the epidemic, HIV was generally portrayed as a “white gay disease” (Mays & Cochran, 1988), the demographics of HIV infection have changed in the past 35 years (Wolf & Mitchell, 2012). Of the total number of women in the U.S. living with diagnosed HIV at the end of 2015, 59% (137,998) were black/African American, 19% (43,086) were Hispanic/Latina, and 17% (38,992) were white (Centers for Disease Control and Prevention [CDC], 2018). Older African American women have been identified as one of the fastest growing populations of new cases of HIV in the U.S., with heterosexual sex as the primary mode of transmission (McCord, 2014; Ebor et al., 2015; Cornelius, Moneyham & LeGrand, 2008). In 2010, African American women between the ages of 50-64 made up about 40% of newly diagnosed cases (Smith & Larson, 2015).

Older African American women are not only sexually active, they also are less likely than their younger counterparts to view condom use as a form of protection from HIV (Mack & Ory, 2003; Lindau, Lundberg, & Jerome, 2006). Some believe that this is because they are post-menopausal, not likely to become pregnant, and view condom use as a form of contraception, not

HIV protection when they engage in sexual behaviors (Cornelius et al., 2008). In addition, because of missed HIV screening opportunities (Adekeye, Heiman, Onyeabor, & Hyacinth, 2012; Skiest & Keiser, 1997), older adults are typically tested for HIV later in the course of the infection than their younger counterparts when the progression of the virus can more rapidly lead to AIDS and a host of associated problems, including death within a year of HIV diagnosis (Durvasula, 2014; Chadborn et al. 2006). HIV risk factors for older African American women are complex and are shaped by the intersections of age, race and gender that may triply influence optimal sexual health outcomes. In addition, it is important to consider the broader historical and cultural context from which African American women in the United States have established their sexual self-image and how, some believe, historical sexual trauma still impacts this group today.

1.2 Intersections Impacting HIV Prevention Efforts for Older African American Women

1.2.0 Historical and Cultural Background

There is evidence in the field of epigenetics indicating that trauma can impact an individual's DNA, which in turn can be genetically passed along generations. One widely reported study demonstrating this is of holocaust survivors passing the effects of trauma to their children and grandchildren (Degruy, 2005; Yehuda, et al., 2016). Likewise, there is evidence to support the assertion that the impact of slavery and the sexual exploitation suffered during slavery continue to still have an impact on the sexual experiences of African American women today (Wyatt, 1997). Some believe (1) that the historical effects of shared trauma among African Americans—having shared nearly 350 years of acute and chronic oppression, the experience of unresolved/undiagnosed physical and sexual trauma, and the associated feelings of depression and anxiety—are similar to the ongoing effects of extreme terror (Wyatt, Myers,

Williams, 2002; Bryant-Davis & Ocampo, 2005); (2) that as a matter of survival, some African Americans developed strategies in order to survive the treachery of this traumatic history; and (3) that protective strategies that helped this group to survive the past, have the capacity to thwart current HIV prevention efforts (Wyatt, 2009). Departing from most evidence-based interventions that focus on the number of sexual partners and unprotected sexual encounters, some current HIV interventionists suggest a more contextual approach that explores the reasons for engaging in sexual behaviors that may place the individual at risk (Marks & Crepaz, 2001; Suarez & Miller, 2001; Overby and Kegeles, 1994; Wyatt, 1997; 2009). For example, there is evidence suggesting that present day African American women are often sexually passive and deferential to men when it comes to making decisions about sexual activities (Wyatt, 2009). This finding supports evidence suggesting that indirect communication patterns among African Americans may be adaptive behaviors that stem from slavery because direct communication and interactions were prohibited during that time (Wyatt, 2009).

1.2.1 Ageism and Sexism (Double Jeopardy)

It is critically important to underscore the double jeopardy faced by older women where ageism and sexism intersect (Chepngeno-Langat & Hosegood, 2012). Researchers posit that ageism, defined as negative attitudes toward ageing, leading to the belief that ageing “makes people unattractive, unintelligent, asexual, unemployable, and mentally incompetent,” cultivates traditional sexism, and through these mechanisms older women are doubly disadvantaged (Minichiello, Hawkes & Pitts, 2011; Atchley & Barusch, 2004, p. 439). As ageism pervades our culture through various platforms, prejudices and discriminatory beliefs, attitudes, and practices become normalized (Wilkinson & Ferraro, 2002). Despite current national research indicating that a substantial number of older adults engage in spousal or other intimate relationships

(Lindau et al., 2007), ageist attitudes have perpetuated myths and prejudices regarding the importance of sexuality to older adults (Chepngeno-Langat & Hosegood, 2012). Research has shown that older adults engage in vaginal intercourse and oral sex well into the eighth and ninth decades of their lives, and regard sexuality as an important part of life (Lindau et al., 2007). This is important because HIV service providers have identified ageism and stigma as barriers to HIV prevention and education efforts aimed at the older, African American population (Nichols et al., 2002). There also are fewer HIV-prevention messages for older women (Neundorfer, Harris, Britton, & Lynch, 2005) and there is evidence that sexist attitudes facilitate a more tolerable approach toward the sexuality of men than of their female-aged counterparts (Chepngeno-Langat & Hosegood, 2012; Guo & Sims, 2017)

1.2.2 Race and Intersectionality

While ageism and sexism together create a doubly disadvantaged circumstance for older women, the layering of a racial and/or ethnic minority status with respect to older African American women presents another challenge for positive sexual health outcomes, making this subgroup triply disadvantaged. This is consistent with the theory of intersectionality, which has its roots in the writings of U.S. African American feminists who challenge the idea of a universal gendered experience. They argue that African American women's experiences are shaped also by race and class (Collins, 1990; Davis, 1981) and that these systems of oppression work together to produce inequality (Cole, 2009; Collins, 1990; Crenshaw, 1991; Schulz & Mullings, 2006). According to Link and Phelan (1995), moreover, racial discrimination consistently produces and reproduces social and economic inequities that in turn can cause disease (see, also, Smith & Larson, 2015). Indeed, public health scholars have identified race and socioeconomic status as social determinants of health (Wallace, 2012; Ford & Airhihenbuwa, 2010) and have

stressed the central role of structural mechanisms of oppression in producing health inequities (Williams & Mohammed, 2009). Consistently, Durvasula (2014) argues in regards to HIV risk reduction strategies that the dynamics of oppression are likely to be magnified in groups who face “intersectional oppression” that is driven by multifactorial etiologies such as poverty, minority statuses, and the cohort in which older women grew up, when oppression, for example, was culturally mandated against many of the roles and identities they held.

1.2.3 Health Disparities/Inequities

Health disparities have been defined as differences in health that are unnecessary, avoidable, and unjust (Whitehead, 1992). Researchers posit that it is our large-scale capabilities to control disease and death coupled with prevailing social and economic inequalities that create health disparities by race and socioeconomic status. This is because as new advancements in healthcare are developed to control disease and death these advances primarily benefit those with access to resources such as knowledge, money, power, prestige, and beneficial social connections (Phelan & Link, 2005). Thus, those who lack access to these resources are impacted adversely and health disparities persist. This is consistent with research demonstrating higher HIV prevalence in the U.S. among people who are poor in comparison with their nonpoor counterparts (Denning & DiNenno, 2010) and the disproportionate impact of HIV among people of color (Adimora & Auerback, 2010; Chepngeno-Langat & Hosegood, 2012; Karon, Fleming, Steketee & De Cock, 2001) despite new advancements in HIV medications that can greatly reduce the chances of transmission if taken correctly and consistently. The present study aimed to fill a portion of the gap in evidence on HIV prevention options for a population at high risk for health disparities related to HIV prevalence.

1.2.3.4 HIV-Related Stigma and the Black Church

The Centers for Disease Control and Prevention have recommended that faith leaders and the black church be included in HIV education and prevention efforts in the African American community (see, for example, Lindley, et. al, 2010; Berkley-Patton, Bowe-Thompson, Bradley-Ewing, Hawes, Moore, Williams, Martinez & Goggin, 2010; Wingood, G., Lambert, D., Renfro, T., Ali, M., & DiClemente, R., 2019). This is consistent with evidence indicating that roughly six-in-ten African American women, particularly older African American women, report attending religious services at least once a week (Pew Forum, 2008). However, in order to carry out an intervention in a church setting, the pastor, faith leaders, and church members must buy-in and voluntarily participate in an educational program that they have not sought.

Researchers have identified stigma as a powerful predictor of risk in women over the age of 50. Stigma can limit the discussions about HIV/AIDS thwarting accurate information or skills needed to manage risk behaviors (Montoya & Whitsett, 2003). Additionally, stigma can act to create a false sense of security regarding susceptibility of contracting HIV for the woman and her partner by reinforcing an “us/them” mentality (Durvasula, 2014). This is important because HIV-related stigma—defined as “prejudice, discounting, discrediting and discrimination directed toward people perceived to have HIV/AIDS” (Lindley, Coleman, Gaddist & White, 2010)—has facilitated substantial barriers to HIV prevention efforts within the African American community.

The impact of HIV-related stigma within the African American community is three-fold: it has been associated with not getting tested for HIV, not disclosing one’s HIV status to potential or current partners, and nonadherence with respect to medication use and healthcare seeking, all of which are associated with the spread of HIV among older African American women at greatest risk of contracting HIV; i.e., those in under-resourced communities who may not have access to HIV education (Buseh, Stevens, McManus, Addison, Morgan & Millon-

Underwood, 2006; Jacobs & Thomlison, 2009). Consequently, Neundorfer et al., (2005) found that older African American women in longstanding relationships did not use condoms because they did not perceive themselves to be at-risk for HIV; however, were subsequently infected. Education has been accredited with reducing HIV-related stigma and victim-blaming that is often reinforced by religious institutions (Lindley et. al, 2010; Swendermen, Rotheran-Borus, Comulada, Weiss & Rothman, 2006). This study aims to inform collaborative efforts between social welfare agencies and community faith-based organizations in the delivery of services to a population at risk for health disparities related to HIV.

1.3 Significance, Research Questions, Design

To date, interventions that focus on providing HIV prevention information and skills to older African American women have yet to be tested systematically. Researchers have pressed the need for empirical research focused on the needs of older women, and stress the need for an understanding of the diverse makeup and needs of this population to inform HIV prevention, intervention and best practices (Durvasula, 2014). Therefore, the present study tested the effect of a brief, 4-week, educational group program developed for older African American women designed to increase knowledge and self-efficacy about HIV, and to decrease stigma-related attitudes towards people living with HIV. In addition, whether participation in the educational group might be associated with improved psychological wellbeing was also tested. Thus, a measure of depressive symptoms was included among the tested variables. Psychological wellbeing is an important factor in decision making about sexual health. Indeed, previous studies have found that some mental health disorders—depressive symptoms in particular—can, contribute to HIV transmission and poor HIV disease prognosis (Cournos, McKinnon and Wainberg, 2005). Using ecological and social cognitive theoretical perspectives

(Bronfenbrenner & Ceci, 1994; Bandura, 2001), together with aspects of the Sexual Health Model (Robinson, 2002; Wyatt, 2009) in order to provide cultural context, three questions were addressed: (1) Do older African American women assigned to the 4-week HIV prevention educational group exhibit a greater increase in knowledge about HIV and the transmission risks for HIV than do their counterparts assigned to the one-session informational comparison condition at the 6-week post-intervention follow-up? (2) Do older African American women assigned to the 4-week HIV prevention educational group exhibit a greater change in feelings about stigma regarding people living with HIV than do their counterparts assigned to the one-session informational comparison condition at the 6-week post-intervention follow-up? (3) Do older African American women assigned to the 4-week HIV prevention educational group report a greater increase in feelings of self-efficacy regarding the initiation of sexual health discussions and appropriate condom use with current sex partners than do their counterparts assigned to the one-session informational comparison condition at the 6-week post-intervention follow-up? It was expected that participation in the intervention would predict increased knowledge about HIV and the transmission risks, reduced stigma regarding people living with HIV, and increased feelings of self-efficacy regarding sexual decision-making.

This study was designed for a population that is affected disproportionately by the HIV epidemic and for which there are few effective HIV prevention interventions that are tailored to their lives (see, for example, El-Bassel, Caldeira, Ruglass, & Gilbert, 2009). Because this population of women is found in large numbers in the black church, it was expected that the present study can inform collaborative efforts between social agencies and community churches to deliver services to a population that is otherwise hard-to-reach for the delivery of HIV intervention services.

There are several key concepts. HIV knowledge was defined as an individual's knowledge about sexual transmission of HIV and protective mechanisms related to HIV (Carey & Schroder, 2002). HIV-related stigma was operationalized to include prejudicial and discriminatory attitudes directed toward people perceived to have HIV/AIDS (Lindley, Coleman, Gaddist & White, 2010). Self-efficacy beliefs were defined as the extent to which an individual regards her life chances as being under her personal control rather than fatalistically ruled (Pearlin & Schooler, 1978), and condom-use self-efficacy was operationalized as the ability to purchase condoms, apply and remove them, and negotiate their use with partners; i.e., behavioral performance (Brafford & Beck, 1991).

These issues were examined using an experimental pretest/posttest comparison group research design. Participants were recruited during the months of August and October 2018 from a large African American church located in the South Bay region of Los Angeles. The study was described to potential participants by the researcher/facilitator during weekly church-based programming as an HIV education program for older women. Women who agreed to participate in the study were given an appointment to attend a group meeting at time 1, held on October 22, 2018. During this group session the study was described again by the researcher/facilitator, questions were encouraged, informed consent was obtained, participants were randomly assigned to the comparison and experimental conditions, and a questionnaire—asking about their knowledge and attitudes about HIV—was completed. The first session for both groups was held at the church on October 29, 2018. This was the only session for the comparison group. The experimental group attended 4 more weekly sessions that ended on November 26. Both groups completed the Time-2 assessment on December 3, 2018.

A convenience sample of 62 African American women aged 50 or older participated in the study. The sessions were held on consecutive Monday mornings so as not to disrupt other church-based programming. Unfortunately, this time constraint made it impossible for several prospective participants to participate in the study.

Organization of Study

Chapter 2 presents a review of the relevant empirical evidence reflecting HIV prevention interventions impacting HIV knowledge. This chapter begins reporting on the age-related gap in educational strategies represented in the literature that may impact the perception of risk among older African American women. Also, literature providing a detailed account of HIV sexual risks specific to this group is discussed. Topics include inconsistent condom use, perceived risk, HIV related stigma, and self-efficacy beliefs and behaviors.

Chapter 3 focuses on the three theoretical models: Ecological Systems Theory, social learning theory and the Sexual Health Model. Bronfenbrenner and Ceci's (1994) Ecological Systems Theory, encompassing microsystems, mesosystems, exosystems, and macrosystems, stresses the importance placed on human ecology through individual and community structures that can include the church for some older African American women (Harrison, Wilson, Pine, Chan & Buriel, 1990; Lincoln & Mamiya, 1990). Bandura's (2001) social learning theory and the sexual health model (Robinson, 2002; Wyatt, 2009) were used to guide the development of the HIV educational group intervention. The literature on these is discussed.

Chapters 4 and 5 focus on the methods and procedures used to collect and analyze the data. Descriptions of the procedures, sample, measures, and analytic strategy, as well as the educational group curriculum for both the experimental and comparison conditions are presented

in chapter 4. Chapter 5 addresses the three research questions. It presents an analysis of the data and the findings relevant to HIV knowledge, stigma, self-efficacy beliefs and behaviors, and depressive symptoms.

Chapter 6, the last chapter, begins with a summary of the findings. It then includes a discussion of what these findings may mean in the context of educational HIV interventions for older African American women. It concludes with a discussion of the usefulness of this study, and some suggestions for additional research.

CHAPTER 2

REVIEW OF LITERATURE

2.1 HIV Prevention Interventions Impacting HIV Knowledge

Educational strategies and HIV prevention interventions targeting older African American women are modestly represented in the literature. Although research purports that these women lack knowledge about HIV, modes of HIV transmission, and perceived HIV susceptibility compared to their younger counter parts (Maes & Luis, 2003), educational strategies and prevention interventions that focus on their needs are sparse. Knowledge of HIV can be limited among older women who are not infected with HIV, as this group may believe that HIV is not a prominent issue for them (Durvasula, 2014; Hillman, 2007; Savasta, 2004). Yet, studies indicate that women who perceive themselves to be at risk for HIV are more likely than those with no such perception to alter risky sexual behaviors (Crosby, Bonney, & Odenat, 2004; Exner et al., 2002; Neundorfer et al., 2005; Winningham et al., 2004b). This is important because older women may not perceive themselves as being at risk and lack interest in being tested for HIV (Durvasula, 2014). In fact, Akers et al. (2007) found that 71% of women in their sample were not interested in testing despite nearly 50% having moderate to high levels of lifetime risk and exposure. Winningham and colleagues (2004b, p. 58) state that, “One of the fundamental lessons learned in nearly 30 years of HIV prevention efforts is that, where HIV prevention interventions are concerned, one size does not fit all.” This is consistent with the extant literature suggesting that more culturally tailored research is needed to inform educational interventions and optimize HIV care for older people (Altschuler et al., 2004; Orel et al., 2010 & Small, 2009; Orel, Stelle, Watson, & Bunner, 2010; Sankar, Nevedal, Neufeld, Berry, & Luborsky, 2011), and the call for

more research that focuses on the disproportionalities of the distribution of infection with a focus on older African American women who bring varied experiences (Durvasula, 2014; Tabnak & Sun, 2000). Yet, studies that have found a significant positive association between knowledge acquisition and testing, however, have focused for the most part on youth, and on men who have sex with men (Sabato, Bernett, Kerr & Wagner, 2013; Knox, Sandfort, Yee, Reddy & Maimane, 2011). One exception is a study conducted by Cornelius et al. (2008) that recruited a sample of 30 older African American women from 3 community churches to collect qualitative data via focus groups about the needs of older African American women. They found that the women in their study were interested in HIV educational information, that the church was an ideal setting for such programming, and that the women took pleasure in sexual activities, but had insufficient knowledge about HIV and their own vulnerability to HIV. Since others have found that perceived susceptibility to HIV is a prerequisite to behavior change regarding HIV (Catania, Kegeles & Coates, 1990), it is important to acknowledge that risk-based screening may not be sufficient in this population due to the inaccuracies or differing definitions regarding their perceptions of risk (Durvasula, 2004). This is consistent with research indicating that older African American women often have less than accurate appraisals of risk – believing that HIV can be transmitted through coughing and little regular condom use (Utz, 2005). While the literature indicates that prevention and HIV knowledge do not translate directly into behavior, it is well documented that knowledge about transmission, susceptibility, and methods of protection are vital components in the battery of HIV prevention behaviors (Durvasula, 2014). Thus, the present study adds to this knowledge by implementing and testing an educational curriculum developed specifically for older African American women which focused not only on HIV knowledge and HIV transmission risks, but also on reduction of stigma and enhanced self- efficacy beliefs regarding sexual decision making.

2.2 HIV Sexual Risk in Older African American Women

Stampley, Mallory and Gabrielson (2005) conducted an integrated review of the literature on studies published between 1987 and 2003 on prevention and risk-taking behaviors regarding HIV transmission among older African American women. Smith and Larson (2015) extended this work, reporting on studies published between 2003 and 2013 that included behavioral, psychological and social factors that contribute to HIV sexual risks practices in this population. The results of these reviews are discussed below.

2.2.1 Inconsistent Condom Use, Perceived Risk

Some have found that older African American women, in comparison with their younger counterparts, have less experience with condom use, yet they may be more likely to participate in high-risk sexual practices (e.g., unprotected sex) than their younger counterparts (Jacobs, 2008; Jacobs & Kane, 2011; Lindau et al., 2006; Winningham et al., 2004a). Others have shown that inconsistent condom use and partner-related factors (e.g., having a partner with multiple sexual partners) also contribute to older African American women's vulnerability to HIV (Neundorfer et al., 2005; Winningham et al., 2004a, 2004b). This is consistent with a research study conducted by Paranjape et al., (2006) which examined HIV sexual risk factors in a sample of 155 older women, a majority (80%) of whom were African American. The researchers found that 81% of the sample was sexually active; yet only 13% practiced condom use consistently. Likewise, Smith & Larson (2015) identified inconsistent condom use as a behavioral factor that contributes to HIV sexual risks among older African American women. Various contributing factors for the latter have been identified across studies. For example, some report that post-menopausal women often view condom use as irrelevant to their lives due to their inability to bare children (Beaulaurier, Fortuna, Lind, & Emler, 2014; Cornelius et al., 2008). Further, lack of perceived risk also plays a

role in increased HIV sexual risk practices. For example, Winningham et al. (2004b) found that lower perceptions of HIV risks were associated with marriage and/or a steady relationship and partner endorsement about condom use within the sexual relationship.

Similarly, to determine the sexual risk practices that place older African American women at risk for HIV, Neundorfer et al. (2005) conducted a study with a sample of 24 older women, about 60% of whom were African American. They found that nearly 50% of the participants reported that they were unsuspecting of their vulnerability regarding contracting HIV and also reported a lack of HIV prevention education. Indeed, while earlier studies purport that African American women's knowledge of HIV risk does not always translate to the use of safer sexual practices (Cornelius et al., 2008; Jacobs, 2008), there is a growing body of literature, as indicated earlier, which suggests that a knowledge deficit of HIV risk and low perceived susceptibility to HIV are barriers to HIV prevention efforts that inhibit protective behaviors for older African American women (Corneille, Zyzniewsk, & Belgrave, 2008; Young, Salem, & Bybee, 2010; Zablotsky & Kennedy, 2003). Thus, risk reduction strategies should be age-specific rather than using existing strategies developed for varying populations (Orel et al., 2010). Further, prevention strategies for older African American women should include a combination of individual and structural factors targeting multiple levels, including the individual and the environments that influence their behaviors (Sumartojo, 2000; Berkman et al., 2005), as the present intervention has done.

2.2.2 HIV-Related Stigma

The association between HIV-related stigma and lower uptake of HIV testing behaviors is well documented (see, for example, Earnshaw & Chaudoir, 2009; Mahajan, Sayles, Patel,

Remien, Ortiz, Szekeres & Coates, 2008; Chesney & Smith, 1999). Credible evidence has demonstrated that higher levels of HIV-related stigma and prejudicial attitudes toward people living with HIV are related to lower levels of HIV testing in the general public (see, for example, Fortenberry et al., 2002; Earnshaw, Smith, Chaudoir and Lee, 2012; Genberg, Hlavka, Konda, Maman, Chariyalertsak, Chingono...Celentano, 2009). There also is evidence suggesting that informal communication is associated with reduced levels of HIV-related stigma (Hutchinson, Mahlalela, & Yukich, 2007) and that HIV initiatives that aim to increase discussions about HIV that take place within existing social networks are associated with more beneficial outcomes regarding HIV testing (Campbell, Nair, Maimane, & Nicholson, 2007). This is consistent with research reporting an association between informal communication about HIV and lower HIV-related stigma (Hutchinson, Mahlalela, & Yukich, 2007). Much of this evidence, however, comes from studies with samples comprised of men and women younger than 50. The current study differs in that it focused solely on older African American women in the context of a church setting where African American women over age 50 can be found in large numbers (see, for example, Pew Forum, 2008). In addition, consistent with the findings of Hutchinson and colleagues (2007), the present study provided opportunities for the women in the experimental group to engage in informal, interpersonal communication within an existing social network about HIV and AIDS. It was expected that this might contribute to a reduction in HIV-related stigma attitudes.

It should be noted, nevertheless, that in some instances HIV-related stigma is perpetuated (sometimes inadvertently and sometimes not) through the ecological environments that exist in some religious organizations (Muturi & An, 2010). Some attribute this to interpretations of some biblical scriptures by some, but not all, faith leaders (Cunningham, Kerrigan, McNeely, &

Ellen, 2011). This is important because the reduction of stigma is vital to reducing HIV-related disparities, according to the National HIV/AIDS Strategy (National Center for HIV/AIDS, 2012). Churches are important, as already stated, because that is where older African American women congregate in large numbers. In addition, churches have always operated as social centers, political meeting spaces, and educational sites for this group (Cornelius et al., 2008). Others believe that community-based educational programs can offset the negative consequences of stigma-related victim-blaming that often is reinforced in religious and other community settings (Lindley et. al, 2010; Swendermen, Rotheram-Borus, Comulada, Weiss & Rothman, 2006). It is important for social agencies that aim to provide service delivery options to populations of older African American women to learn how to engage these populations through community churches. This is consistent with research indicating that many older African American women are sexually active, that they express interest in HIV educational programs, and that community sites such as churches are ideal for programming (Alschuler et al., 2004; Cornelius et al., 2008; Durvasula, 2014).

2.2.3 Self-Efficacy Beliefs and Behaviors

According to Bandura (1977, 1986, 1997) self-efficacy refers to an individual's belief in their ability to implement necessary behaviors required to produce desired outcomes. Self-efficacy has been found to affect whether people consider changing their behavior. In social cognitive theory, perceived self-efficacy is a focal mechanism in human agency. Outcome expectancies refer to the costs and benefits individuals perceive as a result of performing a certain behavior. Key outcome expectancies for this study are a belief in the importance of initiating conversations about sex, condom use when appropriate, and HIV testing.

In the present context, an individual's motivation to learn how to take responsibility for particular sexual health behaviors is influenced by her perception of her ability to execute the behaviors successfully, and by her perception of the costs and benefits; i.e., by the level of her self-efficacy beliefs which can be strengthened by modeling activities that will be a part of the intervention. Although self-efficacy is assessed frequently in HIV prevention research, assessments usually are in relation to medication adherence among HIV positive persons (Barclay, Hinkin, Castellon, Mason, Reinhard, Marion... Durvasula, 2007; Johnson, Neilands, Dilworth, Remien & Chesney, 2007; Johnson, Chesney, Goldstein, Remien, Catz & Gore-Felton, 2006). Studies have found significant relationships between greater self-efficacy beliefs and HIV testing (see, for example, Berendes & Rimal, 2011; Creel & Ramil, 2011; Sabato, Burnett, Kerr & Wagner, 2013). Studies also have found that negative past experiences, like unsuccessful condom negotiation or failed attempts to use a condom correctly, are associated with reduced safer sex self-efficacy (Murray-Johnson & Witte, 2003). Despite this evidence, however, self-efficacy among older African American women regarding condom negotiation and initiation of safer sex conversations with current or new sexual partners is poorly understood. Collaborations between community organizations, including churches, and social service providers are important because data suggest that there are missed HIV screening opportunities by providers in medical settings (Adekeye, Heiman, Onyeabor, & Hyacinth, 2012; Skiest & Keiser, 1997), and older women often are not encouraged to take advantage of testing that is routinely made available to younger women (Ory & Mack, 1998). This study will begin to close some of the gaps in current knowledge concerning how to engage older African American women in HIV prevention service delivery alternatives by testing the efficacy of an intervention delivered by a social work educator in a church setting.

CHAPTER 3

THEORETICAL PERSPECTIVES

3.1 Ecological Systems Theory

Bronfenbrenner and Ceci's (1994) ecological theoretical perspective provides a framework for engaging the black church and older women in an HIV prevention intervention. In this framework, the ecological environment is conceptualized as a set of "nested structures" encompassing microsystems (immediate settings that contain the focal person, such as relations with people in the church or with significant others in the home, romantic, or sexual environments); mesosystems (processes between or among two or more microsystems that contain the focal person, such as relations between and among church members and relations with significant others in the home environment, including family members and/or sex partners); exosystems (processes between or among two or more settings, only one of which contains the focal person, such as relations with sex partners and between sex partners and attachments with others with whom the focal person has no relationship); and macrosystems (influences of the broader social and cultural environments, such as attitudes about male and female relationships, sexual decision-making regarding condom use, attitudes about male promiscuity). These structures serve as an overarching framework for the present study.

It was hypothesized at the outset that older women in some black churches might navigate two relational systems, a biological family and a kinship network within the church (see, for example, Lincoln & Mamiya, 1990). As such, the microsystem might include relations in the church that involve the focal person and the minister, church mothers, and other church members; in the home, this would include relations between and among the focal person and a spouse or partner and/or adult children/grandchildren. Since the mesosystem involves relations

between or among two or more microsystems containing the person, for the participants in this study, the expectation was that this might include their relationships within both the home and church “family” systems. The exosystem—relations between more than one setting, only one of which contains the focal person—might involve relations between the participants and the church “family” (one setting or microsystem) and sexual relations between participants’ significant others with others not known to the participant (microsystem that may influence some aspects of the focal person’s life that the person may be unaware of, and that may, in the current context, involve HIV). The macrosystem involves influences of the broader cultural environment, such as cultural attitudes about male-female relationships and social attitudes about HIV.

Since black churches and leaders within the faith community often play a vital role in mobilizing their congregants in order to address social, economic, and public health concerns (Billingsley, 2002; Lincoln & Mamiya, 1990; Thomas, Quinn, Billingsley & Caldwell, 1994; Berkley-Patton et al., 2010), engaging the church and gaining the buy-in of important gatekeepers concerning the importance of an HIV prevention intervention was considered crucial.

For example, an important part of the intervention involved discussions of high-risk sexual behaviors that put older women in harms way. Some have reported that African American women often are sexually passive and deferential to men when it comes to making decisions about sexual activities including condom use (see, for example, Wyatt, 2000). Studies also suggest that promiscuity among men is accepted in the African American community (Fullilove, Fullilove, Haynes, Gross, & Black, 1999). These are factors in HIV risk (El-Bassel et al., 2009). In addition, HIV-related stigma—defined as “prejudice, discounting, discrediting and

discrimination directed toward people perceived to have HIV/AIDS” (Herek et al, 1998; Lindley, Coleman, Gaddist & White, 2010)—has facilitated substantial barriers to HIV prevention efforts within the African American community. In fact, the impact of HIV-related stigma within the African American community is three-fold: it is associated with not getting tested for HIV, not disclosing one’s HIV status to potential or current partners, and nonadherence with respect to medication use and healthcare seeking. All of these are associated with the spread of HIV among older African American women (Foster, 2007; Buseh, Stevens, McManus, Addison, Morgan & Millon-Underwoods, 2006; Jacobs & Thomlison, 2009). We know also that HIV-related stigma and victim-blaming often are reinforced by religious institutions (Lindley et. al, 2010; Swendermen, Rotheran-Borus, Comulada, Weiss & Rothman, 2006). Therefore, the present intervention was guided also by social cognitive theory (Bandura, 2001).

3.2 Social Learning Theory

This theoretical perspective considers the social environment in which behavior is performed, taking into account interactions of the person, environment, and behavior. In this perspective, self-efficacy refers to the level of a person’s confidence to successfully perform a behavior. Thus, time was spent in the intervention encouraging and modeling for participants’ ways to feel more comfortable taking control of their relations with the men in their lives. According to Bandura, people learn from one another via observation, imitation, and modeling. The educational group curriculum included opportunities to observe both within the group and through peer narratives, as well as imitation through group activities and homework assignments. The primary function of observation, imitation, and modeling is the transmission of information. Thus, models serve as cues to either strengthen or weaken a learner’s existing restraints for a given subject matter. This was achieved through creating an adverse reaction to a particular

behavior in order to weaken participants' restraint toward a desired behavior and creating a more suitable behavior to strengthen/reinforce the more desirable outcome (Bandura, 2001). For example, in the present context, a modeling process included condom negotiation between two long-time friends who were considering engaging in a sexual relationship. By modeling this behavior, the aim was to weaken restraints regarding condom negotiation in order to encourage HIV protective behaviors. In addition, consistent with research indicating the importance of utilizing videos with relevant HIV content focused on older adults (Cornelius et al., 2008), a film derived from entertainment education also was used as a strategy to influence awareness, knowledge, attitudes, and behaviors (Ebor et al., 2015; Moyer-Guse, 2008; Sands & Solomon, 2003), along with content defying myths, safer sex negotiation, self-advocacy, and stigma reduction. Through the use of age-specific, visual and educational content it was expected that the women in the experimental group would show an increase in self-efficacy, in comparison to their counterparts in the comparison group, at the time-2 assessment.

3.3 The Sexual Health Model

Aspects of the Sexual Health Model (SHM) informed the present educational curriculum as well. This model incorporates cultural and historical influences on the sexual identities, attitudes, behaviors, and health of some African American women (see, for example, the work of Wyatt, 1997; 2009). It aims to provide a theoretical framework for improving overall sexual wellbeing and an approach to HIV prevention that is founded in accurate knowledge, personal awareness, and the ability to talk comfortably and explicitly about one's sexual values, preferences, history and behaviors.

There is a significant body of literature underscoring the importance of HIV interventions that are historically and culturally congruent (Mize, Robinson, Bockting and Sheltema, 2002).

Indeed, random control trials that have tested culturally congruent HIV interventions for African Americans have found them to be efficacious in increasing condom use and reducing risk behaviors (see, for example, Kalichman, Kelly, Hunter, Murphy & Tyler, 1993; Harris, Bausell, Scott, Hetherington & Kavanagh, 1998; DiClemente, Wingood & Harrington, 2004; Wyatt, Myers & Loeb, 2004; St Lawrence, Wilson, Eldridge, Brasfield & O'Bannon, 2001). These trials have not included older African American women, and this gap in the evidence is significant.

Integral to the Sexual Health Model is the contention that culture influences one's sexuality and sense of sexual self (Robinson et al., 2002; Wyatt, 1997). Wyatt (1997) argues, for example, that African American women should address the impact of sexual messages directed toward African American women as a result of slavery. Others suggest that this is important because the cultural meaning ascribed to sexual behaviors, identities, and attitudes may drive unsafe or safer sexual practices (Robinson et al., 2002).

The present intervention focused on 3 assumptions and protective strategies outlined in Wyatt's (2009) proposed application of the Sexual Health Model for African Americans: (1) patterns of personal control (self-efficacy) developed in response to external factors such as oppression and gender-based socialization, (2) indirect communication patterns, and (3) mistrust of "outsiders" that limits acceptance of HIV prevention and care.

Wyatt (2009) further described self-efficacy and indirect communication patterns established during slavery when direct interactions regarding the sexual behaviors and preferences of African American women were prohibited in relations with their male slave masters. Thus, Wyatt cautions that sexual messages directed towards African American women as a result of slavery (including the desire of many parents for their daughters to remain sexually

chaste for as long as possible and the paucity of sex education, including safer-sex information directed toward this population) needs to be taken into account in HIV interventions with African American women today (see, also, Robinson et al., 2002). For example, where sex is concerned, communicating directly and disclosing sensitive sexual information may contradict African American cultural and religious values about modesty (Wyatt, 1997, 2009). Thus, during intervention sessions, consistent with Wyatt's (2009) theorizing, there were exercises helping participants to communicate directly about sexual activities and interactions that needed to be distinguished from nonsexual interactions (Wyatt, 2009).

In addition, some believe that African Americans' mistrust of people different from themselves can be problematic where HIV prevention is concerned (King, 2003). Others believe that this mistrust has been fostered by segregated social and living environments that have spawned social networks that do not promote HIV counseling, testing, and prevention (Wyatt, Myers, Williams et al., 2002). The Sexual Health Model is a conceptual framework that addresses adaptive coping behaviors and strategies that promote protective skills. The intervention strategies that follow were informed by Wyatt's (2009) application of this model.

To address external factors that influence self-efficacy or personal control, group participants were encouraged to identify and discuss past experiences and relationships in which someone else controlled them (Sexual Ownership). Strategies for protecting themselves from sexual risks in such situations were role-played using vignettes. Wyatt conceptualized the latter as Body Awareness. To address and refine indirect communication skills, group participants were introduced to conflict-resolution techniques for clear, nonconfrontational sexual and health-related communication (see, also, Raj, Amaro, Reed, 2001; Galambos, 2003), and ways to integrate factual information into sexual discussions. Interconnectedness involved an enhanced identity by being in a relationship and/or family. The concept of "I am because we are" promotes

placing the relationship and wellbeing of others before oneself.

Finally, the limits placed on body awareness due to cultural and religious prohibitions about condom and contraceptive use, body touching and some sexual practices were addressed through using the Sexual Health Model to provide knowledge about how the body works and skills to articulate issues that may require treatment. For example, in the present context, to gain knowledge about how the body works and to articulate problems that may require treatment, as a homework exercise, participants were provided a mirror and a biomedical chart labeling the parts of a woman's reproductive organs. The facilitator encouraged the participants to use the mirrors to identify and become more familiar with their bodies. This "Mirror, Mirror" activity was designed to incorporate concepts of Wyatt's (2009) Sexual Health Model (i.e., sexual ownership and body awareness). The literature has shown that these concepts have the capacity to enhance the uptake of prevention efforts among African Americans (Wyatt, 2009).

CHAPTER 4

RESEARCH METHODS

4.1 Study Design

The study was conducted as a controlled trial. Approval was granted from the UCLA Institutional Review Board (IRB#18-001002-AM-00001). An educational group curriculum, previously developed by the researcher, and pilot tested for a HIV prevention intervention focusing on older African American women aged 50 and over in a church setting, was extended and tested. Enrollment occurred in a large mega-church situated in a predominantly African American neighborhood in the South Bay region of Los Angeles County, an area with large numbers of low-income African American families and high HIV prevalence rates. To engage the sample, the researcher discussed the purposes of the study with church leaders, including the minister(s) and church elders, to gain permission to invite women aged 50 and over to participate in the study. In doing so, the researcher forged a working relationship with the Director of Senior Discipleship who facilitated the recruitment schedule and granted access to attend church-based programming held during the week through the seniors' ministry. The researcher was granted access to potential participants during Spanish, Bible, and exercise classes located on the church's campus. The researcher attended these classes for several weeks for recruitment and to become familiar to church members during the months of August 2018 and October 2018. The Director of Senior Discipleship acted as the liaison/gatekeeper between the church members, the researcher, and the Bishop of the church who ultimately granted permission for the study to commence.

The study was described to potential participants during weekly church-based programming as an HIV education program for older women. Prospective participants also were

told that their participation would be very important in helping us to better understand the needs of a population that is hard to reach and for whom each participant would speak. Indeed, by speaking for many, as part of a sample, each potential participant was told that she would be exercising a measure of control over how a population might ultimately be described. She would be helping us to determine what older women already know and what they want to know about HIV. In short, no assumptions were made about them. This is an example of a consulting, collaborative, respectful approach to sample engagement (Jackson & Ivanoff, 1999).

Women who agreed to participate in the study were given an appointment to attend a group meeting at time 1, during which the study was described again, questions were encouraged, and written informed consent was obtained. The final sample consisted of 62 women. Then participants were asked to complete a questionnaire containing questions and Likert scales measuring their (pre-intervention) knowledge and attitudes about HIV, stigma, and self-efficacy beliefs. Participants assigned randomly to the experimental condition (N=29) were asked to return for 4 additional weekly sessions that started a week later. Those assigned to the comparison condition (N=33) were asked to return a week later for a one-day program, spanning 3 hours. Participants in both conditions completed a posttest questionnaire during week six at time 2. The sole criteria for inclusion in the study were age (at least 50 years old) and gender (female). Race was not an issue, inasmuch as the sample was drawn from a black church.

4.2 Participant Recruitment

The researcher, also a person of color, attended the focal church twice during weekly programming organized by the seniors' ministry to become familiar with the church culture and membership before beginning recruitment. In contrast to the smaller churches used for the pilot

study the mega church possessed a different culture due to its size and large number of congregants. In this regard, numerous ministers and group leaders operated as the point of contact for their respective ministries. Hence, the Director of Senior Discipleship served as the intermediary communicating between the researcher, potential participants and the Bishop of the church. Still, it was important to get the Bishop's permission to carry out the study. With the understanding that a major problem for scholars and researchers interested in examining conditions prevalent among high-risk minority populations—in the present case, older African American women in need of behavioral interventions that might curb HIV risks in this population—is how to maximize the probability of response. Informed by Jackson and Ivanoff's (1999) framework for maximizing response rates in research with marginalized African American families, it was reasonable to conclude that this would involve persuasion, credibility, and motivation. The pastor/bishop along with the director of Senior Discipleship would need to be persuaded that members of their church might benefit from the program by the conceptualization of the problem, the means for problem resolution, and the goals. If the discussions with the church leaders resulted in a high level of commitment to the research, it was expected that the leadership would collaborate with us to engage a sample. In several meetings, the evidence on HIV risks for older African American women, their lack of knowledge about HIV, and the importance of the church in reaching this population were discussed. In particular, our aim was to build rapport with the church leaders by demonstrating credibility, persistence, caring, and knowledge of the subject matter, and by treating them as consultants (e.g., underscoring that their participation would be needed if the study was to be successful). Achievement of this aim resulted in an introduction to church elders/lay leaders ("church mothers") for similar discussions. These activities were followed by descriptions of the study—

endorsed by church leaders—to the senior ministry during several weekly visits during the months of August 2018 and October 2018. In short, our discussions with the church leaders involved highly focused explanations of the purposes of the research using a consulting, collaborative approach in order to enhance their motivation concerning sample engagement (Jackson & Ivanoff, 1999).

4.3 Sample

As indicated earlier, 62 women volunteered to participate in the study. All participants were recruited from one church. Participants were randomly sampled using the `sample` function in the `R` statistical computing language in order to assign the women to the experimental and comparison conditions (R Core Team, 2018). A pretest-posttest comparison group design, as described later, was used to evaluate outcomes. Prior to enrollment in the study, a power analysis with an 80 percent degree of confidence was conducted using G* Power (Erdfelder, Faul, & Buchner, 1996). The results of the power analysis determined that 66 participants would be needed to detect a moderate effect size and 198 participants would be needed to detect a small effect size. Due to limitations in resources, time constraints and feasibility the researcher aimed to recruit 66 participants. While the pilot study was conducted to evaluate the feasibility of engaging a sample through work with a small community-based church, the current study added measures, such as self-efficacy beliefs, more content on stigma reduction, included content to provide cultural and historical components to the curriculum and engaged a large sized mega-church.

4.4 Delivery of the Intervention

The intervention consisted of 4 weekly 90-minute sessions that were delivered on Monday mornings. The participants were provided with a light continental-style breakfast during

each session. The Monday-morning schedule was implemented in order to accommodate the participants' agendas and not to conflict with other church-related programming. As indicated earlier, a female African American facilitator, the researcher, implemented the intervention. Group cohesion was fostered and encouraged before and during sessions by various activities. These included morning engagement time over breakfast, developing group rules to establish a safe place for sharing, and opening and closing rituals. The theme of "building your house upon a rock" was used to establish the necessity of knowing one's history as a metaphor for having a strong foundation from which to thrive as a descendant of enslaved African women (see, for example, Wyatt, 1997). Therefore, the intervention components built upon each other to strengthen and empower the participants, as if, for example, one was building a house from the foundation to the rooftop. African proverbs and quotes from African American women were selected to begin each didactic. The integrated theoretical framework guiding this study was incorporated into the structure, format and content of the curriculum.

4.5 Intervention

4.5.1 Experimental Group

Session 1

Foundation: Cultural and Historical Background

"You Can't Really Know Where you are Going Until You Know Where you Have Been." –

Maya Angelou

The objectives of the first session were to develop group cohesion, build rapport with the facilitator along with the participants of the group and to introduce the cultural and historical components that may have shaped sexuality for present day African American women. The facilitator began the session by stressing the importance of women taking part in

self-care. Through an icebreaker exercise the facilitator encouraged participants to introduce themselves and acknowledge the many responsibilities and roles played in their lives by writing each title held on an index card. The facilitator then collected each card and asked the participants to disregard the titles while attending the 4 sessions in order to relate solely as women with a desire to learn and connect with one another. The purpose of this exercise was to establish our time together as sacred and safe in order to relieve the women (symbolically) of outside duties to enable them to become fully present.

In the first week, Group rules were established by the participants and were written on a whiteboard in the front of the room. The group rules were posted and read aloud by the group at the beginning of each of the three sessions that followed. During Session 1, an overview of HIV and the impact the virus has had on older African American women in the United States was discussed to again familiarize participants with the purposes of the study. Then, the facilitator introduced an exercise in which the participants were divided into 4 groups. Each group was given a vignette. The vignettes were specifically designed to be reflective of the experiences and culture of women within this population. Discussion questions provided opportunities to identify stigma, available social supports, HIV risk and protective factors, and barriers. The vignettes also provided an opportunity to incorporate elements from the Sexual Health Model by fostering a path toward Sexual ownership and Interconnectedness (Wyatt, 2009). After the vignettes were distributed the groups were asked to read the stories and to answer the discussion questions. Each group shared a summary of the individual group discussions with the group as a whole for a larger discussion of each vignette.

Each session ended with the group-appointed chaplain closing with a prayer (one of the rules established by the group was to open and close with prayer). Participants were provided a folder that included space to keep content and notes distributed during the first and subsequent sessions. At the end of each session the facilitator assigned homework. At the end of the first session the homework assignment was for each participant to identify a time when she felt she had been subjected to gossip or stigma associated with a particular circumstance or when she had witnessed someone else being stigmatized. This activity was designed to enhance positive modes of engagement through self-awareness and empathy.

Session 2

Framing: What do you Know About HIV?

“A building of sand falls as you build it.” – Cameroonian Proverb

The objectives of this session were to increase awareness about the vulnerabilities of older women regarding HIV, provide general information about HIV/AIDS and modes of HIV-transmission, and provide information to assess risks for contracting HIV and other sexually transmitted diseases. The facilitator solicited questions/comments in order to ensure that the content from the previous session was clear before moving forward with the new material.

The first activity was borrowed from the Guide to Implementing TAP (Teens for AIDS Prevention): A Peer Education Program to Prevent HIV/STD Infection (Renfrew, Fothergill, Hauser, Jackson, & Klindera, 2002). The purpose of this activity was to increase awareness of how quickly HIV and other STIs can be spread and how they can be stopped and to illustrate effects of peer pressure. This activity provided a fun and interactive method to demonstrate the ways that HIV is transmitted. Each participant received a brown paper bag

with a mixture of Hershey's Hugs & Kisses or Hershey's Almond Kisses, an index card and a pen. The women were then encouraged to share their "Kisses" with other group members while keeping a list of names of every person with whom they shared written on the index card provided. At the end of the activity the women were asked to stand up as a result of the contents within their bags or the names on their cards. The contents of the bag represented HIV infection and the names of the persons with whom candy was shared symbolized those that contracted the virus through sexual contact. This activity provided a practical yet interactive method demonstrating the ways HIV is transmitted. The group members were then given the opportunity to share their feelings about the activity and process the realities of the ways HIV is spread among communities. The second half of the session was divided into two sections A/B:

Section A: The first half of second session began with the distribution of a brief women's risk assessment test comprised of five yes or no questions. The participants answered the five questions and were asked to hold on to their tests until the end of class. The facilitator began to discuss HIV/AIDS while participants followed along using the handouts that were distributed. During this lesson, the focus was on learning HIV/AIDS definitions, how HIV is transmitted, how HIV is spread and not spread.

Section B: The second half of the session began with a brainstorming exercise to determine what the participants knew about stigma. The facilitator drew a spider diagram on a whiteboard in the front of the room. In the center oval the facilitator wrote the words, "meaning of stigma," to represent the main idea of the brainstorming activity. The participants were asked to state what they thought stigma meant. The women replied at random and answers included attitudes and viewpoints such as treating someone as different, prejudice, shaming someone,

blaming, and so on. The responses were then written in the surrounding ovals located on the individual branches by the facilitator. Once this exercise was completed the facilitator gave a brief lesson on HIV-related stigma, demonstrated the ways in which stigma can negatively impact an individual's personally, interpersonally and on the community level. An additional diagram was distributed reflecting the stigmatization process and the participants shared their interpretations and understanding of the diagram. Toward the end of this session the participants were given the answers to the brief women's risk assessment test. They were then encouraged to share their initial feelings about taking the test. Then the women were invited to indicate whether they were surprised (and if so, how) by the outcome/results of the assessment (without disclosing their personal results).

For homework, the women were provided a mirror and a biomedical chart labeling the parts of women's reproductive organs. As discussed earlier, the facilitator encouraged the women to use the mirrors to identify and become more familiar with their bodies. This "Mirror, Mirror" activity (G. Wyatt, personal communication, October 9, 2018) was designed to incorporate concepts of the Sexual Health Model (i.e., Sexual Ownership and Body Awareness). The group-appointed chaplain closed with a prayer and the women recited the group affirmation.

Session 3

Roofing: Even Me (Observational Learning)

"The rain does not fall on one roof." – African Proverb

The objectives of this session were (1) to increase awareness about the epidemiology of sexuality and HIV among older, minority groups; (2) to improve general HIV knowledge, including risk reduction strategies; and (3) to address details about HIV testing through a documentary film (Ebor, et. al, 2005). Regarding the latter, central to developing the

documentary was one of the core concepts within social cognitive theory—observational learning/modeling through observation. The session began with the facilitator introducing the documentary and sharing how the director (A Geriatric Social Worker) found the inspiration for making the film. This introduction included a real life story highlighting the accounts of a relative who contracted syphilis that was overlooked by medical providers for decades. As a result of this oversight, the disease progressed to neurosyphilis, (infection of the brain) despite annual medical visits exhibiting questionable symptoms. After having the personal doctor dismiss the symptoms and attribute them to aging (misdiagnosed as dementia) the filmmaker chose to develop a tool (via educational film) in order to educate and bring awareness to sexual health concerns among individuals in this population.

After the facilitator introduced the film and discussed the inspiration for making it, the participants viewed the 24-minute film. Directly after viewing the film the participants were given the opportunity to process the content and take part in a discussion/Q&A. For homework, participants were given a choice of choosing between two assignments. The first encouraged participants to make an appointment with their doctor to discuss her sexual health and to request a HIV test; the second encouraged participants to discuss what they have learned in program with someone outside of the group. These activities were designed to foster self-advocacy and empowerment, while also enhancing communication skills and promoting open and direct discussions about sexual health, HIV and STIs.

Session 4:

Finishing: HIV & AGING

“If you wish to move mountains tomorrow, you must first start by lifting stones today.” – African Proverb

The objectives of this session were to provide HIV information specific to an aging population, increase awareness of symptoms of HIV that may mimic other diseases of aging, and to provide experiential opportunities to communicate sexual health concerns with medical providers and current sexual partners. The facilitator began with a discussion to reinforce the fact that older adults have a lot of the same risk factors for HIV infection and transmission as younger groups (e.g., engaging in unprotected sex, sharing needles and bodily fluids). However, there are ways of contracting HIV that are unique to an older population that differ from younger groups that include physiological changes like postmenopausal vaginal dryness and tissue thinning, use of sexual performance medications, and potential generational or cohort differences, to name a few. With this in mind, the facilitator provided information about the symptoms of HIV that mimic other diseases of aging such as HIV dementia, Pneumocystis pneumonia, fatigue, weight loss, flu-like symptoms and night sweats. The participants were encouraged to ask questions for clarity and to provide further information that may be needed.

The second half of this session involved activities aimed to enhance condom use self-efficacy and to review the content from the overall program. Each participant was given a female condom (FC2) and watched a short video with instructions for use. The next activity included a game of Sexual Health BINGO. The facilitator distributed BINGO CARDS to each participant. The BINGO trivia was designed specifically for this particular group and included questions covering the content of the entire program. The first 3 participants to earn a BINGO won a 1st, 2nd and 3rd place prize.

At the end of this session the women were asked to inform the facilitator of their overall experience as participants in this intervention. For homework, the women were encouraged to return the following week for the closing ceremony and to complete the post-test survey. The group-appointed chaplain closed with a prayer and the women stood up and recited the group affirmation.

These 4 sessions comprised the intervention for the experimental group. Each participant received a weekly phone call and email to express the importance of their participation and as a gentle reminder to attend the next session. The weekly phone calls reportedly deepened the rapport between the facilitator and participants. Some of the women shared that they came to expect and looked forward to receiving a call each week. The women in the program also expressed their gratitude for this type of programming. Some indicated that they were not aware of the need for such programming until agreeing to participate. Others expressed their desire for more sessions stating that they would miss getting together on Mondays. Several of the group members asked for copies of handouts and materials to share with others outside of the group.

4.5.2 Comparison Group

Comparison Group: The one-session informational program consisted of an educational film and a structured discussion. The objectives of this session were (1) to increase awareness about the epidemiology of sexuality and HIV among older, minority groups; (2) to improve general HIV knowledge, including risk reduction strategies; and (3) to address details about HIV testing through a documentary film (Ebor, et. al, 2005). These objectives mirrored those for Session 1 of the experimental group.

As with the experimental group, the session began with the facilitator introducing the documentary and sharing how the director (A Geriatric Social Worker) found the inspiration for making the film. This introduction included a real life story highlighted earlier. Then the film was shown. Directly after viewing the film the participants were given the opportunity to process the content and take part in a discussion/Q&A. The structured discussion included the following topics:

1. **Perceived vulnerability** (HIV awareness, HIV and aging)
2. **General HIV Knowledge** (HIV modes of transmission, HIV myths vs. facts, HIV protective behaviors)
3. **HIV Stigma** (implications of HIV related stigma on micro and macro levels)
4. **Film related Q & A** (participants given the opportunity to ask questions and engage in group discussions)

This session comprised the intervention for the comparison group. After the 3-hour session, the women were given a folder with HIV/STI-related pamphlets and readings pre-designated for weeks two, three and four. Each participant received a weekly phone call and email to express the importance of their participation and as a gentle reminder to complete the assigned readings. During these communications the women were also reminded that they would be asked to return during week 6 to complete the time-2 questionnaire.

4.6 House Warming: Closing Ceremony

The program ended with both groups gathering over breakfast in week 6 of the study. Participants from the experimental and comparison groups were thanked for their participation in

the study and asked to complete the time-2 questionnaire. After each woman completed her questionnaire and the questionnaires were checked for missing data by this researcher, as a culminating activity—consistent with the theme of “building your house upon a rock,”—the participants engaged in a closing “rock ceremony.”

Each woman had been asked to choose a white rock from a basket placed at the entryway table upon their arrival. After all of the questionnaires, had been completed, breakfast was served, as the women sat around several tables. Each table was provided with a small bucket of colorful sharpies. The women were encouraged to think of one word that described their overall feelings about completing the program and to decorate their rocks. When the participants finished decorating the rocks, volunteers from each table stood up to share the meaning and ways that the rocks were decorated. This ceremony was designed to provide a memento for the women to take with them as a reminder of what was learned during the program. The group meeting closed with a prayer led by the group-appointed chaplain then the women were asked to stand in a circle, join hands, and recite the group affirmation for the last time.

4.7 Measures

Variables consisted of multiple-item scales whose values represented the mean. Items were reversed as necessary so that a higher score indicated more of the attribute named in the label. Alpha coefficients were obtained for all of the scales.

HIV Knowledge. 29 Items (1 = Very Likely to 3 = Unlikely) from the Brief HIV Knowledge Questionnaire (Carey and Schroder, 2002), the National Health Interview Survey of AIDS knowledge and Attitudes, and the AIDS Attitude scale (Carey and Schroder, 2002; Herek, Capitanio & Widaman, 2002; Fitti & Cynamon, 1990; Froman & Owen, 2001; Loue, Cooper,

Traore, Fiedler & Locus, 2004) measured HIV Knowledge. These items have been used in studies of HIV-related knowledge in street outreach, fieldwork, and intervention settings and are thought to be suitable for use with low-literacy populations (Carey & Schroder, 2002).

Participants were asked how likely it is that a person could get HIV by engaging in behaviors like: “sharing plates, forks or glasses with someone who has HIV,” “using public toilets,” or “being bitten by mosquitoes or other insects.” Cronbach’s alpha was .61 at time 1 and .67 at time 2 .

HIV Stigma. HIV stigma was assessed by a 6-item, four-point scale (1 = strongly agree to 4 = strongly disagree). These items 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 (Herek, Capitanio & Widaman, 2002; Fitti & Cynamon, 1990; Froman & Owen, 2001; Loue, Cooper, Traore, Fiedler & Locus, 2004). Participants were asked to indicate the extent of their agreement or disagreement with statements such as the following: “I think people who inject drugs deserve to get AIDS,” “I think homosexuals deserve to get AIDS,” “AIDS is a punishment from God for sin.” Cronbach’s alpha was .80 at time 1 and .81 at time 2.

Self-Efficacy. Perceived self-efficacy was assessed using the Mastery Scale. This 7- item, four-point scale (1 = strongly agree to 4 = strongly disagree) measures the degree to which people feel that they have control over the things that happen to them. Developed by Pearlin and Schooler (1978), who define mastery as the extent to which individuals view their successful goal achievement to be in their control, sample items include the following: “I have little control over the things that happen to me,” “there is little I can do to change many of the important things in my life,” “I can do just about anything I really set my mind to do.” Cronbach’s alpha

was .69 at time 1 and .64 at time 2.

Condom Use Self-Efficacy. Condom use self-efficacy was assessed using 10 items from the four point (1 = strongly agree to 4 = strongly disagree) Condom Use Self-Efficacy Scale (Brafford and Beck, 1991). The items measure 3 constructs (appropriation, STDs and partner's reaction) related to condom use. The instrument has been adapted and utilized with other populations including older African American women living in rural communities (Winningham, Corwin, Moore, Richter, Sargent and Gore-Felton, 2004). Sample items include the following: "I feel confident in my ability to put a condom on myself or my partner," "I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think that I thought they had a sexually transmitted disease." Cronbach's alpha was .77 at time 1 and .82 at time 2.

Depressive Symptoms. Depressive symptomology was assessed using the Center for Epidemiologic Studies Depression scale (CES-D). The *CES-D* is a 20-item self-report scale designed to measure depressive symptomatology in the general population. The items on the scale are symptoms associated with depression that have been used in previously validated longer scales (Lenore Sawyer Radloff, 1977). Sample items asked participants to describe how often they felt or behaved in the following ways during the past week: "I was bothered by things that usually don't bother me," "I did not feel like eating," "my appetite was poor," "I felt that I could not shake off the blues even with help from my family or friends." Response options ranged from Less than 1 day to 5-7 days in the past week. Cronbach's alpha was .81 at time 1 and .84 at time 2.

4.8 Analytic Strategy

All data from the pretest and posttest questionnaires were entered and analyzed in SPSS version 25. To evaluate the difference in HIV knowledge, stigmatizing attitudes toward people living with HIV, self-efficacy regarding the initiation of sexual health discussions and appropriate condom use with current sex partners, and depressive symptoms between women in the comparison condition and the experimental condition at time 1, five independent-measures *t test* were conducted. The assumptions of normality and homogeneity of variance were assessed and met. Then, between-within subjects' analyses of variance were carried out to determine whether the experimental intervention condition had an effect on HIV knowledge, stigmatizing attitudes toward people living with HIV, self-efficacy regarding the initiation of sexual health discussions and appropriate condom use with current sex partners, and depressive symptoms for women in the experimental group and comparison group over two time points (from baseline at time 1 to 6 weeks later at time 2). Specifically, the between-subjects main effect examined whether there was a change in the five variables of interest among participants across the two time points. The within-subjects main effect examined whether there was variability (difference) among participants in the sample (as a whole) from pretest (time 1) to posttest (time 2) in the scores for HIV knowledge, stigmatizing attitudes about HIV, self-efficacy beliefs and behaviors, and depressive symptoms. The interaction effect examined whether the differences in these scores among the women in the study from time 1 to time 2 varied as a function of group membership; i.e., whether the participant was in the comparison group or the experimental group. Finally, because of the limited sample size, $p < .10$ was interpreted as a meaningful finding.

CHAPTER 5

RESULTS

Sixty-two African American women ages 50-89 participated in this study. Participants assigned randomly to the experimental condition (N=29) were asked to participate in a brief 4 week HIV prevention program. Those assigned to the comparison condition (N=33) were asked to participate in a one-day program, spanning 3 hours, and were given weekly readings to complete as homework. The average woman who completed the study was 68.32 years old (SD = 8.43, range 50-89), most (76%) has some education beyond high school and were no longer employed ((73%). Slightly over half were divorced (53%) and almost a third (31%) indicated that they were currently in a romantic relationship. Close to a fourth (24%) reported that this relationship was sexual. The mean time-1 HIV knowledge score was 60.58 (SD = 3.57) for women in the experimental group and that for women in the comparison group was 61.71 (SD = 3.74). The results of an independent-measures t-test revealed no significant difference between the two groups of women on the acquisition of HIV knowledge at time 1 ($t = 1.11$, $df = 50$, $p = .27$). For women in the experimental group, the mean time-1 score for stigmatizing attitudes toward people living with HIV was 21.93 (SD = 2.33), and that for women in the comparison group was 21.65 (SD = 3.45). The results of an independent-measures t-test revealed no significant difference between the two groups on stigma scores at time 1 ($t = -3.74$, $df = 58$, $p = .71$). The mean time-1 self-efficacy score, regarding mastery over the degree to which people feel they have control over the things that happen to them, was 35.66 (SD = 4.93) for the experimental group and 36.13 (SD = 4.05) for the comparison group ($t = -1.57$, $df = 57$, $p = 0.27$). Regarding the initiation of sexual health discussions and appropriate condom-use self-efficacy in relations with current sex partners, for women in the experimental group, the mean

score was 35.66 (SD = 4.93) and that for women in the comparison group was 36.13 (SD = 4.05). The results of an independent-measures *t*-test revealed no significant difference between the two groups at time 1 ($t = .41$, $df = 59$, $p = .69$). Finally, the mean time-1 depressive symptoms score for women in the experimental group was 8.56 (SD = 7.09), and that for their counterparts in the comparison group was 8.31 (SD = 6.68). The results of an independent-measures *t*-test revealed no significant difference between the two groups of women with respect to their scores on the CES-Depression scale ($t = -.133$, $df = 52$, $p = .895$).

In sum, there were no significant differences between participants in the experimental group and the comparison group at time 1 on the variables of interest. This was expected, given the random assignment to groups. Table 1 displays the time-1 means, standard deviations and independent samples *t*- tests for each variable included in the study.

Table 1. Time 1 Means, Standard Deviations, and Independent Samples *t*-Tests: HIV Knowledge, HIV-Related Stigma, Mastery/Self-Efficacy, Condom-Use Self-Efficacy, Depressive Symptoms.

Measure	Control M (SD)	Experimental M (SD)	<i>t</i>	<i>df</i>	<i>p</i>
HIV Knowledge	61.71 (3.74)	60.58 (3.57)	1.11	50	0.27
HIV-Related Stigma	21.64 (3.45)	21.93 (2.33)	-0.38	59	0.71
Mastery/Self-Efficacy	3.46 (0.45)	3.65 (0.46)	-1.57	57	0.27
Condom-Use Self-Efficacy	36.13 (4.05)	35.66 (4.93)	0.41	59	0.69
Depressive Symptoms	8.31 (6.68)	8.56 (7.09)	-0.13	52	0.90

The remainder of this chapter focuses on the three questions. HIV knowledge—the acquisition of information and skills acquired through participation in the educational group program, including knowledge about sexual transmission of HIV and protective mechanisms related to HIV (Carey & Schroder, 2002)—is addressed first. The findings with respect to HIV-related

stigma, operationalized as prejudicial and discriminatory attitudes directed toward people perceived to have HIV/AIDS (Lindley, Coleman, Gaddist & White, 2010), are presented second. These are followed by the analyses of self-efficacy (mastery), defined as the extent to which an individual regards her life chances as being under her personal control rather than fatalistically ruled (Pearlin & Schooler, 1978), and condom-use self-efficacy, operationalized as the ability to purchase condoms, apply and remove them, and negotiate their use with partners (Brafford & Beck, 1991). Finally, the analyses for depressive symptoms are presented because psychological wellbeing is an important factor in sexual health decision-making (Cournos et al., 2005).

5.2 HIV Knowledge

Question 1: Do older African American women assigned to the 4 week HIV educational group exhibit a greater increase in knowledge about HIV and the transmission risks for HIV than do their counterparts assigned to the one-session informational comparison group at the 6-week post-intervention follow-up?

It was predicted that women in the intervention group would show a greater increase in HIV knowledge than women in the comparison group. This was expected based on the ecological, social cognitive and sexual health theoretical perspectives.

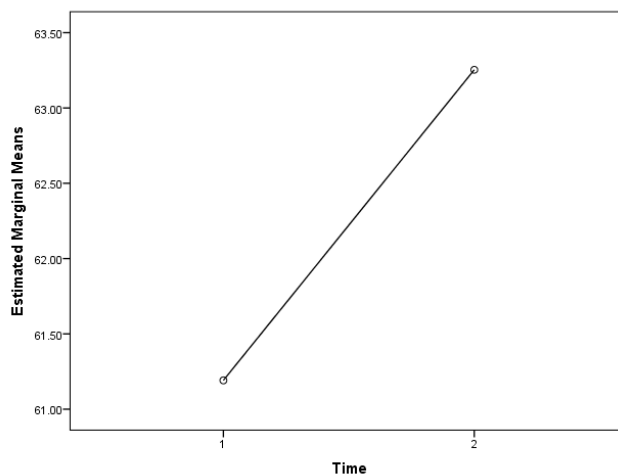
5.3 Analyses of HIV Knowledge Acquisition. A between-within subjects analysis of variance showed a significant within-subjects main effect, *Wilk's Lambda* = .820, $F(1,41) = 9.03$, $p = .005$, indicating a difference in HIV knowledge acquisition among all participants from time 1 to time 2, averaged over condition. Specifically, the mean HIV knowledge score for all participants, regardless of condition, was 61.19 (SE = .57) at time 1 and increased to 63.25 (SE =

.56) at time 2. Figure 1 illustrates the results of the within-subjects main effect which shows the overall increase in HIV knowledge from time 1 to time 2 for all participants.

Recall that time is the “within-subjects” factor; i.e., whether there was variability among participants in the sample as a whole from time 1 to time 2. Variability among participants in the experimental or comparison/control group forms the “between-subjects” factor. The primary purpose of this analysis, and the ones that follow for stigma, self-efficacy, and depressive symptoms, was to understand if there was an interaction between group membership and time on the dependent variable. Concerning knowledge acquisition, neither the between-subjects main effect nor the interaction effect was significant, indicating no significant difference in HIV knowledge acquisition between the experimental and control/comparison conditions from time 1 to time 2. Therefore, while being a part of the study was associated with an increase in HIV knowledge, this increase was not significantly different among those in the experimental group in comparison with those in the comparison group. These results are displayed in Figure 1.

Figure 1. Estimated marginal means of HIV knowledge for participants averaged over condition.

Estimated Marginal Means of Overall HIV Knowledge



5.4 HIV-Related Stigma

Question 2: Do older African American women assigned to the 4 week HIV prevention educational group exhibit a greater change in feelings of stigma regarding people living with HIV than do their counterparts assigned to the one-session informational comparison condition at the 6-week post-intervention follow-up? It was predicted that women in the experimental group would exhibit a greater decrease in HIV-related stigma from time 1 to time 2 in comparison with their counterparts in the comparison/control group based on the theoretical perspectives that informed the intervention. For example, in addition to social cognitive theory, aspects of the sexual health model informed the educational curriculum as well.

5.5 Analyses of HIV-Related Stigma. Results of the between-within subjects analysis of variance models revealed no significant effects for HIV stigma scores, *Wilks' Lambda* = .974, $F(1,55) = 1.46, p = .23$. These results were unexpected; possible reasons for this lack of significance are discussed in the concluding chapter.

5.6 Self-Efficacy - Mastery and Condom Use

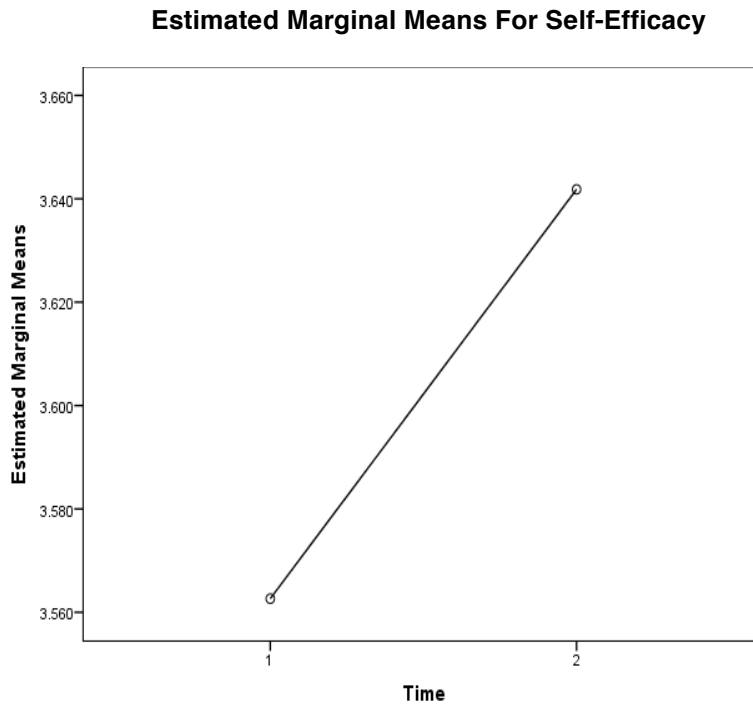
Question 3: Do older African American women assigned to the 4 week HIV prevention educational group report a greater increase in feelings of self-efficacy regarding the initiation of sexual health discussions and appropriate condom use with current sex partners than do their counterparts assigned to the one-session information comparison group at the 6-week post-intervention follow up?

It was predicted that women in the experimental group, in comparison with those in the comparison/control group, would report a greater increase in self-efficacy from time 1 to time 2

concerning their view of life chances as being under their personal control rather than fatalistically ruled (mastery). In addition, it was anticipated that the women who participated in the intervention group, in comparison with their counterparts in the comparison group, would show a significantly increased ability from time 1 to time 2 to purchase condoms, apply and remove them, and negotiate their use with partners, as a result of demonstrations of these procedures. These expectations were informed by social cognitive theory and the sexual health model.

5.7 Analyses of Self-efficacy. Concerning self-efficacy vis-à-vis taking personal control of one's life, a between-within subjects analysis of variance showed a marginally significant within-subjects main effect, *Wilk's Lambda* = .943, $F(1,53) = 3.21, p = .079$, indicating a marginally significant change in self-efficacy among all participants from time 1 to time 2, averaged over condition. Specifically, the mean self-efficacy mastery score for all participants increased from 3.56 (SE = .062) at time 1 to 3.64 (SE = .051) at time 2. Neither the between-subjects main effect nor the interaction effect was significant. This means that while being a part of the study was associated with an increase in self-efficacy beliefs about taking control of one's life concerning HIV prevention, this increase was not significantly different among those in the experimental group in comparison with those in the comparison group. Similar analyses for condom use self-efficacy revealed no significant effects regarding the initiation of sexual health discussions and appropriate condom use with current sex partners, *Wilk's Lambda* = .977, $F(1,54) = 1.28, p = .26$. Figure 2 displays the results of the within-subjects main effect for self-efficacy mastery scores.

Figure 2. Estimated marginal means of feelings of self-efficacy for participants averaged over condition.



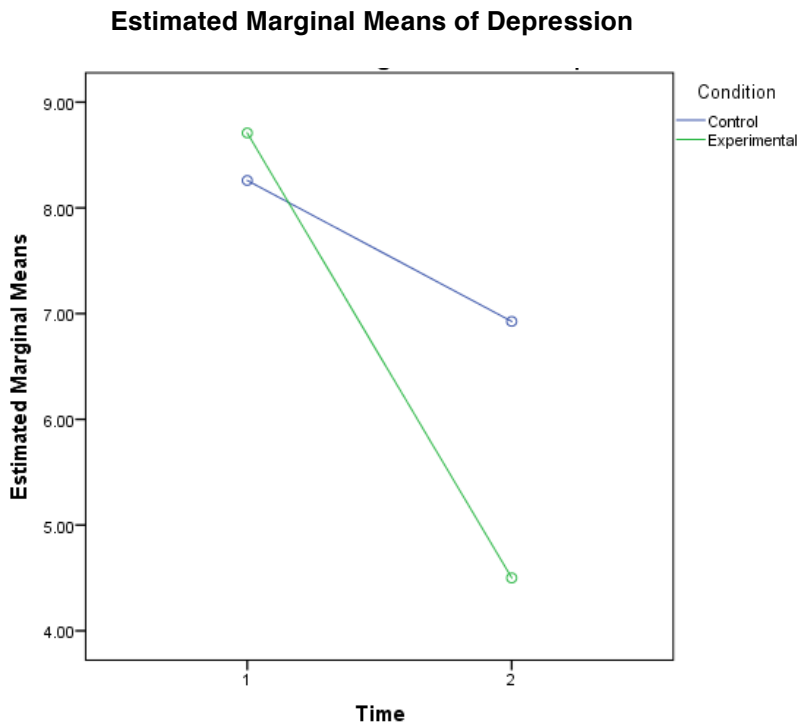
5.8 Depression

As indicated earlier, a measure of depressive symptoms was also included in the study because psychological wellbeing is an important factor to consider for HIV prevention efforts. It was predicted that those who participated in the intervention group program would exhibit a greater reduction in depressive symptoms from time 1 to time 2 than those in the comparison group.

5.8.1 Analyses of Depression. As expected, the change in depression scores before and after the intervention (from time 1 to time 2) was greater for those who participated in the intervention (experimental condition) than that for those in the comparison condition. A between-within subjects analysis of variance showed a marginally significant interaction between time and experimental condition, *Wilk's Lambda* = .942, $F(1,49) = 3.024$, $p = .088$, indicating that the change in depressive symptoms partly depended on the experimental

condition assignment. Figure 3 displays the results of the interaction between time and experimental condition. Specifically, simple effects tests revealed a significant decrease in depression scores for participants in the experimental condition from time 1 ($M = 8.71$, $SE = .144$) to time 2 ($M = 4.50$, $SE = .89$), $Wilk's\ Lambda = .800$, $F(1,49) = 12.237$, $p = .001$. Simple effects tests showed no such change for participants in the comparison condition from time 1 ($M = 8.26$, $SE = .135$) to time 2 ($M = 6.93$, $SE = .84$), $Wilk's\ Lambda = .973$, $F(1,49) = 1.38$, $p = .245$.

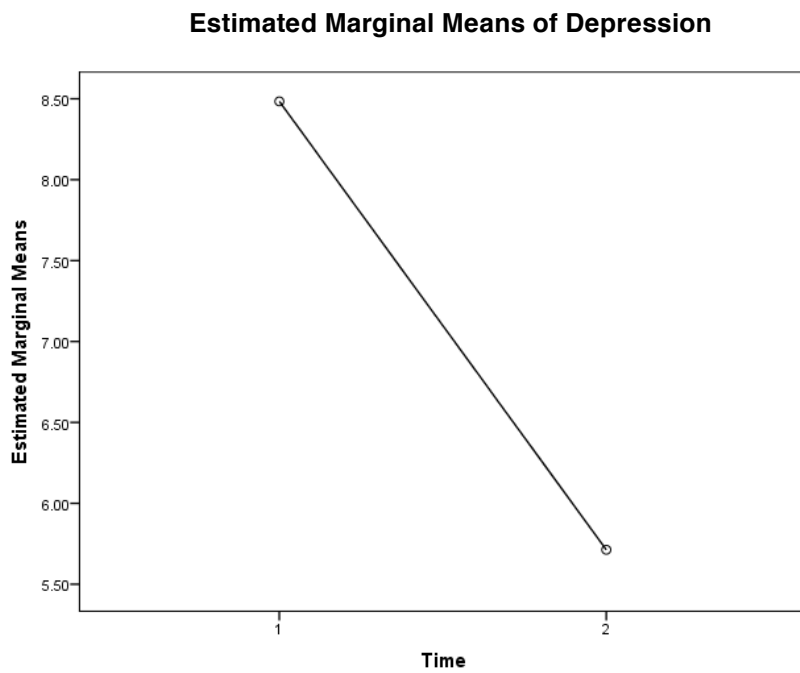
Figure 3. Estimated marginal means of depression for participants across time by condition.



Additionally, the between-within subjects analysis of variance showed a marginally significant within-subjects main effect, $Wilk's\ Lambda = .813$, $F(1,49) = 11.234$, $p = .002$, indicating a difference in depression among all participants from time 1 to time 2, averaged over condition. Specifically, the mean depression score for all participants decreased from 8.48 ($SE =$

.99) at time 1 to 5.71 (SE = .61) at time 2. Figure 4 displays the results of the within-subjects main effect. The interaction effect and within-subjects main effect were significant. These findings indicate that, while depression scores were lower for the sample as a whole at time 2, participation in the intervention was associated with a greater decrease in depressive symptoms when compared to the control condition.

Figure 4. Estimated marginal means of depression for participants averaged over condition.



CHAPTER 6

DISCUSSION AND CONCLUSIONS

6.1 Overview

This study was conducted as a controlled trial involving an HIV prevention program designed and tailored to the lives of older African American women and carried out in a church setting. Women assigned randomly to the experimental condition (a 4-session group educational program) or the control/comparison condition (a 1-day group educational program spanning 3 hours) were assessed pre- and post-intervention to test the effect of the intervention on HIV knowledge, self-efficacy beliefs and behaviors, stigma attitudes, and psychological wellbeing. Three questions were addressed: (1) Do older African American women assigned to the 4-week HIV prevention educational group exhibit a greater increase in knowledge about HIV and the transmission risks for HIV than do their counterparts assigned to the one-session informational comparison condition at the 6-week post-intervention follow-up? (2) Do older African American women assigned to the 4-week HIV prevention educational group exhibit a greater change in feelings of stigma regarding people living with HIV than do their counterparts assigned to the one-session informational comparison condition at the 6-week post-intervention follow-up? (3) Do older African American women assigned to the 4-week HIV prevention educational group report a greater increase in self-efficacy regarding the initiation of sexual health discussions and appropriate condom use with current sex partners than do their counterparts assigned to the one-session information comparison condition at the 6-week post-intervention follow up?

Using ecological and social learning theoretical perspectives together with the sexual health model and the evidence on HIV interventions, the principal predictions were that women

who participated in the 4-week experimental program would reveal a greater knowledge about HIV and the transmission risks, increased feelings of self-efficacy regarding safer sex decision-making, reduced stigma regarding people living with HIV/AIDS, and greater psychological wellbeing (fewer depressive symptoms) than their counterparts who participated in the 1-day comparison/control program spanning 3 hours at the 6-week time 2 assessment.

In this chapter, the findings are first summarized. The discussion section considers each question separately in the context of the theoretical perspectives and the empirical evidence. The conclusion addresses the results broadly and suggests some implications for practice and future research.

6.2 Summary

Participation in the study was associated with an increase in HIV knowledge, self-efficacy regarding taking control of one's life and circumstances, and a decrease in depressive symptoms among all participants, regardless of group assignment. Although experimental group participation did not result in significantly improved knowledge about HIV, self-efficacy beliefs and behaviors regarding safer sex, and stigma reduction in attitudes about people with HIV/AIDS, women in the experimental group did show a significant improvement in psychological wellbeing. The results for depressive symptoms are important because while it is possible that the measures for knowledge, self-efficacy, and stigma may not have been nuanced enough to differentiate between and among the women in this study based on the intervention programs, it is clear that the CES-Depression scale is a highly validated measure of depression symptoms in the general population. This is all the more important when one considers that the experimental program included only 4 sessions, which were quite similar in content to the 3-hour

single session offered to the comparison group. The biggest difference between the programs was the extended opportunity those in the experimental program had to relate to each other.

Contrary to expectations, the results for condom-use self-efficacy and stigma were nonsignificant across both groups.

6.3 Discussion

6.4 HIV Knowledge

While contrary to expectations the results indicate increased HIV knowledge among all participants regardless of group assignment, this outcome can be interpreted as promising given that both groups received an intervention that exceeded the standard of care. The decision to provide the comparison group with an intervention was based on the researcher's conviction that HIV education and awareness should be available to all participants involved in the study. This was in part decided based on the neglect of older African American women in the discourse on sexual and reproductive health, the omission of this group from HIV prevention efforts by some service providers, and the severity of the consequences of these oversights. Research has shown that there are missed HIV screening opportunities by providers in mainstream medical settings (Adekeye, Heiman, Onyeabor, & Hyacinth, 2012; Skiest & Keiser, 1997), and that older adults are typically tested for HIV later in the course of the infection than their younger counterparts when the progression of the virus can more rapidly lead to AIDS resulting in death within a year of HIV diagnosis (Durvasula, 2014; Chadborn et al. 2006).

Further, while it was expected that the women in the experimental condition would report more HIV knowledge than those in the comparison condition, the fact that all participants across conditions showed an increase in HIV knowledge defies ideologies regarding ageism and negative stereotypes suggesting that older adults are disinterested in content about HIV for a

number of reasons, including sexual inactivity (Minichiello, Hawkes & Pitts, 2011; Atchley & Barusch, 2004). The present findings suggest that this population can be successfully engaged to participate in an HIV prevention program and acquire new knowledge if the material is made available and demonstrates relevancy to their lives. This important knowledge about HIV should be targeted to older women who are not infected with HIV, but who are at risk because women who perceive themselves to be at risk are more likely than those with no such perception to alter risky sexual behaviors (Crosby, Bonney, & Odenat, 2004; Durvasula, 2014; Exner et al., 2002; Hillman, 2007; Neundorfer et al., 2005; Savasta, 2004; Winningham et al., 2004b).

The biggest difference in the two interventions was the amount of time the women spent together under the direction of the facilitator. Although the comparison group received a one-day, 3-hour program that was similar in content to the content that was spread over 4 sessions for the women assigned to the experimental condition, there was very little interaction between and among the women in the former group. More specifically, both groups received a program involving the viewing of an educational film that was conceived by the researcher and informed by social cognitive theory (Bandura, 2001; Leutzinger & Newman, 1995), the health belief model (Rosenstock, Strecher, & Becker, 1988), and entertainment educational methods (Moyer-Guse, 2008). The aim was to increase awareness and encourage protective behaviors related to HIV among older adults. Included in this educational film were the experiences of older African American women in a relatable and culturally relevant documentary (see, Ebor et. al, 2015). Additionally, participants in the comparison group were provided—at the outset—with HIV/STI-related pamphlets and readings pre-designated for weeks two, three and four that coincided with similar content that was actually discussed in the experimental group meetings during weeks two, three, and four. Each participant in the comparison condition received a weekly phone call

and email to encourage continued participation; these calls and emails to experimental group participants were to encourage attendance at meetings. In short, the 4-week, face-to-face intervention allowed the women to relate to each other and the facilitator/researcher interpersonally. While the findings revealed an increase in HIV knowledge for all participants, regardless of group assignment, the findings showed that participation in the experimental condition (but not the comparison condition) was associated with significantly improved psychological wellbeing (a decrease in depressive symptoms). This is consequential because psychological wellbeing is an essential component to contain the spread of HIV (Cournos, McKinnon & Wainberg, 2005) while other research suggest individuals who report depressive symptoms may be less confident in their ability to refuse sex and use condoms consistently (DiClemente et al., 2001; Seth et al., 2009; Seth et al., 2011).

Unfortunately the relations between and among depressive symptoms, self-efficacy beliefs regarding safer sex, and HIV testing among older African American women were not tested. This is certainly a matter for future research because if group interaction is predictive of enhanced psychological wellbeing beyond the acquisition of greater knowledge and if together these are predictive of a greater likelihood that women at risk for HIV will actually seek HIV testing, then this is certainly important information with respect to intervention programming.

6.5 HIV-Related Stigma

The results for HIV-related stigma were nonsignificant. This was unexpected. HIV-related stigma was operationalized to include prejudicial and discriminatory attitudes directed toward people perceived to have HIV/AIDS (Lindley, Coleman, Gaddist & White, 2010). HIV-related stigma was examined in this way because feelings of disgrace associated with HIV/AIDS may cause those who are infected to delay or refuse treatment, or hide their disease from others

and these can be important factors in disease prevalence (Saki, Mohammad Khan Kermanshahi, Mohammadi, & Mohraz, 2015).

An examination of the independent-measures t tests shows that the mean scores for stigma at time 1 were 21.64 (SD = 3.45) for the control condition and 21.93 (SD = 2.33) for the experimental condition; at time 2 the corresponding scores were 21.37 (SD = 3.86) and 22.46 (SD = 2.08) respectively. The 6-item, four-point scale ranged from 0 – 24. A lower score indicated greater stigma. Importantly, the change in stigma from time 1 to time 2 was nonsignificant. This may be because the sample was very low in stigma to begin with and there was little room for improvement on this variable in the present sample. It could be that because the women were older, they also were more sophisticated than expected regarding HIV/AIDS, or it could be that the measure lacked sufficient nuance.

6.6 Self-Efficacy Beliefs

A between-within subjects analysis of variance showed a marginally significant within-subjects main effect for the mastery self-efficacy scale, indicating that the sample as a whole improved from time 1 to time 2 in their beliefs about their ability to take control of their lives, their sex lives in particular. The experimental group did not score significantly higher on this variable than their counterparts in the comparison group. This was unexpected given that social cognitive theory informed the intervention activities. Nevertheless, noting that both groups received an intervention that exceeded the standard of care, due to reasons stated in the previous section in the discussion of knowledge acquisition, it is promising to see that the sample overall benefited from the interventions. It is particularly encouraging when considering that self-efficacy relates to one's belief in her ability to implement necessary behaviors required to produce desired outcomes, according to Bandura (1977, 1986, 1997).

Condom-use self-efficacy was nonsignificant in this study. It could be that the women were relatively comfortable with their abilities in this respect to begin with. Their scores on this measure seem to suggest that this might have been the case, as with stigma. For condom-use self-efficacy, the highest score on the scale was 40.00 on a 10-item, 4-point scale. The mean scores on this scale for the present sample at time 1 were 36.13 (SD = 4.05) for the comparison group and 35.66 (SD = 4.93) for the experimental group, indicating the women were high in condom-use self-efficacy to begin with.

6.7 Psychological Wellbeing

Psychological wellbeing was a variable of interest based on the extant literature indicating that poor mental health—depressive symptoms in particular—can contribute to HIV transmission, sexual risk taking, and less favorable HIV disease prognosis (Cournos, McKinnon and Wainberg, 2005). It was predicted that participation in the experimental intervention group program would be associated with improved psychological wellbeing at time 2, measured by scores for depressive symptoms. This expectation was borne out by the findings. As expected, the change in depression scores before and after the intervention (from time 1 to time 2) was greater for those who participated in the intervention (experimental condition) than that for those in the comparison condition. The between-within subjects analysis of variance showed a marginally significant interaction—the only such finding in the study—between time and experimental condition. In other words this change in depressive symptoms partly depended on being assigned to the experimental condition. Although the mean scores on the CES-Depression scale for both groups indicated that neither group was at risk for depression, the significant change for the experimental group seems to suggest that it may have been the interpersonal contact with peers and the chance to discuss issues in depth that may explain the enhanced

psychological wellbeing score for those in the 4-week, face-to-face intervention. This possibility should be tested by future researchers because, as indicated earlier, psychological wellbeing is an essential component in HIV prevalence (Cournos, McKinnon & Wainberg, 2005) and also is related to the confidence in one's ability in the refusal of sex and consistent condom use (DiClemente et al., 2001; Seth et al., 2009; Seth et al., 2011).

Through observation, the progression of the bonding process that took place over the course of the present 4-week program was noted in the following ways. Over the weeks, conversing between and among group members became more and more lengthy as they became more familiar with one another. Initially the first 10 minutes prior to the start of the program was allotted for breakfast and informal engagement. This time for engagement increased from 10 minutes to 15 minutes and then 20 minutes by the last session. This camaraderie also extended beyond the formal meetings as the women would often congregate inside and outside of the classroom following sessions, continuing to socialize and converse with each other. As stated previously there is evidence that HIV initiatives that take place within existing social networks are associated with more beneficial outcomes regarding HIV testing (Campbell, Nair, Maimane, & Nicholson, 2007). This has implications for collaborative efforts between social agencies and community-based churches in the outreach for and delivery of intervention services to hard-to-reach populations.

6.8 Conclusion

In consideration of the foregoing, an aspect of this study that merits further discussion pertains to the engagement efforts employed to recruit a sample of women that has been identified as comprising a hard-to-reach population with respect to HIV programming. On the basis of past research (and the ecological theoretical perspective), we wondered whether we

would be able to persuade the pastor, faith leaders, and church members to participate voluntarily in an educational program they had not sought. Based on this theory, we expected that older African American women could be recruited to participate in the study if we tapped into their relationships within both the home and church “family” systems (mesosystem). Further, we expected that the macrosystemic efforts employed would be vital to the success of this study. These efforts aimed to engage the church’s broader cultural environment as a critical intervening component in HIV prevention efforts for older African American women. The recruitment of our sample was guided by the ecological theoretical perspective and aspects of the sexual health model. One large mega-church was engaged, a sample of 62 older African American women was successfully recruited, and an intervention with a pretest/posttest experimental designed was carried out.

Based upon aspects of the Sexual Health Model we anticipated that the effects of deep seeded skepticism and mistrust of “outsiders” as a result of the historical trauma that continues to influence some in this population would yield a high level of suspicion toward research and unknown researchers. Based on the well-documented mistrust of “outsiders” that many African Americans may feel (Wyatt, 2009) we expected that ample time would be needed to build rapport in order to gain a level of trustworthiness not only to recruit the sample but to retain them as well. We predicted that the engagement efforts that began several months prior to the start of the study would increase familiarity and consistent/transparent interactions. Based on the extant literature we expected that these strategies would be instrumental in minimizing mistrust or alleviating some of the “healthy paranoia” that some African Americans may feel towards “outsiders;” i.e., the researcher (Daunt, 2003; Hughes, Peterson, Ramirez et al, 2004; Brach and Fraser, 2000; Wyatt, 2009).

Through this approach, a deepening of commitment to the process and meaningful interactions between both the facilitator and the women and among the women and each other developed. Verbal group feedback from the participants identified 5 unique contributions to the successful recruitment and retention of the sample: (1) weekly calls and emails by the facilitator; (2) comfortable/private room to meet; (3) breakfast and engagement time; (4) homework assignments that required reporting back; (5) organized facilitation and being well prepared.

Although there are limitations regarding to whom the present findings generalize, given that the sample was small in number and came from one church, the results provide important insight into effectively implementing HIV curricula focusing on older African American women in a church setting. Stressing the importance of intersectionality, the results support the utility of curricula specifically designed for a population rarely addressed in the extant literature, a population that is disproportionately affected by the HIV epidemic and for which there are few effective HIV prevention interventions that are tailored to their lives (see, for example, El-Bassel, Caldeira, Ruglass, & Gilbert, 2009). As such, this study begins to fill an important gap in the literature while also providing a roadmap for social work practice serving older African American women.

Finally, this study has several important implications for future research. First, at the present time there are few empirical data concerning HIV interventions with older African American women. This study is an attempt to correct this gap in current knowledge. Second, the study extends the evidence on possible collaborations between social agencies and other community organizations, including community-based churches, to deliver services to hard-to-reach populations. In the present instance, an ecological theoretical perspective was used successfully to engage both a church in an under-resourced neighborhood and a sample. Third, it

suggested questions for additional research, particularly regarding possible associations between and among psychological wellbeing, self-efficacy, knowledge acquisition, safer sex, condom use, and HIV testing for older African American women who may be unaware of their risks for HIV.

The questions tested here merit further study with a larger sample from more than one church. It also is possible that four sessions were insufficient for the knowledge, self-efficacy, and stigma outcomes expected. However, the findings for depressive symptoms suggest that older African American women may benefit from programs that involve informal interpersonal communication with an existing social network, consistent with the findings of Hutchinson and colleagues (2007).

ID # _____

Questionnaire

Appendix A

ABOUT HIV- I

Please circle the number to the right of each statement that best indicates the extent to which you think the statement is True or False.

	TRUE	FALSE
1. Coughing and sneezing DO NOT spread HIV.....	1	2
2. A person can get HIV by sharing a glass of water with someone who has HIV.....	1	2
3. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.....	1	2
4. A woman can get HIV if a man puts his penis in her anus/butt.....	1	2
5. Showering, or washing one's vagina/penis, after sex keeps a person from getting HIV.....	1	2
6. All pregnant women infected with HIV will have babies born with AIDS.....	1	2
7. People who have been infected with HIV show serious signs 7 days after being infected.....	1	2
8. There is medication that can stop adults from getting HIV.....	1	2
9. People are likely to get HIV by deep kissing (putting their tongue in their partner's mouth) if their partner has HIV.....	1	2
10. A woman cannot get HIV if she has sex during her period.....	1	2
11. There is a female condom that can help decrease a woman's chance of getting HIV.....	1	2
12. A person will NOT get HIV if she or he is taking antibiotics.....	1	2
13. Having sex with more than one partner can increase a person's chance of being infected with HIV....	1	2
14. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.....	1	2
15. A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.....	1	2
16. A person can get HIV from placing their mouth on their partner's vagina or penis.....	1	2
17. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.....	1	2
18. Married women cannot contract HIV.....	1	2

Appendix A

	TRUE	FALSE
19. After menopause (when a woman's period stops) she does not need to use condoms to protect herself from contracting HIV.....	1	2
20. Symptoms of HIV can be mistaken for the aches and pains of normal aging.....	1	2
21. Anyone, at any age, can contract HIV.....	1	2

Appendix A

ABOUT HIV - II

Please indicate by circling the answer to the right of each statement how likely it is that a person could get HIV by engaging in the following...

	Very Likely	Somewhat Likely	Unlikely
22. Sharing plates, forks, or glasses with someone who has HIV.....	1	2	3
23. Using public toilets.....	1	2	3
24. Being bitten by mosquitoes or other insects.....	1	2	3
25. Being kissed on the cheek by someone who has HIV.....	1	2	3
26. Being coughed or sneezed on by someone who has HIV	1	2	3
27. Donating or giving blood.....	1	2	3
28. Getting tested for HIV.....	1	2	3
29. Having unprotected oral sex (mouth on the vagina or penis) with someone who has HIV.....	1	2	3
30. Having unprotected anal sex (penis in the anus/butt) with someone who has HIV.....	1	2	3

Appendix A

31. Having unprotected vaginal sex (penis in the vagina) with someone who has HIV	1	2	3
32. Having sex with multiple partners.....	1	2	3
33. Sharing needles for drug use with someone who has HIV	1	2	3

Appendix A

ABOUT YOUR FEELINGS - I

Please indicate by circling the number to the right of each statement how strongly you agree or disagree with each of the following statements.

	1	2	3	4
	STRONGLY	AGREE	DISAGREE	STRONGLY
	AGREE			DISAGREE
34. I have little control over the things that happen to me.....	1	2	3	4
35. There is really no way I can solve some of the problems I have.....	1	2	3	4
36. There is little I can do to change many of the important things in my life.....	1	2	3	4
37. I often feel helpless in dealing with the problems of life.....	1	2	3	4
38. Sometimes I feel that I'm being pushed around in life.....	1	2	3	4
39. What happens to me in the future mostly depends on me.....	1	2	3	4
40. I can do just about anything I really set my mind to do.....	1	2	3	4

Appendix A

ABOUT YOUR FEELINGS – II

Below is a list of the ways you might have felt. Please circle the number for each statement that best describes how often you felt or behaved this way—DURING THE PAST WEEK.

	Less than 1 day	1-2 days	3-4 days	5-7 days
DURING THE PAST WEEK:				
41. I was bothered by things that usually don't bother me.....	0	1	2	3
42. I did not feel like eating; my appetite was poor.....	0	1	2	3
43. I felt that I could not shake off the blues even with help from my family or friends.....	0	1	2	3
44. I felt that I was just as good as other people.....	0	1	2	3
45. I had trouble keeping my mind on what I was doing.....	0	1	2	3
46. I felt depressed.....	0	1	2	3
47. I felt that everything I did was an effort.....	0	1	2	3
48. I felt hopeful about the future.....	0	1	2	3
49. I thought my life had been a failure.....	0	1	2	3
50. I felt fearful.....	0	1	2	3
51. My sleep was restless.....	0	1	2	3

Appendix A

ABOUT YOUR FEELINGS – II (Cont.)

Below is a list of the ways you might have felt. Please circle the number for each statement that best describes how often you felt or behaved this way—DURING THE PAST WEEK.

	Less than 1 day	1-2 days	3-4 days	5-7 days
52. I was happy.....	0	1	2	3
53. I talked less than usual.....	0	1	2	3
54. I felt lonely.....	0	1	2	3
55. People were unfriendly.....	0	1	2	3
56. I enjoyed life.....	0	1	2	3
57. I had crying spells.....	0	1	2	3
58. I felt sad.....	0	1	2	3
59. I felt that people disliked me.....	0	1	2	3
60. I could not get “going”.....	0	1	2	3

Appendix A

ABOUT YOUR FEELINGS – III

Please indicate by circling the number to the right of each statement that demonstrates how strongly you agree or disagree with each of the following statements.

	1	2	3	4
	Strongly Agree	Agree	Disagree	Strongly Disagree
61. I think people who inject drugs deserve to get AIDS.....	1	2	3	4
62. I think homosexuals deserve to get AIDS.....	1	2	3	4
63. AIDS is a punishment from God for sin.....	1	2	3	4
64. I have little sympathy for people who get AIDS virus from sexual promiscuity	1	2	3	4
65. Most people who have AIDS only have themselves to blame.....	1	2	3	4
66. People with AIDS should be treated with the same respect as anyone else ...	1	2	3	4

Appendix A

MORE ABOUT YOUR FEELINGS

Please indicate by circling the answer that best demonstrates how strongly you agree or disagree with each of the following statements.

	1	2	3	4
	Strongly Agree	Agree	Disagree	Strongly Disagree
67. I feel confident in my ability to put a condom on myself or my partner.....	1	2	3	4
68. I feel confident I could purchase condoms without feeling embarrassed.....	1	2	3	4
69. I feel confident I could remember to carry a condom with me should I need one.....	1	2	3	4
70. I feel confident I could gracefully remove and dispose of a condom after sexual intercourse	1	2	3	4
71. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have had a homosexual (gay) experience.....	1	2	3	4
72. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think that I have a sexually transmitted disease (STD).	1	2	3	4
73. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think that I thought they had a sexually transmitted disease.....	1	2	3	4
74. If I were to suggest using a condom to a partner, I would feel afraid that he or she would reject me.....	1	2	3	4
75. If I were unsure about my partner's feelings about using condoms I would not suggest using one.....	1	2	3	4
76. If my partner and I were to try to use a condom and did not succeed, I would feel embarrassed to try to use one again (e.g. not being able to unroll condom, putting it on backwards or awkwardness).....	1	2	3	4

ABOUT YOUR BACKGROUND

The following questions will ask you about your background.

77. In what year were you born and what is your current age?

19 _____
(YEAR)

78. _____
(CURRENT AGE)

79. What is the highest grade or year of regular school you have completed?

1 **GRADE SCHOOL**

2 **SOME HIGH SCHOOL**

3 **HIGH SCHOOL DIPLOMA**

4 **GED**

5 **SOME EDUCATION BEYOND HIGH SCHOOL**

6 **AA DEGREE** _____

7 **BA/BS DEGREE** _____

8 **OTHER DEGREE (SPECIFY):** _____

80. Which of these categories best describes your situation?

1 **NEVER MARRIED**

2 **SEPARATED**

3 **DIVORCED**

4 **MARRIED**

5 **WIDOWED**

7 **DOMESTIC PARTNERSHIP**

8 **OTHER (SPECIFY):** _____

81. Are you currently in a romantic relationship?

1 **YES** _____

2 **NO** _____

82. Are you currently in a sexual relationship?

1 **YES** _____

2 **NO** _____

83. Are you currently employed?

1 **YES [HOURS PER WEEK]** _____

2 **NO**

84. Please think about your total combined FAMILY income during the past 12 months for all members of the family. Include money from jobs, social security, retirement income, unemployment payments, or any other money income received, and so forth. Which of these income brackets is closest to the total household income in your home?

- | | |
|----|----------------------|
| 1 | LESS THAN \$5,000 |
| 2 | \$5,000 TO \$9,999 |
| 3 | \$10,000 TO \$14,999 |
| 4 | \$15,000 TO \$19,999 |
| 5 | \$20,000 TO \$24,999 |
| 6 | \$25,000 TO 29,999 |
| 7 | \$30,000 TO \$34,999 |
| 8 | \$35,000 TO \$39,999 |
| 9 | \$40,000 TO \$49,999 |
| 10 | \$50,000 TO \$59,999 |
| 11 | \$60,000 TO \$74,999 |
| 12 | \$75,000 TO \$99,999 |
| 13 | \$100,000 OR MORE |
| 99 | DON'T KNOW/REFUSED |

University of California, Los Angeles

CONSENT TO PARTICIPATE IN RESEARCH

(control)

HIV Intervention Study For African American Women 50+

Megan Ebor, MSW, Principal Investigator, Doctoral student from the Luskin School of Public Affairs, Aurora P. Jackson, Ph.D., Advisor, Professor of Social Welfare from the Luskin School of Public Affairs at the University of California, Los Angeles (UCLA) are conducting a research study.

You were selected as a possible participant in this study because you identify as an African American woman aged 50 or older. Your participation in this research study is voluntary.

Why is this study being done?

This study is being done in order to provide HIV education for older African American women within a church setting. This study will help us to learn how to engage older African American women in a HIV education program within a church setting.

What will happen if I take part in this research study?

If you volunteer to participate in this study, the researcher will ask you to do the following:

- The HIV Education program will be conducted one-day spanning 3-4 hours.
- The session will be conducted in a private church setting.
- Participants will complete a survey before program begins and will be asked to complete another survey 4 weeks later. You will receive weekly phone calls to ask any questions you may have. At week 6 you will be asked to return to take another survey.
- We will ask questions about HIV transmission, stigma and attitudes through a questionnaire and survey. We will also ask questions about condom use self-efficacy and your feelings.
- Questions will be asked about explicit sexual behaviors and how HIV is transmitted (penis in vagina, penis in the anus/butt, mouth on penis/vagina).

Appendix B

- Groups may be composed of women who know each other, may or may not have HIV, have concerns about HIV or would like to learn more about the topic.
- Elders and leaders of the church may or may not be present for the group sessions.
- The session will include visual media education and discussion.
- At the end of the session participants will be asked to share their ideas about how to improve the intervention to better suit their needs. These sessions may be audio taped.

How long will I be in the research study?

Participation will involve a one-time 2-3 hour session.

Are there any potential risks or discomforts that I can expect from this study?

Risks to participants are minimal. However, you will be in a group setting with people from your church. Due to the topic some participants may feel uncomfortable engaging in intimate discussions involving sexual content.

Are there any potential benefits if I participate?

You will not directly benefit from your participation in the research. However, the information you provide will add to our understanding of how to engage older African American women ages 50+ in participating in HIV educational interventions.

Will information about me and my participation be kept confidential?

Any information that is obtained in connection with this study and that can identify you will remain confidential. It will be disclosed only with your permission or as required by law. Confidentiality will be maintained.

- All records related to your involvement in this research study will be stored in a locked file cabinet.
- Your identity on these records will be indicated by a case number rather than your name, and the information linking those case numbers with your identity will be kept separate from the research records.
- You will not be identified by name in any publications of the research results.

Appendix B

- The data collected may be stored for future research by the principal investigator.

What are my rights if I take part in this study?

- You can choose whether or not you want to be in this study, and you may withdraw your consent and discontinue participation at any time.
- Whatever decision you make, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any questions that you do not want to answer and still remain in the study.

Who can I contact if I have questions about this study?

The research team if you have any questions, comments or concerns about the research, you can talk to the one of the researchers. Please contact: Megan Ebor, at the UCLA Luskin School of Public Affairs, 3250 Public Affairs Building, BOX 951656 (telephone 818-261-3733 meganebo@ucla.edu) and/or Aurora P. Jackson (telephone: 310-825-7504 or ajacks@ucla.edu).

UCLA Office of the Human Research Protection Program (OHRPP):

If you have questions about your rights as a research subject, or you have concerns or suggestions and you want to talk to someone other than the researchers, you may contact the UCLA OHRPP by phone: (310) 206-2040; by email: participants@research.ucla.edu or by mail: Box 951406, Los Angeles, CA 90095-1406.

You will be given a copy of this information to keep for your records.

University of California, Los Angeles

CONSENT TO PARTICIPATE IN RESEARCH

HIV Intervention Study For African American Women 50+

Megan Ebor, MSW, Principal Investigator, Doctoral student from the Luskin School of Public Affairs, Aurora P. Jackson, Ph.D., Advisor, Professor of Social Welfare from the Luskin School of Public Affairs at the University of California, Los Angeles (UCLA) are conducting a research study.

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This study is being done in order to provide HIV education for older African American women within a church setting. This study will help us to learn how to engage older African American women in a HIV education program within a church setting.

What will happen if I take part in this research study?

If you volunteer to participate in this study, the researcher will ask you to do the following:

- The HIV Education program will be conducted once a week for 1 hr. 30 min. for a total of 4-weeks. Week 5 you will be asked to return to complete the post-test questionnaire.
- The weekly sessions will be conducted in a private church setting.
- Participants will complete a survey before the 4-week program begins and will complete another survey after the 4-week program ends (during week 5).
- We will ask questions about HIV transmission, stigma and attitudes through a questionnaire and survey. We will also ask about condom use self-efficacy and about your feelings.
- Sessions will cover questions about your knowledge of HIV transmission, age-specific HIV knowledge, stigma and attitudes towards people living with HIV and condom use self-efficacy.

- Activities will include: sexual-health discussions (talking circle), educational training, role-play, stigma-reducing exercises and educational film viewing.
- At the end of each week the participants will be asked to share their ideas about how to improve the intervention to better suit their needs. These sessions may be audio taped.
- You will receive a total of \$50 in gift cards. The gift cards will be administered in two payments of \$25. The first card will be administered at the first group session (week 1). The second gift card will be distributed during the last group session (week 6).

How long will I be in the research study?

Participation will take a total of 4-weeks. Sessions will span 90 minutes.

Are there any potential risks or discomforts that I can expect from this study?

Risks to participants are minimal.

Are there any potential benefits if I participate?

You will not directly benefit from your participation in the research. However, the information you provide will add to our understanding of how to engage older African American women ages 50+ in participating in HIV educational interventions.

Will information about me and my participation be kept confidential?

Any information that is obtained in connection with this study and that can identify you will remain confidential. It will be disclosed only with your permission or as required by law. Confidentiality will be maintained.

- All records related to your involvement in this research study will be stored in a locked file cabinet.
- Your identity on these records will be indicated by a case number rather than your name, and the information linking those case numbers with your identity will be kept separate from the research records.

- You will not be identified by name in any publications of the research results.
- The data collected may be stored for future research by the principal investigator.

What are my rights if I take part in this study?

- You can choose whether or not you want to be in this study, and you may withdraw your consent and discontinue participation at any time.
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- You may refuse to answer any questions that you do not want to answer and still remain in the study.

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UCLA Office of the Human Research Protection Program (OHRPP):

If you have questions about your rights while taking part in this study, or you have concerns or suggestions and you want to talk to someone other than the researchers about the study, please call the OHRPP at (310) 825-7122 or write to:

UCLA Office of the Human Research Protection Program 11000 Kinross Avenue, Suite 211, Box 951694 Los Angeles, CA 90095-1694

You will be given a copy of this information to keep for your records.

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