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# Barriers to HIV couples testing: The African American woman's perspective

Frederick Scott Smith

# BARRIERS TO HIV COUPLES TESTING: THE AFRICAN AMERICAN WOMAN'S PERSPECTIVE

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

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In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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June 2010

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ABSTRACT

African American Women continue to contract HIV/AIDS at an alarming rate. Of all the women living with AIDS in the United States, 64% were African American and two out of three African American women got HIV from having unprotected sex with a man. Barriers that limit the effectiveness of HIV prevention efforts that are directed toward African American Women must be identified and eliminated. The purposes of the study are to Identify Perceived Barriers to HIV Testing of the intimate partners of African American Women and subsequently identify an effective couples HIV testing strategy.

ACKNOWLEDGMENTS

I would like to thank my professors for being great stewards of the principles of social work. Advocacy and empowerment are the foundation of the Masters of Social Work and I am grateful that these principles have been shared with me. Dr.'s Janet Chang, Tom Davis, Ray Liles, Rosemary McCaslin, and Stanley Taylor, have given me a gift that I will not only utilize but share with others. Thank you.

# DEDICATION

This accomplishment is not my own. This adventure has only been possible due to the encouragement and expectations of others. Specifically, this project is dedicated to my wife who Is an alumni of the MSW program at CSUSB, and my five children who I love unconditionally.

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# CHAPTER ONE

# INTRODUCTION

African American Women continue to contract HIV/AIDS at an alarming rate. The Centers for Disease Control [CDC] noted that of all the women living with AIDS in the United States, 64% were African American and two out of three African American women got HIV from having unprotected sex with a man (CDC, 2009b). Barriers that limit the effectiveness of HIV prevention efforts that are directed toward African American Women must be identified and eliminated. The purposes of the study are to Identify Perceived Barriers to HIV Testing of the intimate partners of African American Women and subsequently identify an effective couples HIV testing strategy.

## Problem Statement

African American Women continue to contract HIV/AIDS at an alarming rate. Originally HIV/AIDs predominantly impacted men who have sex with men. However, the Centers for Disease Control and Prevention's current report on HIV and women asserts that if new HIV infections continue at their current rate worldwide, women with HIV may soon

outnumber men with HIV (Centers for Disease Control, 2009a).

The Centers for Disease Control [CDC] noted that of all the women living with AIDS in the United States, 64% were African American and two out of three African American women got HIV from having unprotected sex with a man (CDC, 2009b). El-Bassel et al. (2009) reported that African American Women continue to be disproportionately affected by the HIV/AIDS epidemic, yet there are few effective HIV prevention interventions that are exclusively tailored to their lives and that address their risk factors. The rate of AIDS diagnoses for black women is 22 times the rate for white women (CDC, 2009c). However, current prevention efforts are currently utilizing a one size fits all strategy that does not reflect the inherant barriers that African American Women face.

It is urgent that research on the perceived barriers that are preventing African American Women from learning the HIV status of their intimate partner be conducted. For black women, the most common way of contracting HIV is having unprotected sex with a man who has HIV (CDC, 2009a). Barriers that limit the effectiveness of HIV

prevention efforts that are directed toward African American Women must be identified and eliminated. HIV/AIDs impacts African American Women disproportionately. In 2002, HIV/AIDS was the number one cause of death for African American Women aged 25-34 years and the numbers are projected to increase anually (US Department of Health and Human Services, 2007).

The CDC has reported that barriers to effective HIV/Aids prevention efforts may not be directly related to race or ethnicity, but rather to some of the perceived barriers faced by many African American Women, such as poverty and stigma (CDC, 2009b). Poverty and stigma are labels that have become permanently, socially linked with African Americans and if barriers to testing are not identified HIV/AIDS may also become permanently, socially linked with African Americans.

This research project investigated the impact perceived barriers have on the ability of African American Women to learn the HIV status of intimate partners. By identifying perceived barriers this project also identified a prevention effort model that is client centered and culturally sensitive to African American Women. Current efforts to reduce the transmission of

HIV/AIDS have been effective in mitigating infection rates among several high-risk populations. However, African American Women are a high-risk subpopulation that is experiencing an increase in new infections (Health and Human Services, [HHS] 2007).

Policy Context

The stated policy of the CDC's worldwide effort to eliminate HIV/AIDs is targeted at behavior change. The current prevention philosophy is implemented through the acronym A.B.C., Abstinence, Being faithful and Condom use (HHS, 2007). The ABC strategy has not been effective in slowing infection rates of African American Women because following the ABC principles has not protected them from the highest risk factor for infection, which is unknowingly having sex with an intimate partner who is HIV positive. Sadly, statistics show that for black women, the most common way of getting HIV is having unprotected sex with a man who has HIV (CDC, 2009a).

African American Women are a subpopulation that has been found to be at higher risk for HIV transmission. However, they have not benefited from current HIV/AIDS prevention efforts. These prevention efforts are not

client centered, but instead are focused on changing behaviors associated with the transmission of HIV/AIDS.

Practice Context

Social work as a field is currently adopting a philosophy of providing client centered services. Programs that impose a rigid behavior change design like the A.B.C. strategy would seem to be at odds with client centered models. Davis, Williams, and Akinyela (2009) have noted that:

> Social work researchers who identify and define social problems run the risk of leaving their social fingerprints on such problems, as well as their favored solutions to them. As a result, the direction of the research agenda is driven by the focus of the research problem formulation, instead of the cultural relevance. (p. 1)

## Purpose of the Study

The purposes of the study are to Identify Perceived Barriers to HIV Testing of the intimate partners of African American Women and subsequently identify an effective couples HIV testing strategy. The research study investigated the primary causes for low HIV testing

rates of African American couples. Study subjects were asked questions to ascertain their opinions and perceptions of barriers to testing. Specific questions were asked to gauge how strongly barriers are perceived. Barriers of interest in this study are: Empowerment, stigma, anxiety/fear and accessibility of testing.

The expectation was to draw a correlation between perceived barriers to HIV testing and low HIV testing history of study participants and their partners. The research sought to determine which barriers influence testing the most.

This study identified the views of African American Women to determine the need for culturally competent HIV prevention efforts that identify empowerment as a needed component in overcoming perceived barriers. False barriers to testing were also identified.

A secondary purpose of this study was to identify an effective HIV prevention strategy that can overcome perceived barriers to HIV testing. This study identified how changes to prevention efforts can improve opinions and perceptions of HIV testing by improving the negotiating leverage of African American Women by eliminating perceived barriers to HIV testing. The

specific change in prevention efforts this study advocates is implementation of confidential couples testing, via door-to-door opt out HIV testing utilizing the 20 minute saliva Rapid-Test HIV test. Subjects were also questioned to determine willingness to buy an over the counter [OTC] 20 minute saliva, HIV Rapid-Test.

The Center for Disease Control and Prevention identifies unprotected heterosexual intercourse as the leading cause of HIV infection for African American women. A person should avoid unprotected sex with a partner who is HIV infected or who does not know his or her HIV status, (Health and Human Services [HHS], 2009). However of those 1 million people living with HIV, 1 out of 5 do not know they are infected. People who have HIV but don't know it can unknowingly pass the virus to their partners (CDC, 2009).

It is important for African American Women to identify risky behavior as unprotected sex with any male partner who has HIV infection or does not know his HIV status (Kaiser, 2009).

The researcher hopes that participation in this study will have a positive influence on subjects. Hopefully participation in this study will enable

subjects to identify their own high-risk behaviors. At a minimum participation in this study should generate a dialogue among participating African American Women regarding the feasibility of HIV testing of intimate partners.

The study is an agency based quantitative study. This researcher collaborated with a community-based organization that provides services to African American Women. Study participants were recruited from various community locations. Primarily research subjects were found at California State University, San Bernardino [CSUSB] and the surrounding community. All participants are members of a population at risk of contracting HIV. Participants were asked to complete a questionnaire that sought their opinions on topics relevant to the prevention of the spread of HIV/AIDS.

This study utilized a quantitative method to maximize confidentiality of participants. A review of available research literature has identified no previous agency that has conducted research on this specific subject. Raiford, DiClemente, and Wingood, conducted a study that identified barriers to negotiating condom use. However, even though the subject population was African

American Women the questionnaire assessed them for fear of abuse because of negotiating condom use instead of barriers to HIV testing of intimate partners (Raiford, 2009).

## Significance of the Project for Social Work

Behavior change seems to be simple, direct and understandable, however attempts to change the behavior of African American Women have been ineffective because African American Women do not identify themselves as a high-risk group. The stigma attached to being in a high-risk group for HIV is so undesirable that African American Women do not view themselves as members of this group. Also, according to researchers Davis, Williams, and Akinyela, African American Women do not view heterosexual intercourse as an undesirable behavior. A myth from the oppressive history of African American Women is that unprotected sex equates to love (2009) Therefore; unprotected sex is not viewed as unnatural, deviant, or high-risk. Efforts need to be devoted to developing a client-centered philosophy that values African American Women as part of the solution and not the problem (Wyatt, 2009).

A recent report released by Harvard Health Publications [HHP] reports that doctors now consider HIV a chronic condition that can be controlled with medications and healthy lifestyle choices (HHP, 2009). The findings of the Harvard Health Publication concur with the recent national survey by the Kaiser Family foundation finding that Americans' sense of urgency about HIV/AIDS has fallen dramatically (Kaiser Family Foundation, 2009). These trends in public opinion are disturbing because every 9½ minutes (on average), someone in the United States is infected with HIV, the virus that causes AIDS (CDC, 2009). Culturally competent outreach efforts need to be developed with a sense of urgency before the current level of high HIV/AIDS infection rates among African American Women become socially accepted.

There is a need for a more diverse field of HIV researchers that can deliver prevention efforts that are culturally sensitive to African American Women. Social Workers, Anthropologist, and Sociologist are now welcome as well as researchers from diverse cultural backgrounds. Research conducted from a bio-social perspective has been found to produce prevention efforts that are more culturally sensitive and gender specific (Wyatt, 2009).

Social Workers are concerned with this social problem because this devastating disease disproportionately impacts their clients. The descriptors of HIV/AIDS high-risk populations mirror the descriptors of the populations that require assistance from Social Workers.

The findings of this study can change Social Work practice on several levels. Social workers strive to "meet clients where they are." This generalist approach increases the likelihood that social workers have accepted anecdotal assumptions about the population that they serve without questioning these assumptions.

For example, there are widespread anecdotal assumptions that have been used to define populations that are at high risk of contracting HIV/AIDS. Homosexual, promiscuous, intravenous drug use, and African Americans have become code words to describe morally bankrupt populations that contract HIV/AIDS at astronomical rates. Social workers have not refuted these labels, to the contrary, social workers have embraced these labels in an effort to focus on serving our clients and mitigating this disease.

The findings of this study has contributed to social work research and policy by empirically proving that access to confidential and convenient HIV testing, decreases perceptions of barriers to HIV testing. The simple reality is the majority of people that contract HIV through sexual intercourse do not get tested and/or do not require their partners to be tested for HIV. Hopefully, the outcomes generated by this study will result in a commonsense yet effective approach to HIV prevention efforts. This study may influence community based organizations to provide confidential and convenient HIV testing.

More empirically based research will need to be identified and cited for this study. Specifically, research that investigates and identifies perceived barriers to testing.

- Lack of empowerment
- Accessibility
- Anxiety/Fear
- Stigmas associated with HIV

## Research Question

The question this research is asking is: Do perceived barriers negatively impact the ability of African American Women to effectively negotiate with a sexual partner to be tested for HIV/AIDS? In order to answer this question, the researcher formed two research questions: (1) That African American Women would identify several barriers that negatively impact their ability to negotiate with an intimate partner to be tested for HIV pre-intercourse. (2) That subjects that respond in the affirmative to the statement "Being aware of an intimate partners HIV status is very important" would also report a willingness to utilize confidential and convenient HIV testing ie, door to door testing, or over the counter HIV rapid test if available.

# CHAPTER TWO

# LITERATURE REVIEW

## Introduction

This chapter reviews relevent literature that explore perceived barriers (Empowerment, stigma, anxiety/fear and accessibility of testing)that are hampering HIV testing among African American Women and their intimate partners. This chapter also reviews relevent literature devoted to culturally competent prevention strategies. In conclusion several theories guiding conceptualization highlight the need to implement programs in a culturally competent manner.

## Empowerment

The concept of "empowerment education" originally proposed by Paul Freire suggest that cultures set their own priorities regarding social issues and choose their own unique methods of communication (1970). This concept establishes that the African American culture will readily accept natural community members that have the natural role as information sources (Wallerstein & Berstein, 1988). HIV prevention efforts focused on African American Women have not been as effective as

prevention efforts focused on other populations, possibly due to the messenger. When non-community members present health education information the health worker may lack credibility within the African American culture (Lieberman & Harris 2006). Researchers Lieberman and Harris (2006) suggest that due to cultural appropriateness respected community members can best disseminate health related information. A culturally competent HIV prevention program should acknowledge and include the strengths of a community's cultural heritage (Davis & Voegtle, 1994).

## Stigma

A barrier to couples HIV testing within the African American community is African American men's attitudes toward going to a sexually transmitted infections [STI] clinic. African American Women have been unable to negotiate couples testing with their intimate partners partially due to Men's anxieties due to stigma related to HIV testing (Lichtenstein, 2004).

Men's avoidance of STI screening is gender and stigma related and African American Women need negotiating tactics that address the causes of African

American men's avoidance of testing. Lichtenstein identified three areas of fear and or stigma in relation to African American Men attending clinics for HIV testing. These three areas are; Gender anxiety (attacks on masculinity), social anxiety (damage to social reputation through stigma), and racial anxiety (AIDS as genocide) (2004).

The stigma based barrier that this study hopes to refute is damage to the African American Males social reputation if he submits to an HIV test. The Stigma most closely associated with initial damage to social reputation is the fear of being seen at the STI clinic. This perception was based on the fact that STI screening and treatment was the only service available to men at most Health Department clinics, while a range of gender based services at the clinics (pediatric, gynecologic, social) allowed women to pass as regular clients. (Lichtenstein 2004). The fear of being seen was present regardless of the location of the clinic because "there's only one reason for us to be there, and that's to be checked for STDs [sexually transmitted diseases]" (Lichtenstein, 2004, p. 379). The results of this study are expected to show that confidential door to door

testing remedies the stigma associated with being seen at the clinic.

Following the theme of fearing being seen at the clinic is the fear that your name will be reported to the government if you test positive. HIV stigmatization influences the preference for the type of testing used to detect the virus. Persons at risk for HIV are more likely to seek testing when it is offered anonymously (i.e., no names are recorded) rather than confidentially (i.e., names are kept in confidential records (Fehrs et al., 1988). If an African American Woman has the option to submit to anonymous door to door HIV testing her ability to negotiate testing with her intimate partner will be increased significantly. Many of the barriers historically in place may be removed by employing anonymous testing at locations other than the STI clinic.

Possibly the worst stigma associated with social reputation is the fear of being shunned by family and friends that accompanies the possible consequences of testing positive for HIV (HEREK, 1999). The fear of social isolation is a significant factor in testing avoidance. African Americans and Hispanics are more likely than non Hispanic White Americans to overestimate

the risks of HIV transmission through casual contact and these populations have endorse policies that would separate People With AIDS [PWAs] from others (Herek & Capitanio, 1998). The fear of being shunned is easily refuted with current public health information.

## Anxiety/Fear

Anxiety/fear is a barrier to HIV testing that can be addressed with current public health information from trusted sources. The consequences of allowing fear to determine whether or not the intimate partners of African American Women are or are not tested for HIV are unacceptable.

A highly respected medical epidemiologist Harry F. Hull, M.D. studied people who opted out of confidential HIV testing when it was offered, he found that these individuals are more likely to be HIV positive. For example, in a study of patients in New Mexico, those who opted out of testing when it was offered were found to be 5 to 8 times more likely to be HIV positive than those who agreed to testing. Again the primary reason given for refusing the test was fear of stigmatization (Hull et al., 1988)

## Accessibility

Lack of accessibility to HIV testing is a barrier that hampers HIV outreach efforts. The concept of accessibility refers to not only the source or physical location but also services offered, times when testing is offered and responsiveness to consumers. African American Women require a source of reliable health information in a setting that is easily accessible and acceptable to them (Wallerstein & Berstein, 1988).

The source of HIV testing is relevant because many people who are identified as high risk for infection do not have health insurance; these people mostly rely on publicly funded testing sites. Leibowitz and Taylor specifically studied Low-income Los Angeles residents, and found that they largely rely on publicly funded sites for HIV testing (2007). In addition to funding source the proximity to the nearest publicly funded test site affects HIV testing also (Leibowitz & Taylor, 2007).

Respondents to this survey are expected to desire confidential and convenient HIV testing, however there is no consistent standard among existing HIV testing programs that establishes anonymous and or confidential testing policies (Grusky et al, 2004). Services that are

available at HIV testing sites vary dramatically, therefore, a testing site may be physically close but inappropriate if the services that are offered are not consistent with the consumers need for confidentiality.

Black and white adults have been found to use the same sources to gather information on HIV/AIDs prevention, however, Blacks are 4 times more likely to receive information from a religious source and 1 ½ times more likely to receive information from friends or community associates (Cunningham et al, 1999)

Informal, confidential door to door HIV outreach efforts may appear more culturally acceptable to African American couples. More than 50% of African Americans surveyed receive HIV/AIDs related information from friends and associates, not from public health agencies, possibly, collaboration between public health agencies and community members (community workers) can provide targeted African American Women with access to HIV testing (Cunningham et al, 1999).

Grusky et al., utilized A telephone survey to contact HIV testing sites. Only 50% of the sites could be contacted and indicated that HIV testing was available.

Hence, a consumer who tried to reach one site had only a 50-50 chance of success (2004).

In conclusion, when publicly funded HIV testing sites are more distant, at risk populations are less likely to use them and less likely to get tested (Leibowitz & Taylor, 2007). HIV testing sites must strive to make their services accessible and be perceived by African American Women as responsive to their need for confidentiality if they are to be effective service providers (Grusky et al., 2004). To encourage HIV testing among groups where HIV is growing fastest, public health agencies must keep the time and money costs of HIV testing low (Leibowitz & Taylor, 2007).

## Confidential and Convenient Prevention Strategies

Confidential and convenient prevention strategies are warranted to increase HIV testing, particularly among persons who are disproportionately affected by HIV infection (Morbidity and Mortality Weekly [MMWR], 2008). Two perceived barriers to HIV/AIDS testing include convenience and confidentiality. Convenience and confidentiality are main factors that lead people to choose home HIV testing kits (HHS, 2009). For a rapid

test, a health care worker usually collects the sample. Instead of sending the sample to a laboratory, the test is run at the site where the sample is collected. Rapid tests can produce results within 20 minutes (Food and Drug Administration [FDA], 2009).

This study is a proponent of eliminating the role of the health care worker and making these FDA approved test available over the counter [OTC] or confidentially door to door via para professional community health care workers.

Self administered home test kits are the preferred option. Home HIV tests require consumers to collect the sample, run the test and interpret the results themselves. However, there are currently no FDA approved self administered home test kits (FDA, 2009). Home test kits are as accurate as the test that is administered in a clinic. Clinical studies have shown that current HIV home collection test systems are able to correctly identify 100% of known positive blood samples, and 99.5% of HIV negative blood samples (FDA, 2009).

HIV/AIDS transmission rates have been reduced to near zero in two High Risk categories, Blood transfusions and Mother to new born. This reduction has been

accomplished by implementing opt-out policies. Opt-out simply means that you will be tested for HIV/AIDS unless you refuse to be tested for HIV/AIDS. The opt-out approach to HIV counseling and testing was responsible for a 22.5% increase in testing among this population (Zimba, 2006). Over 98% of pregnant women were tested utilizing opt out to just 76% who were tested when presented with written consent forms and HIV/AIDS testing was presented as an option.

There is an urgent need for robust, replicable approaches that meet the need for rapid expansion of HIV testing services (Marum, 2006). One partial solution is to simply make the oral HIV test as easy to get as a pregnancy test and then apply the principle of opt-out testing. If you do not want a HIV test simply refuse to buy one, however, the researcher anticipates an enthusiastic response to confidential and convenient rapid testing either door to door or OTC.

## Culturally Competent Prevention Strategies

Despite current prevention efforts, African American Women are affected by HIV/AIDS more than other populations. The occurrence of these diseases at greater

levels among certain groups more than in others is often referred to as a health disparity. In addition the CDC has found that poverty, unequal access to health care, lack of education, stigma, and racism are linked to health disparities of African American Women (CDC, 2009).

A way to combat health disparities is to acknowledge and include the strengths of a community's cultural heritage (Davis & Voegtle, 1994). Similarly, culturally competent social work researchers advocate the importance of understanding the life experiences and realities of African American Women (Mertens, 1999; Schiele, 2000,).

Gail Wyatt, John Williams, Tina Henderson, and LeKeisha Sumner of the Department of Psychiatry and Bio-behavioral Sciences, University of California, Los Angeles, the National Institute for Mental Health (NIMH) and The UCLA AIDS Institute have attempted to explain the HIV infection health disparity that impacts African American Women.

Wyatt et al, key finding is a correlation between increasing culturally competent prevention efforts by increasing cultural diversity among the ranks of researchers. Their collaborative writings also disclosed a need for researchers with more diverse areas of

specialization such as social workers, anthropologists, and sociologists. The UCLA/ NIMH article recognized that voluntary, widespread, routine testing is the key to containing the AIDS epidemic (Wyatt, 2009).

HIV/AIDS researchers are attempting to develop and use culturally congruent theories and measures in HIV/AIDS prevention efforts (Wyatt. 2009). There is now awareness for the need of a biosocial approach to prevention and mitigation of HIV and AIDS. Research is now at the tipping point where resources are being shared between search for a cure or vaccine and an increased focus on prevention.

For black women, the most common way of getting HIV is having unprotected sex with a man who has HIV (CDC, 2008).

Prevention efforts have focused on changing behavior of people in high-risk groups as opposed to identifying the infected and preventing transmission to the uninfected. A saliva HIV test is already in production but it has not been approved by the FDA for OTC sales to the public.

## Theories Guiding Conceptualization

There are many theories that can be applied to this social problem and this identified population. I will apply theories that can lend insight into how African American Women developed norms that are associated with high risk dating rituals. I will specifically look to cultural deficiency theory, systems deviance theory, and attachment theory to try to gain an understanding of the African American Women's experience in negotiating couples HIV testing.

## Cultural Deficiency Theory

The Cultural Deficiency Theory usually is utilized to emphasize characteristics of minorities and explains poverty in terms of cultural behavior (Popple, 2009). This theory explains that people in the underclass make choices needed to cope with living in the underclass that actually keep them in the underclass. Applying this theory to HIV testing would imply high HIV infection rates are attributed to cultural behavior and deficiencies. The model explains that deficient cultural values include: present versus future time orientation, immediate instead of deferred gratification, an emphasis

on cooperation rather than competition, and placing less value on education and upward mobility (Barrera, 1979).

Cultural deficit theories have limitations because they have been labeled as racist and flawed with anecdotal findings; however, this model is useful in an attempt to explain rising infection rates in this isolated population. In essence the cultural deficiency model explains that disenfranchised populations engage in behaviors that are necessary to survive however, these very same behaviors continue to cause them to remain disenfranchised.

When this theory is applied to HIV transmissions I propose that African American Women display behavior that appears self destructive but is rational to them. African American Women that are not in a mutually monogamous relationship engage in what is now deemed as high risk sexual behavior (dating), because they desire to be in a mutually monogamous relationship.

The majority of African American Women have limited opportunities to find Black men with incomes capable of supporting families. The "Male marriageable index" by sociologist William Julius (1987) indicates that 72% of Black men between the age of twenty and twenty-four were

either unemployed, employed only part-time, or working full time but earning below poverty wages as cited in (Takaki, 2008, p. 412). The male marriageable index partially explains how African American Men can resist the urging of their intimate partner to be tested for HIV because they have the ability to date multiple partners.

## Systems Deviance Theory

When the efforts to address the HIV/AIDS pandemic are viewed from a macro perspective, systems theory is easily applied. Martin and O'Connor (1989) observed that a system was a whole composed of transacting parts. Current HIV prevention efforts can be categorized into three transacting parts Prevention, Treatment and Care. The notion of a system is that a set of elements are interrelated in a specific manner (Martin and O'Connor 1989). When viewed as interdependent parts Undesirable outcomes can be linked to the impact of ineffective prevention efforts.

It is unclear if rising infection rates are due to entropy, inadequate response to change or slowness of adaptation. What is clear is that the current HIV transmission rates among African American Women

identifies a failure at some point in the system. To focus on entropy implies that there was never synergy among the prevention, treatment, and care outreach efforts.

The researcher believes when the history of this pandemic is viewed in its entirety the ineffective outreach efforts directed toward African American Women can be attributed to slowness of adaptation. The scope of the disease changed very rapidly and outstripped systems ability to adjust (Brueggmann, 2006).

## Summary

I have provided insight into a topic that has had very little research devoted to it. Relevent literature identified perceived barriers to HIV testing which included (Empowerment, stigma, anxiety/fear and accessibility of testing). I have provided examples of the impact culturally competent prevention strategies can have on these perceived barriers. In conclusion several theories guiding conceptualization highlight the need to implement programs in a culturally competent manner.

# CHAPTER THREE

# METHODS

## Introduction

This section includes a detailed outline of the methods and procedures that were utilized to carry out this study. The study design, sampling method, data collection and instruments are described, along with procedures, and a statistical data analysis plan. Finally, all details and considerations of the researcher's efforts to preserve and protect the rights of Human Subjects during the course of the study are also included.

## Study Design

The study is an agency based quantitative study. a community-based organization that provides services to African American women was utilized. The purpose of the study is to explore African American women's perceptions of barriers to HIV testing. It is hoped that this study will assist the agency in getting higher ratios of tested couples or in getting ideas that may be implemented.

This study utilized a quantitative method using self-administered questionnaires. The study assessed the

impact perceived barriers have on the ability of African American women learning the HIV status of their intimate partners. The following research questions are tested in this study:

The African American women in this study will perceive lack of Empowerment as a barrier to testing of intimate partners. Perceive stigma as a barrier to couples testing.

Perceive Anxiety/fear of a positive test as a barrier to testing. Perceive that inaccessibility is a barrier.

The rationale for implementing a quantitative research design is to enhance confidentiality. The nature of this study requires subjects to share truthful responses regarding opinions on high-risk sexual practices. Therefore, a qualitative design that utilizes interviews or focus groups may negatively impact a subject's sense of confidentiality.

There are limitations to quantitative research. For example, large samples are required and there are inherent difficulties with gathering the desired numbers of participants. With this study, recruiting the desired number of participants from the community based

organization with which this study is collaborating with is not feasible. Therefore, recruitment efforts will be expanded to include the Cal State San Bernardino campus and surrounding community.

An additional limitation of quantitative research is the rigid structure of questionnaires. There is no inherent flexibility for the instrument to adapt for participants with physical disabilities or learning disabilities. In addition a questionnaire may not provide the range of answers that the participant requires to fully express themselves (Grinnell, 2008).

Moreover, data analysis for quantitative research relies on the researchers competence utilizing the SPSS for windows. Errors when entering data into SPSS can completely skew the accuracy and validity of a quantitative research study (Grinnell, 2008).

## Sampling

This study utilizes purposive sampling, which is a nonprobability sampling procedure in which research participants with particular characteristics are purposely selected for inclusion in a research sample; also known as judgmental or theoretical sampling

(Grinnell et al, 2008, p. 554). This method of sampling was chosen because the sampling criteria is specifically targeted at African American women, gathering information from other cultures and genders would provide misleading results.

The primary data source will be fifty African American Women who reside in a region of southern California referred to as the inland empire. Subjects will be chosen from each of the following, Community Based Organizations; Working wonders counseling agency, universities; Cal State University San Bernardino, Churches; Life church of God and Christ and beauty salons; It's a hair thing. African American Women were chosen as subjects of this study because their demographic is considered at high risk for HIV infection (Federal Drug and Alcohol administration [FDA], 2009). The desired sample size is only fifty therefore Inclusion of other genders or cultures would lead to misleading findings.

## Data Collection and Instruments

I have located no surveys or research targeting this social problem, therefore, a collection instrument had to

be adapted by applying questions from Lichtenstein's research on the stigma associated with being, Caught at the Clinic: African American Men, Stigma, and STI Treatment. Survey questions were pretested with two focus groups comprised of professionals in the field of HIV testing and the community based organization that is collaborating with this study. While this study may lack validity and reliability there is a lack of previous studies.

The strength associated with this survey instrument is its narrow focus on the social issue relevant to this study, stigma that forms barriers to HIV testing. The limitation associated with this survey instrument is a lack of documented validity and reliability, which make projectability of results unreliable. The instrument used to collect data is a self-administered questionnaire. Participants were asked 35 questions regarding perceived barriers to HIV testing, demographic information and opinions on possible interventions to overcome barriers to HIV testing. It should take approximately fifteen minutes to complete the questionnaire. Referrals for HIV testing and counseling will be available.

The survey instrument will utilize likert scales and closed ended questions with sections alternating from nominal to ordinal and then concluding with another nominal section to collect quantitative data. The questions were taken from a study conducted by Lichtenstein (2004) (see appendix A).

The survey will consist of three sections: the first section consists of seven demographic questions, race, age, gender, relationship status, religion, and educational status. The second section contains twelve questions focused on participants' personal experiences and opinions regarding HIV testing. The third section contains sixteen likert scale questions that reflect how strongly participants' perceptions regarding perceived barriers to HIV testing are. Their perceptions of stigma related to testing are also measured, as well as their ability to negotiate with their partner to be tested for HIV. Fear of inaccurate results and fear of potentially testing positive are both areas included in the likert scale

## Procedures

Permission was obtained from school administrators at Cal State San Bernardino [CSUSB] to administer research questionnaires on campus. Study participants were solely comprised of African American Women recruited from locations on the CSUSB campus and surrounding community. Identical questionnaires were distributed to randomly selected African American women between January and May 2010. All participants provided written consent for participation. The questionnaire takes approximately fifteen minutes to complete.

Surveys were offered immediately following approval of study by the Institutional Review Board. Participants were recruited on the CSUSB campus on Tuesdays and Thursdays. Participants were recruited from the surrounding community on Wednesdays and Fridays. Surveys were handed out until the targeted number of 50 was achieved.

## Protection of Human Subjects

Confidential handling of questionnaires protected the anonymity of subjects. Participants were not asked to sign questionnaires or put any identifiable marks on the

questionnaire. Questionnaires are identical with no identifiable characteristics. As a Social Worker bound by ethical standards the researcher tried to assure that there would be no harm to survey subjects. The researcher considered the possible impact of the questions included in the survey and possible stigma from participating in a HIV study. The Institutional Review Board reviewed the research question, population, and survey instrument. The Institutional Review Board deemed the study to be of minimal risk.

All consent forms were collected separately and stored separately. The questionnaires collected for the study are stored in a locked file cabinet. Finally, all surveys will be destroyed following completion of the study (APPENDIX 2 Informed consent).

## Data Analysis

This data was analyzed by using quantitative data analysis techniques. Descriptive statistics were used to describe the characteristics of the sampled participants particularly, frequency distributions, measures of central tendencies (by mean) and variability, standard deviation was also be calculated.

This study is descriptive in nature, utilizing quantitative data analysis. Opinions and perceptions of barriers to couples HIV testing were examined. This researcher utilized the SPSS for Windows to analyze the information obtained from each of the questionnaires used in this study to apply a value to the opinions and perceptions of African American Women.

## Summary

This section included a detailed outline of the research study and the methods and procedures that were utilized. Study design, Sampling method, Data Collection and Instruments were described, along with Procedures, and a statistical Data Analysis plan. Finally, all details and considerations of the researcher's efforts to preserve and protect the rights of Human Subjects during the course of the study were also included.

# CHAPTER FOUR

# RESULTS

## Introduction

This chapter provides a presentation of the findings of this study and a discussion in regards to the perspectives of a sample of African American women on perceived barriers to HIV Testing of intimate partners. As was mentioned in chapter three, the researcher sought a minimum of 50 completed questionnaires. On February 9, 2010 the California State University, San Bernardino Social Work Institutional Review Board Sub-committee approved the format of the research questionnaires. On February 16, 2010 the first group of questionnaires were dispensed at a CSUSB Graduate Health Scholars event at the lower commons, 14 completed questionnaires were collected. On February 25, 2010 the second group of questionnaires were dispensed at an Angela Davis Speaking event at the San Manuel Student Union, 25 completed questionnaires were collected. By March 5, 2010 the researcher completed the administration of the questionnaires in the community surrounding CSUSB. There were 5 additional questionnaires collected at the Working

wonders counseling agency. Another 4 completed questionnaires were collected from Life church of God and Christ with another 6 questionnaires collected from It's a hair thing beauty salon. After the data collection was complete the total number of completed questionnaires equaled 54; thereby giving this research study an *N* of 54.

## Statistical Analysis Plan

Statistical analysis of completed questionnaires originated with coding the responses on the questionnaires by converting all the responses to numerical codes, assigning names to variables and developing a codebook. The researcher utilized the Statistical Package for Social Sciences to further organize and analyze the data.

## Presentation of the Findings

### Analysis of Demographic Data

The questionnaire was split into three sections. Part 1 of the questionnaire consisted of nominal level data needed to determine characteristics of demographic data, which included age, race, relationship status, religion, education and the number of times participants

had been tested for HIV. Univariate analysis was utilized to calculate Frequencies and Percentages of demographic characteristics.

There were a total of 54 people who agreed to participate in the study. All participants were female (100%, N = 54) and African American (100%, N = 54). The ages of participants ranged from 17 to 68 years of age. The 19-year-old participants amounted to (13%, N = 7). The majority of participants were 20 years old, they accounted for (20.4%, N = 11). There was 1 participant age 17 (1.9%), 2 participants 18 years old (3.7%), 5 participants 21 years old (9.3%) 3 participants were 22 years old (5.6%), 3 participants were 23 years old (5.6%), 3 participants were 24 years old (5.6%), 3 participants were 25 years old (5.6%),3 participants were 26 years old (5.6%), 5 participants 27 years old (9.3%), There was 1 participant representing age 28, 31, 32, 35, 36, 42, 45, and 68 accounting for (1.9%) of the total frequency each, see Table 1.

The majority of participants were single (77.8%, N = 42), with 1 participant identifying as divorced (1.9%). Only 4 out of 54 total participants identified as

being married (7.4%), However, (13%) 7 participants total, stated that they were partnered, see Table 2.

A significant number of participants have attended some college (66.7%, N = 36). Only 3 participants stated that they had only attended high Scholl (5.6%). 9 clients are college graduates (16.7%) and 11.1% (N = 6) had graduated from a trade or vocational school, see Table 3.

All 54 participants responded to the question how many times have you been tested for HIV. Nearly half of all participants stated that they have never had an HIV test (43%, N = 23), see Table 4.

Analysis of other Nominal Level Data

Part 2 of the questionnaire was also populated with nominal level questions. However, there were three types of questions in this section with a total of 16 Yes or No responses. The three types of questions were designed to discern the participants, History of testing for HIV, the participant's feelings of personal empowerment, and the participant's ability to negotiate couples testing with their intimate partner.

The first type of question in this section involved the participant's history of testing for HIV. Participants were asked, "Have you ever tested for HIV?"

All 54 participants responded to the question, the majority of participants (57.4%, N = 31) stated that they had previously been tested. However, 23 participants (42.6%) stated that they had never been tested for HIV, see Table 5.

The second type of question in this section involved the participant's feelings of personal empowerment. Ex participants were asked, "Do you know the HIV status of your intimate partner?" (46%, N = 25) stated that they were aware of their intimate partners HIV status, see Table 6.

The third type of question in this section involved questions that were designed to discern the participant's ability to negotiate couples testing with their intimate partner. Ex participants were asked, "Have you and your intimate partner been tested for HIV together?" (9%, N = 5) stated that they had been tested for HIV together, see Table 7.

Analysis of Likert Scale Data

Part 3 of the questionnaire was comprised of 17 likert scale questions with a total of 7 scale responses ranging from: 1 = strongly disagree, 2 = disagree, 3 = fairly disagree, 4 = neutral, 5 = fairly agree,

6 = agree, and 7 = strongly agree. These questions were formulated, and all variables measured at the ordinal level.

The researcher determined that calculations for descriptive data were appropriate for use with the Likert scale ordinal data due to it's standardized format. Items on the standardized scales had numerical values assigned to them. The values attached to each participants response were then processed through the descriptive formula on SPSS and estimated scores of means were derived for each item. In addition to the variables included in Table 8, there were other variables related to perceptions of barriers to couples HIV testing that are listed in Table 9.

The analysis of the likert scale responses indicates the participants recognized HIV testing has a stigma. When asked if there is a negative stigma associated with being tested for HIV Only 10 of the 54 participants gave a response score of less than four. Four was the value assigned to neutral feelings toward the question. Scores of 3, 2, and 1, showed progressive levels of disagreement with the question, see Graph 1. However, the participant's responses also indicted that they did not

perceive stigma as a barrier to their personal ability to be tested for HIV. Only 13 of the 54 participants gave scores that were below 4, indicating that they would feel embarrassed if they were seen in line to get a HIV test, see Graph 2.

When Participants were asked questions regarding the best method for their intimate partners to agree to be tested the traditional method of HIV testing (at the health dept) scored lower than either door-to-door testing or Over the Counter HIV test. Testing at the health clinic received scores of 5, 6, or 7 indicating progressive levels of agreement from only 17 of 54 participants, see graphs 3, 4, and 5.

## Summary

Demographically the participants of this study were African American, females and within the age category of 17-68. On average she was most likely single and had attended some college. The reported demographic responses seemed to have little bearing on the responses participants had to the questions that were included in the questionnaire. Those participants that disclosed a

history of HIV testing and those that reported no history of HIV testing spanned the range of demographic options.

The statistics show that nearly half of the participants of the study had never had an HIV test and that less than 1 in 10 had accompanied an intimate partner for a test.

Participant's affirmative responses indicate feelings of empowerment in regards to individual HIV testing and there were consistent responses throughout the range of participant demographics that indicated powerlessness in regards to influencing intimate partners to be tested.

Table 1. Age

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 17.00 | 1 | 1.9 | 1.9 | 1.9 |
| | 18.00 | 2 | 3.7 | 3.7 | 5.6 |
| | 19.00 | 7 | 13.0 | 13.0 | 18.5 |
| | 20.00 | 11 | 20.4 | 20.4 | 38.9 |
| | 21.00 | 5 | 9.3 | 9.3 | 48.1 |
| | 22.00 | 3 | 5.6 | 5.6 | 53.7 |
| | 23.00 | 3 | 5.6 | 5.6 | 59.3 |
| | 24.00 | 3 | 5.6 | 5.6 | 64.8 |
| | 25.00 | 3 | 5.6 | 5.6 | 70.4 |
| | 26.00 | 3 | 5.6 | 5.6 | 75.9 |
| | 27.00 | 5 | 9.3 | 9.3 | 85.2 |
| | 28.00 | 1 | 1.9 | 1.9 | 87.0 |
| | 31.00 | 1 | 1.9 | 1.9 | 88.9 |
| | 32.00 | 1 | 1.9 | 1.9 | 90.7 |
| | 35.00 | 1 | 1.9 | 1.9 | 92.6 |
| | 36.00 | 1 | 1.9 | 1.9 | 94.4 |
| | 42.00 | 1 | 1.9 | 1.9 | 96.3 |
| | 45.00 | 1 | 1.9 | 1.9 | 98.1 |
| | 68.00 | 1 | 1.9 | 1.9 | 100.0 |
| | Total | 54 | 100.0 | 100.0 | |

Table 2. Relationship

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Married | 4 | 7.4 | 7.4 | 7.4 |
| | Single | 42 | 77.8 | 77.8 | 85.2 |
| | Partnered | 7 | 13.0 | 13.0 | 98.1 |
| | Divorced | 1 | 1.9 | 1.9 | 100.0 |
| | Total | 54 | 100.0 | 100.0 | |

Table 3. Education

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | High School | 3 | 5.6 | 5.6 | 5.6 |
| | Some College | 36 | 66.7 | 66.7 | 72.2 |
| | College Gradyate | 9 | 16.7 | 16.7 | 88.9 |
| | Graduate of Trade or Professional School | 6 | 11.1 | 11.1 | 100.0 |
| | Total | 54 | 100.0 | 100.0 | |

Table 4. How Many Times have you Been Tested for HIV?

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | .00 | 23 | 42.6 | 42.6 | 42.6 |
| | 1.00 | 11 | 20.4 | 20.4 | 63.0 |
| | 2.00 | 10 | 18.5 | 18.5 | 81.5 |
| | 3.00 | 4 | 7.4 | 7.4 | 88.9 |
| | 4.00 | 3 | 5.6 | 5.6 | 94.4 |
| | 5.00 | 2 | 3.7 | 3.7 | 98.1 |
| | 6.00 | 1 | 1.9 | 1.9 | 100.0 |
| | Total | 54 | 100.0 | 100.0 | |

Table 5. Have You Ever Tested for HIV?

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 31 | 57.4 | 57.4 | 57.4 |
| | No | 23 | 42.6 | 42.6 | 100.0 |
| | Total | 54 | 100.0 | 100.0 | |

Table 6. Do You Know the HIV Status of Your Intimate Partner?

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 25 | 46.3 | 56.8 | 56.8 |
| | No | 19 | 35.2 | 43.2 | 100.0 |
| | Total | 44 | 81.5 | 100.0 | |
| Missing | System | 10 | 18.5 | | |
| Total | | 54 | 100.0 | | |

Table 7. Have You and Your Partner been Tested for HIV Together?

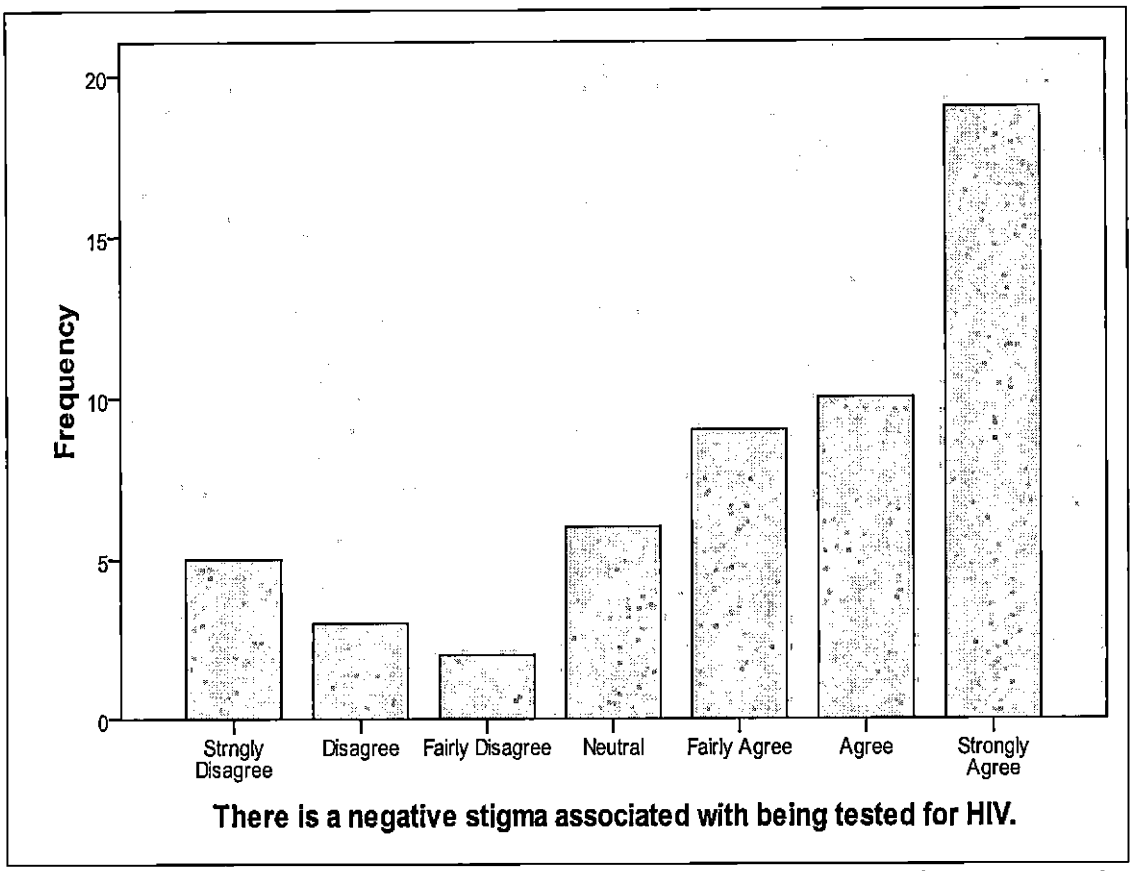
| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Yes | 5 | 9.3 | 10.2 | 10.2 |
| | No | 44 | 81.5 | 89.8 | 100.0 |
| | Total | 49 | 90.7 | 100.0 | |
| Missing | System | 5 | 9.3 | | |
| Total | | 54 | 100.0 | | |

Table 8. Depicting Mean and Standard Deviation for First Half of Likert Scale Questions

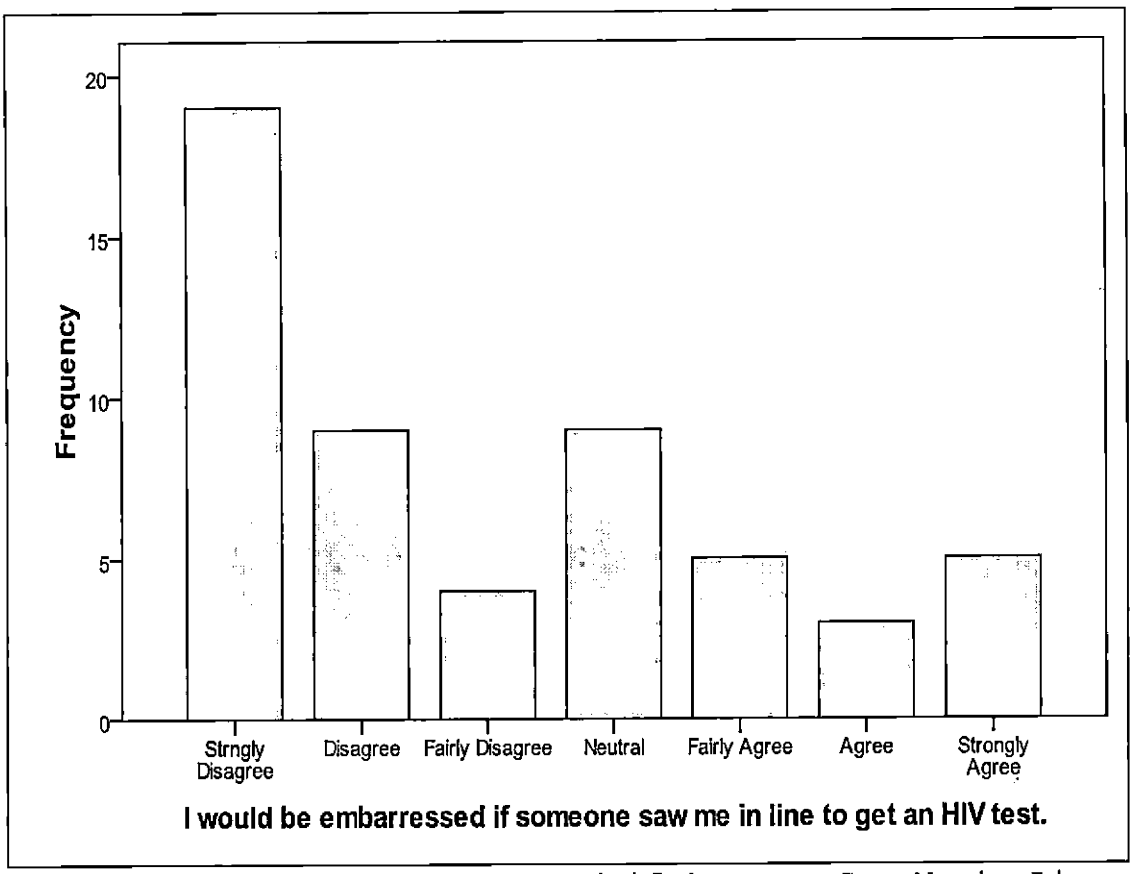
| | N | Mean | Std. Deviation |
|---|---|---|---|
| I would be embarrassed if someone saw me in line to get an HIV test. | 54 | 3.0185 | 2.04193 |
| There is a negative stigma associated with being tested for HIV. | 54 | 5.1667 | 1.96910 |
| There is a negative stigma associated with going to a health clinic for a HIV test. | 54 | 5.0556 | 1.88756 |
| I am concerned about false negative test results. | 54 | 4.7407 | 2.19076 |
| I am concerned about false positive test results. | 54 | 5.0556 | 1.96590 |
| I am concerned about test being administered improperly. | 54 | 5.2778 | 1.85733 |
| If I ask someone to get a HIV test prior to having sex, they may misinterpret my request and think I believe they have many sexual partners | 54 | 4.3889 | 1.68698 |
| If I ask someone to get an HIV test prior to having sex, they may think it shows how much I care. | 54 | 4.9444 | 1.48472 |
| I believe asking someone to get an HIV test prior to having sex indicates how mature you are | 54 | 6.1111 | 1.36902 |

Table 9. Depicting Mean and Standard Deviation for Second Half of Likert Scale Questions

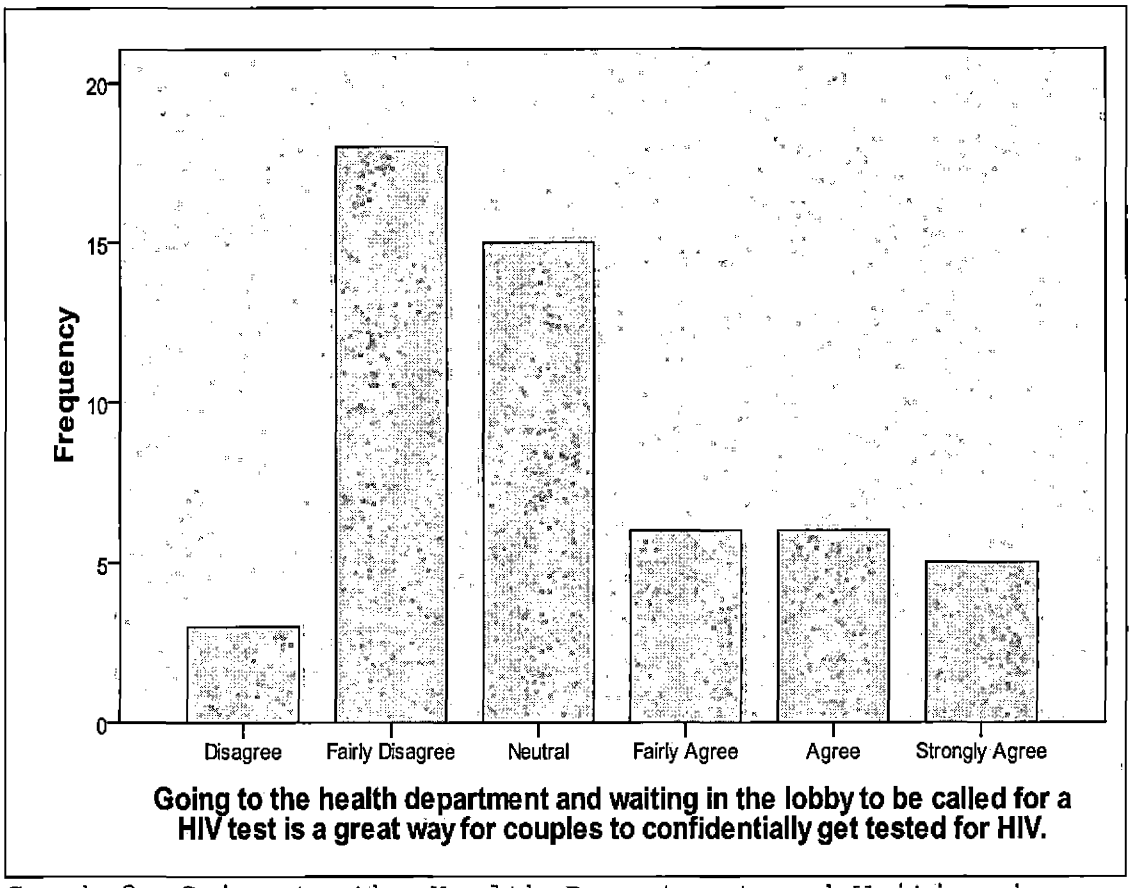
| | N | Mean | Std. Deviation |
|---|---|---|---|
| It is an invasion of privacy to ask someone you haven't had sex with to be tested for HIV. | 54 | 2.2778 | 1.41976 |
| Buying a 20 minute saliva rapid test at the local store, to be used in the privacy of your own home, is a great way for couples to confidentially get tested for HIV. | 54 | 5.3889 | 1.77420 |
| Going to the health department and waiting in the lobby to be called for a HIV test is a great way for couples to confidentially get tested for HIV. | 53 | 4.1698 | 1.41062 |
| My intimate partner would agree to use an over the counter 20 minute HIV test in the privacy of our home. | 53 | 4.6981 | 1.73853 |
| My intimate partner would agree to a door to door HIV test | 53 | 4.3396 | 1.65185 |
| Door to door HIV testing by trained health workers is a great way for couples to confidentially get tested for HIV in the privacy of their own home. | 54 | 5.0000 | 1.71563 |



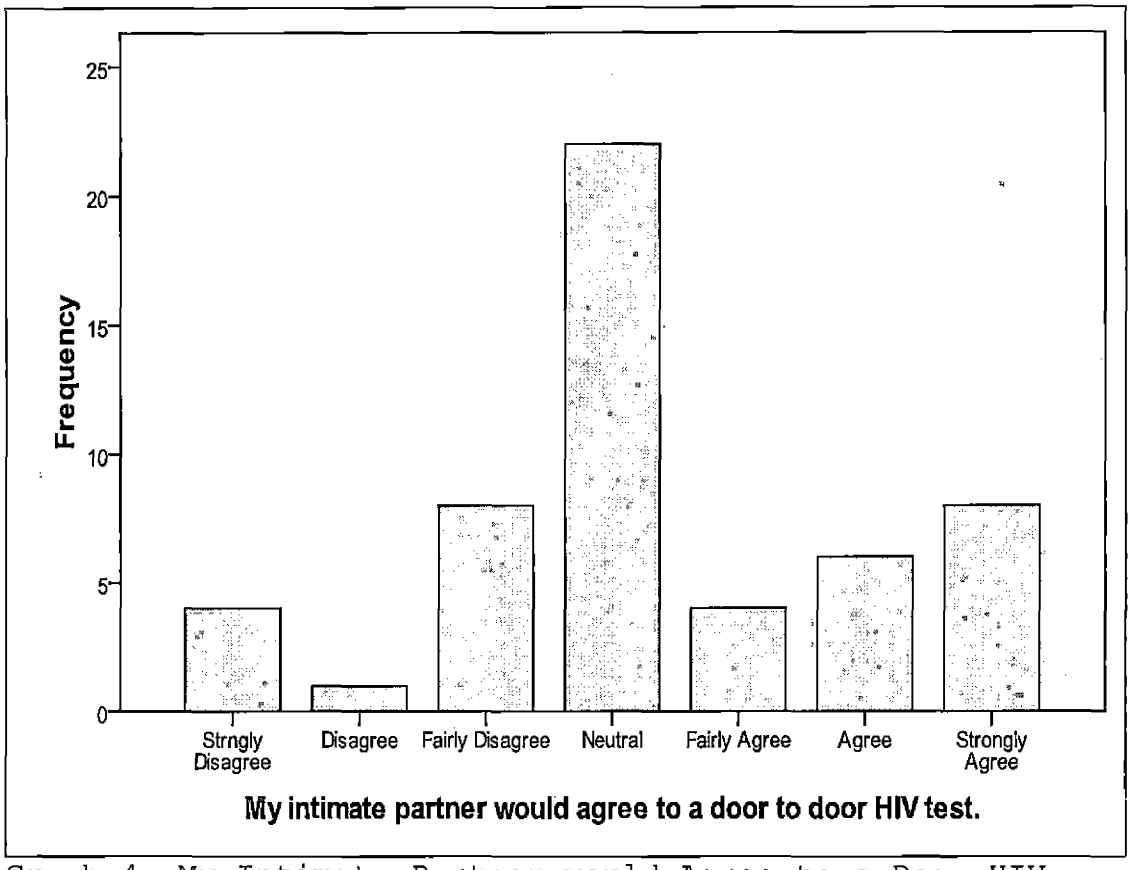

Graph 1. There is a Negative Associated with being Tested for HIV



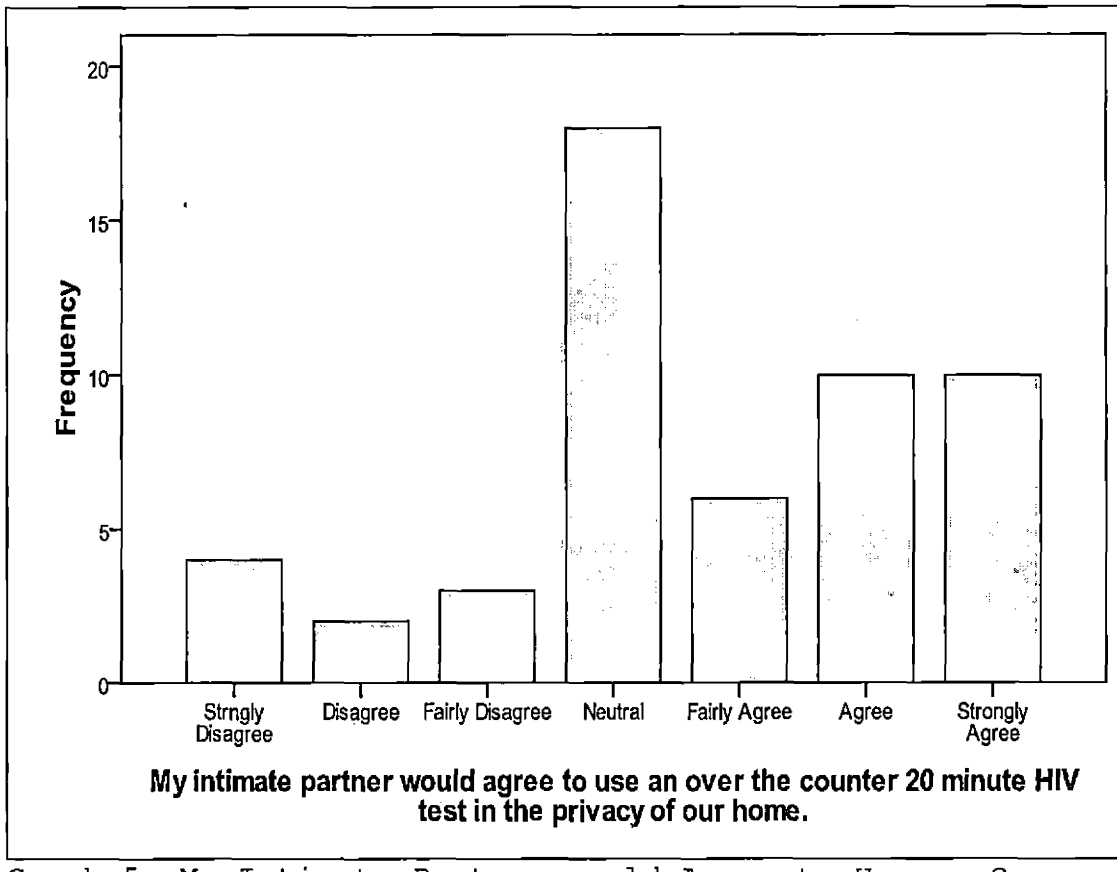

Graph 2. I Would be Embarrassed if Someone Saw Me in Line to get an HIV Test




Graph 3. Going to the Health Department and Waiting in the Lobby to be Called for a HIV Test is a Great Way for Couples to Confidentially get Tested for HIV




Graph 4. My Intimate Partner would Agree to a Door HIV Test




Graph 5. My Intimate Partner would Agree to Use an Over the Counter 20 Minute HIV Test in the Privacy of Our Home

# CHAPTER FIVE

# DISCUSSION

## Introduction

This research project will be helpful to the social work profession because it addresses an area that has impact on both levels of intervention; both macro and micro. This social problem has disproportionately impacted the physical and mental health of African American women. The effects of stigma and dating rituals are acknowledged as negatively impacting African American women who are at high risk of contracting HIV (Wyatt, 2009).

As stated in Chapter one the researcher sought answers to two research questions. The first was to Identify Perceived Barriers to HIV Testing of the intimate partners of African American Women. The second question sought to subsequently identify an effective HIV testing strategy.

## Barriers to Couples Testing

The statistical outcomes of the research questionnaire clearly indicate that the majority of participants perceive the issue of HIV testing as being

stigmatized. That may partially explain why 42% of participants disclosed that they have never been tested for HIV, see Table 5, (Hull et al., 1988). The fear of being shunned by family and friends that accompanies the possible consequences of testing positive for HIV, may also help to explain the low testing rates of individuals that are in high risk groups (HEREK, 1999). There was also a relatively consistent low score in the participant's ability to negotiate couples testing with their intimate partner, see Graph 2.

## Testing Strategies

The findings in this study point to a need to develop confidential and convenient HIV testing methods. However, there is no consistent standard among existing HIV testing programs that establishes anonymous and or confidential testing policies (Grusky et al., 2004). Overwhelmingly participants scored the option of purchasing an over the counter HIV test the highest of all testing options, however the product is not currently available in stores. In addition 42.6% of the African American women that participated in this study report never being tested for HIV. However, inconsistently (94%

N=51) of participants stated that it is important to know their HIV status.

Less than 50% of participants report knowing their intimate partners HIV status (46%, N = 25). However, less than one in ten participants (9%, N = 5) report actually participating in couples HIV testing, therefore over 80% of participants that think they know the HIV status of their intimate partner are relying on their partner to self report their status. This inconsistency in responses identifies a need for a different approach to HIV testing.

## Empowerment

Based on the results of this project, the researcher has concluded that the overall barrier to HIV couples counseling for African American women is an overall lack of empowerment. The participant's responses consistently show that they do not feel that the stigma associated with HIV testing is stigmatizing to them as individuals. This feeling of empowerment is expressed by the majority of participants stating that they would not be embarrassed to be seen in line waiting for a HIV test. However, as stated earlier, there is a relatively low

statistical rate of testing history among participants and little to no history of couples testing.

## Ambivalence or Powerlessness

Several of the responses to the questionnaire indicate a consensus that the participants were confident women with empowered self-images. However, their actual history of HIV testing and their knowledge of their intimate partners status indicate either Ambivalence or Powerlessness.

Sadly on likert questions associated with opinions toward couples HIV testing the response (Neutral), outscored all responses. Many participants spoke strongly regarding their personal opinions, however the participants displayed ambivalence toward their role in learning their partners HIV status.

Future studies need to be conducted to determine if African American women are ambivalent to their partners HIV status or HIV testing history. Additionally further studies need to be conducted to determine if African American women are simply powerless in their relationships with African American men.

## Recommendations

The recommendation of this researcher is to develop a HIV testing philosophy that empowers African American women to take an active role in protecting themselves from transmission of HIV. This can be accomplished through enhanced negotiating skills and confidential and convenient testing options.

A culturally sensitive method of addressing HIV testing should take in consideration the African American woman's lack of negotiating skill regarding the issue of couples HIV testing. Any innovative HIV testing strategy should work to enhance the African American woman's negotiating leverage by offering the type of confidential and convenient, over the counter delivery method that was identified in this study.

When Participants were asked questions regarding the best method for their intimate partners to agree to be tested the traditional method of HIV testing (at the health dept) scored lower than either door-to-door testing or Over the Counter HIV test, see graphs, 3, 4, and 5.

## Conclusions

After thoroughly reviewing and analyzing the responses of the 54 African American women who graciously volunteered for this study. The researcher sadly concludes that African American women suffer from a combination of low testing rates of both individuals and couples in combination with actions consistent with overconfidence.

This combination of low-test rates and overconfidence has created an atmosphere of ambivalence toward the true risk of contracting HIV. The researcher will advocate for continued studies on this social issue.

# APPENDIX A

# QUESTIONNAIRE

Impact of Perceptions of Barriers to HIV Testing:

The African American Woman's Perspective

I would like to ask a few background questions about you. Please answer all the questions to the best of your knowledge. If you have any questions about the questionnaire please feel free to ask

***PART I: Demographic Questions-Please mark the answer that best represents your response.***

1. **How old are you?** _____
2. **My ethnic background is:** (Mark all that comply) African American____

   Latin/Hispanic____ Asian____ Caucasian____ Native American____

   Pacific islander____ Other(Please describe)____
3. **My relationship status is:** Married____ Single____ Partnered____

   Divorced____ Widowed____ Other(Please describe)____
4. **My religion is:** Christian____ Muslim____ Buddhism____ Hinduism____

   Judaism____ No Religious Affiliation____
5. **Education:** Some High school____ High school____ Some college____

   College graduate____ Graduate of trade or professional school_____

   Other(Please describe)_____
6. **How many times have you been tested for HIV?** _____

***PART II: Please mark the answer that best represents your response.***

The following questions are designed to understand your opinions regarding HIV testing. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can.

1. **Have you ever tested for HIV? Yes____ No____**

2. **Do you know your HIV status? Yes____ No____**

3. **Did anyone accompany you when you tested for HIV? Yes____ No____ (Never tested)____**

4. **Is it important to know your HIV status? Yes____ No____**

5. **Have you ever accompanied someone while they were being tested for HIV? Yes____ No____**

6. **Would you be willing to ask your partner their HIV status? Yes____ No____**

7. **Would you be willing to ask your partner their HIV status before first sexual intercourse? Yes____ No____**

8. **Do you know the HIV status of your intimate partner? Yes____ No____**

9. **Have you and your intimate partner been tested for HIV TOGETHER? Yes____ No____**

10. **If you could receive a anonymous HIV test discreetly at a time and at a location of your choosing, would you get tested: Yes____No____**

11. **If you and your partner could receive an anonymous HIV test together, discreetly, at a time and at a location of your choosing, could you convince your partner to be tested with you? Yes____ No____**

12. **Do you think it's important to be aware of an intimate partners HIV status? Yes____ No____**

***PART III: Circle the number that best represents your level of agreement with the following statements. A response of "1" means you strongly disagree and a response of "7" means you strongly agree.***

The following questions are designed to understand your opinions regarding stigma associated with HIV testing. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can.

**1. I would be embarrassed if someone saw me in line to get a HIV test.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**2. There is a negative stigma associated with being tested for HIV.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**3. There is a negative Stigma associated with going to the health clinic for a HIV test?**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**4. I am concerned about false negative test results.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**5. I am concerned about false positive test results.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**6. I am concerned about test being administered improperly?**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

7. **If I ask my intimate partner to get a HIV test they may feel ambushed or insulted.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

8. **My intimate partner does not see a need to get tested for HIV because we are in a relationship and neither of us are HIV positive**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

9. **If I ask someone to get a HIV test prior to having sex they may misinterpret my request and think I believe they have many sexual partners.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

10. **If I ask someone to get a HIV test prior to having sex, they may think it shows how much I care.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

11. **I believe asking someone to get a HIV test prior to having sex indicates how mature you are.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

12. **It's an invasion of privacy to ask someone you haven't had sex with to be tested for HIV.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**13. Door to door HIV testing by trained health workers is a great way for couples to confidentially get tested for HIV in the privacy of their own home**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**14. Buying a 20 minute saliva rapid test at the local store, to be used in the privacy of your own home is a great way for couples to confidentially get tested for HIV**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**15. Going to the health department and waiting in the lobby to be called for a HIV test is a great way for couples to confidentially get tested for HIV**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**16. My intimate partner would agree to a door to door HIV test**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

**17. My intimate partner would agree to use a over the counter 20 minute HIV test in the privacy of our home**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Strongly Disagree | Disagree | Fairly Disagree | Neutral | Fairly Agree | Agree | Strongly Agree |

# APPENDIX B

# INFORMED CONSENT

## INFORMED CONSENT

The study in which you are being asked to participate is designed to identify and assess the impact perceived barriers have on the ability of African American women learning the HIV status of their intimate partners. This study is being conducted by Mr. Frederick Scott Smith, a Master of Social Work graduate student under the supervision of Assistant Professor Stanley Taylor, School of social Work, California State University, San Bernardino. This study has been approved by the Social Work Human Subjects Sub-Committee of the Institutional Review Board, California State University, San Bernardino.

**PURPOSE:** The purpose of the study is to identify and explore African American women's opinions and perceptions of barriers to HIV testing of intimate partners.

**DESCRIPTION:** You are being asked to complete a questionnaire that asks questions regarding the barriers that prevent African American Women from negotiating HIV testing of their intimate partners.

**PARTICIPATION:** Participation is totally voluntary, refusal to participate will not involve a penalty or loss of benefits to which you are entitled and you may discontinue participation at any time without penalty.

**CONFIDENTIALITY:** The information you give will remain confidential and anonymous. You name will not be associated with the study. Data will only be presented in group format.

**DURATION:** The questionnaire will take approximately 20 to 30 minutes.

**RISKS:** There are no foreseeable risks to you if you participate in this research.

**BENEFITS:** There is no direct benefit to participants, however, a potential benefit of taking part in the assessment will be to have a role in formulating an innovative outreach program that will provide an opportunity to formulate a effective HIV prevention model.

**CONTACT:** If you have questions about this project, please contact my research supervisor, Dr. Stanley Taylor, School of Social Work, California State University, San Bernardino, 5500 University Parkway, San Bernardino, CA 92407 Staylor@csusb.edu, (909) 537-5584.
**RESULTS:** The results of this research project will be available at the Pfau library, California State University, San Bernardino after September 2010

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