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AFRICAN AMERICAN WOMEN'S PERCEPTIONS OF HIV PREVENTION
COMMUNICATION WITH THEIR REPRODUCTIVE HEALTH PROVIDERS

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University.

by

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DEDICATION

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ABSTRACT

AFRICAN AMERICAN WOMEN'S PERCEPTIONS OF HIV PREVENTION COMMUNICATION WITH THEIR REPRODUCTIVE HEALTH PROVIDERS

By Valerie Nichole Burge-Hall, Ph.D.

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2015.

Major Director: Joann T. Richardson, Ph.D., Associate Professor,
Health Education and Promotion, Department of Kinesiology and Health Sciences

In spite of a decline in HIV incidence rates among African American women, they still bear the most significant disease burden among U.S. women. Findings from numerous studies indicate probable explanations for the disparity, such as the impact of poverty, limited healthcare access, low literacy, and living in areas with high HIV rates. Additionally, many study results provide insight regarding prevention strategies. However, the aim of this study is to explore African American women's perceptions regarding what HIV prevention communication, if any, occurred with their reproductive health providers (RHPs). In this study, 20 African American women with unknown HIV status participated in face-to-face interviews designed to explore their perceptions about HIV prevention communication with their RHPs. Audio-taped interviews were transcribed verbatim and coded using NVivo10 software. Guided by constructs of the Health Belief Model, inductive and deductive coding yielded four key themes: (1)

patients' lack of expectation to receive information; (2) failure of RHPs to initiate and offer information; (3) patients' desire to receive information; and (4) patients' recommendations regarding their preferred methods to receive HIV prevention communication. Results indicated that RHPs missed prime opportunities to initiate and offer HIV prevention information during routine reproductive health visits with women at greatest risk. These findings and recommendations for practice will be useful when designing, implementing and evaluating HIV prevention patient education protocols. The recommendations provide strategies to help RHPs seize every opportunity to address HIV prevention with this highly vulnerable population.

Key Words: African American women, HIV prevention, patient-provider communication, reproductive health provider, qualitative, USA

CHAPTER ONE

INTRODUCTION

Even though “every nine and a half minutes someone in the United States contracts the human immunodeficiency virus (HIV), African Americans are disproportionately affected” (U.S. Department of Health and Human Services [DHHS], 2014, p. vii). In the United States, African Americans make up approximately 12 percent of the population, yet account for approximately 40 percent of new HIV infections (CDC, 2015). Furthermore, in the United States, women account for one of every four new HIV cases with African American women accounting for approximately two of every three cases (DHHS, 2012). In 2009, the incidence rate for African American women was 15 times higher than for White women and over three times higher than for Hispanic women (Centers for Disease Control and Prevention [CDC], 2011). Furthermore the death rate from Acquired Immunodeficiency Syndrome (AIDS) is worse among certain age groups of African American women. AIDS is the fifth leading cause of death for African American women aged 25-34 and the fourth leading cause for those aged 35 to 44 (CDC, 2013). Additionally, deaths from AIDS are 20 times more likely to occur in African American women as compared to White women (The Henry J. Kaiser Family Foundation [KFF], 2013). Alarming rates such as these provoke an examination of multiple factors that may put African American women at greater risk for HIV.

Findings from numerous studies indicate plausible risk factors that contribute to the HIV epidemic among African American women. The most prevalent factor is unprotected sex with a

male partner (DHHS, 2012). Williams (2003) states, “the risk of infection among African Americans is primarily associated with...the exchange of semen, blood, or vaginal fluids” (pp. 299-300). Additional risk factors for HIV transmission among African American women include: biological influences, such as a history of sexually transmitted infections (STIs), culture and gender norms (e.g., lack of condom negotiation with male partners, sexual abuse), as well as structural influences which are social, policy, and economic barriers (e.g. low literacy, poverty, stigma and limited access to health care) (Brown, Taylor, Mulatu, & Scott, 2007; Essien, Meshack, Peters, Ogungbade, & Osemene, 2005; KFF, 2012; Mays & Cochran, 1988). Researchers investigated a constellation of risk factors that put African American women at greater risk for HIV infection (El-Bassel, Calderia, Ruglass, & Gilbert, 2009). Risk factors included: childhood sexual abuse, posttraumatic stress disorder (PTSD), relationship dynamics, and a history of abuse as well as a fear of intimate partner violence (IPV). Inasmuch as African American women account for approximately 66 percent of the new HIV cases in American women (DHHS, 2012), this disparity warranted an inspection of contributing risk factors. In order to fully examine this topic, it was necessary to better understand African American women’s perceptions of personal HIV risk as well as their health provider’s role in HIV education and screening, testing practices, and the need for patient-provider communication.

Perceptions of Personal HIV Risk

Research findings indicate there is a relationship among a person’s perception of risk and their risk reduction behaviors, therefore a factor for consideration for African American women is their perception of personal HIV risk. Jamara, Belgrave, Bradford, Young, and Honnold (2007) used an exploratory qualitative study to investigate social and cultural influences on the sexual interactions of 51 African American women. The researchers asked the women about

their personal perception of HIV risk as well as their participation in risk behaviors (i.e. lack of condom use, sex with someone who had been incarcerated, and substance use during sex). The women perceived their HIV risk as nonexistent or very low, even though they reported participating in risk behaviors. Risk behaviors included sexual activity with men who had an incarceration record to engaging in sex while under the influence of alcohol. Thirty-nine percent of the women reported having a sexual partner with an incarceration history and 70% reported the lack of consistent condom use. Additionally, 42% of the women admitted to using alcohol when engaging in sexual activity. These results called attention to the finding that women who engage in high risk behaviors may have a very low perception of personal risk. According to a report by the KFF (2012), overall only 30% of women say that they are “very” or “somewhat” concerned about being infected with HIV. Fifty-four percent of African American women acknowledged concern and many stated they did not receive condom counseling from the health care provider (CDC, 2011).

Patient Perspectives of Provider Role in HIV Education and Screening

Female patients viewed healthcare providers as their preferred source for sexual health information (KFF, 2012). Yet, the lack of communication between provider and patient regarding HIV/AIDS risk reduction is a major concern (KFF, 2012). According to the HIV Law Project (2009), providers may not take advantage of clinic visits to discuss HIV prevention strategies including testing with women who come for sexual health appointments. However, reproductive health check-ups provide an opportunity for providers to encourage HIV prevention and periodic screening.

Testing Practices

Based on the literature, testing may be a HIV prevention strategy for many at risk of infection, including African American women (Brown et al., 2007; CDC, 2011; CDC, 2012; KFC, 2012). Berkley-Patton, Moore, Hawes, Thompson, and Bohn (2012) share revealing information about HIV testing practices among African Americans. The authors explain that African Americans have higher HIV testing rates than other ethnic groups, yet have the highest prevalence of undiagnosed HIV (22%). The investigators highlighted that African Americans who are screened usually perceive themselves at risk and see health providers. However, many African Americans do not see themselves at risk, and have limited access to healthcare. In addition, Berkley-Patton et al. (2012) acknowledged African Americans were more likely to have delayed HIV diagnosis and treatment which may contribute to high rates of HIV transmission among the ethnic group. According to the CDC (2008), approximately one-third of African Americans have never tested and more than 70% of their health care providers have not offered the screening. Providing information about the need for HIV testing and resource information can help to improve self-efficacy and lower perceptions of HIV risk.

In 2006, the CDC issued revised HIV screening recommendations for individuals aged 13 to 64 years in all healthcare settings. The primary purpose of the revision was to reach the high proportion of individuals who were undiagnosed or those who received a late diagnosis because of the lack of HIV testing (CDC, 2006). In comparison to the revised guidelines, the 2001 recommendations suggested that providers should offer HIV screening for people who were at high behavioral risk such as men having sex with men and intravenous drug users. The revised recommendation, in contrast to the earlier guidelines, sought to broaden the population for screening to all, regardless of behavioral risk.

Other changes were the CDC (2006) policy did not require pre-test counseling and provided an “opt out” clause for individuals who wanted to decline the testing. Burke et al. (2007) asserted that the revised recommendations probably would not result in prevalent increase of HIV screening because of the lack of widespread participation in screening based on the earlier version of testing recommendations. After the aforementioned study conducted by Burke et al. (2007), Burrage et al. (2008) examined the reactions to the revised recommendations by women who attended community health clinics. What the researchers noted is “little if any evidence is provided from the perspective of the patient/consumer who would be subject to the recommendation” (p. 67). This underscored that the women who would be affected by the revised policy did have input regarding the recommendation.

Need for Patient-Provider Communication about HIV Screening

The literature recommends that providers should talk with their young female patients about sexual and reproductive health regardless of perceived risk (CDC, 2006; HIV Law Project, 2009). Topics for dialogue may include risk reduction and HIV testing. Freeman (2010) asserts culturally-specific clinical practices are needed for African-American females. A recommendation from the study states that messages need to be provided during health visits and should address HIV risk reduction and screening. According to research, promoting testing is a strategy to reduce the transmission of HIV among African American women (CDC, 2014; Freeman, 2010).

Aim of the Study

The aim of this study was to explore African American women’s perceptions regarding what HIV prevention communication, if any, occurred with their reproductive health providers. Furthermore, it elucidated: (a) the content of the reproductive health providers’ messages; if the

prevention communication is occurring; (b) what HIV prevention information, if any, the participants expected from their reproductive health providers; and (c) the influence of HIV prevention provider-patient communication on the intent to perform preventive behaviors among the participants. Even though studies exist that examine the relationships of patients with their providers, there was a dearth of qualitative research specifically addressing HIV prevention patient-provider communication from the patient's perspective.

Research Questions

Given the aim of the study, the specific research questions for the study were:

- (1) What HIV prevention information, if any, do urban, historically underserved, African American females with unknown HIV status receive from reproductive health providers to influence their perception of personal susceptibility and severity of HIV?
- (2) What HIV prevention information, if any, do urban, historically underserved African American females with unknown HIV status, receive from reproductive health providers to influence their perception of benefits and barriers when considering engaging in HIV preventive behaviors?
- (3) What HIV prevention information, if any, do urban, historically underserved African American females with unknown HIV status, expect to receive from reproductive health providers?
- (4) How does provider communication with urban, historically underserved African American females with unknown HIV status, influence their intent to engage in HIV preventive behaviors including screening?

- (5) What recommendations do urban, historically underserved African American females with unknown HIV status offer regarding how reproductive health providers should provide HIV prevention information?

Definitions

The definitions of the variables for the research questions were:

- (1) African American will be defined as those who identify as non-Hispanic, Black or African American.
- (2) Reproductive health providers (RHPs) include any professionals who examine, diagnose, treat or educate patients during reproductive visits in primary care facilities. Examples of healthcare providers include physicians, nurses, nurse practitioners, medical assistants and health educators.
- (3) Reproductive health visits include services rendered to adult females 20 to 44 years, including routine gynecological exams, pregnancy or sexually transmitted infection (STI) testing, emergency contraception and family planning. Prenatal care and postnatal care are not included in this definition.
- (4) Historically underserved includes individuals who are traditionally hard to reach, have limited access to healthcare, are socioeconomically disadvantaged and may have low literacy levels.
- (5) Screening and testing are used synonymously to define a preliminary enzyme immunoassay (EIA) test used to detect if an individual has been exposed to HIV and if antibodies are present. The test is not used to confirm an individual's status as positive or negative.

- (6) Unknown status is defined as lack of awareness of an individual's exposure to HIV and/or confirmed by a health provider. This term will be used for individuals who do not know if they are HIV-positive or HIV-negative.
- (7) Urban describes a geographic location with a dense population of people with low socioeconomic status, low occupational attainment, and a large number of subsidized housing options. The community has not experienced gentrification.

Research Design

In the qualitative study, the researcher conducted semi-structured interviews with 20 African American females who received a reproductive health service at a primary care facility in an urban area. The facility was located in a city in southeastern Virginia within a community with a high rate of HIV/AIDS. This researcher utilized a purposive sample of women with unknown HIV status and who were ages 20 to 44 years. During reproductive health visits, the clinic nurse provided information about the study to prospective participants. The nurse also introduced the researcher to the women after they expressed interest in the study. Immediately after the women finished with the reproductive health provider, the researcher met with the prospective participants to discuss the research purpose, screen them using the study criterion, and confirm their willingness to participate.

In addition to the interviews, the researcher conducted an observation of the reproductive health suite as well as performed a document analysis of HIV prevention educational resources. The researcher examined the two waiting areas and a reproductive health exam room to document any available HIV prevention information. In order to conduct the document analysis, the researcher searched the reproductive suite and gathered patient health education materials

used for HIV prevention. Both the observation of the setting and the review of educational resources happened once during the study.

Theoretical Framework

In order to examine HIV prevention communication between African American females and their reproductive health providers, the Health Belief Model (HBM) provided the theoretical framework for this study. The HBM is used in a variety of health promotion and education programs, including those focused on HIV prevention (Glanz, Rimer, & Lewis, 2002).

Components of the model include self-efficacy, perceptions, and pathways to an individual's possible response to a health recommendation. The HBM also includes the influence of socio-cultural traits such as demographics, socioeconomic, and knowledge on a person's behavior. More specifically, the theoretical framework delineates the process of how socio-cultural traits, personal risk perceptions, and information influence behavior.

Summary

Studies exist regarding HIV prevention among African American women and the role of healthcare providers to share culturally sensitive risk reduction messages. However, there are very few studies examining what prevention messages urban, historically underserved African American women with unknown HIV status expect and receive from health care providers. At the time of this study, the investigator was unable to identify any studies that addressed HIV prevention patient-provider communication between health providers and the defined priority population who were seeking a reproductive health service. Because African American females are at high risk for contracting HIV, research was warranted to gather information from their perspective. The information gleaned from hearing their lived experience can be used to create

effective HIV prevention interventions. The results of this study will inform the development of strategies to lessen the burden of HIV disease among African American females.

CHAPTER TWO

REVIEW OF THE LITERATURE

The literature review analyzed several broad areas of existent research relevant to the research questions, including: (a) incidence and prevalence of HIV infection in African American women, (b) risk factors, (c) perceived HIV risk, (d) patient/client perceptions about health care provider roles in HIV counseling and testing, (e) HIV screening practices, and (f) the need for provider-patient HIV prevention communication. The literature review mainly covers the period 2002 to 2013, a time span marked by significant HIV prevention milestones relevant to African American women. Those milestones were:

1. a heightened focus on HIV/AIDS as a major health threat for African American women. And yet, even though in 1998 President Bill Clinton allocated national funding to address HIV/AIDS among minority populations, in 2003 Black women accounted for almost 66% of the new cases of AIDS occurring in women. Furthermore, women of color still were most heavily affected by HIV disease in 2004 (Androite, 2005; Reif, Geonnotti, & Whetten., 2006);
2. in 2007, the national agenda began to include research that addressed African American women (Rose, Sharpe, Ralieg, Reid, Foley, & Cleveland, 2008) evidenced by a meeting entitled, *HIV/AIDS among African American women: A*

Consultation Supporting CDC's Heightened National Response to the HIV/AIDS Crisis Among African Americans;

3. in 2010, President Barack Obama allocated national funding to implement the *National HIV/AIDS Strategy*, a plan to lessen the HIV/AIDS epidemic in the United States. Even though the goals of the national strategic plan are not specifically designed to address African American women only, it does acknowledge the high rates of HIV disease among them. Furthermore, one of the major goals of the strategic plan is to lower the number of Blacks who do not know their HIV status (DHHS, 2014).

Despite these major efforts, the need still exists for current and continuous momentum to reduce HIV infection nationally, specifically targeting high risk populations (CDC, 2013).

The literature review is organized and presented as follows:

- Literature Review Methodology
- African American Women and HIV Disease
- Risk Factors for HIV among African American Women
- Perception of Personal HIV Risk by African American Women
- Patient Perspectives about Provider Role in HIV Education and Screening
- Healthcare Providers' Perceptions about HIV Prevention and Screening
- HIV Screening Practices
- Providers' Missed Opportunities for HIV Counseling and Testing
- Recommendations
- Theoretical Framework

- Summary of the Relevant Literature

Literature Review Methodology

In order to ascertain relevant literature, the investigator searched academic databases for peer reviewed articles covering the period, 2002 to 2013. This timeframe captured research that brought attention to HIV/AIDS as a disease that could significantly impact African American women through the present. The time span encompassed, 2007, the year when the national research agenda, for the first time, included a focus on African American women (Rose et al., 2008).

The keyword searches included combinations of the following terms: “African American females,” “young adult,” “heterosexual,” “HIV prevention,” “HIV screening,” “HIV negative,” “HIV/AIDS,” “HIV/STI prevention,” “patient provider communication,” “perception about HIV risk,” and “United States.” Table 1 displays the combination of search terms, the databases and the numbers of articles found. Although the search yielded 363 articles, only 29 were used for the literature review because they most closely related to the research population and topic area. Those discarded did not meet the criteria for race/ethnicity, gender, sexual orientation, HIV negative status, or United States (US) citizenship. Many of those articles focused on HIV positive females, men who had sex with men and women, individuals who did not live in the United States, adolescents and young, gay men. Additionally, the search terms that yielded large results were due to the databases finding articles linked to one or two keywords, but did not meet the full search criteria. After reviewing the articles found in the databases, additional articles were identified from the reference lists.

Table 1

Literature Search Criteria and Returns

Search terms	Title of Database	Number of returns
HIV prevention and African American women and United States	Academic Search Complete	69
HIV/AIDS among African American women and United States	Academic Search Complete	10
Perception of HIV risk by heterosexual African American women and United States and young adults	Health Source: Nursing/Academic Edition and CINAHL	40
Perception of HIV risk by heterosexual African American women and United States and young adults and 19 to 44 years	Health Source: Nursing/Academic Edition and CINAHL	3
Patient provider and African American females and United States and HIV	Pub Med	146
HIV screening and patient provider communication and African American females and United States	Pub Med	86
HIV negative African American women and patient healthcare provider communication and HIV/STI prevention and United States	Pub Med	9
Total Articles Found		363
Articles Included in Literature Review		29

African American Women and HIV Disease

Even after 30 years of knowledge about how to diagnosis, treat, and prevent HIV/AIDS, HIV- related illness and AIDS continue to be major health concerns in the United States.

According to the CDC (2012), more than one million men and women are living with HIV. Of those living with HIV in the United States (US), approximately 20% do not know their HIV status (CDC, 2012). This year 50,000 adults are expected to learn they are HIV infected (CDC, 2014). According to the CDC (2014), those who do not know their status are most likely to infect others.

In the United States, African Americans make up less than 14 percent of the population, yet account for most of the cases of HIV and AIDS and more than 40 percent of new HIV infections (CDC, 2012). Those who are most susceptible to HIV infection are men having sex with other men, intravenous drug users, and heterosexual women (CDC, 2012). Of the new HIV cases in America, women account for approximately 25 percent; yet African American women account for close to 66 percent of the new cases among women (DHHS, 2012). Although the rates of HIV/AIDS are remaining stable or declining in certain populations including African American women, the burden of disease on this population is enormous.

Since the early 1980s, women have been affected by HIV/AIDS. However, during the early decades, the national research agenda focused on white, homosexual men. More than 20 years later, HIV/AIDS landmark research emphasizing African American women occurred. In 2007, the CDC hosted a national meeting, *HIV/AIDS among African American women: A Consultation Supporting CDC's Heightened National Response to the HIV/AIDS Crisis among African Americans*, to bring national attention to the health disparity. During this meeting, researchers, health professionals and community leaders identified four focus areas for

prevention strategies. The four areas were: expansion of prevention services, increase in diagnostic and treatment options, intervention development, and community mobilization (CDC, 2007).

At the time of the national meeting, AIDS was the leading cause of death for African American women ages 25-34 years (CDC, 2007). However, in 2009 AIDS was the fifth leading cause of death for this same age group and the third leading cause of mortality for African American women ages 35 to 44 years (CDC, 2012). Even with the recent decrease in mortality rates, deaths from AIDS are greater than 15 times more likely to occur in African American women as compared to White women (CDC, 2012). Rates such as these provoke an examination of risk factors and possible HIV prevention interventions for African American women.

Rose et al. (2008) illuminated significant decisions that occurred during the landmark meeting in 2007 in which public health leaders and other experts shared their expertise. The meeting participants acknowledged “poverty, racism, discrimination, and sexual abuse” (p. 322) as structural risks (i.e., social, policy, and economic barriers) and admonished public health providers to devise ways to address the aforementioned risks. The participants noted, “African American women with HIV/AIDS often feel shame, stigma, and some level of guilt” (p. 323). Realizing the complexity of the crisis, the group of experts looked at the impact of several factors influencing the transmission rates. The assembly believed the higher rates of sexually transmitted diseases among African American women may result from them not getting adequate screening or treatment for sexually transmitted diseases, including HIV.

Risk Factors for HIV Disease among African American Women

When examining the burden of HIV/AIDS within the United States, African American women have significantly higher rates of morbidity and mortality than any other group of

women. Factors such as poverty, unequal access to healthcare and stigma contribute to why urban, African American women may engage in risky heterosexual behavior (Anaebere et al., 2013). Anaebere et al. (2013) stated, “African American women from urban communities often have decreased access to health care, experience poverty and/or low income status” (p. 115). The researchers underscored those as factors that are associated with risky health behaviors.

Prejean, Tang and Hall (2013) analyzed the CDC reports of new cases of HIV for the period 2007-2010. When looking at 17 southern states and the District of Columbia collectively, the authors concluded people living with HIV in the southern region had the poorest outcomes when compared to those in other geographic areas of the United States. The analysis identified African Americans and women as the groups with the worst outcomes from HIV disease. The investigators also noted low socioeconomic status, limited access to healthcare, high rates of sexually transmitted diseases (STDs), and a lack of affordable housing as potential factors for the health disparity. Subsequent research by Prejean, Tang, & Hall (2013) reported that in 2003, leaders from state health departments and territories, as well as AIDS and STD Directors, convened from 14 southern states to examine the emerging epidemic and to provide recommendations to slow its progression. Although participants implemented strategies as a result of this meeting, very little happened to slow the disease burden, and challenges still remained in the southern region.

In 2008, similar public health officials as well as other strategic leaders came together and examined contributing factors to the health epidemic. The group realized the impact of poverty and inadequate healthcare on HIV/AIDS. According to Prejean, Tang, & Hall (2013), “The impact of HIV/AIDS on populations that also disproportionately reflect vast poverty and inadequate support continues to fuel the challenges of: (1) reducing new infections; (2)

identifying infections as early as possible, and (3) providing adequate care, treatment, and housing” (p.415). Although the rates of morbidity declined during the three year timeframe from 2007 to 2010, the CDC continued to look for ways to lower the rates of HIV in the south. A few of the strategies included implementing culturally sensitive and cost-effective interventions, condom distribution, and HIV testing (Prejean et al., 2013).

Perception of Personal HIV Risk by African American Women

Even though studies highlighted the social, cultural, and behavioral factors influencing sexuality, there were not many that exclusively gleaned perspectives about personal risk from urban, historically underserved African American women. The perspectives of African American women can provide insight which may be used to create effective messages and interventions for HIV risk reduction. Anaebere et al. (2013) conducted a qualitative study to investigate how urban African American women conceptualized safer sex behaviors. From this study, themes emerged about phases of a relationship, relationship types, and roles and responsibilities of sexual relationships. Based on the level of a relationship, a woman would decide what level of sexual risk she would take. A noteworthy finding from this study was a female’s perception about risk taking behaviors was not consistent with general public health guidelines. For example, if a participant was in a monogamous relationship, then the perceived risk of HIV was low, even if she was unsure of a partner’s sexual history.

McLellan-Lemal et al. (2013) conducted interviews to gain insight into relational schemas, relationship scripts and partner selection. Sixty African American and Hispanic females shared thoughts about relationship challenges, power negotiation and HIV risk perception. The participants believed risk “was a problem faced by others, who were seen as being ‘not like’ the participant” (p. 5). The results highlighted the ignorance about personal HIV

risk. Although the study included women of color other than African American, it is important to note the lack of perceived risk.

Nunn et al. (2011) examined personal risk perception of nearly 6,000 adults who received rapid HIV testing in Philadelphia based clinics. During the two year period of the study, the rate of new cases of HIV was about five times greater than the national average and African Americans accounted for most of the cases (Nunn et al., 2011). The study had almost an equal number of male and female participate in the study. The participants were African American with an average age of 35. Common risk behaviors for men and women were: inconsistent condom use, multiple sex partners within a 12-month period, and substance use. The investigators found the participants who deemed themselves at zero or low risk were actually at high risk for contracting HIV. Another finding was “90% who tested HIV positive reported not using or inconsistent condom use” (p. 233). The researchers recognized there was a significant gap between perceived and actual risk perception. Nunn et al. (2011) support routine HIV testing as a manner to de-stigmatize screening.

Patients’ Perceptions of Provider Role in HIV Education and Screening

In addition to personal risk perception, it was important to identify individuals’ perception of medical providers serving as proponents of specific health information and screenings. Friedman and Bloodgood (2010) conducted a qualitative study to explore how African American, Latina and Caucasian women, aged 15 to 25 years, communicated with healthcare providers, parents, peers, and partners about Chlamydia screening. The researchers investigated: the scope and frequency of participants’ conversations about STD testing with significant others; where they sought information about STDs; how they would respond if a friend wanted STD counseling; and what could facilitate discussions about STD testing.

Interviews were conducted in 10 metropolitan areas with a total of 125 target population members participating. The study revealed there were missed opportunities to share STD prevention information in clinic and school settings. Even though the study focused on Chlamydia, it is important to note that almost 30% of the respondents explained they had not talked about STD prevention with the healthcare providers. However, the results indicated that healthcare providers were the preferred providers of STD information.

King and Pate (2014) conducted a qualitative study focusing on African American, Caucasian, Hmong and Latina women's healthcare experiences and their perspectives on health information and perceptions about perinatal HIV testing and HIV disease. The researchers conducted five focus groups with 37 women of childbearing age with low socioeconomic status to discuss their patient-provider interaction. Most of the participants were HIV negative, but one focus group was comprised of women who were HIV positive. Results from the study were categorized by experiences with health care during the perinatal period, sources of information, perceptions of perinatal testing, and perceptions of HIV/AIDS in general. King and Pate (2014) stated, "provider's ability to make women feel welcome and cared for as individuals contributed to positive experiences" (p. 112). Additional findings included that the African American, Caucasian and Hmong participants "valued written information from providers to raise their awareness and processing of health information" (p. 114). Furthermore, lack of positive patient-provider relationships and not getting general information about HIV or perinatal HIV testing are factors that are major reasons perinatal women decide not to be screened (King and Pate, 2014). Moreover, "the interpersonal component of the patient-provider relationship is a critical factor in a woman's engagement in health-care services and receptiveness to HIV testing" (p. 119). Although the study focused on three racial/ethnic groups for their purposes, the findings are

useful when dealing with African American females of reproductive age with low socioeconomic status.

Reilly et al. (2013) conducted a study among Black women to identify factors related to HIV infection. The researchers recruited participants who were in the second round of the National HIV Behavioral Surveillance study of high-risk heterosexuals, sponsored by the CDC in 2010. Ethnographic researchers selected eight heterosexual males and females from communities with high HIV rates to recruit members of their social network as prospective participants for the study. As a result of the recruitment efforts, researchers gained a pool of 625 heterosexual male and females. Reilly et al. (2013) used the study eligibility criteria to acquire 153 Black women for the study. Most of the participants were unmarried, engaged in unprotected sex within the last 12 months, were unemployed, had health insurance and visited a healthcare provider within the last year. In addition, approximately 60% participated in binge drinking episodes in the past 12 months. They self-reported their HIV status as negative or unknown status, and resided in or had social networks within communities with high HIV prevalence rates and a large number of impoverished residents.

Of the 153 study participants, 15 tested HIV positive even though they reported their status as HIV negative or unknown (Reilly et al., 2013). From those who tested positive, almost eight percent of them reported seeing a healthcare provider within the last year, yet only five of them recalled the provider offering the HIV screening test. Almost half of the HIV infected participants reported never having a screening test. The women who did get tested reported the fear of learning they were HIV positive as the greatest reason for not getting screened.

Study results from Reilly et al. (2013) highlight age, risk behavior, and lack of screening as factors for the high rate of HIV among low income, African American women. Most of the

participants who tested positive were 40 years and older, engaged in transactional sex (i.e., exchange sex for money or drugs), and had partners who used crack. The study highlighted older women may have older partners who do not know their status, as well as these women do not receive reproductive care where they are likely to be offered the screening. They also highlighted providers may perceive older women as sexually inactive so they do not offer the test. The authors acknowledged the potential for missing the opportunity to identify women who are HIV positive because they decline HIV testing in primary care facilities and hospitals. Reilly et al. (2013) suggest future research should “explore how to encourage HIV testing in this population of high risk women” (p. 752).

HIV Screening Practices

In 2006, the CDC revised HIV screening recommendations for individuals aged 13 to 64 years. The primary purpose of the revision was to reach the high proportion of individuals who were undiagnosed or those who received a late diagnosis because of the lack of HIV testing. The recommendation was to provide HIV screening tests in healthcare settings for all individuals aged 13 to 64 years, regardless of risk behaviors. The CDC (2006) policy provided an “opt out” clause for individuals who wanted to decline the testing.

Specifically, the major revisions regarding HIV testing were:

For patients in all health-care settings

- HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening);
- Persons at high risk for HIV infection should be screened for HIV at least annually. Those who inject drugs, exchange sex for money or drugs, or have more than one sex partner or whose partner has had another sex partner should be screened every three to six months;
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing;
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings.

For pregnant women

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women;
- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening);
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing;

- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women (CDC, 2006, p.1).

Prior to the implementation of the 2006 CDC screening recommendations, guidelines were in place for pregnant women to be offered HIV testing (Coleman, Morgan, Carlson, Hawkins & Schulkin, 2008). In order to investigate patients' experiences with physicians regarding HIV testing practices, Coleman et al. (2008) provided 687 obstetrician-gynecologists with surveys for their patients and one questionnaire for the physician to complete. The physicians were asked to distribute the surveys to 15 patients in order to ascertain patients' perspectives about physicians' recommendation of HIV screening and how the physicians assessed HIV risk. The sample consisted of 851 White, African American, Asian/Pacific Islander, and multiracial pregnant and non-pregnant women and 68 physicians.

Realizing the potential for obstetricians and gynecologists to promote HIV testing, the researchers wanted to “(1) determine the percentage of patients who had received HIV testing, (2) examine risk behaviors and knowledge of risk behaviors including sexual activity and injectable drug use, (3) identify reasons women would not get tested, and (4) examine women's recollection of how the physicians recommended testing” (Coleman et al., 2008, p. 356). Most of the participants had a primary care physician in addition to the reproductive health physician. However, 30% of the respondents stated the obstetrician-gynecologist was their primary care physician. This study illuminated the role and influence of obstetrician-gynecologists as specialists and/or primary care providers and the response to their HIV testing recommendations by women who were of reproductive age. The investigators found most of the study participants did not recall that their obstetrician-gynecologist ever recommended an HIV screening. Yet, the obstetrician-gynecologists reported moderately or strongly recommending HIV screening to all

pregnant patients. The findings from the study did highlight the potential role of specific types of physicians in HIV prevention; especially obstetrician-gynecologists who are reproductive health providers.

Need for Patient-Provider Communication about HIV Screening

Tao, Branson, Anderson, and Irwin (2003) conducted a cross-sectional study to investigate if physicians provided counseling with HIV and STD testing in physician offices and hospital outpatient departments. The researchers analyzed data from two national surveys of ambulatory care visits in private settings for people ages 18 to 64 years. Of the nearly 13 million outpatient visits that included HIV and STD testing, 35% of the visits had documented counseling sessions, whereas only 28% of women with prenatal visits did. Additionally, Tao et al. (2003) noticed counseling occurred less when testing for HIV (21%) or a specific STD (37%) alone as compared to combining HIV and STD testing (50%) for the men and women in the study. “Patients aged 18 to 29 years accounted for 65% percent of visits that included HIV and STD counseling, compared to 24% for HIV only” (p. 1246). The authors noted the primary reason for women having an outpatient visit was related to pregnancy or family planning accounting for 38% of visits which included HIV and STD testing.

According to Lewis and Black (2006), there are a variety of needs for women during their reproductive years (e.g., prenatal care, pregnancy, and the prevention and treatment of sexually transmitted infections). The researchers elucidate that health providers have patient history forms with questions related to sexuality, but “often offer little discussion on issues related to sexuality unless the patient raises the issue” (p. 29).

The authors assert:

It is within the scope of practice of each of these clinicians [childbirth educators, lactation consultants, nurses, midwives, and physicians] to address sexuality concerns, validate women's feelings, and provide suggestions of modifications in sexual practices to meet women's needs for sexual expression within the range of activities that are safe and acceptable (p. 29).

When considering the roles of reproductive health providers during childbearing years, the significance of patient-provider communication within women's sexuality education becomes apparent.

Findings from the Coleman et al. (2008) study also underscore physicians' missed opportunities to assess and educate women of childbearing age about HIV risk and the recommended preventive behaviors. Most of the pregnant women reported having an HIV test with most of the group getting their results from the obstetrician-gynecologist. On the other hand, about half of the women, who were not pregnant, had not had a test. Although most of the entire sample reported having an HIV test at some point, most of those did not remember the obstetrician-gynecologist recommending the screening. Of the women, "young, pregnant, Hispanic, and African-American patients were more likely to recall an obstetrician-gynecologist had recommended HIV testing" (p. 358). In regard to personal perception of HIV risk, less than five percent saw themselves at risk even though about half of them reported having unprotected sex with more than one partner or not knowing if their partner used injectable drugs. Of those who reported risky behavior, "26% had never been tested for HIV" (p. 363). The most commonly cited reason for declining the HIV test was the perception of low risk even when they stated they participated in high risk sexual behavior. For those who declined testing, "nine

percent would want their obstetrician-gynecologist to follow-up by explaining why HIV testing is important” (p. 359). Key considerations from this study include the need for physicians to: (1) educate patients about what constitutes HIV risk and risk taking behavior and explain treatment options, (2) promote HIV testing consistently to pregnant and non-pregnant women, and (3) follow up with clients who decline the testing to identify barriers and provide education.

In 2008, a report by the CDC stated that healthcare providers only offered HIV prevention counseling to approximately 38% of young women who received a contraceptive service as a result of unprotected sex, such as a pregnancy test or emergency contraception (CDC, 2008). This suggested that more than half of the young women who participated in some type of high risk sexual behavior did not receive information about STD/HIV risk and prevention. According to the HIV Law Project (2009), “In effect, healthcare providers are failing to offer necessary STD/HIV counseling, testing, or treatment to over 60% of those young, female patients who are engaging in unprotected sex” (p.7). Based on this report, the potential exists for providers to share HIV risk-reduction information and recommend screening. However, the opportunity is far too often missed (HIV Law Project, 2009).

Realizing the need to promote HIV testing, the CDC implemented the Expanded Testing Initiative (ETI). From 2007 to 2010, the ETI worked to increase HIV testing for African Americans in order to support the revised 2006 testing recommendations (CDC, 2012). According to the CDC (2011), more than 21% of HIV infections among African Americans are undiagnosed. Due to the number of people who do not know their HIV status, 25 jurisdictions with the highest prevalence of AIDS cases among African Americans received funding to offer testing in the ETI project. According to the ETI (CDC, 2012), more African American adults (52%) report being tested for HIV as compared to Whites (34%) and Hispanics (38%). In

addition, approximately one-third of African Americans have never tested and more than 70% of their health care providers have not offered the screening (CDC, 2008). For women who are HIV positive, 31% received a late HIV diagnosis in a healthcare setting and within one year of testing learned they had AIDS (KFF, 2012).

Theoretical Framework

In order to explore what factors impact patient-provider HIV prevention communication among urban, historically underserved African American women with unknown HIV status, the study used a theoretical framework that includes components regarding personal demographics, personal risk perception, the influence of reproductive health provider recommendation, and the effect of self-efficacy on HIV preventive practices. The Health Belief Model (HBM) can be used to examine each of the aforementioned. According to DeBarr (2004), the HBM is one of the most widely used theories in health education and promotion programs. During the 1950s, social psychologists Hochbaum, Rosenstock and Kegels developed the theory to explain the failure of a tuberculosis screening program. However, over the years the use of the model has expanded. In health promotion and education, the model has served as the theoretical foundation for research studies and health interventions that focus on individuals' preventive health behaviors, including HIV prevention and risk reduction.

As noted in Table 2, the theory consists of six constructs which move from a person's perception about developing an illness to his/her belief of being able to avoid contracting the condition (National Cancer Institute, 2005). According to Janz and Becker (1984), the construct of perceived barriers is the strongest predictor of whether or not individuals will comply with the recommended action and perceived severity is the weakest predictor. In the study, each of the

six constructs was examined in order to gain a comprehensive understanding of patient-provider communication among the defined priority population.

Table 2

Health Belief Model Components

Concept	Definition	Application
Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low.
Perceived Severity (Seriousness)	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.
Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action

In the HBM, the message/recommendation is introduced and the recipient of the message responds based on the perceived threat (belief of risk and magnitude of risk [susceptibility/severity]). In addition to perceived threat, modifying factors (e.g., cues to action, knowledge, race, age, and gender), the effects of the action (i.e., if perceived benefits outweigh perceived barriers), and self-efficacy impact whether a person is going to engage in a recommended behavior (likelihood of taking recommended preventive health action). Within this model, cues to action, are provided by health providers, mass media campaigns, or clinic

reminders in order to motivate a person to follow a recommended action (Corpai et al., 2007). Following in Figure 1, is a diagram of each of the constructs and how they influence the possibility of an individual accepting a health recommendation. In this study, the constructs were grouped as displayed in the figure (e.g. individual perception of threat is a combination of perceived susceptibility and seriousness).

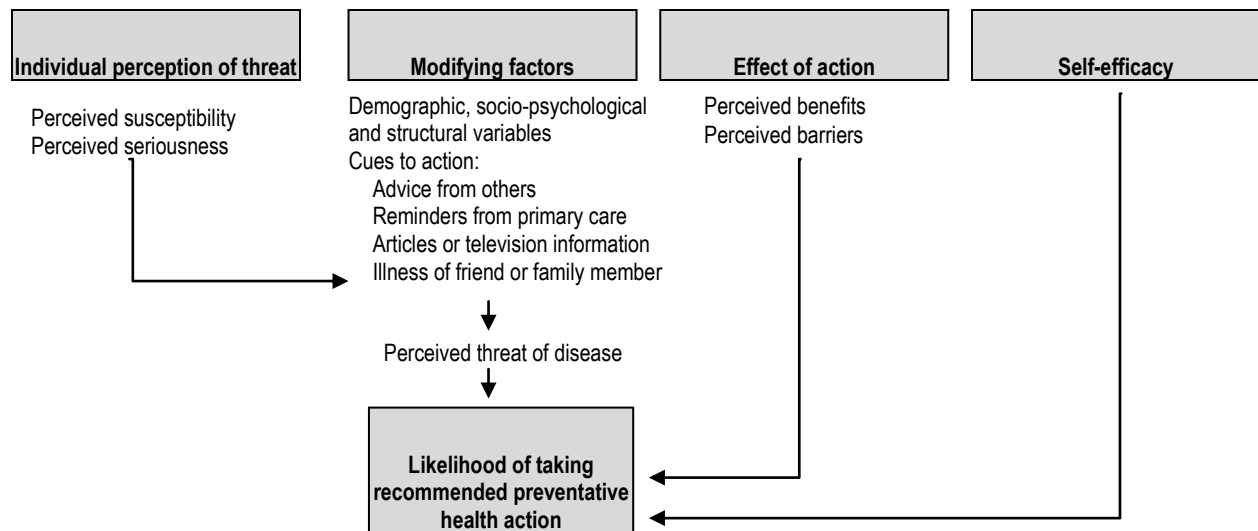


Figure 1: The interrelations of constructs in the Health Belief Model. This figure illustrates how multiple constructs influence an individual’s likelihood to implement a preventive health action.

Summary of the Relevant Literature

The prior research provides insight to why such a large HIV health disparity exists among urban, historically underserved African American females as compared to other ethnic groups of women. Many studies pinpoint biological, cultural and structural risks factors for HIV disease among this population; yet only a few studies offer insight of African American women's perceptions about HIV risk, testing and the influence of patient-provider communication on decision making about taking a HIV screening test. When examining patient-provider communication, researchers recommend that providers should talk with their childbearing age female patients about sexual and reproductive health regardless of perceived risk (HIV Law Project, 2009). Freeman (2010) asserts culturally-specific clinical practices are needed for African-American females provided during health visits and should address HIV risk reduction and testing. A significant finding in the research is the effectiveness of using HIV testing as a strategy to reduce the transmission of HIV among adults including African American women (CDC, 2012; DHHS, 2012). A major gap in the research is qualitative studies exploring patient-provider communication among urban, historically underserved African American females, during their prime reproductive years, a population unequivocally burdened with HIV disease.

CHAPTER THREE

METHODOLOGY

The purpose of this exploratory study was to examine the perceptions of urban, historically underserved African American females aged 20 to 44 years with unknown HIV status regarding what, if any, HIV prevention communication occurred with their health providers during their reproductive health visits. Furthermore, it elucidated: (a) the content of the reproductive health providers' messages, if the prevention communication occurred, (b) what this group of African American women expected from reproductive health providers in addressing HIV prevention, and (c) the influence of HIV prevention provider-patient communication on the intent to perform preventive behaviors among this specified group.

Research Questions

The research questions for the study were:

- (1) What HIV prevention information, if any, do urban, historically underserved, African American females with unknown HIV status receive from reproductive health providers to influence their perception of personal susceptibility and severity of HIV?
- (2) What HIV prevention information, if any, do urban, historically underserved African American females with unknown HIV status, receive from reproductive

health providers to influence their perception of benefits and barriers when considering engaging in HIV preventive behaviors?

- (3) What HIV prevention information, if any, do urban, historically underserved African American females with unknown HIV status, expect to receive from reproductive health providers?
- (4) How does provider communication with urban, historically underserved African American females with unknown HIV status, influence their intent to engage in HIV preventive behaviors including screening?
- (5) What recommendations do urban, historically underserved African American females with unknown HIV status offer regarding how reproductive health providers should provide HIV prevention information?

Table 3 displays the correlation of the theoretical framework to the research questions.

Table 3

Health Belief Model Constructs Linked to Research Questions

HBM Constructs	<i>Research Question Numbers</i>				
	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
Perceived Severity/Seriousness	X				
Perceived Susceptibility	X				
Cues to Action			X	X	X
Perceived Barriers		X			
Perceived Benefits		X			
Self-Efficacy				X	

Note. An “X” denotes alignment of the HBM construct to the research question.

Research Design

The study used a qualitative design because it deepens the researcher's understanding of individuals' lived experiences and allows for in-depth insight as compared to analyzing responses from a survey or questionnaire. According to Holloway (1997),

Qualitative research is a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live.

A number of different approaches exist within the wider framework of this type of research, but most of these have the same aim: to understand the reality of individuals, groups, and cultures. Researchers use qualitative approaches to explore the behavior, perspectives and experiences of the people they study.

The basis of qualitative research lies in the interpretive approach to social reality (p.2).

Even though studies exist to explore the patient-provider relationships, there is a sparse amount of qualitative research specifically addressing HIV prevention patient-provider communication from the patient's perspective.

In this exploratory study, the researcher utilized semi-structured interviews, document analysis and a field observation of a primary care setting in order to gain a better perspective of African American women's experiences regarding HIV prevention communication with their reproductive health providers. The qualitative method of inquiry fits best with this research project because it is "emergent rather than tightly prefigured" (Creswell, 2003, p. 181). In other words, the design allowed the researcher the flexibility to gain a greater perspective about the participants' lived experiences. In qualitative research, the investigator can provide a rich description of the participants, locations and actions (Bogdan & Biklen, 2007). Therefore, the

researcher used the qualitative design to explore historically underserved African American females' experiences with and perceptions of HIV prevention communication with their reproductive health providers.

The researcher collected primary data from urban, underserved African American female patients with unknown HIV status who received reproductive health services at a primary care facility in an urban southeastern Virginia city. Selection of this site provided an opportunity to examine perceptions about patient-provider communication in a setting that serves a geographic area that has a very high rate of HIV infection in the Commonwealth of Virginia.

The researcher worked at this primary care facility twenty years ago and in the spring of 2013 completed an externship focusing on women's health at the facility. Throughout these experiences, a desire to gain greater insight into what role health providers could play in HIV prevention deepened. The researcher recognized that working within this setting and with women similar to the study participants may stimulate unwarranted assumptions and influence the interpretation of the data. Therefore, in order to lessen the opportunity for unintentional bias, the researcher made reflective notes and discussed viewpoints and assumptions with members of the dissertation committee.

Selection of the Research Participants

The researcher utilized a purposive sample of 20 participants who received reproductive health services at the primary care facility in an urban community. The primary care facility was located in the center of an urban community and is a major source for healthcare for individuals within the community. The general mission of the facility is to provide exemplary healthcare for those who are in need of medical services regardless of their ability to pay (Virginia Health Care Foundation, 2014). Prior to soliciting approval from the senior level administrator to conduct the

study at the primary care clinic, the researcher obtained approval from the appropriate Institutional Review Board (IRB) at Virginia Commonwealth University (VCU). After receiving IRB approval from the university, the researcher met with the primary care facility's administrative leaders to secure access to the site. At the conclusion of the meeting, the researcher obtained the senior administrator's approval to conduct the study.

Once on site the researcher worked with the nursing staff to recruit study participants. The researcher provided the nursing staff with a recruitment flier, Research Study Interest Form (Appendix A), and asked them to offer the form to African American women with reproductive health appointments. When the researcher was on-site, the nurse provided the potential participants with the Interest Form and introduced them to the researcher for more information. The researcher discussed the study with the potential participants using the Script for Scheduling Interviews (Appendix B). If a woman expressed her willingness to be interviewed at the current time, then the researcher commenced with the inclusion criteria screening process. Because of the high incidence of HIV among the priority population, then the researcher focused on specific demographic characteristics: (a) African American, who identifies as non-Hispanic, Black, (b) age 20 to 44 years old, (c) participated in a reproductive health visit (e.g., routine gynecological exam, family planning, sexually transmitted infection or pregnancy testing, and/or emergency contraception), and (d) willing to be a part of the research project. If the woman met the aforementioned criteria, then the researcher assessed the final criterion of unknown HIV status. If all eligibility requirements were met, the researcher conducted the interview at once. If the researcher was unavailable on-site to meet with the prospective participants at the time of their visits, then the nurses asked the women to contact the investigator directly by using the contact information on the Interest Form; however no participants contacted the researcher.

Data Collection Methods

The researcher utilized three approaches for data collection: (1) patient interviews, (2) document analysis of HIV educational materials available at the facility, and (3) observations of exam rooms and waiting areas for HIV information. Denzin (1989) believed that using multiple methods of data collection overcome validity challenges presented by using just one method. Creswell (2003) touted the advantages of using the aforementioned approaches are: documents are an “unobtrusive source of information,” observations are “useful in exploring topics that may be uncomfortable,” and interviews are “useful when participants cannot be observed directly” (p. 186).

The primary data collection method was patient interviews, using a semi-structured interview format. Patton (2002) explained that interviews are best used when the researcher wants to have be able to control what questions will be asked in order to gather deeper perspectives. In this inquiry, the researcher sought to obtain in-depth information regarding what women expected and received from health providers about HIV prevention. Creswell (2003) also identified two limitations when using the interview method: (1) “participants may offer false answers because the researcher is present, and (2) not all participants have the ability to express themselves and (their) thoughts well” (p. 186). Even though there were limitations to the interview method, the researcher believed this to be the most effective method to allow a marginalized group to express their voices.

Research Procedures

The procedures for the three data collection methods were as follows:

Interview Process. The dissertation committee and a master’s level graduate student who had extensive experience working with women of similar backgrounds as the study

participants reviewed and made suggestions for revisions to the interview questions. Based on the recommendations, the researcher made modifications for clarity and to ensure the questions aligned with the theoretical framework and research questions (Table 4).

Table 4

The Interview Questions Linked to Research Questions

Interview Questions	<i>Research Question Numbers</i>				
	1	2	3	4	5
1. Expectation of Prevention Information			X		
2. Receipt of Prevention Information	X	X			
3. How Provider Offered Information	X	X			
4. Visibility of Prevention Information	X	X		X	
5. Perception of Risk Before Appointment	X				
6. Influence of Provider on Risk Perception	X			X	
7. Beneficial Recommendation		X		X	
8. Self Efficacy-Prevention Methods		X		X	
9. Preferred Method of Communication					X
10. Prevention Topics					X
11. Number of Times Tested in Year				X	
12. Influence on Screening Behavior		X		X	

Note. X denotes alignment of the interview question to the research question.

Prior to conducting the interviews with participants, the researcher conducted a mock interview with a woman who met the study criteria. The purpose of the mock interview was for the researcher to practice interviewing skills and to ensure the questions would be

understandable to the study participants and relevant to the research questions. The researcher would have been made if necessary; however, no revisions were required.

During the interview appointment, the researcher engaged in informal conversation before discussing the interview process. After the conversation, the researcher reviewed the Project Description (Appendix C) and the Informed Consent (Appendix D). The researcher emphasized (a) how the study protocol would ensure the participant's anonymity, (b) the participant's option of not responding to questions, and (c) the participant's right to withdraw from the study at any time. The participant read and signed the informed consent, and the interview began. If the participant requested assistance with reading the informed consent, the researcher would have complied with the request but no participant requested assistance.

The researcher utilized the Interview Guide (Appendix E) to facilitate the use of the Interview Instrument (Appendix F). The Interview Instrument consisted of two components: (1) a demographic survey and (2) a set of open-ended, semi-structured questions related to patient-provider communication about HIV prevention. The participant's responses to the demographic survey were documented in writing only. However, the participant's responses to the open-ended questions were audio-recorded and supplemented with the researcher's observational notes which were utilized to capture facial and body language which may indicate emotions (e.g., anxiety, uneasiness, nervousness). If clarification was needed or additional information was wanted about a construct, then the researcher asked probing questions. During the interview, if a participant expressed a need for emotional, healthcare, or social support, then the researcher would have provided a list of community resources (Appendix G), but no participant communicated a need for support. In an effort to protect anonymity, the participant chose an

alias to be called during the interview and this alias was used in the transcription and reporting of data.

After the interviews were completed, the researcher generated verbatim transcripts of the audio-taped sessions. In addition to the interview transcripts, the researcher transcribed the observational comments taken during the interviews. This observational narrative included perceptions about the participants' nonverbal communication and concluded with any additional reflective notes such as impressions about the group members (Creswell, 2009). The researcher stored the study documents and audio-recordings in a secured file in a private office in order to protect the participants' identity. As a requirement of the university's IRB protocol, the researcher agreed to securely store the study information for five years.

Lastly, the researcher gave participants thank you notes (Appendix H) and a small gift (Appendix I) valued at no more than \$20 for being a part of the study. The gift bag included: condoms, personal lubricant, HIV prevention information, and a \$10 Wal-Mart gift card.

Document Analysis. The researcher analyzed HIV prevention and screening educational pamphlets distributed to women who received a reproductive health service. Because educational materials may have influenced patient-provider communication the researcher examined the educational materials the providers could offer to the African American women when they received a reproductive health service. In order to assess health education content presented in the pamphlets, an *a priori* code list was used to analyze the educational resources (Miles and Huberman, 1994) (Appendix J). The predetermined code list focused on gender specificity, racial/ethnic representations, and content themes. The researcher obtained the pamphlets from the literature stands in the reproductive health suite and from the health educator. All available educational resources received an examination for HIV information and

prevention recommendations, however only those that addressed HIV received extensive review. During the review of the materials, the researcher assessed whether the following topics emerged: (1) definition of HIV/AIDS, (2) who is susceptible to the disease, (3) ways of transmission, signs and symptoms, (4) testing, suggestion to seek health care provider, (5) graphics focusing on African American women, and (6) the provision of resource phone numbers.

Observations of Patient Settings. The researcher observed areas within the facility where the participants gathered. During the observations, documentation included what the researcher “hears, sees, experiences, and thought when collecting and reflecting on the data in a qualitative study” (Bogdan & Biklen, 2007, p.119). These patient settings included general waiting areas and the exam rooms utilized for reproductive services. Prior to the observations, the researcher documented preconceived thoughts regarding the settings. The observations of the patient settings occurred when patients were not in them. The researcher documented what sources of information were available such as magazines, brochures, or electronic media and noted how they were used by the health providers and participants. Additionally, the researcher documented the location of the materials within the health facility. After the observation, the researcher wrote a reflective memo. As a part of the peer debriefing process, an experienced qualitative researcher reviewed the observations and researcher’s reflections.

Data Analysis

After conducting the participant interviews, the researcher analyzed the collected data following the stages of qualitative analysis as identified by Miles and Huberman (1994). The three stages were: (1) data reduction, (2) data display, and (3) conclusion drawing/verification. Data reduction was the process of decreasing the large quantity of collected data by removing

unrelated information. In the data reduction stage, the researcher began to organize the data by coding and writing summaries. Coding was the primary method of data reduction.

Trochim (2006) described coding as the process for putting information into categories and telling the details of these categories. He explained open coding happens when the researcher uses the data to formulate initial categories and selective coding focuses on linking data to the core concept of the research (Trochim, 2006). For this study both types of coding were used.

The second stage, data display, is where the researcher develops a graphic representation which can be used in the final stage of the process in order to draw conclusions about the data (Miles and Huberman, 1994). Data display may take the form of a table, chart or other graphic representation and happens continuously throughout the analysis process. The researcher used tables to display pertinent information such as quotes and observations. Reflective notes were written with each graphic.

According to Miles and Huberman (1994) the final stage is conclusion drawing/verification. This is when the researcher formulates conclusions based on the gathered data. The theoretical constructs served as the foundation for interpretation of the themes. In this study, the researcher used the electronic research software program, NVivo 10, to create the detailed theme analysis of the transcripts. All of the data sources from the study were used to draw conclusions. Figure 2 is a graphic representation illustrating how the study was conducted.

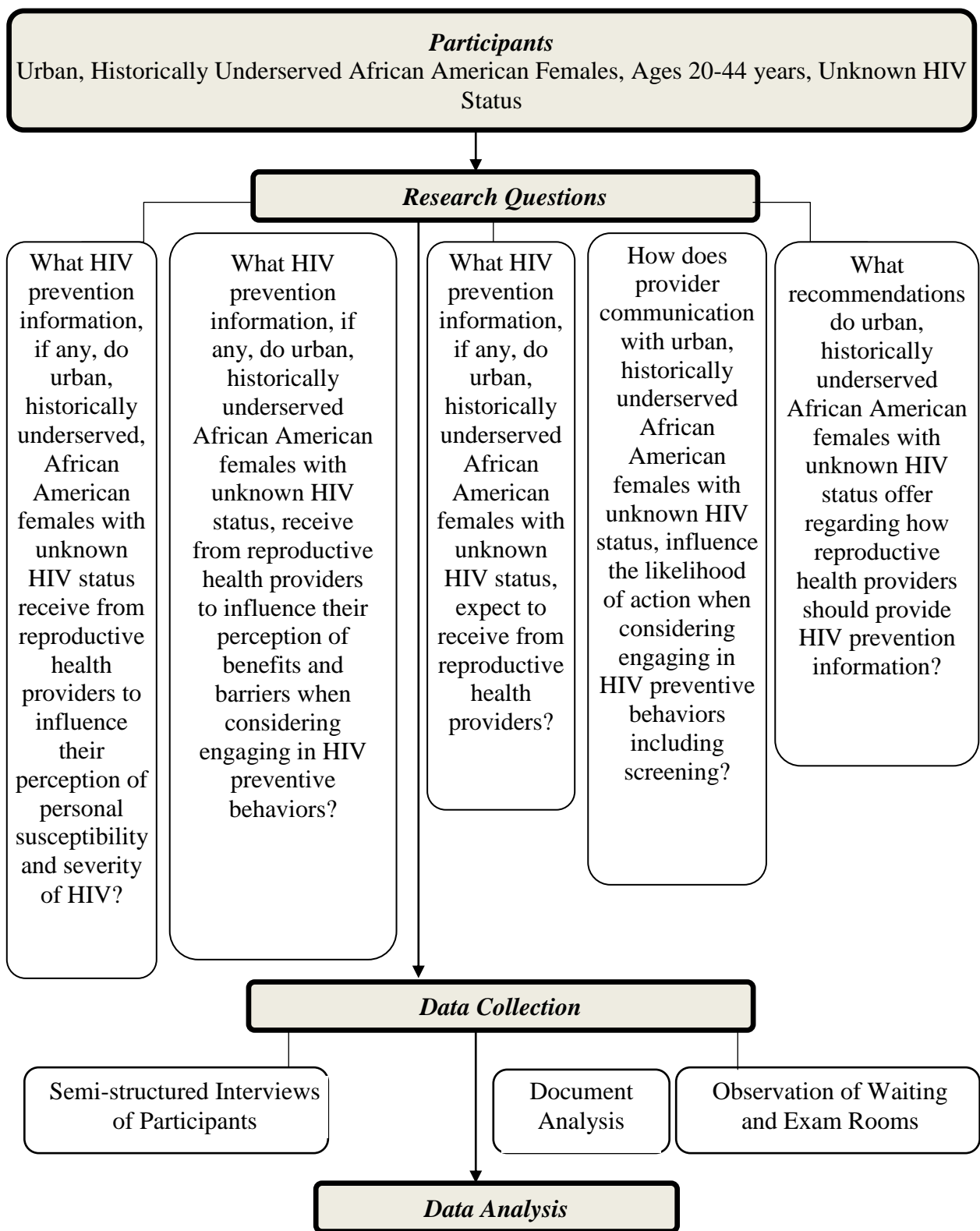


Figure 2. Flow chart of the study. This figure illustrates how the study was conducted.

Methods to Ensure Accuracy of the Findings

Creswell (2003) identified eight common methods to ensure the accuracy of findings: (1) triangulate, (2) use member-checking, (3) use rich, thick description, (4) clarify the bias, (5) present negative or discrepant information, (6) use peer debriefing, (7) use an external auditor, and (8) spend prolonged time in the field (p. 196). In order to establish validity, this study used four of the strategies. The strategies were: (1) triangulation, (2) rich, thick descriptions, (3) clarifying the bias, and (4) peer debriefing.

One strategy to be used by the researcher is to “clarify the bias” (p. 196). In this study, the researcher used the memo process to record thoughts and impressions in order to reveal any biases. The interviewer kept a reflective journal to document any preconceived notions about the interviews and draft memos regarding the review of educational materials and setting observations.

Another strategy by Creswell (2003) is using “rich, thick description to convey the findings” (p. 196). The researcher’s observational notes, coupled with direct quotes from study participants, were used to provide detailed accounts in order to provide an accurate description. In this study, the researcher used direct quotes and observations in order to highlight themes. The quotes and observations were used to create a comprehensive view of the topic.

Peer debriefing is another strategy that was utilized in this study (Creswell, 2003). The researcher worked with two peer debriefers to ensure the “accounts in the study resonate with people other than the researcher” (p. 196). The debriefers were experienced qualitative researchers who reviewed the study and asked questions to ensure clarity of the project. The goal of debriefing was to make certain individuals other than the researcher could understand the research.

Lastly, the researcher used multiple sources to gather data about the patient-provider communication. Creswell (2003) used the term triangulate to describe the process of collecting information from a variety of sources to “build a coherent justification for themes” (p. 196). In the study, interviews, documents, and observations were the information sources. The information from the sources was used to provide evidence for the research questions.

Institutional Review Board (IRB) Review and Approval

An application was submitted to the Institutional Review Board of Virginia Commonwealth University for review and approval of the investigation as an Expedited study. This was the initial procedure for conducting the research study. After receiving IRB approval, the researcher met with the senior level administrators of the health facility to delineate the roles and responsibilities of the researcher and the facility as well as to receive approval to initiate the study. The senior administrator granted approval. Data collection commenced within one week of the approval.

Delimitations

The researcher’s intent was to provide a research analysis of how patient-provider communication influences HIV prevention among a group of African American women with the highest HIV incidence rates. Therefore, the study is limited to urban, historically underserved African American females ages 20 to 44 with unknown HIV status who received reproductive health services at a primary care facility in southeastern Virginia. The primary health facility was located in a community with high HIV rates and serves clientele who are indigent. The literature often highlights poverty as a risk factor for acquiring a sexually transmitted infection including HIV (Brown et al., 2007; Essien et al., 2005; & KFF, 2012). The literature also

highlighted physicians' barriers to talking about HIV prevention during reproductive health services (White, Warren, Scribner, & Frazee, 2009).

By utilizing this health agency, the researcher gathered information about HIV patient-provider communication from a group of women who were most at risk for HIV infection. The qualitative interviews allowed this adversely affected group to have a voice (DHHS, 2010). These findings may be utilized to inform best practices in designing, implementing and evaluating patient education protocols for this highly vulnerable population. The goal of the study was to provide information that could be used to fill a gap and improve HIV prevention techniques for a population with a significant health disparity.

CHAPTER 4

RESULTS

The results presented in this chapter are the perceptions of 20 urban, historically underserved African American women ages 20 to 44 years regarding HIV prevention communication, if any, occurred with their reproductive health providers. In addition to the results, the findings included in this chapter are the observations regarding available HIV prevention information in the patient waiting areas and exam room as well as an analysis of the patient education materials. The chapter is organized into the following sections: (a) participant characteristics, (b) linking of theoretical framework to the study, (c) interview results, (d) observation results, (e) document analysis results, (f) summary of study findings, (g) identified themes, and (h) summary of results.

Participant Characteristics

Twenty women met the study criteria and agreed to participate in the study. The participants completed the first portion of the interview in order to provide information about their demographics, experiences during the reproductive health visit, and sexual behavior (Table 5). The table displays information regarding age, education, and relationship status.

Table 5

Participant Demographic Characteristics

	Participants completing the interview (N=20) n/N (%)		
Age Categories			
20-24	3	3/20	(15)
25-29	5	5/20	(25)
30-34	6	6/20	(30)
35-39	4	4/20	(20)
40-44	2	2/20	(10)
Education			
Less than high school graduate	3	3/20	(15)
High School Graduate/GED	9	9/20	(45)
Tech/trade school, college	8	8/20	(40)
Relationship Status			
Single	11	11/20	(55)
Married	4	4/20	(20)
Living with significant other/unmarried	3	3/20	(15)
Divorced	2	2/20	(10)

The age categories for the women interviewed were: 20 to 24, 25 to 29, 30 to 34, 35 to 39 and 40 to 44 years. The largest percentage of the women (30%) were between the ages of 30 to 34, followed by 25% in the 25-29 age range, 20% in the 35-39 age range and 15% in the 20 to 24 age range. The smallest percentage (10%) of the participants was in the 40-44 age range. Most of the participants (45%) had no more than a high school education whereas 40% reported varying levels of education beyond high school and 15% did not complete high school.

Eighty percent of the women were unmarried and specifically reported their status as single (55%), unmarried and living with a significant other (15%) and divorced (10%). Of the sixteen unmarried participants, six reported engaging in unprotected sex with men in the last year. Of these six women, one reported having unprotected sex with multiple partners while under the influence of alcohol and/or drugs, and another reported having unprotected sex under the influence.

Regarding the reproductive health visits, the participants saw three types of reproductive health providers and received care for a variety of reasons. The gynecologist examined 16 of the participants, two internal medicine physicians provided care for two of the women, and the nurse practitioner delivered care to two participants. Nine received pap tests, seven had routine well women exams, three requested birth control, and one had a specific reproductive health complaint. Most of the participants (n=18) had only one to two visits with the provider in the last year, and 85% reported feeling comfortable or very comfortable talking to the provider about sensitive topics.

Sixty-five percent of the participants reported having a HIV test in the last year, yet at the time of the interview they were unaware of their status because of participating in risk behaviors since being screened. Table 6 presents the data related to the reproductive health visits and sexual behaviors. The data provides an overview of whether participants engaged in unprotected sex, sex with multiple partners and sexual under the influence of alcohol and drugs. It also displays the type of reproductive health provider, the purpose of the visit, the number of times they were screened for HIV and their comfort level with their provider.

Table 6

Participant Sexual Behavior and Reproductive Health Visit Characteristics

	Participants completing the interview (n=20) n/N (%)	
Sexual Behavior in Last Year		
*Sex with men only; did not use condoms most times	6	6/20 (30)
#Sex with men only; did not use condoms most times; under the influence of drugs or alcohol	2	2/20 (10)
Sex with men only; did not use condoms most times; under the influence of drugs or alcohol; more than 1 partner	1	1/20 (5)
Sex with men only; did use condoms most times	4	4/20 (20)
Sex with men only; did use condoms most times; more than 1 partner	3	3/20 (15)
Sex with men and women; did use condoms most times	1	1/20 (5)
#No Sex	3	3/20 (15)
Number of Times Received HIV Test in Last Year		
0	5	5/20 (90)
1	13	13/20 (65)
2	2	2/20 (10)
Type of Reproductive Health Provider		
Gynecologist	16	16/20 (80)
Internal Medicine Physician	2	2/20 (10)
Nurse Practitioner	2	2/20 (10)
Purpose of Reproductive Visit		
Pap Test	9	9/20 (45)
Well Woman Exam	7	7/20 (35)
Birth Control	3	3/20 (15)
Specific Complaint	1	1/20 (5)
Comfort Level with Provider		
Somewhat	1	1/20 (5)
Neutral	1	1/20 (5)
Comfortable	7	7/20 (35)
Very Comfortable	11	11/20 (55)

Note. *Two women in this category were married. # One woman in this category was married.

Linking of the Theoretical Framework to the Study

Corpai et al. (2007) modified the six original Health Belief Model (HBM) constructs by combining related concepts. The revised model has four categories: (a) individual perception of threat (i.e., perceived susceptibility and severity), (b) modifying factors (i.e., demographics and cues to action), (c) effect of action (i.e., perceived benefits and barriers), and (d) self-efficacy. For this study, the researcher utilized the Corpai et al. (2007) revised model as the framework because it was well suited to explore the process and influence of patient-provider on HIV preventive behaviors among African American women. All of the model's constructs were examined in this study.

Interview Results

Interview Process. All participants were interviewed in a private office within the primary care facility immediately following their reproductive health appointment. After each interview, the researcher wrote a reflective note in order to capture any thoughts or emotions as well as to identify key points shared during the session. Each of the audio-taped interview sessions was transcribed and uploaded into NVivo 10 within two weeks of the face-to-face session. After reviewing each transcription, the investigator identified participant statements which related to the Health Belief Model constructs and noted the patterns of comments that did not fit into the framework. The researcher utilized the titles for the framework constructs as codes and the emergent data were the key identified themes. The chapter presents the findings associated with each of the framework constructs and the four key identified themes. Following are the codes that are derived from the theoretical framework.

Individual perception of threat. Interview questions five and six focused on the individual's perception of threat (i.e., how likely it is to become HIV infected and how bad it

would be if infected). Question five asked: “Before coming for the reproductive health appointment, what did you think about your HIV risk?” Question six asked, “What information, if any, did you receive during your appointment that made you think about your HIV risk? ”

Universally, the women reported they did not think about their HIV risk prior to their reproductive health appointment. When asked about risk perception prior to coming to the appointment, 17 women reported they did not consider themselves at risk. The participants’ comments indicated there was not even the slightest consideration of HIV risk prior to the reproductive health visit. One participant stated, “Uh, um, I didn't think I was at no high risk for getting HIV at all.” Another stated, “I didn't think nothing of HIV [laughing] because I don't have HIV.”

Moreover, 14 women reported they did not receive any information during the health visit that made them think of their HIV risk. The participants indicated they did not see, discuss, or receive anything that made them consider their risk. One participant from the 30 to 34 year old category, responded, “um, none.” when asked what information, did she receive from the provider that made her think of her HIV risk. This was the common response by all of the women who stated they did not receive HIV prevention information from the provider.

Even though most respondents (n=14) reported not receiving any information from the provider, six women stated the provider said something to make them think about their risk. They described how the provider’s questions about sexual behavior, condom use, or birth control prompted them to think of their risk. Because of the prompt by the provider, one woman shared comments which provided insight regarding the risk she took even after knowing her partner was unfaithful.

She stated,

...being sexually active, uh, with my daughter father at one point and time was very risky. And you know, when you with someone that you really love and adore him, you really try your best just to trust him. And you really don't think of you getting it [HIV] or him transferring a disease as such to you, so.

Four participants noted how other factors including personal sexual history or HIV information obtained from different sources impacted their risk perception. One participant explained that nothing the provider said prompted her to think about HIV risk, but her past history of having a sexually transmitted infection did influence her sexual behavior. When asked if the doctor shared anything that made her think about her risk, she responded,

Well no, 'cause um, years, a long time ago I had Chlamydia. And after that I got really serious about, um, not taking anything from guys you know (laughed). Make sure they wear condoms, seriously so that is why I've not been trying to have sex with nobody whose just going to take advantage of me, you know (laughed).

None of the women offered comments that indicated how they internalized how HIV disease could affect them. However, two of the six women who talked about fear and stigma in their interview displayed a grave concern regarding HIV. One participant told the researcher that the health provider thought she had a common and curable vaginal infection and shared her desire for the provider to be correct. The participant said, "God I hope she's right. Please Lord let her be right (chuckled)." The remaining four women explained how fear and stigma were barriers to HIV prevention for other people, but did not mention those as obstacles to incorporating preventive behaviors in their lives. They stressed how individuals were apprehensive to discuss HIV prevention with their provider or get screened because of

embarrassment, the concern about the lack of confidentiality regarding testing, and the likelihood of social isolation if they received a HIV diagnosis. One participant highlighted fear when she responded,

I think cause a lot of people are scared to talk about those type of issues and don't wanna, you know, seem embarrassed or think it's somebody judging them or know their information and scared they gonna tell [if they are HIV positive].

Based on the analysis of the interview transcripts, it appears the women did not perceive they were likely to be infected with HIV. Three of the 20 participants explained why specific risk factors did not apply to them. One said, “Well, I've never been the type into drugs, never done needles. I've always I've never been too have, I can count on one hand the number of sexual partners I've had in my life and the person I'm with I've been with for the last seven years and I haven't had any issues, so.” Later in the interview the same participant stated, “I always get the tests even though I know I don't have it you never know.” Responses such as this did not make it clear if the women were truly ignorant of their risk behaviors or if they were avoiding the consideration of personal risk as a type of self-protective behavior.

Even though the women were willing to be interviewed, it seemed as if they were uncomfortable talking about personal risk. The women shared comments about how others, not they, may be embarrassed to receive HIV education and screening. They also stated people were afraid to have HIV disease. When addressing concerns about personal risk, many of the participants acknowledged partner infidelity. Seven women shared comments regarding their concern about their partner's faithfulness. Even those who were in long term relationships, including one who was married, commented about their partners' fidelity. Based on the contradictory statements, comments regarding fear, stigma, and partner infidelity, as well as

nervous laughter, it appeared the women recognized they were at risk. However, according to the participants' statements, it seemed they were not seriously evaluating their risk behavior.

Cues to action. Although cues to action can come from different sources, questions two through four focused on cues given during patient-provider communication within the primary care setting only. Question two was, "What HIV prevention information, if any, did the doctor, nurse, or health educator give you?" The third question was, "How did he/she give you the HIV prevention information (told you to do something, gave you a handout, both ways)?" Question four asked, "During your appointment, what HIV prevention information, if any, did you see or read in the waiting area or exam room?"

Consistently, the women responded they did not get any HIV prevention information nor did they see any in the waiting area or exam room. Fourteen women stated they did not receive any HIV prevention information from the reproductive health provider. When asked about receiving information one woman responded, "No, no information whatsoever." Another said, "Absolutely none." Of those who reported not receiving information, two acknowledged the researcher was the only one to mention HIV to them during their reproductive health visit. When one of the women was asked did she receive any information she said, "No, I haven't had a conversation! You're the first person that even acknowledged it. Ha! (laughs out loud). That's not funny is it? Sorry. It's sad. It is really sad." Although they were the only two who voiced their dismay, their poignant comments amplified that a majority of the respondents did not perceive HIV prevention communication as an integral component of reproductive health visits.

Six of the participants reported having a discussion about HIV prevention with their provider or getting educational materials about abstinence, condom use, and birth control. One

participant received the following recommendation: “Um, to practice abstinence or use condoms.” A participant in the 35 to 39 year old range stated:

Well, I got pamphlets and of course they talked to me about everything. [Interviewer: So you got specific pamphlets? And it was talking about HIV, or was it talking about HIV and birth control or was it talking about the whole nine?] Yes, the whole nine. [Okay, [interview question] number three how did she give the prevention information to you, conversation and handouts?] Both.

Although the women reported that they received information, none of them had it easily visible during the interview.

Four participants reported seeing or reading something related to HIV prevention in the facility. The most commonly cited resources were posters about HIV, a flier regarding voluntary blood testing, and pamphlets. One participant offered the following comments in response to questions about receiving HIV prevention information, “She [the doctor] gave me information, ah, about birth control. She [the doctor] asked me if I was using birth control and did I want to.” The same participant reported that she noticed the birth control poster on the wall. However, during the observation of the setting and the document analysis of the educational resources, the researcher did not find evidence to support the four participants’ responses. Based on the results of the facility observation, the poster in the examination room did not mention HIV, but it did have descriptions and images of hormonal, barrier, and permanent methods of birth control.

Three participants made contradictory statements in their interviews. For example, one participant stated she [the doctor] did not provide any HIV prevention recommendations, yet later in the session she referred to a recommendation. When asked what recommendations did she receive that seemed like they were good for her to do, she responded with, “Condoms.” This

may indicate the participants were not aware that HIV prevention patient-provider communication was occurring because the provider offered commonly known HIV prevention practices such as using condoms and practicing abstinence.

Instead of receiving HIV prevention from their reproductive health provider, four women stated they received it from other sources (e.g., news, internet, and documentaries). The information they received prompted them to engage in HIV screening. Two of the four participants mentioned the media as information sources. One explained the reason she decided to be tested by stating, “Just reading about it [HIV] and hearing about in the news about all the African Americans, the high percentage, I guess, the percentage of those contracting the disease.” It is important to note a significant source of health information for these women was from popular media.

Effect on action. Participants shared their perceptions regarding the benefits and barriers (i.e., effect on action) of adopting the provider’s recommendation. Question seven asked: “What HIV prevention recommendations did you get that seemed like they were good for you to do? In order to get perceptions about the benefits or barriers regarding HIV screening, question 12 asked, “What factors helped you decide about getting/not getting a HIV test?”

Fifteen women realized the benefits of HIV risk reduction practices (e.g., condom use, monogamy, and screening). Six participants recalled that their reproductive health provider emphasized condom use, abstinence, and birth control. Each of these six women expressed confidence in their ability to perform the protective behaviors. One participant was sure that she could “continue to protect myself” because she was already doing so. When asked if there was anything that she felt she could not do, her response was, “No.” Seven women who did not receive provider recommendations acknowledged they practiced abstinence, used condoms, or

were in a monogamous relationship. The results indicated that a majority (65%) of the participants understood the benefits of preventive practices.

Although most participants did not directly state that fear, stigma or mistrust were barriers to HIV prevention, a few women did admit those concerns. One of the women expressed fear when she stated, “Um (moderate pause) for real, for real I don't like hearing about it. It just freaks me out just to hear about it.” Another participant underscored how fear prevented people from talking about HIV with a provider or getting tested.

I mean I think a health provider should be able to talk to you, but it depends on how comfortable that patient is. ‘Cause you got some people who don't want to talk about it and like, ah no, I'm not taking no HIV test I'm good. And, you know, they never know. And you got some people that's scared to find if they're HIV positive or not.

Another woman compared the stigma of mental illness to HIV/AIDS. She explained:

I know people don't want talk about it, but it is important. It's still like a stigma to it. I mean AIDS has been around for a long time now, you know, when people have relatives and friends that have it. And it's almost like, ‘cause I suffer from mental illness. You know it's almost like that. I compare it to that. You know, I mean forget the stigma, we have to talk about it.

Although not directly addressed as barriers, fear and stigma were obstacles to preventive actions.

For three women, a barrier to requesting a HIV test was the presumption that it was a part of their routine exams. The women only assumed they were tested when other screenings were done. When asked about how often she was screened, a participant stated, “I haven't. Oh wait, they normally do that when they do blood work, don't they?” [Interviewer: “Not unless you

request it.”] “I haven't (Laughed).” Therefore, it was possible the women perceived they were tested even when they were not.

An unexpected finding was the significant influence other sources had on African American women's screening behavior. Fifteen women reported being screened for HIV within the last year, yet no one said it was because the provider recommended screening. The factors contributing to decisions about HIV screening included: HIV information from sources other than their reproductive health provider, personal relationships with people infected with HIV, and concerns about partner infidelity. One participant discussed the impact of her aunt being infected. She said, “it was like a big slap in the face because you knew it was there.” A participant stated she was not at risk for HIV, but later noted the reason for requesting an HIV test was because she was not sure about her husband's fidelity. Regarding her perception of her HIV risk she stated, “I don't have a risk.” But then when asked about what factors influenced her decision to be screened for HIV she stated:

Well, I mean it's my health and even though I love my husband, you know, I can't really trust him. So give me, like a clear conscience knowing that I'm good and I know he's good for now.

Five women explained they did not have the test done because they were: abstinent, in a committed and monogamous relationship, or erroneously believed they had the screening as a part of the routine exam.

Even with only six women receiving HIV prevention recommendations, it was evident the women perceived benefits and experienced barriers to HIV prevention. Condom use and HIV screening were the most beneficial practices based on the number of women who reported engaging in those practices. Most of the participants reported being screened (n=15) however, it

is uncertain if the participants were actually tested or if they erroneously believed the screening was a part of routine lab tests. Because so many of the participants reported the lack of having a discussion with their provider about HIV, it is questionable if the number of women reporting they were screened was accurate. Although the women did not explicitly state fear and stigma as reasons for them not to be screened, they were barriers to women practicing HIV prevention.

Self-Efficacy. In order to explore participants' perceptions regarding how confident they were in their ability to follow the provider's recommendations, question eight asked: "Of the information and/or recommendations you received about HIV prevention during your appointment: (a) what do you feel you can do now? Why? (b) what do you feel you cannot do now? Why not?"

Most of the participants answered they didn't receive any information so they could not respond to question eight. However, the women who received a prevention recommendation felt confident in their ability to engage in the suggested behavior. According to six participants' responses, the providers discussed condom use, abstinence, and birth control as methods to prevent HIV. Of the six women who reported receiving prevention recommendations, all of them expressed confidence in their ability to successfully engage in HIV preventive behaviors. When a participant was asked what she was doing to protect herself, she responded, "Um, the same things I was doing before (laughed)." [Interviewer: "Okay, the same practices, so that was using condoms?"] "Um hum and now birth control." Even seven of the women who reported not receiving a provider recommendation stated they were confident in their ability to use condoms, limit the number of sexual partners and maintain monogamous relationships. None of the respondents stated there was something that they felt they could not do now.

The six women who reported receiving recommendations from their provider felt confident in their ability to implement the suggested practices. Even though eight women reported using a condoms or receiving a recommendation to use condoms, nine participants reported lack of consistent condom use on the demographic portion of the interview instrument. This finding demonstrates a noteworthy gap between knowledge and practice. Overall, the women seemed to be confident that they could engage in prevention, but they lacked the desire or skills to actively incorporate the preventive behaviors into their lives.

Document Analysis Results

Document Review Process. At the beginning of the study, the researcher obtained the educational resources which providers may offer to the study participants during their reproductive health visits. The patient education materials were obtained from the health educator, the educational file located in the reproductive health suite, and the waiting areas. Although educational materials covered a variety of topics, only those related to HIV received critical review. The researcher used the Coding Checklist (Appendix J) to review three written educational resources. When obtaining the documents, the researcher learned the physician referred patients to the health educator for patient education after the confirmation of a sexually transmitted infection. However, the nursing staff confirmed that the physician served as the primary patient educator during reproductive health visits.

Analysis of the Educational Resources. Three HIV/AIDS educational documents available to patients were analyzed (Appendix K). The documents included a booklet, a magazine, and a handout. Collectively, the documents contained messages about the definition of HIV/AIDS, ways HIV is spread, HIV screening and practices to lessen HIV transmission including using condoms and pre-exposure prophylaxis. Other prevention techniques mentioned

were: intravenous drug cessation, safer needle practices (i.e., using clean needles and using bleach to clean needles), and monogamous sexual behavior with a partner with confirmed negative HIV status. All of the resources advised the reader to seek the counsel of a healthcare provider. Each of the resources included diverse ethnic and gender representatives. Following is a description of each resource:

(1) The booklet, “*Anyone Can Get HIV and AIDS*” was provided by the Virginia Department of Health. The booklet had a red and white cover with black and white pencil typed sketch drawings of a group of multi-ethnic men and women. The purpose of the booklet was to provide very basic information regarding HIV/AIDS and to encourage condom use, intravenous drug cessation, and HIV testing. It also included sections that reviewed and dispelled myths regarding HIV transmission and the physical appearance of someone who had HIV. This booklet was the only resource that was written in English and Spanish and the only one with contact information for other resources, specifically the toll free number and website address for the Centers for Disease Control and Prevention.

(2) “*POZ*” is a contemporary style magazine that is geared to promoting healthy living among HIV positive individuals. It is a magazine filled with advertisements for medications for HIV prevention and disease as well as the treatment of side effects associated with HIV medicines. The articles are filled with personal stories of individuals who themselves or their loved ones have HIV disease. The October/November 2014 issue focused on stories shared by homosexual men and the controversy surrounding PrEP (pre-exposure prophylaxis). Other stories focused on overcoming the criminalization of those living with HIV. Throughout the magazine,

pictures of males, females, families, groups and a few inanimate objects such as gavel, a broken glass and mural appeared. Overall, the magazine seemed geared to education for those living with HIV and showing the issues people living with HIV face daily. It did not have a depressed tone, but it did present the realities of the disease through the articles and pictures.

(3) “HIV Infection and Women” is an educational handout produced by The American College of Obstetricians and Gynecologists (ACOG). It extracted information from the ACOG website and the printed date was January 3, 2003. The topics addressed how HIV is transmitted, methods of detection, and the effect on pregnancy. Pictures of women, a female provider, a lab screening, and how to use a condom were featured. However, no contact numbers for referral to testing centers or to get more information were included. A section was provided with information about how to re-order the pamphlet from ACOG.

A significant lack of resources was noticeable. Although the three educational resources were available to the participants, none of the women reported receiving these documents from the provider. Only one woman mentioned that she noticed POZ in the waiting area. Three women reported receiving handouts, yet the investigator did not see any information in their possession when they were being interviewed. Not one of the women offered to show the information during the interview. Comments from a few women also supported the idea that birth control methods other than condoms could be viewed as HIV prevention.

Observation Results

Observation Process. In order to identify any HIV prevention information available to study participants, the researcher conducted an observation of the medical office’s main and

overflow waiting areas as well as the reproductive health exam rooms. Prior to visiting any of the areas, the researcher created a field journal memo regarding what was expected to be accessible. At the beginning of the study, the researcher walked in, sat, made notes and took pictures of each of the areas when they were unoccupied. The notes included a description of the materials and equipment in the area. For example, the main waiting area had a television playing the current popular generic news. In addition, there were many patient education pamphlets with a variety of topics such as the early detection of cancer, diabetes, cards for pharmacy assistance programs, and prenatal information. After the observation of the area, the researcher completed a descriptive and reflexive memo detailing the areas. The findings from the observation of the settings were used along with the participants' interview transcripts to further answer the research questions.

Observation of the Waiting Areas. Two waiting areas accommodated reproductive health patients (Appendix L). The larger waiting area had a TV that stays on the CNN channel. It featured all of the top stories of the day, not just health information. Numerous magazines and patient education material are placed on a large table about 2-3 feet away from the seating area. The health and non-health magazine titles included: *Guide to Diabetes*, *Parents*, *Coastal Virginia*, *POZ: Health, Life & HIV*, *Pregnancy*, *Pregnancy and Born*, *Family Fun*, *The Voice and People*. The one magazine that specifically addressed HIV/AIDS was *POZ*. The cover of the magazine has an African American male with a caption reading, "*PrEP Pride-Coming out about pre-exposure prophylaxis*". According to their website, the mission statement for *POZ* is "POZ is an award-winning print and online brand for people living with and affected by HIV/AIDS. Offering unparalleled editorial excellence since 1994, *POZ* and *poz.com* are identified by our readers as their most trusted sources of information about the disease" (*POZ*,

2014, para.1). Additionally in the larger waiting room, health education pamphlets, health service fliers, and business cards were available. None of the educational pamphlets or fliers included anything specifically addressing HIV/AIDS. Above the table were two bulletin boards that displayed information about food safety and healthy pregnancy.

The smaller waiting area was located across from the offices for the Pharmacy Assistance Program Coordinator and the Spanish Interpreter. The smaller area had a few copies of a variety of magazines on a turn style magazine rack. The magazine titles were: *American Baby*, *Parents*, *Cosmopolitan*, *Coastal Virginia* and *Family Fun*. Framed art with pictures similar to Anne Geddes babies were on the wall above the chairs. Prior to the obstetrics program closure, the area was used for prenatal patients. During the time of the observation, the nurses used the waiting area to seat patients as they waited to see the doctor after completing their physical assessment. No literature in this area specifically addressed HIV prevention.

Observation of the Examination Rooms. The reproductive examination rooms contained reproductive health information including a small model of the uterus and a poster of contraceptive methods. Other patient-centered information included a flier with a statement regarding the right to service regardless of the ability to pay, a flier encouraging patients to bring all medications to their appointments, and other fliers regarding flu prevention, colon cancer screening, and voter registration. A bulletin board with wellness information was on the wall (Appendix M). The bulletin board contained information about smoking cessation, weight management, healthy eating, physical activity and blood pressure, cholesterol and glucose management, and a listing of available services at the health facility. The services included: free health education services, nutrition/weight loss counseling, diabetes education, breast health

services, smoking cessation education and family planning information. Other posted information included a calendar and BMI chart.

The purpose of the observations was to examine if HIV prevention information was available to women even if the provider did not have a conversation or give educational literature. Based on the participants' comments and researcher's observation of the facility, limited prevention information was available to the women. Only one participant mentioned the title of an educational resource. When asked did she see or read anything about HIV prevention in the facility, she mentioned POZ, but explained it was about HIV disease not prevention. Bulletin boards and literature display stands in the waiting areas and exam rooms were major potential areas to post basic information about HIV prevention as well as resource information. The areas had information about chronic health conditions, health services, and general wellness tips, but not HIV prevention. Based on participants' comments, many of them did pay attention to television advertisements and educational shows.

Summary of the Study Findings

Data collected using face-to-face interviews, observations of the facility settings, and a document analysis of educational resources provided a comprehensive examination of how urban, historically underserved African American women, ages 20 to 44 perceive HIV prevention communication with their reproductive health providers. The primary source of the findings was the face-to-face interviews. Findings from the interviews were supported by the observation of the facility and the document analysis. Table 7 documents the participants' perceptions of patient-provider communication. All data were reviewed to identify the key themes.

Table 7

Participants' Perceptions Regarding Patient Provider Communication

Data Collection Source	Participant Response <i>n/N (%)</i>	
	Yes	No
Interview		
Received HIV prevention recommendation (verbal or written) from provider	6/20 (30)	14/20 (70)
*Verbal	3/6 (50)	
*Written	1/6 (17)	
*Verbal and Written	2/6 (33)	
Expected to receive HIV recommendation	9/20 (45)	11/20 (55)
Received HIV information from sources other than reproductive provider	7/20(35)	13/20(65)
Wanted doctor to share HIV prevention information	12/20(60)	8/20(40)
Observation of waiting area and exam room		
Did see or read HIV prevention information	4/20 (20)	16/20 (80)

Note. * N= number of participants who received provider recommendations.

Most of the participants reported they did not receive any HIV prevention recommendations or cues to action from their provider during their reproductive health visit. Unfortunately, the facility observation and document analysis supported the lack of communication through those sources as well. Because there was little evidence that communication occurred among the participants and their reproductive health provider, no data supported if provider communication influenced participants' personal perception of HIV risk or self-efficacy regarding preventive behaviors.

Identified Themes

In this study, the cues to action were linked to three of the five research questions because they influenced the threat of perception, effect of action, and likelihood of engaging in HIV preventive behavior. During the reproductive health appointments, cues to action included the exchange of verbal and written HIV prevention information between the reproductive health

provider and the study participants. Most participants reported they did not receive any HIV prevention information. After reviewing the interview transcripts, conducting observations within the facility setting and analyzing educational documents, four key themes emerged. The key themes were: (1) lack of expectation to receive information (2) failure of reproductive health providers to initiate and offer information; (3) desire for reproductive health providers to share prevention information; and (4) recommendations regarding how providers should provide HIV prevention information. Figure 3 illustrates the number of participants who mentioned each theme during their interview. Fear/stigma and partner infidelity were not included in the major themes due to fewer than 10 participants acknowledging those topics.

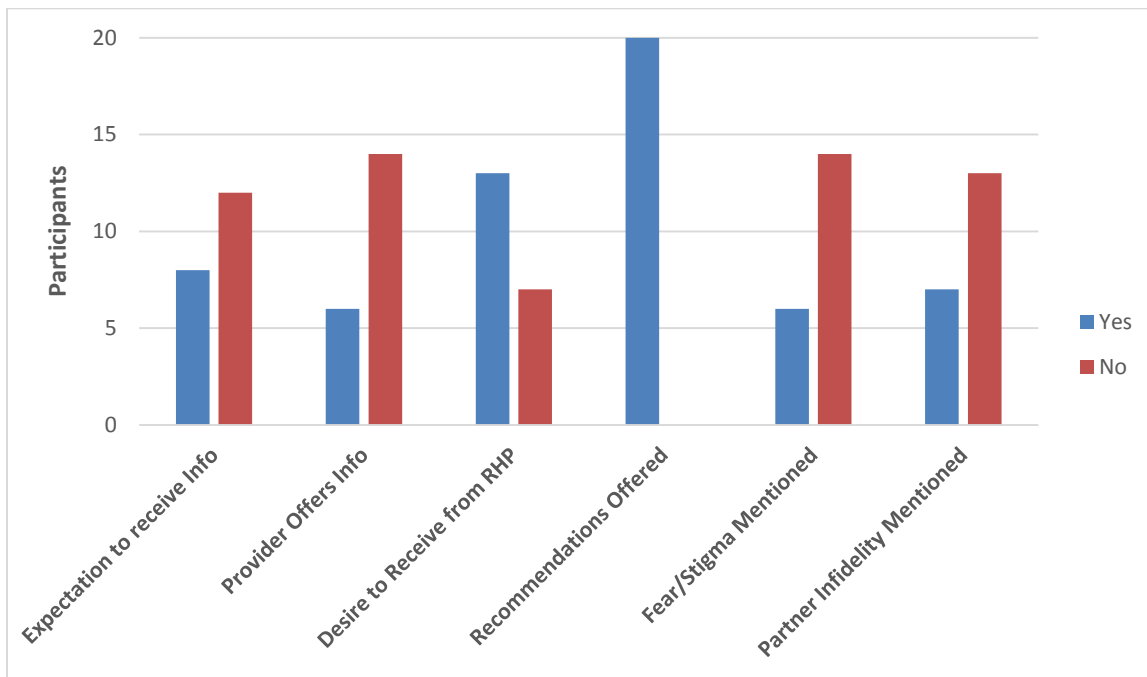


Figure 3: Graphic representation of the major themes.

A discussion of each theme follows:

Patients’ Lack of Expectation to Receive Information. Eleven participants did not expect to receive any HIV prevention information during their reproductive visit. Eight of the women responded none to the interview question regarding what type of HIV prevention they

expected when they came for the reproductive health visit. Only three women offered explanations for why they did not expect to receive any information. The main reason was because HIV prevention was not the purpose of the appointment. One participant said, “I don’t know, nobody told me nothing and I didn’t expect nothing.”

Failure of Providers to Initiate and Offer Information. Most participants perceived that providers did not start conversations about HIV or offer any prevention recommendations. Fourteen women stated they did not receive any information from their reproductive health provider orally or through educational handouts. One woman shared how she thought providers should address HIV prevention. She stated:

I believe that no matter what a patient comes to see the doctor, the provider or nurse about even if it's just seeing the assistant or LPN it should just be more generally suggested. Like, I feel like the doctors and healthcare providers they should be like more sensitive and just ask, like you know, everyone has sex. They should be like hey are you sexually active? Just keep it casual like don't put people on the spotlight. And just like if people are having sex and if they are having multiple partners that's just their job to be like are you being safe? When was the last time you got tested? Like ask questions. But from today's visit I'm not really I'm not trying to throw them under the bus, but from my today's visit nobody asked me.

The six participants who did report receiving a recommendation stated they received the information both orally and written. Of these six, two of them acknowledged their family, friends, and career training as personal sources for HIV information. The influence of a provider’s recommendation on HIV preventive behavior is evidenced by a participant who when asked why she thought she could follow the doctor’s recommendation to be in a monogamous

relationship and to use protection, replied “Um, cause it’s recommended.” Another expressed that she began self-evaluation after the provider asked her a question. Another participant voiced her desire for patient-provider communication when she responded to the interview question regarding what topics she wanted the doctor to share with her about HIV prevention. She replied, “All of them, um, if he is willing to talk to me about them.”

Based on the report of most participants, they did not receive any cues to action from the provider nor did they observe any HIV prevention information in the facility. To underscore the significant role that information plays on influencing personal behavior, the women highlighted how getting knowledge from other sources prompted them to get screened. Because most of the participants acknowledged being comfortable or very comfortable with their providers, there appeared to be missed opportunities for patient-provider communication.

Patients’ Desire for Providers to Share Information. Even though participants reported having sources for HIV information, 60% of the women (n=12) expressed a desire to receive information from their reproductive provider. The participants wanted their provider to share basic information about transmission, prevention, screening and treatment. One participant highlighted the lack of HIV education in schools as a reason for providers to promote HIV prevention. She said, “Well, I think ... pamphlets and talking to them ‘cause the way they are doing it in schools now, I don't think they should do it like that.” However, she did not offer an explanation of how students received HIV prevention information in schools.

Most of all, the women wanted the provider to be sensitive and open about HIV prevention. One participant addressed the desire for sensitivity, anonymity and referral to other services in her comments.

She said,

Ah, just your general information like, you know, continue having safe sex or what could cause, um, HIV/AIDS what could lead up to it. You know, not only sex but, you know, doing drugs, dirty needles, everything. And, like, I guess for other patients or patients in general, just a suggestion like where to go if you don't want to see your doctor, like, other clinics. Um and then I don't know I feel like doctors shouldn't just be, like, inhumane just seeing us like as a subject or their next client. They should be, like you know, everyone's human. It should be more personal, more friendly, more sincere. [Interviewer: Gotcha. Okay. One question I have for you. So you were saying, um, maybe give referrals to other clinics and things of that nature? Are you talking about to get condoms or to get tested or what?] Um, like you know, clinics like to get tested, to get condoms and everything just in case they don't want to come to your doctor to find out. [Interviewer: To feel more comfortable?] That way it's more anonymous.

Patients' Recommendations and Preferred Methods for HIV Communication. All of the participants provided recommendations for providers describing preferred communication methods. The suggested approaches were to use traditional techniques (e.g., pamphlets, posters, and bulletin boards), social media, and public events to educate and screen women. Many of the women addressed the need to make the HIV prevention information relevant and accessible in a variety of forms. One woman said,

Um, (pause) try to relate it to their everyday life. Like maybe give them a visual as to why it would be important, important for them to do. Um, have more literature about it to educate them. Just make it a comfortable conversation for them to have. [Interviewer: It sounds like you are saying when you come in for a health appointment just like you

talk about birth control, weight, blood pressure that kind of stuff just add it {HIV prevention} in?] Yeah, um hum, make it simple.

One woman responded,

Um, I think with women in my age group it could just be shared verbally or even just ask do you have any questions or concerns about HIV and maybe share some facts about HIV and how they are affecting people today and just given this information that I shared with you about HIV do you have any questions about women in your age group.

Another participant included comments regarding the need to educate women regardless of their ability to pay. She said,

I think they should share it with them verbally, you know, cause a lot of people can't understand, read, write and then stuff like. Explain what risks they are at, you know, just being sexually active period it doesn't matter if it's unprotected you just had it period. I think it should be that opportunity that it be shared with everybody. It should be afforded to everyone regardless. Whether I'm paying or not, on a sliding scale whatever the case may be I think it should be across the board.

Other recommendations included hosting public gatherings for education and screening.

A woman from the 25 to 29 year old age category said, "Um, (long pause), I guess health fairs, commercials, um, health events, commercials and doctor visits, women's health exams." A few women encouraged the use of social media. One participant shared an example of how to use social media. She responded, "Now I would think more text messages. Everybody be on their phone text messaging, Facebook, Instagram, Twitter. I think they should at least get a text message from your doctor...once a month." In regard to relevance of HIV prevention information, one participant said,

I feel like they should make it interesting to learn and read about. Sometimes you just think you get HIV and if you get it then you are going to die or something like that. I think they need to make it more, I don't know how to put it, more understanding.

Two respondents mentioned offering HIV screening along with education. One offered the following recommendation:

Group meetings. [Interviewer: Okay, so tell me how a group meeting would work. Is it just have, um, like say one Friday from 4 to 6 [pm] offer pizza and do testing and information, what do you think?] Yeah, I mean like cookies per se. [Interviewer: Okay, something light? Like a little light refreshment.] Yeah something light. It doesn't have to be expensive and I'm pretty certain a lot of people will come out because there is a lot of people and it's a free test. A lot of people who don't have insurance and they do want to come and take the test but they don't have the money to take the test; they will come out and they can be more educated and get more knowledge.

The participants provided a variety of recommendations for the providers with most of them centered on the provider having a conversation with them about HIV prevention.

Summary of Results

The results from the interviews, observation of facility setting and document analysis were used to provide answers to the research questions. Overall, most women did not expect to receive any HIV prevention information nor did they perceive that the provider offered any. Additionally, the results from this study highlighted that many of the participants wanted their provider to share some type of HIV prevention information with them during their reproductive visit. Of the three educational documents that were obtained during the observation of the facility, only one participant mentioned observing one of them. During the observation of the facility waiting areas and reproductive health examination rooms, the researcher observed the same document as the participant. The other two documents were located in a hanging wall file near an office in the reproductive health suite and in a display stand in the health educator's office.

Four key themes that emerged from the study were: (1) lack of expectation to receive information; (2) failure of reproductive health providers to initiate and offer information; (3) desire for reproductive health providers to share prevention information; and (4) recommendations regarding how providers should provide HIV prevention information. The findings supported African American women's perception that there is little to no HIV prevention communication with their reproductive health providers. The results highlighted that there may be missed opportunities for reproductive health providers to offer HIV prevention information to women at greatest risk.

CHAPTER 5

DISCUSSION

This qualitative study explored African American women's perceptions of HIV prevention communication with their reproductive health providers. From the data analysis of participant narratives, observation of settings within the primary care clinic and document analysis of educational resources, four key themes emerged: (1) lack of expectation to receive information (2) failure of reproductive health providers to initiate and offer information; (3) desire for reproductive health providers to share prevention information; and (4) recommendations regarding how providers should provide HIV prevention information. The themes highlighted the need to strengthen the current process of patient-provider communication as a way to reach women who are most adversely affected by HIV disease. In this study, clear indications that the women desired to receive information emerged, yet providers missed prime opportunities to initiate and offer it during routine reproductive health visits. The findings from this research can be used to inform best practices in designing, implementing and evaluating patient education protocols to help facilitate reproductive health providers to seize the opportunities to address HIV prevention in this highly vulnerable group.

The discussion chapter is organized into these sections: (1) relationship of the Health Belief Model to the research questions; (2) responses to the research questions; (3) recommendations for practice; (4) study limitations; (5) future research; and (6) conclusion.

Relationship of Health Belief Model to Research Questions

Each of the research questions was linked to the Health Belief Model. Three of the research questions were directly linked to the constructs of the Health Belief Model. Research question one examined the individual's perception of threat (e.g. perceived severity and susceptibility). Research question two explored the participant's effect on action (e.g., perceived benefits and barriers to the provider's recommendation). Research question four investigated the influence of the cues to action on a participant's intent to engage in the recommended action. Research question three was indirectly related to cues to action and examined if the participants expected to receive any prevention information. Research question five explored participants' suggestions of how reproductive health providers could effectively offer HIV prevention information.

After linking the Health Belief Model constructs to the collected data, the researcher drew the following conclusions. First, most of the participants reported they did not receive any HIV prevention recommendation (i.e., cues to action) from their provider during their reproductive health visit. Unfortunately, the facility observation and document analysis supported the perception of very limited patient-provider communication occurring. However, the participants received recommendations from sources other than the providers. Secondly, because there was little evidence that patient-provider communication occurred, there was also a lack of evidence to indicate the amount of influence that communication had on participants' personal perception of HIV risk, the effect on action or self-efficacy. However, this study did

reveal that women wanted to receive HIV prevention information from their providers. The research also pinpointed that when women received a provider recommendation they felt they could successfully incorporate it into their lives and intended to do so. Based on the women's responses, the researcher concluded the Health Belief Model constructs is relevant and applicable for developing an effective protocol for HIV prevention patient-provider communication.

Linking Responses to Research Questions

Research question one. "What HIV prevention information, if any, do urban, historically underserved, African American females with unknown HIV status receive from reproductive health providers to influence their perception of personal susceptibility and severity of HIV?" The purpose of the question was to examine the participant's perspective about the threat of being infected with HIV as well as the potential consequences of having HIV disease.

Despite the alarmingly high HIV morbidity and mortality rates for African American women of childbearing age, 14 of the women in this study perceived their risk for HIV infection was nonexistent or very low. They reported having a low perception of HIV risk prior to their reproductive appointment and stated they did not receive any information during the appointment that made them think any differently. Due to the lack of patient-provider communication about HIV, most of the women did not consider their personal HIV risk even after the reproductive health visit. Nunn et al. (2011) pointed out the significant gap between perceived and actual risk perception which is a finding supported by this study.

Many of the women's narratives and nonverbal cues alluded to their discomfort with evaluating personal risk. It was as if the women felt less susceptible to HIV because they were not considering their risk behaviors. Younge, Salem and Bybee (2010) found that women in

their study had sexual optimistic bias, “the tendency to view themselves as less likely than others to experience negative life events related to sexual behavior” (p. 67). The findings from this study support the sexual optimistic bias concept. In order to reduce the health disparity experienced by this priority population, providers may need to identify ways to communicate about risk behaviors.

Most of these women seemed to believe they were at a decreased risk for HIV because they perceived they were in monogamous relationships. Participants would mention being in a monogamous relationship; yet, later in the interview they would express their concern about their partner’s faithfulness. This finding of low perceived risk by those in committed relationships is supported by the literature. Anabere et al. (2013) found that African American women perceived their risk as low and used condoms less when participating in a committed relationship. McLellan-Lemal et al. (2013), found there was evidence that African American women had low perceptions about risk even when they realized their partner’s behavior may contribute to being infected with HIV. The researchers emphasized African American women recognized and to some extent accepted that their male partners would cheat. Even when aware of this risk, the researchers acknowledged the study participants were not willing to use condoms.

Research question two. “What HIV prevention information, if any, do urban, historically underserved African American females with unknown HIV status, receive from reproductive health providers to influence their perception of benefits and barriers when considering engaging in HIV preventive behaviors?” The purpose of this question was to examine what recommendations seemed beneficial and to identify any obstacles to implementing the recommended actions.

The six participants who received recommendations felt the advised action was beneficial. The most commonly cited recommendation was to use condoms. Even though the participants did acknowledge that the providers offered the HIV test, most participants were screened within the year which indicates they perceived it as beneficial. What was unclear about the testing practices was if the provider offered the test and the women failed to recognize that as a cue to action or if the women believed they were being tested as a part of the routine exam. Burke et al. (2007) conducted a review of the literature regarding physician testing practices; more specifically, which barriers kept physicians from testing patients for HIV. The findings revealed a greater level of hesitancy about testing on the part of the providers, not the participants.

A few participants in this study mentioned that people do not get tested because they are afraid that someone will find out if the test is positive. This finding was supported by Bond et al. (2005) when they admonished future researchers to consider barriers to HIV testing, including personal concern about the loss of anonymity regarding testing and the process of mandatory name reporting of test results to health officials. The women in the current study recognized the benefits of using condoms and being tested, yet they acknowledged fear and stigma as barriers to HIV preventive behavior, including screening. The current study found physicians have prime opportunities to address these fears and offer information to promote screening and the benefits of early detection and treatment.

Research question three. The third question was, “What HIV prevention information, if any, do urban, historically underserved African American females with unknown HIV status, expect to receive from reproductive health providers?” The purpose of the question was to

examine if participants anticipated receiving HIV prevention information from their provider during their reproductive health visit.

More than half of the participants did not expect to receive anything from the providers. Only a few of the participants commented as to why they did not expect information. They responded that they did not expect information because it was not the purpose of the visit. Based on the lack of details from the majority of the participants, it is difficult to identify clearly articulated reasons for their lack of expectation.

Seven participants mentioned they received HIV information from other sources, thus another reason for the lack of expectation could be because of feeling they already knew what they needed to know regarding HIV prevention. This finding was supported by Young et al., (2010) who noted that women receiving social services including services at health agencies may be exposed to HIV prevention information.

Research question four. The fourth question was, “How does provider communication with urban, historically underserved African American females with unknown HIV status, influence their intent to engage in HIV preventive behaviors including screening?” The purpose of this question was to assess the influence of provider’s recommendations on participants’ preventive behaviors.

A majority of the women reported they did not receive HIV prevention messages from their provider. However, those who did stated they felt comfortable and capable of engaging in the recommended preventive behavior. A study conducted by Bond, Lauby and Batson (2005) demonstrated the need for HIV testing to be encouraged in primary care settings. When specifically looking at the women participants, who were mostly African American, the researchers found most of those who had not been tested for HIV were never asked by their

providers to be screened. Even though men and women participated in that study, it is important to note that most of the study participants explained they would have taken the test if their provider recommended it. Also, the researchers acknowledged the need to focus on promoting HIV screening to women who would not receive prenatal testing. In other words, providers needed to focus on offering HIV tests to women who do not want to experience childbirth or those who are past their childbearing years. This study supported the findings by Bond et al. (2005).

Research question five. “What recommendations do urban, historically underserved African American females with unknown HIV status offer regarding how reproductive health providers should provide HIV prevention information?” The purpose of this question was to receive suggestions from the participants regarding how they would like for the provider to communicate with them.

All of the participants responded to this question. The women wanted to receive information from their providers primarily via conversation during reproductive health appointments. Other ways they wanted to become informed were through a variety of conventional methods such as pamphlets, television, bulletin boards, and social media. Most of the women stressed the need for the provider to just talk to them as people. Suggestions included providers should ask if a patient wanted to be screened or if they would like to talk to someone about HIV prevention. Comments from a few participants encouraged the provider to have a conversation about the risk associated with partner infidelity. Many of the women who asked for a dialogue stressed the need for provider sensitivity (i.e., treat as a human, notice when a patient is uncomfortable discussing an issue). They also wanted the provider to offer education via

traditional methods (i.e., pamphlets, posters) if the participant seemed uncomfortable during the discussion.

Most participants recommended the provider should use traditional methods such as bulletin boards, pamphlets, television commercials, DVDs and posters to educate everyone, not just African American females, about HIV prevention. A few women stressed providers should not 'single out' a specific group, but make the information available to everyone. Lastly, two participants asked for social media to be used to promote HIV education. One participant stated the provider should send a health fact to patients at least once per month via text message.

Regardless of the method of communication, it was obvious that the participants wanted their providers to make HIV prevention information accessible. It is important to note that King and Pate (2013) found African American women esteemed the written health information they received from providers. They valued the information because it made them aware and helped them to process health information. Even though the study participants in the King and Pate study were low income African American women who were pregnant or within a year of delivering an infant, the finding was consistent with the findings in this study as well.

Recommendations for Practice

In order to lower the burden of HIV infection among African American women, a variety of multilevel interventions are needed including utilizing a culturally sensitive approach to patient-provider communication. Findings from this study reinforce the need for reproductive health providers to offer multiple strategies to reach urban, historically underserved African American women. Based on the participants' comments, the best model should include addressing their desire for information and treating them as people. Participants made comments about being treated humanely and not as a number. The women also commented about the need

for the reproductive health provider to be sensitive when inquiring about or offering information about HIV preventive behaviors. Additionally, based on the findings, the provider needs to incorporate HIV prevention information and screening opportunities as a part of routine reproductive care. According to Epstein et al. (2005), patient-centered communication includes the following:

- (1) eliciting and understanding the patient's perspective-concerns, ideas, expectations, needs, feeling and functioning;
- (2) understanding the patient within his or her unique psychosocial context;
- (3) reaching a shared understanding of the problem and its treatment with the patient that is concordant with the patient's values;
- 4) helping patients to share power and responsibility by involving them in choices to the degree that they wish (p. 1517).

Furthermore, according to Epstein et al. (2005), the patient-centered communication model has four constructs: (a) patient factors (e.g. perceived severity, socioeconomic status, assertiveness, and expectations), (b) health system factors (e.g. access to care, choice of physicians, and courtesy of staff), (c) clinician factors (e.g., personality knowledge, risk aversion, patient-centered orientation), and (d) relationship factors (e.g., concordance of beliefs/values, trust, and duration of relationship) (p. 1517).

In the current study, participants' comments can be linked to each of the communication model's constructs. During the face-to-face interviews, the respondents described several of the model's patient factors (e.g., perceived severity of illness, socioeconomic status, and personal expectations). Other patient characteristics associated with the study were assertiveness and culture. A few of the participants mentioned health system factors. They commented about

being frustrated with the wait time for the health visit, concerned with access to healthcare, specifically health insurance coverage, and expressed the desire to receive electronic communication. Some respondents addressed clinician factors when they discussed the level of comfort with the provider and the need for the physician to acknowledge them as people and not just patients. Relationship factors were not directly examined in this study, but those observed were duration of their relationship with the provider and racial concordance. By aligning findings from the study to the factors of the patient-centered model, a tailored approach to the model by Epstein et al. (2005) is recommended for providers to communicate with African American women during reproductive health visits.

Participants shared their perceptions of the significant patient, health system, clinician, and relationship factors which impacted patient-provider communication. The patient factor addressed in this study was self-efficacy. The women who received prevention recommendations from the provider believed they could confidently implement the HIV risk reduction practices. In regards to the health system factors, the amount of time waiting to see the provider was a concern. As for the clinician factors, the women expressed a desire to have providers who treated them humanely by viewing them as individuals and providing relevant HIV prevention information through pamphlets, posters, and educational television documentaries. In order to enhance the patient-provider relationship, a few of the participants suggested utilizing methods such as electronic communication and social media for patient-provider communication.

The researcher suggested modifying the Epstein et al. (2005) model to incorporate the recommendations of the priority population. The tailored model would utilize the

recommendations of the participants with the constructs of the original patient-centered model to create opportunities for patient-provider communication (Figure 4).

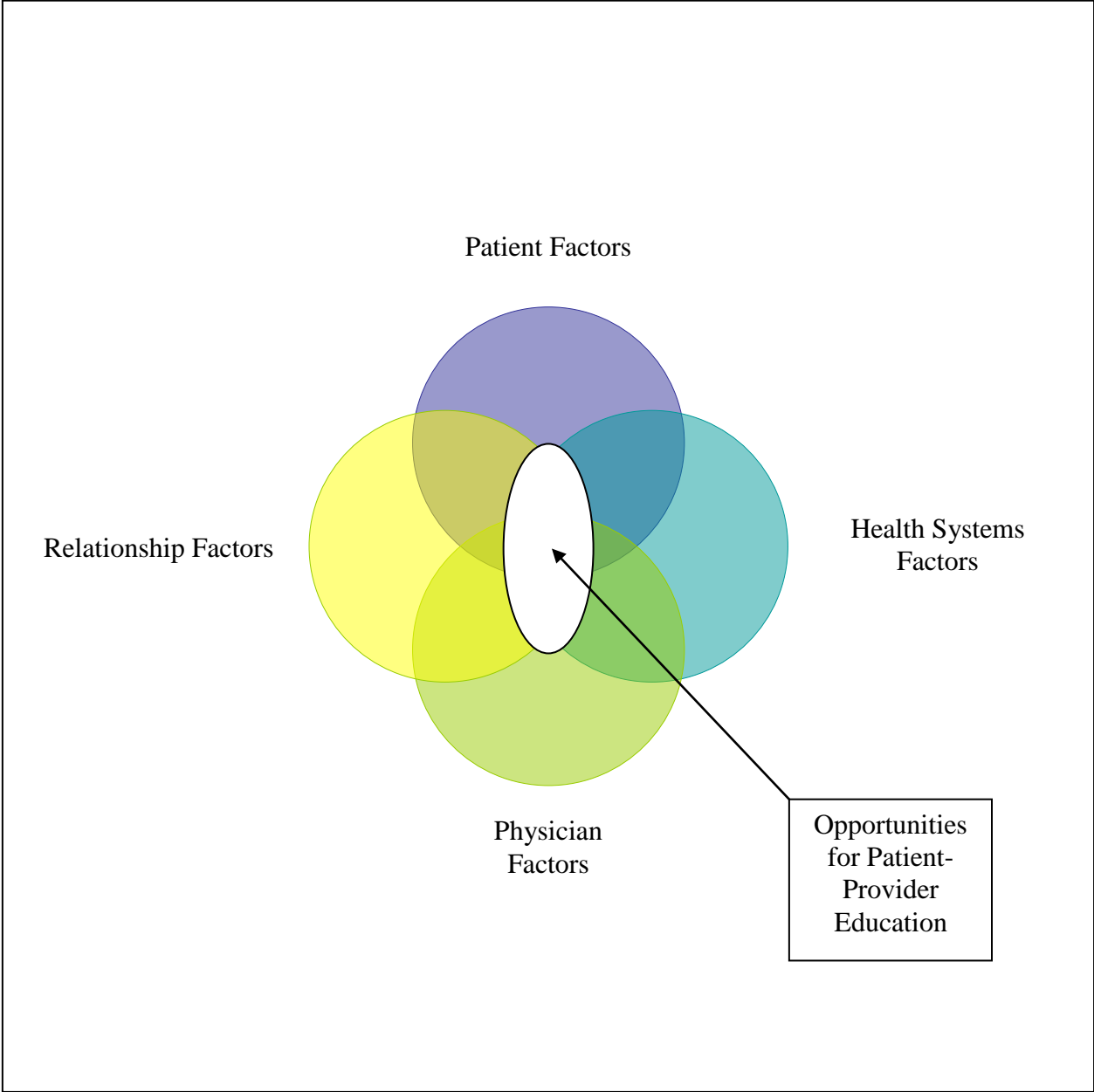


Figure 4: Tailored Patient-Centered Communication Model for HIV. This figure demonstrates the optimal opportunity for providers to deliver HIV prevention information at times and in ways that the patient is most likely to receive.

Waiting time between arriving for the appointment and seeing the doctor is an opportune time for women to be educated about illness severity and access to care. Education could occur in multiple methods. Traditional techniques such as posters, bulletin boards, pamphlets and televised documentaries can be accessible in the waiting areas. During the nurse's assessment, questions can be included to identify if the patient would like information about general topics such as blood pressure, cholesterol, smoking cessation, weight reduction and more specific gynecologic information such as birth control options, STIs including HIV, as well as breast, cervical, and ovarian cancers. The reproductive health provider can address any of the patient's concerns as revealed and documented during the nurse's assessment. Additionally referrals may be made to other resources within and outside of the facility such as the health educator, nurse educator, or an outside social service agency. If patients have a lengthy wait, they could be escorted to a resource room with accessible educational resources or the patients could use that time to meet with the health educator, reproductive health nurse educator or case worker.

Trust is known as an integral component of an effective patient-provider relationship. Providers may seize a variety of opportunities to communicate with their patients. Reproductive health providers may establish rapport with patients by affirming the nurse's report with the patient. When in the exam room, the provider can acknowledge the requests for information and provide as much information on that topic as feasible. The provider can ask if there is something specific within the requested topic that the patient is most concerned with and then address it.

Additionally, HIV screening can and should be promoted as a part of the routine gynecologic lab work. At the conclusion of the appointment, the provider can offer a reproductive health packet which may include general health information, birth control and HIV/STI prevention literature, condoms and lubricant, an explanation regarding how to negotiate

condom use, and a list of health, social and community service resources. Since the respondents reported wanting to receive health information through electronic communication, providers can connect with patients on a consistent base (e.g., monthly) via text and email. The electronic communication can also be utilized to establish and enhance rapport and while providing education to the women.

In summary, the patient-centered model can be tailored to address the needs and desires of this historically, underserved group of African American women. The key considerations of the model are: (1) initiate a conversation about HIV prevention including screening a part of routine care; (2) provide information in a way that reduces stigma and fear about HIV and emphasizes the benefits of early detection, (3) ask the patient what information does she want and actively listen to the patient; (4) utilize wait times to offer prevention information through traditional methods and referral to health educators; (5) maintain consistent contact with patients who elect to receive healthy living information on a regular basis. Based on the results from the data collected and the four key themes that emerged, this model will advance the patient-provider communication process. Realizing cost may be a factor impacting what an organization can and will do, this tailored model is one that can be implemented on a smaller scale and still be effective at reaching women at greatest risk for HIV.

Study Limitations

Interpretation of the study results must be conducted in light of considering its limitations. Realizing the purpose of qualitative research is to gain a deeper understanding of the respondents' lived experiences, the study used a purposive sample (Patton, 2002). Yet, a few limitations were related to the sample. One limitation was the sample size of 20 participants. However, in order to minimize threats related to sample size, the study was designed to recruit

enough participants to reach theoretical saturation. Another limitation was the participants' self-reported sensitive sexual health information. Hobffoll, Jackson, Lavin, Britton, and Shepherd, (1993) had a similar concern, but noted self-reporting about sexual behavior was “reasonably dependable” (p. 487).

Another limitation was that all of the women received service from the same urban, primary care facility which serves a high percentage of low income patients. Most of the women received routine reproductive health care from the one gynecologist, two internal medicine doctors, and one nurse practitioner on staff. Therefore, the findings from this study may be limited when trying to generalize to women who: (a) do not seek reproductive health services, (b) receive reproductive care at other types of health facilities with multiple reproductive providers, or (c) live in rural or metropolitan locations.

Having only one researcher is another limitation of the study. In order to lessen the threat of bias, the researcher used interviews and two additional methods: (a) observation of the setting and (b) document analysis. The researcher also kept a field note journal to capture thoughts and insight during the study. Lastly, the researcher used two peer debriefers to help ensure the fidelity of the findings.

Future Research

Even though there are studies that address African Americans and HIV prevention, there is a dearth of qualitative studies to explore African American women's perceptions regarding HIV prevention with their reproductive health providers. This study attempts to help fill this gap by providing a rich and often unheard description of patient-provider communication as experienced by historically underserved African American women. Based on the findings from this study, topics for future study include: (a) why women lack the expectation to receive HIV

information from reproductive health providers, (b) what is their current level of awareness regarding HIV prevention including knowledge regarding screening, (c) why do they perceive themselves at low risk for HIV even when participating in moderate to high risk behaviors, and (d) what barriers do they face that lessen or negate their intent to implement the reproductive health provider's recommendations.

In order to further explore HIV prevention patient-provider communication among African American women and their providers, researchers may consider utilizing a mixed methods research design. A survey instrument may be utilized to examine African American women's attitudes, beliefs, and knowledge of HIV. Based on the results of the survey, researchers could utilize focus groups or interviews to probe further about how their perceptions influence their preventive behaviors. Because of the high rates of HIV disease in certain communities, it would be beneficial to recruit participants from communities with high rates of HIV disease. A future researcher may gain deeper insight by including women who report their HIV status as unknown or negative and receive reproductive health services at a variety of medical facilities (e.g., community health centers, physician's offices, and public health departments). Additionally, the study could include interviews with the reproductive health providers of the study participants to identify what facilitates or hinders the provision of HIV prevention information to African American women in order to gain an in-depth perspective regarding patient-provider communication.

Conclusion

Results from this study supported the CDC (2008) and the HIV Law Project (2009) findings that during a reproductive health visit, reproductive health providers did not offer HIV prevention counseling to approximately 60 to 70% of women who had engaged in unprotected

sex. Additionally results from this study brought to light that many of the participants wanted their provider to share some type of prevention information with them during their reproductive visit. The same finding was in the 2012 Kaiser Family Foundation report which noted that most women viewed their providers as the preferred source for sexual health information (KFF, 2012). The findings from this study elucidated that African American women perceived that there was little to no HIV prevention communication with their reproductive health providers even though they desired to be educated. The results indicated there may be missed opportunities for reproductive health providers to offer HIV prevention information to women at greatest risk.

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Appendix A

Research Study Interest Form

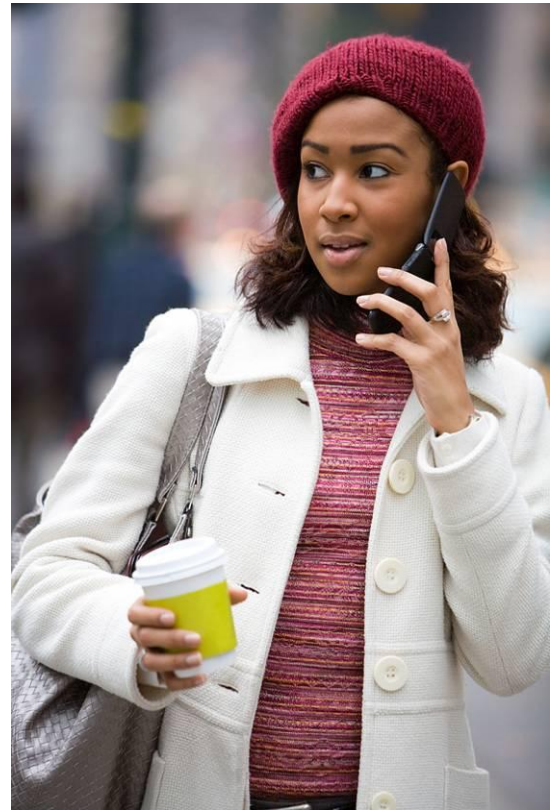
Excuse Me...

Are you an African American female between
ages 20 and 44 years?

Are you here for a reproductive health appointment such
as getting a pap smear, pregnancy test or to get your
birth control prescription?

Are you willing to talk to someone about the health
issues facing African American women?

***If you answered yes to these questions,
then I have an opportunity for you!***



If you are interested in participating in a project about women's health, please complete the form below and return the bottom portion to the box at the nurses' station or contact Valerie at (757) 303-6390 or burgehallv@vcu.edu.

(Return this section to the box at the nurses' station or use the information above to contact Valerie directly.)

Name _____

Best Way to Contact You: Phone/Text _____ or Email _____

Do you describe yourself as non-Hispanic African American or Black? ____ Yes ____ No

Are you between the ages of 20 and 44 years? ____ Yes ____ No

Are you willing to talk to someone about health issues affecting African American women?
____ Yes ____ No

*Thank you for your interest.
Someone will contact you within a week to discuss the project!*

Appendix B

Script for Scheduling Interviews

SCRIPT

Prospective Participant Willing to Talk After Appointment

“Thank you for your interest in the project. The project’s purpose is to get information about African American women’s experiences communicating with their reproductive health provider, such as a doctor or nurse, about HIV prevention. Are you still interested in the project? [If she says no, then thank her for her time. If she says yes, then thank her for her interest and continue with the script.] Now, I need to ask you a few questions. Do you identify as a non-Hispanic African American/Black female who is between the ages of 20 and 44 years old? Have you had a reproductive health appointment (which can be one to get your birth control, a well woman check or testing for sexually transmitted infections or pregnancy) within the last month that was not a follow up visit for a problem? Lastly, do you know if you are HIV positive or negative?”

[If the age, ethnicity, or reproductive appointment criteria are not met, then the question regarding HIV status will not be asked. She will be thanked for her time and told she does not meet the criteria for the study. Document whether criteria are met on the Interest Form. If ALL criteria are met confirm her willingness to participate and schedule the interview. Document the date, time and location for the interview. If ALL criteria are not met or she does not want to participate, then thank her for her time and let her know she does not meet the criteria for the study.]

Reminder Call if Necessary

“Hi. May I speak to _(participant name)_? [Wait for her to get on the phone]. Hi, _ (name) _, this is Valerie Burge-Hall and I am contacting you to remind you of our interview appointment on [state date, time, and location]. Is that still good for you? [Wait for response. If no, ask her for a good time to reschedule.] Great, I look forward to meeting you. Have a great day/evening/night.”

Appendix C

Project Description

PROJECT DESCRIPTION

TITLE: African American Women's Perceptions of HIV Prevention Communication with Their Reproductive Health Providers

INVESTIGATORS: Joann T. Richardson, PhD, CHES (Principal Investigator)

Valerie Burge-Hall, MA, CHES (Doctoral Student)

This project description may contain words that you do not understand. Please ask for an explanation of anything that is not clear to you.

PURPOSE OF THE STUDY

The purpose of this study is to explore African American women's perceptions regarding what HIV prevention information, if any, they receive from their reproductive health providers such as doctors, nurses, health educators or other health professionals. You are being asked to participate in this study because as an African American female, we value your opinion about how to reach and inform women about HIV prevention.

DESCRIPTION OF THE STUDY

In this study, a researcher will interview 20 women ages 20 to 44 years, to get their opinions regarding what HIV prevention information, if any, they received during a recent reproductive health visit (i.e., family planning/birth control, a yearly well woman check, testing for sexually transmitted infection or pregnancy). During the interview, the researcher will ask about age, race/ethnicity, HIV risk behaviors and what information, if any, was shared about HIV prevention. There is no right or wrong answer to the questions the interviewer will ask, so feel free to provide your honest opinion. The interview will take approximately 60-90 minutes with a portion of it being audio-recorded. The recording will not include any identifiable information such as age, sexual lifestyle, or relationship status.

RISKS AND DISCOMFORTS

Participation in this study is relatively free of risk to the participant. While there are no physical risks, minimal psychological risks may occur due to the sensitive nature of some questions regarding HIV risk behavior. As a participant, you have the right to refuse to answer any questions for any reason. However, it is hoped that participants will answer all the questions so that the researchers may gain the most insight into African American females' perspectives on HIV prevention.

BENEFITS

This is not a treatment study. Direct benefits from your participation in the study include knowledge of personal HIV prevention behavior, testing, and treatment. In addition to direct benefits to you, the information from this study may lead to better methods of providing HIV prevention programs to African American women.

COSTS

You are not charged for participating in this study.

PAYMENT FOR PARTICIPATION

You will receive a small gift valued at no more than \$20.00 for participating in this study.

ALTERNATIVE TREATMENT

This is not a treatment study, so there is no alternative treatment.

CONFIDENTIALITY

The information you provide in this study will be kept confidential. The researchers will handle the recorded interviews and notes in a confidential manner consistent with federal and state laws and regulations. You should know that the research data collected might be reviewed or copied by the investigators or the Virginia Commonwealth University Committee on the Conduct of

Human Research, but no personally identifying information will be shared. Additionally, results of this research may be presented at meetings or in publications, but your personal identity will not be disclosed.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

If you decide not to participate in this study, then you may freely withdraw from the study at any time. Your decision will not change your future medical care at this site or institution.

QUESTIONS

If you have questions, then please ask the receptionist, nurse, or medical assistant if I am in the building. If not, then contact me at:

Valerie Burge-Hall

Virginia Commonwealth University

(757)303-6390

If you have questions about your rights as a research subject, you may contact:

Office of Research Subjects Protection

Virginia Commonwealth University

1101 East Marshall Street, Room 1-032/PO Box 980568

Richmond, VA 23298

(804)828-0868

Thanks for your time!

Appendix D

Informed Consent

INFORMED CONSENT

PURPOSE OF THE STUDY

The purpose of this study, *African American Women's Perceptions of HIV Prevention Communication with their Reproductive Health Providers*, is to explore African American females' perspectives regarding what HIV prevention information, if any; they receive from their reproductive health provider (e.g., doctor, nurse, or health educator or other health professional). The outcomes of this study have the potential to make a significant contribution to public health by identifying barriers to getting HIV prevention information. Your participation is important as little is known about how African American women view this issue. You will be asked to respond to questions during a 60 to 90 minute interview.

RISKS AND DISCOMFORTS

Participation in this study is relatively free of risk to the participant. While there are no physical risks, minimal psychological risks may occur due to the sensitive nature of some questions regarding HIV risk behavior. As a participant, you have the right to refuse to answer any questions for any reason. However, it is hoped that participants will answer all the questions so that the researchers may gain the most insight into African American females' perspectives on HIV prevention.

CONFIDENTIALITY

Responses to all questions will remain confidential. Only the research team will have access to the entire transcript and recording. Once transcribed and after five years, the recordings will be destroyed. Your name will not be used in any writings or presentations related to the research. In the event that questions or concerns arise regarding this study, please feel free to contact the

researcher Valerie Burge-Hall, Virginia Commonwealth University, (757) 303-6390, and burgehallv@vcu.edu.

VOLUNTARY PARTICIPATION AND WITHDRAWAL

As a voluntary participant in this study, you have the following rights:

- The right to exercise free power in deciding whether or not to participate in the study
- The right to withdraw your consent at any time during the study without prejudice or retaliation
- The right to have questions concerning the study answered by the researcher
- The right to view completed data as available from the researcher.

The researcher can be contacted at the indicated email address to receive a copy of the final research report after May 15, 2015.

At this time, you are asked to choose one of the following selections by placing an 'X' in the space provided:

_____ I voluntarily (freely) give my consent to participate in this study

_____ I do not wish to participate in this study

_____	_____	_____
Signature of Participant	Name of Participant (print please)	Date

_____	_____	_____
Signature of Witness/Interviewer	Name of Interviewer (please print)	Date

FUTURE RESEARCH PARTICIPATION

This research project may result in continued or follow-up study of African American females’ experiences with healthcare providers. This may include, but is not limited to, focus groups, personal interviews, document review, or requesting that participants record their experiences throughout reproductive health visits such as routine gynecological exams, pregnancy testing, HIV and STI (sexually transmitted infection) testing, and family planning. If you would be willing to participate in continued or a follow-up study, please indicate this by signing and printing your name, as well as your phone number and email in the space provided below. Note that participation in continued or a follow-up study will require your consent at the time of the study, so an indication of interest at this point in time does not obligate you to participate in the future.

_____	_____	_____
Signature	Name (print please)	Date
_____	_____	_____
Phone	Email	

Please circle the best way to contact you: Phone Text Email

Modified protocol (Hawkins, 2009).

Appendix E

Interviewer's Guidelines/Protocol

INTERVIEWER'S GUIDELINES/PROTOCOL

Weekly Tasks Prior to Interviews

- Provide receptionist or designee with Research Study Interest Forms for upcoming reproductive health appointments.
- Collect Research Study Interest Forms from collection box.
- Contact potential participants to schedule interview appointment.
- Provide agency staff with the weekly interview appointment schedule.
- Prepare supplies needed for interviews: packet with informed consent forms, interview questions, notepads and pens, and digital recorder.

Interviewing Itinerary

The itinerary is an overview of the step by step interview process. Following the itinerary is a detailed script for each step of the bulleted list.

- Greet/welcome the participant, introduce myself, and establish rapport.
- Review Purpose of Study and Informed Consent.
- Execute the Informed Consent.
- Confirm readiness to complete the interview.
[If she is willing to participate but cannot complete the interview at this time ask for a good time to reschedule the interview.]
- Complete Part One of the Interview Questions/Instrument.
- Begin recording responses to Part Two of the Interview Questions/Instrument.
- End recording.
- Thank participant and provide incentive.

Greeting/Welcome

[Begin when the interviewee arrives.]

“Thanks again for taking the time to participate in today’s interview. As we talked about, the purpose of this study is to find out African American females’ thoughts about what HIV prevention information, if any, was shared during their reproductive health appointment. Before we start, I need to confirm criteria for participation. Do you identify as a non-Hispanic African American/Black female who is between the ages of 20 and 44 years old? Have you had a reproductive health appointment within the last month that was not a follow up visit for a problem? [If the criteria regarding age, ethnicity, or reproductive health appointment are not met, then do not ask her to disclose HIV status. Thank her for her time and tell her she does not meet the study criteria. If she does meet the criteria, then ask the last question regarding HIV status.] Lastly, do you know if you are HIV positive or negative?” [If all criteria are not met, then thank her for her time and let her know she does not fit the criteria for the study.]

Review of Project Description & Informed Consent

“Let’s take a few minutes to talk about the project. [Give the participant a copy of the Project Description and allow her to read. Afterwards, the researcher will summarize the major components of the Project Description].

Before we begin the interview, we need to take care of one more item which is the Informed Consent.

[Review the Informed Consent, emphasizing the following points:

- o Confidentiality of information
- o Interviewer will take notes and use of tape recordings
- o Destruction of original recordings
- o Right to withdraw at any time.]

“Are there any questions about the informed consent form? [Answer any questions] If not, I need to invite a witness in before you sign any paperwork. [The witness comes into the office.] Please sign and print your name at the bottom of the form, then date.

[Witness signs the form and exits the office.] There is a copy of the form in the folder for you to take home with you.”

[Collect the signed Informed Consent.]

Interviewing

[Explain the session will be divided into two parts.]

“During the first portion of the interview, I will ask questions to learn more about you such as age, education, and relationship status. After we complete that section, I will ask you more questions. This part of the interview will be audio taped and last for about an hour. Most of the conversation will center on you and not include me. Please be aware that I will stop you and ask for more information if needed. I may also take a few notes while you are talking. I want you to know any information shared or used in reports will be presented using general characteristics of the group not just your information. If individual information is used then it will be reported using the fake name (pseudonym) you will choose for yourself in this project. Only the research team will have access to

the information you share with me. My notes will not include your real name, just your fake name. Do you have any questions before we get started?"

[If there are no questions, begin the interview. Once the interview is complete, then researcher will thank participant using the Closing Statement.]

Thank You/Closing Statement

"Well, that is all of the information I need from you. However, if I need to ask a few follow up questions is it okay for me to contact you by using your preferred method of contact? [Document her response regarding how to contact.]

Do you have any questions for me? If so, I will answer them for you. [Allow participant to ask questions.] If you think of something later you may contact me at (757) 303-6390 and leave a message. I want to thank you for your time and help with this project. The information gained from this project will be used to develop health education messages and practices for doctors, nurses and other health professionals to offer HIV testing and treatment referral services to help African American women."

Modified Protocol (Hawkins, 2009)

Adapted Interview Guidelines (Creswell, 2003)

Appendix F

Interview Instrument

Part One: Interview Demographic Survey

The information asked of you will be used for descriptive purposes only and will remain confidential.

Name: _____ **Date:** ____/____/2014 **Time:** _____

What fake name would you like to be called for this project? _____

Best Way to Contact You: Phone Text Email

Mailing Address _____

Demographic Characteristics

Age: 20-24 25-29 30-34 35-39 40-44 45-49 50 or older

Highest Education Level Completed: _____

Relationship Status:

Single Married Living with significant other-unmarried Separated Divorced
Widowed Other _____

Experiences During Recent Reproductive Health Visit (not a follow up appointment)

Date & purpose of appointment: _____

What is the name of the provider you saw for that visit? _____

How many times have you seen this provider in the past year? _____

How comfortable are you about talking to your provider about sensitive issues?

Not at all Somewhat Neutral Comfortable Very Comfortable

If not at all, why? _____

Sexual Behavior in the Last 12 months: Mark all that apply.

Behavior	Under influence of alcohol/drugs	Used condoms most times	Did not use condoms most times
Had sex with men only in the last year			
Had sex with women only in the last year			
Had sex with both men and women in the last year			
Had sex with more than one partner in the last year			
Have not had sex with anyone in the last year			
Other			

Part Two

Expectation of What HIV Prevention Would Occur

1. What HIV prevention information did you expect to receive during your appointment?

Influence on Individual Perception of Threat and Effect on Action Constructs

2. What HIV prevention information, if any, did the doctor, nurse, or health educator give you?
3. How did he/she give you the HIV prevention information (told you to do something, gave you a handout, both ways)?
4. During your appointment, what HIV prevention information, if any, did you see or read in the waiting area or exam room?

Influence on Individual Perception of Threat Construct

5. Before coming for the reproductive health appointment, what did you think about your HIV risk?
6. What information, if any, did you receive during your appointment that made you think about your HIV risk? (Probes: what information did you get during your appointment that changed your mind about your risk? How did it change your mind?)

Influence on Effect on Action and Self Efficacy

7. What HIV prevention recommendations did you get that seemed like they were good for you to do?
8. Of the information and/or recommendations you received about HIV prevention during your appointment:
 - a. what do you feel you can do now? Why?
 - b. what do you feel you cannot do now? Why not?

Recommendations to Providers

9. How do you think health providers should share HIV prevention information with African American women in your age group?
10. What topics or types of HIV prevention information, if any, did you want the doctor to share with you?

Self Efficacy and Influence on Likelihood of Action

11. How many times in the last 12 months have you been tested for HIV?
12. What factors helped you decide about getting/not getting a HIV test?

CLOSING INTERVIEW STATEMENT

“Well, that is all of the information I need from you. However, if I need to ask a few follow up questions, is it okay for me to contact you by using your preferred method of contact? Do you have any questions for me? If you do, then I will answer them for you. If you do think of something later you may contact me at (757) 303-6390 and leave a message. I want to thank you for your time and help with this project. The information gained from this project will be used to develop health education messages and practices for doctors, nurses and other health professionals to offer HIV testing and treatment referral services to help African American women.”

Appendix G

Community Resource List

Community Resources for the Virginia Peninsula

Counseling Services

CATHOLIC CHARITIES OF EASTERN VIRGINIA

www.cceva.org

5361-A Virginia Beach Boulevard, Virginia Beach, VA 23462

Bus: (757) 456-2366 Bus. Fax: (757) 456-2367

Provides compassionate, professional help for all. Services include clinical counseling, adult guardianship, pregnancy counseling, adoptions, credit and housing counseling, mediation, education, prescription assistance, senior care.

CENTER FOR CHILD & FAMILY SERVICES

www.kidsandfamilies.com

2021 Cunningham Drive, Suite 400, Hampton, VA 23666

Bus: (757) 838-1960 Bus Fax: (757) 838-3280

Provides counseling services to children, adults and families, which includes mental health, family violence counseling, youth violence prevention, financial debt counseling, childcare resources and referral.

HAMPTON-NEWPORT NEWS COMMUNITY SERVICES BOARD

<http://www.hnnscsb.org/>

300 Medical Drive, Hampton, VA 23666

Phone: (757)788-0300/757-788-0011

The Hampton Newport News Emergency Services Department offers crisis intervention services 24 hours, 7 days a week. Our goal is to provide crisis intervention and recovery based services for individuals who are experiencing symptoms of mental illness and/or substance abuse problems. Services will be provided in an environment that meets the needs of each person. We are committed to helping you.

Domestic Violence

TRANSITIONS FAMILY VIOLENCE SERVICES

www.transitionsfvs.org

P.O. Box 561, Hampton, VA 23669

Bus: (757) 722-2261 Bus Fax: (757) 723-2717

Provides shelter, hotline, crisis intervention, case management, advocacy, counseling and self-sufficiency services to adult and child victims of family violence.

Food, Clothing and Shelter

FOODBANK OF THE VIRGINIA PENINSULA

www.hrfoodbank.org

2401 Aluminum Avenue, Hampton, VA 23661

Bus: (757) 596-7188 Bus Fax: (757) 595-2507

Distributes food effectively through collaborative efforts that minimize hunger, promote nutrition and self-reliance through education.

Community Resources for the Virginia Peninsula

Food, Clothing and Shelter

H.E.L.P, INC.

www.helpushelpu.org

1320 LaSalle Avenue, Hampton, VA 23669

Bus: (757) 727-2577 Bus Fax: (757) 723-0649

Serves the homeless and those in crisis by providing shelter, food, financial assistance, medical and dental care.

LINK of HAMPTON ROADS

www.linkhr.org

10413 Warwick Boulevard, Newport News, VA 23601

Bus: (757) 595-1953 Bus Fax: (757) 595-3428

Protects children/adults with and without disabilities; promotes self-sufficiency, provides shelter for homeless, permanent supportive housing, basic needs, food, clothing, and advocacy.

NATASHA HOUSE

www.natashahouse.org

P.O. Box 1869, Yorktown, VA 23692

Bus: (757) 898-1993 Bus Fax: (757) 898-0293

Transitional home for homeless women and children that empowers and equips them to achieve and maintain self-sufficiency.

SALVATION ARMY, PENINSULA COMMAND

www.uss.salvationarmy.org

1033 Big Bethel Road, Hampton, VA 23666

Bus: (757) 838-4875 Bus Fax: (757) 827-8467

Christian ministry assists with food, rent, mortgage, utilities; shelters homeless veterans and families with children; and provides youth programs in scouting, team sports, and music.

Referral Line

FIRST CALL INFORMATION AND REFERRAL

If you NEED HELP with food, shelter, rent, utilities or other basic needs, call **757.594.4636**. First Call operators are standing by to take your call, Monday through Friday from 8:30am-6pm. Calls for emergency shelter are taken 24 hours a day, seven days a week.

Appendix H

Thank You Note

THANK YOU NOTE

Thank you so much for your willingness to participate in the project regarding HIV prevention communication between African American women and their reproductive health providers. The information you provided will benefit many African American women. Your responses will be used to develop materials to help doctors, nurses, and other health professionals in preventing and controlling HIV/AIDS. If you have any questions or want more information about the project, please contact me at (757) 303-6390 or burgehallv@vcu.edu.

Sincerely,

Valerie Burge-Hall

Appendix I

Photograph of Participant Thank You Gift Bag

PHOTOGRAPH OF GIFT BAG



Appendix J

Coding Checklist for Educational Resources

CODING CHECKLIST

Code	Name and Type of Resource/Date Checked	Name and Type of Resource/Date Checked	Name and Type of Resource/Date Checked
Pictures/Titles of People in Educational Resources			
Male(s)			
Female(s)			
Male(s) with Female(s)			
Medical Provider with Client			
African American			
Asian			
Caucasian			
Hispanic/Latino			
Other Race/Ethnicity			
For Heterosexual Couples			
For Same Sex Couples			
For Youth, Young Adults, Middle Age, Seniors			
Information Provided in Educational Resources			
What HIV/AIDS Is			
Who Gets the Disease			
Ways HIV Is Transmitted or Spread			
HIV Testing			
Advice to Seek Healthcare Provider			
Resource Numbers			
Interaction of People			
Positive (smiling)			
Negative (frowning)			
Neutral (neither)			

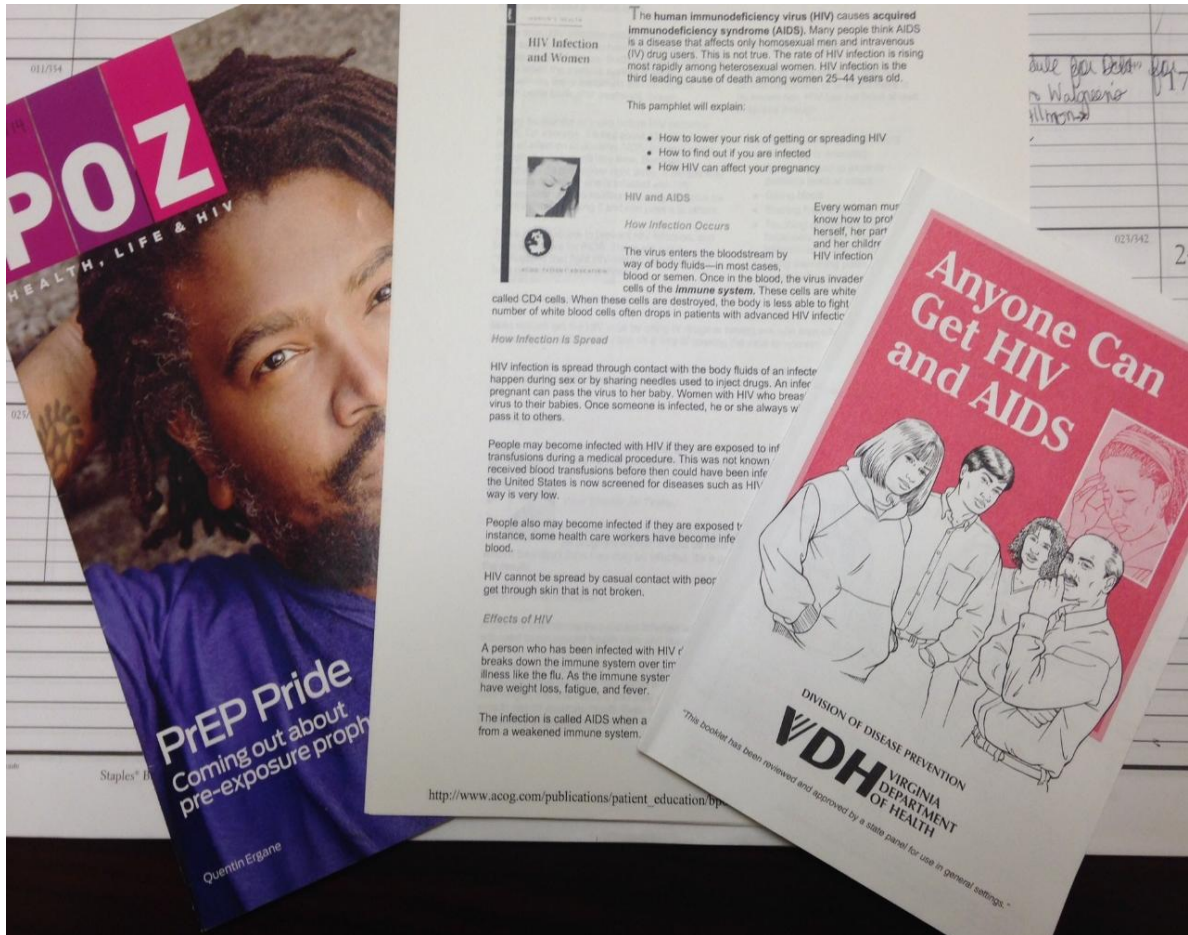
If the resource was mentioned by a participant,

Name of Participant _____ No. of Coding Sheets ___ of ___
 Additional comments about the resources (provider distributed, location of material, etc.):

Appendix K

Photograph of Educational Resources

PHOTOGRAPH OF EDUCATIONAL RESOURCES



Appendix L

Photographs of the Waiting Areas

PHOTOGRAPHS OF WAITING AREAS



Different views of the main waiting area



Literature in the main waiting area including POZ Magazine



Smaller waiting area with magazine rack

Appendix M

Photographs of the Examination Rooms

PHOTOGRAPHS OF EXAM ROOM AND BULLETIN BOARDS

