An exploratory study: the relationship between perception, education, accessibility and social marketing on the help seeking behaviors of HIV infected African Americans over 50

Roshaunda R. Leopold
Clark Atlanta University

Follow this and additional works at: http://digitalcommons.auctr.edu/dissertations

Part of the Arts and Humanities Commons

Recommended Citation
AN EXPLORATORY STUDY: THE RELATIONSHIP BETWEEN PERCEPTION, EDUCATION, ACCESSIBILITY AND SOCIAL MARKETING ON THE HELP SEEKING BEHAVIORS OF HIV INFECTED AFRICAN AMERICANS OVER 50

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY
ROSCHAUNDA R. LEOPOLD

WHITNEY M. YOUNG, JR., SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
MAY 2008
This study will examine the relationship between perception, education, accessibility and social marketing on the help seeking behaviors of HIV infected African Americans over age 50. This study builds upon the current knowledge base by using grounded theory to identify strategies for assisting the target population. Data will be collected through focus groups and individual interviews. This study will target 30 African Americans adults over 50 who are infected with or by HIV/AIDS. It is the researcher’s assumption that when adults over the age of 50 participate in HIV/AIDS services geared specifically for their age group it will, reduce their transmission rate, enhance their awareness, and education while enhancing their quality of life. The Social Marketing strategy is used as the conceptual framework for this study. Visibility, understanding of effective services, understanding of consumer needs, and effective communication techniques are all-important elements in addressing issues associated with the help seeking behaviors of HIV/AIDS infected/affected adults over 50. Through education and awareness, adults over 50 will be inclined to take full ownership of their sexual behaviors/activities, while limiting their risk of contracting or transmitting HIV/AIDS. The spread of HIV/AIDS continue to increase at an alarming rate, preventive messages and treatment should be addressed within all populations. As change agents, effective change relies in our ability to effectively educate and communicate the risk of HIV/AIDS among the African American adults over 50.
AN EXPLORATORY STUDY: THE RELATIONSHIP BETWEEN PERCEPTION, EDUCATION, ACCESSIBILITY AND SOCIAL MARKETING ON THE HELP SEEKING BEHAVIORS OF HIV INFECTED AFRICAN AMERICANS OVER 50

A THESIS SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY

ROSHAUNDA R. LEOPOLD

WHITNEY M. YOUNG, JR., SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

MAY 2008
Acknowledgements

This journey has not been easy. Without the support of family and friends, none of this would have been possible. First, I want to thank God, for allowing me the opportunity and tools needed to complete this process. To my family, thanks for instilling in me the drive to pursue higher education, thanks for the words of encouragement and support.

Secondly, I want to thank my friends Natika Everett, Marquie Gregory, Carnella Harvey, and Jason Anderson. Thanks for listening to my concerns and being a support system as I matriculated through the Master of Social Work Program. To Dr. Sarita Davis thanks for guiding me during this process and being very thorough in providing clear directions. I could have never done this without you.

Lastly, to all of the individuals who shared their personal stories, concerns and triumphs. These experiences will never be forgotten.
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS ........................................................................................................... ii

LIST OF TABLES ...................................................................................................................... v

CHAPTER PAGE

I. INTRODUCTION ................................................................................................................... 1
   Purpose of the Study .............................................................................................................. 2
   Background of the Problem ................................................................................................. 5
   Statement of the Problem ................................................................................................... 7
   Significance of the Study ..................................................................................................... 8
   Summary ............................................................................................................................. 10

II. REVIEW OF LITERATURE ............................................................................................. 12
   History of HIV/AIDS ......................................................................................................... 12
   The HIV Pandemic ............................................................................................................ 14
   Access and Utilization of Treatment Services for Adults Over 50 .................................... 19
   HIV Policy Issues ............................................................................................................. 20
   Barriers to Treating HIV among Adults Over 50 ............................................................. 24
   Limitation of the Literature ............................................................................................... 27
   Conceptual Framework ..................................................................................................... 27
   Summary ............................................................................................................................ 30

III. METHODOLOGY ............................................................................................................. 32
   Design ............................................................................................................................... 33
   Sample ............................................................................................................................. 34
   Measure ............................................................................................................................ 36
   Procedures ........................................................................................................................ 36
   Analysis .............................................................................................................................. 38
   Summary ............................................................................................................................ 39

IV. FINDINGS ........................................................................................................................ 40
    The Participants ................................................................................................................. 41
    Overview of the Properties and Categories .................................................................... 47

iii
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American Adults Over 50 Understanding of HIV/AIDS</td>
<td>50</td>
</tr>
<tr>
<td>Minimal Individual Risk</td>
<td>50</td>
</tr>
<tr>
<td>Lack of Formal Education</td>
<td>52</td>
</tr>
<tr>
<td>Sexual Behaviors</td>
<td>54</td>
</tr>
<tr>
<td>Promiscuity or Monogamy</td>
<td>54</td>
</tr>
<tr>
<td>Risk Associated with Contracting HIV</td>
<td>56</td>
</tr>
<tr>
<td>Accessing Services</td>
<td>60</td>
</tr>
<tr>
<td>Population Disconnect</td>
<td>60</td>
</tr>
<tr>
<td>Age Specific Services</td>
<td>62</td>
</tr>
<tr>
<td>Invaluable Resources</td>
<td>62</td>
</tr>
<tr>
<td>Education Deficiency in Media Messages</td>
<td>64</td>
</tr>
<tr>
<td>Summary</td>
<td>65</td>
</tr>
<tr>
<td>V. CONCLUSION</td>
<td>68</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>74</td>
</tr>
<tr>
<td>Suggested Research for Future Practice</td>
<td>75</td>
</tr>
<tr>
<td>VI. IMPLICATIONS FOR SOCIAL WORK</td>
<td>76</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>80</td>
</tr>
<tr>
<td>APPENDIX A: IRB APPROVAL FORM</td>
<td>81</td>
</tr>
<tr>
<td>APPENDIX B: RESEARCH FLYER</td>
<td>82</td>
</tr>
<tr>
<td>APPENDIX C: INFORMED CONSENT</td>
<td>83</td>
</tr>
<tr>
<td>APPENDIX D: CLIENT DEMOGRAPHIC FORM</td>
<td>86</td>
</tr>
<tr>
<td>APPENDIX E: INTERVIEW GUIDE</td>
<td>87</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>89</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fiscal Year 2006 Funding for HIV/AIDS in Georgia</td>
<td>23</td>
</tr>
<tr>
<td>2. Categories and Properties</td>
<td>49</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Over 25 years ago, Dr. Michal Gottlieb reported five cases of a rare pneumonia among homosexual men in Los Angeles (Russell, 2006). Now 25 years later it is estimated that 33.2 million people are living with the Human Immunodeficiency Virus (HIV) virus that cause AIDS Acquired Immunodeficiency Syndrome worldwide (Kaiser Family Foundation [KFF], 2007). Originally, the virus was linked solely to the homosexual population. However, today the virus has been recognized as being transmitted among male to male sexual contact with an estimated number of 454,106 cases, injection drug use at an estimate of 242,006 cases, male to male sexual contact and injection drug use estimated at 66,082 cases, high risk heterosexual contact estimated at 164,850 cases and perinatal and other types at an estimate of 20,542 cases through 2005 (Center of Disease Control DC, 2005). Through research, significant data has been recorded regarding the spread of this infectious disease among children, adolescents and young adults. Given the widespread nature of the disease, prevention and education efforts should address all population and not limit information to particular age groups. According to recent surveillance reports on HIV/AIDS treatment, prevention, and services there is a significant lack of services that serve the over 50 population specifically (Shippy, 2004). This study explores how HIV infected African Americans over age 50 understand and negotiate their risk. First, we examine their
perception of risk, followed by their knowledge of HIV/AIDS, ending with a discussion of the adequacy of HIV/AIDS services in their local community—especially as it impacts their help-seeking behavior. Together these findings are used to identify the gaps in service delivery, make recommendations to inform HIV prevention education messages, services, and HIV policy.

Adults age 50 and older have less knowledge of the general population about HIV/AIDS (Strombeck & Levy, 1998). Unfortunately, the belief that particular groups were safe from the virus has resulted in high prevalence rates among these groups (Tucker-Brown, 2007). The age of people being diagnosed with and living with HIV/AIDS has increased over the last decade. Many older adults do not know that HIV/AIDS occurs in their age group (Chiao, Ries, & Sande, 1999). This study will explore the relationship between perceptions, education, accessibility and social marketing on the help seeking behaviors of HIV infected African Americans over 50. The significance of this study is that it specifically focuses on an emergent risk group, African Americans adults over 50 and the lack of age specific services available within metropolitan Atlanta. The remainder of the paper will explain the purpose of this study, the background of the problem, and significance of the proposed research.

Purpose of the Study

The purpose of this study is to inform and improve HIV social marketing health messages targeting adults over 50 and the communities in which they reside. This study seeks to examine the efficacy of age specific services and the dissemination of
education and prevention information and their ability to promote healthy life choices for adults over 50. The resulting information will be used to identify effective intervention strategies and services that can be used to reduce HIV/AIDS while promoting quality of life.

In Georgia, approximately 22,147 persons were knowingly living with HIV/AIDS. Among those persons, 24% were female. African Americans accounted for 71% of persons living with HIV/AIDS, but only accounted for 29% of Georgia’s population (Statehealthfacts.org, 2007). Majority of persons living with AIDS in Georgia were 40 years of age. Among individuals infected with HIV/AIDS, 25% were 50 years of age and older. According to the Center for Disease Control 2005 Surveillance report, approximately 2,963 HIV/AIDS cases among individuals 55 years of age and older in the 33 states were reported. Among this estimate, 1,535 were between 55-59 years of age, 768 were between 60-64, and 660 among 65 and older, which signifies the person’s age at the time of diagnosis. In metropolitan Atlanta, there are very few HIV/AIDS programs designed specifically for individuals over the age of 50.

According to the Center for Disease Control (CDC) 2007, a cumulative estimate of HIV/AIDS cases through 2005 among African Americans was 397,548. The age of people being diagnosed and living with HIV/AIDS has increased over the last decade. An article “HIV, AIDS and Older People” written by the National Institute on Aging suggest, older American know less about HIV/AIDS than younger people, health care providers and educators often do not talk with older people about prevention, and doctors may not ask
older patients about their sex lives, drug use or risky behaviors which indicates the growing number of HIV/AIDS cases.

The goal is to raise awareness of HIV/AIDS within their community, teach seniors about sexually transmitted disease, condoms, risky sexual behaviors, prevention, testing, treatment, overall health, and education on infectious diseases with special emphasis on HIV/AIDS. In many cases adults over 50 believe HIV/AIDS is a disease of young promiscuous youth. They often believe that they are not at risk of becoming infected. According to an article provided by AIDS InfoNet, 2007, older people get HIV the same way as younger people. However, they may not be aware that they are at risk of HIV infection. They also may not know how to protect themselves from HIV transmission. There are several reasons why older people are getting infected:

1. Lack of knowledge regarding the risk factors for HIV infection.
2. Limited prevention education.
3. Misperception that HIV only affects younger people.
4. Unprotected sex (heterosexual or homosexual).
5. Sharing needles.
6. Being newly single, many older people get divorced or lose their mates. While they had a partner they may have ignored HIV prevention messages.

For an older person, an HIV/AIDS diagnosis can cause disbelief, denial, and fear of disclosure and retaliation (Cyr, 2004).
Background of the Problem

Although African Americans account for approximately 13% of the US population, an estimated 49% of people who contract HIV/AIDS are African American (CDC, 2007). According to the 2003 United States Census Bureau, the elderly population represents 12 percent of the total population. Yet the need for further understanding of the effect of HIV/AIDS among adults over 50 goes unrecognized, and unaddressed. Age sixty-five and older was arbitrarily chosen to define old age by the New Deal Congress in 1935, and in the mid-1960s by the creators of Medicare (Transamerica Insurance, 1999). However, age 50 is being used more often to keep statistics on older people with HIV/AIDS. Between 15 to 19% of United States AIDS cases occur in people over the age of 50, because of people living longer healthier lives and a combination of drug therapy and other activity enhancement drugs the number of new cases are expected to increase.

Because of the increase of divorce rates, need for sex, America's change of dating norms and drugs like Viagra, this promotes an active sex life, which assists in the increasing number of older Americans at risk for exposure to HIV/AIDS (Linsk, 2000). About 78,000 people age 50 or over have AIDS in the United States. This is about 10-15% of all people living with AIDS (AIDS.ORG, 2007). About half of the older people with AIDS have been infected for one year or less, sparking the concern of why older people are becoming infected (AIDSINFONET, 2007). Researchers have offered several explanations for the continued increase in HIV prevalence among the African American population. These explanations include feelings of powerlessness leading to

HIV among seniors is not a new discovery. HIV in persons older than 50 has accounted for 10% of all cases since the early 80's (He, Sengupta, Velkoff, & Debarros, 2005). Although, the primary mode of transmission changed from blood transfusion to heterosexual contact and injection drug use, adults over 50 are still at risk of becoming infected. Many times our adults over 50 are left isolated; however, society and medical professionals must not forget the need for intervention and information within communities of older adults. Many adults over 50 are newly single. They get divorced or lose their mates. While they had a partner they may have ignored HIV prevention messages although they may be now potentially at risk as a result of their current sexual activities (Cyr, 2004).

According to Baldwin, (2001), the most prevalent mode of transmission of HIV among adults over 50 is through sexual intercourse, not through contaminated blood products as indicated in previous research. Current research also indicates that among infected seniors male-to-male sexual contact is the primary risk factor at 30%, followed by no risk reported at 26%, injection drug use at 19%, and heterosexual contact at 15%. Although, 84% of seniors affected with HIV/AIDS are male, statistics indicate that approximately 18% cases in the United States female population are in women older than 50. Despite the illusion that seniors are not sexually active, older women can be at
the same risk for HIV infection as younger women depending on their sexual behaviors. Since most adult women over 50 have gone through menopause, they are not concerned about becoming pregnant. They rarely think about the need for condoms as preventive methods of sexually transmitted diseases (STD).

Jane Flower (2005) in “HIV and Older Women” argues, “For aging women, there is another consideration. Vaginal walls become thinner and can tear more easily, and there is a decrease in the fluid that lubricate. This can put older women at higher risk during unprotected sexual intercourse.” Adult women over 50 are often the unforgotten audience when researcher, health professionals, advocates, and volunteers are presenting preventive information. Consequently decreasing their awareness and increasing their chances of becoming infected. The message to all regardless of age should be high-risk unprotected heterosexual contact, injection drug use and other risky behaviors can increase the chances of becoming infected with HIV/AIDS. HIV prevention, education and awareness are all tools needed in order to decrease the risk associated with HIV among adults over age 50.

Statement of the Problem

Older individuals are often misdiagnosed due to stereotypical thinking that seniors are not sexually active or drug users. Health care providers often may not feel the need to test adults over 50 for HIV/AIDS because of stereotypical thinking that older people are not sexually active. Thus, creating a misdiagnosed or under diagnosed older adult patient. The reality is older adults acquire HIV/AIDS the same way as
younger individual, however, the imbalance is prevalent due to the lack of vital preventive information distributed to older adults. Research suggests that adults over 50 are becoming infected as a direct factor of being uninformed of the risk of the infection, the misconception that HIV/AIDS only affects younger people, no training in safer sexual activities, the risk of having unprotected heterosexual or homosexual sex and sharing needles (AIDSINFONET, 2007).

In order to combat the issue of HIV/AIDS among adults over 50, those who care for them (i.e., Social Workers, Health care providers, and family members) should echo the same message given to adolescents and young adults in the community. True impact depends heavily on our collective ability to effectively educate and communicate the risk of the HIV/AIDS infection regardless of race, gender, and age. Consequently, social marketing approach is requisite to affirm the sexuality of older adults while simultaneously educating them and their communities of support, on the challenges and safe practices that can improve prevention education outcomes.

Significance of the Study

Today the demographic face of HIV/AIDS is becoming increasingly rural, female, black, and heterosexual. Unfortunately, many of these cases occur in the Southern states (Alvear, 2003). According to the AIDS Survival Project (2007), seven of the 10 states with the highest AIDS cases rates in the nation are located in the South.
Despite the previously mentioned myths and stereotypes about seniors and HIV, they are at the same risk as other age group. As stated by the U.S. Department of Health and Human Services, National Institute on Aging (2004), seniors are often uninformed of prevention methods further increasing their chances of becoming infected.

According to recent surveillance reports on HIV/AIDS treatment, prevention, and services there is a significant lack of services that serve the over 50 population specifically (Shippy, 2004). These biases are recognized because of local funding for this unrecognized population. For example, health care professionals do not consider testing individuals over the age of 50 for HIV/AIDS, which causes misdiagnosis or undiagnosed individuals. Since older individual have other health concerns that can be attributed to getting older, many health care professionals rule out symptoms of HIV/AIDS even if presented, due to lack of awareness or myths that seniors are not drug users or sexually active. Due to lack of testing in adults over 50, the true representation of HIV/AIDS cases remains unknown.

In addition, adults over 50 are not routinely tested because they are not recognized as participants in high-risk behaviors, thus causing biases and possibility of skewed statistics. Although, the main transmission trend of HIV/AIDS is men who sleep with men (MSM) an increasing number of new cases are being identified in heterosexuals and drug users over the age of 50. Lieberman (2000) reported that the infection rate of older women now surpasses older heterosexual men, and that sexually active older women who do not fear pregnancy and do not know about the risk of HIV infection may not insist on using a condom. Finally, the basic principles for universal
access, has to be equitable, accessible, affordable, comprehensive and sustainable over long periods of time (Cyr, 2004).

Because of this study’s emphasis on understanding how adults over 50 perceive their sexual risk and the factors in their environment that help and hinder that process it hopes to make several contributions to the body of knowledge: 1) to learn what current prevention education practices work; 2) to learn what gaps in service currently exist; and 3) to learn how to bridge the existing gaps through individual and collective efforts.

The immediate term impact of this result for older adult communities of care in metropolitan Atlanta is that this information can inform local HIV/AIDS policies and practices to services for the HIV/AIDS population, policy makers include low income, those who are limited to resources, an array of services for diverse population and treatment programs design to sustain over the progress of the disease.

Summary

HIV cases in person older than 50 continues to grow, further acknowledging that seniors and specifically HIV is not a new phenomenon. Yet the need for a universal preventive message to combat the spread of HIV/AIDS is needed regardless of age. Seniors are often confronted with stigma and discrimination, fear of contagion, loss of trust with loved one, and lack of support or understanding from family and friends (Zelenetz & Epstein, 1998). Often support groups are not geared to deal with specific problems of older adults. The immediate need for prevention programs and services for individuals over 50 are greatly needed within the metropolitan Atlanta area. This study
seeks to explore the relationship between perceptions, education, accessibility and social marketing on the help seeking behaviors of HIV infected African American over age 50. This study is designed to highlight problems were limited knowledge is identified. Due to the lack of services and resources with the metro Atlanta area, it is this researcher’s assumption that when adults over age 50 participate in HIV/AIDS services geared specifically for their age group it will, reduce their transmission rate, enhance their awareness and education while enhancing their quality of life. The following chapters will address the relevant literature regarding this study, the methods used in collecting and analyzing the data, the conclusions and implication for social work practice.
CHAPTER II

REVIEW OF LITERATURE

This chapter gives an overview of the effects of HIV among adults over 50. This includes a discussion of the Ecological Systems Theory and the behaviors of older adults in the context of their life experience. Also, included is a discussion of the health concerns of the target population. This section details how these confounding health issues further complicates adequate health prevention education. This chapter will provide detailed background information on the history of HIV/AIDS, how HIV/AIDS effects the over 50 population, the access of treatment services for individuals living with HIV/AIDS, HIV policy and barriers to treating HIV among older adults. This section is also designed to understand a worldview that will aid in the human societal transformation toward spirituality, ethics, values and morals.

History of HIV/AIDS

Human Immunodeficiency Virus (HIV) is the virus that causes AIDS Acquired Immunodeficiency Syndrome. HIV/AIDS both attack the immune system, which is designed to fight the infections that enter the body. However, with HIV the virus destroys the portion of the immune system needed to fight disease; white blood cell (T cells or CD4 positive cells).
The final stage of HIV infection is AIDS. AIDS is determined when the virus has weakened the immune system to which the body has difficulty fighting infections.

A healthy, uninfected person has approximately 800 to 1,200 CD4+ T cells per cubic millimeter of blood. Once an individual is infected with the virus these blood cells progressively declines. When the CD4+ T cell count falls below 200, an individual is more vulnerable to opportunistic infections and cancers that illustrate AIDS. Over 25 years ago, a rare pneumonia among homosexual men was exposed. This disease, which did not have a name or any information on origin, showed significant signs of a depressed immune system. During this time, researchers believed this disease posed no imminent danger to the heterosexual population or women. However, new cases of the disease were later noted in injection drug users, Haitians and hemophiliacs (CDC, 1982).

By 1982, HIV and AIDS had firm footing in American landscape. During this time, researchers began to identify potential methods of transmission, risk factors and prevention technique. According to the Center for Disease Control and Prevention [CDC] (2007), HIV is primary found in the blood, semen, or vaginal fluid of an infected person. HIV is transmitted in 3 main ways: Having sex (anal, vaginal, or oral) unprotected with someone infected with the virus, sharing needles and syringes with someone infected and being exposed (fetus or infant) to HIV before or during birth or through breast feeding (CDC, 2007). During the early 1980s, as many as 150,000 people became infected with HIV each year, by the early 1990s, this rate had dropped to
about 40,000 each year, where it remains today (CDC, 2007). Although, the disease first emerged among marginalized groups such as injection users, homosexuals, and prostitutes; today it has expanded among various groups such as adolescence, children, women, and the elderly (Russell, 2006).

The HIV Pandemic

Between 11 to 15% of United States AIDS, cases occur in people over the age of 50 (AIDSINFONET, 2007). Age sixty-five and older was arbitrarily chosen to define old age by the New Deal Congress in 1935, and in the mid-1960s by the creators of Medicare (Transamerica Insurance, 1999). However, age 50 is being used more often to keep statistics on older people with HIV/AIDS (CDC, 2007). Ironically, many do not consider age 50 to be old, because today, people in the United States are living longer and healthier lives than ever before. The National Association on HIV Over Fifty (2007) suggest the number of new cases are expected to increase, as a result of people living longer healthier lives and a combination of drug therapy and other activity enhancement drugs. Older individuals are often misdiagnosed due to stereotypical thinking that seniors are not sexually active or drug users. Many factors increase adults over 50 chances of becoming infected such as isolation, lack of knowledge, past substance abuse issue that was never addressed and poor communication.

According to Brown & Sankar (1998) many of the older persons presenting with HIV/AIDS come from minority cultures that reflect non-mainstream worldviews. People from oppressed groups frequently have difficulty trusting outsider and
institutions. This can be particularly true for older adults who may feel a deep sense of shame and embarrassment (Brown & Sankar, 1998). Along with perceived risk, social and cultural pressures may affect one’s ability and willingness to protect themselves from HIV infection (Stuntzer-Gibson, 1991; Wingood & Diclemente, 2000).

Worldwide in 2004, more than 3 million people died from AIDS. During that same year an estimated 5 million people acquired HIV increasing the number of people living with HIV to 38.6 million. Over a 5-year span AIDS have claimed the lives of over 92,505 individuals over the age of 50 (CDC, 2005). Worldwide there is very limited information on the effects of HIV/AIDS specifically within the over 50 population. Solely the numbers of infected or ill individuals cannot be ignored. In the Caribbean and Latin American countries approximately 2.1 million people are living with HIV/AIDS, yet they continue to make admirable progress in providing treatment and care. Asia and the Pacific estimated 8.2 million people are living with HIV/AIDS, which is an 8% increase since 2002, (CDC, 2005). Eastern Europe and Central Asia states approximately 1.6 million individuals are living with HIV/AIDS and continue to be their fastest growing epidemic. In 2007 alone over, 22.5 million people are living with HIV/AIDS in the Sub-Saharan Africa. HIV/AIDS is the leading cause of deaths within this region. Statistics support that without adequate treatment and care, most of those living with HIV will not survive the next decade. Regardless of race/ethnicity, age, location or transmission categories, HIV/AIDS is claiming the lives of individuals worldwide at a startling rate.
According to the CDC, in 2005, the estimated number of diagnoses of AIDS in the United States and dependent areas was 41,897. Of these, 40,608 were in the 50 states and District of Columbia and 982 were in the dependent areas. In the 50 states and District of Columbia, adult and adolescent AIDS cases totaled 40,540 with 29,766 cases in males and 10,774 cases in females, and 68 cases estimated in children under age 13. The cumulative estimated number of diagnoses of AIDS through 2005 in the United States and dependent areas was 984,155. Of these, 952,629 were in the 50 states and District of Columbia and 30,386 were in the dependent areas. In the 50 states and District of Columbia, adult and adolescent AIDS cases totaled 943,525 with 761,723 cases in males and 181,802 cases in females, and 9,101 cases estimated in children under age 13. Since that time approximately 1.7 million people in the United States have been infected with HIV, including more than 550,000 who have already died and an estimated 1.2 million living with HIV/AIDS today (KFF, 2007).

In Georgia, approximately 22,147 persons were knowingly living with HIV/AIDS. Among those person 24% were female. African Americans accounted for 71% of persons living with HIV/AIDS, but only accounts for 29% of Georgia’s population (Statehealthfacts.org, 2007). Majority of persons living with AIDS in Georgia were 40 years of age. Among individuals infected with HIV/AIDS 25% were 50 year and older. According to the Center for Disease Control 2005 Surveillance report approximately 2,963 HIV/AIDS cases among individuals 55 years of age and older in the 33 states were reported. Among this estimate 1,535 were between 55-59 years of age, 768 were between 60-64 and 660 among 65 of age and older, which signifies the
person’s age at the time of diagnosis. In metropolitan Atlanta, there are very few HIV/AIDS programs designed specifically for individuals over the age of 50.

According to the Center for Disease Control (CDC), 2007 a cumulative estimate of HIV/AIDS cases through 2005 among African Americans was 397,548. The age of people being diagnosed and living with HIV/AIDS has increased over the last decade. An article “HIV, AIDS and Older People” written by the National Institute on Aging (2004) suggest, older American know less about HIV/AIDS than younger people, health care providers and educators often do not talk with older people about prevention, and doctors may not ask older patients about their sex lives, drug use or risky behaviors which indicates the growing number of HIV/AIDS cases.

Often the elderly population does not receive education or prevention information on safe practices to protect them from becoming infected with the virus or infecting others (AIDSINFONET, 2007). Prior to alternate medical practices, the over 50 population was at risk of contracting the virus through blood transfusions. Current research suggests that older adults contract the virus primarily through homosexual activities, heterosexual actives, and intravenous drug usage. In a study conducted by Enzi, Gasparini & Inelman (2005), findings indicated, only a small minority of individuals over age 70 said that they consistently used condoms even though they reported having more than two partners in the past five years. This is due in part to condom use, which is historically linked to pregnancy prevention and consequently ignored as a safe sex practice by heterosexuals and older adults (Leigh, Temple &
Trocki, 1993). Yet, in part because of a lack of education and prevention efforts targeted at older populations, older women appear to be less capable of accurately assessing their lifetime risk of HIV even when they have significant risk factors and live in communities with high rates of infections (Akers, 2007).

Older adults with little knowledge pertaining to HIV and low perceived personal risk of contracting HIV/AIDS were less interested in HIV testing, which was consistent with attitudes in much younger, high-risk adults (Akers, 2007). It was also reported that progression to AIDS in this population was quicker and initial mortality rate is greater (Cantania, Turner, Kegeles, et al, 1989). Progression of the virus in this population occurs at an accelerated rate due to the aging immune system (Adler, Bender, & Nagel, 1998). Health care professionals fail to administer HIV tests to this population on a regular basis, therefore, if diagnosed their symptoms are exhibited at a rapid course and presents a shorter survival time after diagnosis.

According to Mariner, Baker, McCartin, & Rappoport, (2006), seniors are often dealing with multiple health issues. This may make it more difficult for a doctor to distinguish between symptoms of HIV/AIDS and other medical decisions, delaying an HIV/AIDS diagnosis. In addition, some medical providers may be less likely to associate HIV/AIDS with older populations. Both of these factors may contribute to the fact that older persons are more likely to be diagnosed at a late stage of infections (NAHOF, 2007). Consequently, the ability for over 50 African Americans to access and utilize HIV/AIDS treatment services is a critical element in addressing the spread and treatment of the disease.
Access and Utilization of Treatment Services for Adults Over 50

Treatment and prevention services are intricate components when fighting the spread and reducing the risk of new cases of HIV/AIDS. HIV treatments such as antiretroviral drugs (ARVs) seem to work just as effectively in older people as in younger people. Unfortunately, we do not have good information on older people because they usually do not participate in clinical drug trials (AIDSINFONET, 2007). People who become infected when they are over 50 seem to do about as well as people who started receiving HIV treatment before age 50 and then got older. Treatment side effects may not be any more frequent in older people. However, changes caused by aging can resemble or worsen treatment side effects. As people age, they develop health issues that continue for the rest of their lives. Often older people take many different medications to deal with their other health problems (AIDSINFONET, 2007).

According to AIDSINFONET (2007), this can make it more difficult for a health care provider to choose ARVs because of interactions with other medication. Some ARVs may increase the risk of diabetes, high blood pressures, or osteoporosis. This makes it harder to choose the right HIV regimen (AIDSINFONET, 2007).

While researching the array of services and treatment programs available within metro Atlanta, there is a significant deficiency in the number of programs geared specifically for individuals over the age of 50. In reviewing the various services available for specific population, metropolitan Atlanta, the research concluded that the city has more services than previously thought. There are approximately 30 services specifically for women, approximately 31 services for low income/homeless,
approximately 27 services for people of color, approximately 40 services specifically for adolescents, approximately 69 specific services for Hispanic, approximately 5 specifically for inmates/ex-offenders and numerous services for transgender, transsexual, homosexual, lesbian, and bisexual populations.

**HIV Policy Issues**

In an effort to alleviate issues associated with HIV/AIDS treatment and early medical intervention, in November 2005 the US Senate passed an Amendment to Budget Reconciliation Act Based on Early Treatment for HIV Act (ETHA). The amendment would provide $450 million to states that provided Medicaid coverage for antiretroviral treatment for low-income, HIV-positive individuals before they develop AIDS. The amendment, is similar to the Early Treatment for HIV Act, which provides additional Medicaid funds to states that invest in HIV treatment and allow states with budget deficits to continue to provided medical treatment to HIV-positive, low-income individuals. Under the current Medicaid rules, HIV-positive people must wait until they can be categorized as “disabled” before receiving treatment through the programs. This Act insures HIV treatment at the beginning stages of the disease. The Treatment Access Expansion Project [TAEP] (2003) retained PricewaterhouseCoopers (PwC) to assess the effects of early health care access under ETHA. A study found that early treatment could significantly delay HIV disease progression and that ETHA could reduce the death rate for HIV-positive people by 50%. This study also estimates that over ten years,
ETHA will result more individuals with healthier immune systems than under the current Medicaid program.

In attempts to improve the quality and availability for medically underserved individuals and families affected by HIV/AIDS, the federal government enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act, administered by the HIV/AIDS Bureau of the Health Resources and Services Administration [HRSA] 2006 provides funding to states, territories and other public and private nonprofit sectors to develop, organize, coordinate and operate effective and cost efficient systems for the delivery of care and services to people living with HIV/AIDS and their families. For the 2006 fiscal year, Georgia received $92,428,796 for HIV prevention programs (Statehealthfacts.org, 2007). These funds were provided by the Center for Disease Control and Prevention. In totaling, Georgia received $69,678,496 in Ryan White funds; the table 1 demonstrates how the funds were distributed during the fiscal year 2006 (Statehealthfacts.org, 2007).

According to Kaiser Family Foundation (2007), title I funds provides funding to eligible metropolitan areas disproportionately affected by the HIV epidemic. Title II funds helps state health departments improve the quality and availability of HIV health care and support services. This title also contains AIDS Drug Assistance Program (ADAP), which provides medications to individuals with low income and supplemental grants for emerging communities (cities reporting between 500 and 1,999 AIDS cases in past five years). Title III supports competitive grants to provide medical treatment and support. This also includes HIV testing, early intervention services, risk reduction,
counseling, case management, outreach, oral health, nutrition and mental health services. Title III also supports an Early Intervention Services (EIS) grant that provides services for HIV positive individuals with low income who are uninsured or underinsured. Title IV focuses on the operation and development of primary care systems and social services for women and youth. AIDS Education & Training Centers Program, AETCs provide training, consultation and information to HIV health care providers through a network of 11 regional centers; and dental reimbursement and community-based dental partnership programs. Minority Aids Initiative, MAI funds target programs to enhance effective HIV/AIDS efforts that directly benefit racial and ethnic minority communities (KFF, 2007). Special Projects of National Significance (SPNS) address emerging needs of clients and assist in developing standard electronic client information data system. SPNS is funded through set-asides of general Public Health Service evaluation funding, separately from the amount appropriated by Congress for Ryan White (KFF, 2007).
Table 1

Fiscal Year 2006 Funding for HIV/AIDS in Georgia

<table>
<thead>
<tr>
<th>Department</th>
<th>GA Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title I</td>
<td>27%</td>
<td>$ 18,869,561</td>
</tr>
<tr>
<td>Title II</td>
<td>54%</td>
<td>$ 37,822,590</td>
</tr>
<tr>
<td>Title III</td>
<td>13%</td>
<td>$ 8,801,732</td>
</tr>
<tr>
<td>Title IV</td>
<td>2%</td>
<td>$ 1,049,749</td>
</tr>
<tr>
<td>AETC</td>
<td>3%</td>
<td>$ 2,153,962</td>
</tr>
<tr>
<td>SPNS</td>
<td>1%</td>
<td>$ 849,413</td>
</tr>
<tr>
<td>Dental Reimbursement Program</td>
<td>0%</td>
<td>$ 131,489</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>$ 69,678,496</td>
</tr>
</tbody>
</table>

According to Kaiser Family Foundation, StateHealthFacts.org (2007), Georgia received a total of $ 92,428,796 in FY 2006 toward HIV/AIDS Federal funding. Of that CDC HIV/AIDS funded $13,495,340 and the Ryan White program funded $69,678,496. According to “Funding Cut for Key AIDS program in Georgia”, an article published by Ryan Lee in Southern HIV (2007), the HIV section of the Georgia Department of Human Resources [DHR] is bracing for even more reductions in its prevention and treatment funding when federal dollars are distributed later this year. As stated in the article, Governor Sonny Perdue’s office said the state contributes $18.2 million dollars
to the HIV section “which funds HIV/AIDS prevention, screening, and counseling activities.” Perdue’s office claims the federal government only contributes $7 million to the HIV section. However, as indicated in the article, DHR officials were unfamiliar with the numbers the governor’s office cited. The article further stated, in 2006 the members of Georgia’s Community Planning Council, devised a list of priority populations that were suppose to be used to shape the funding DHR’s HIV section requested from the CDC, said Rudolph Cam, who serves as urban co-chair of Georgia’s Community Planning Council. “What happened was, our recommendation for the priority populations were African American [homosexual and bisexual men] were No. 1, and black women were No. 2, and the money was supposed to follow the priorities,” said Carn, who is also executive director of the Atlanta-base National AIDS Education & Services for Minorities. The DHR HIV section responded by funding approximately a dozen community-based organization throughout Georgia. The HIV/AIDS epidemic continues to claim the lives of million people worldwide. Unfortunately, some get the care they need, however, many do not. As stated in a press release by Senator Gordon Smith (R-OR) (2005), this is literally a life-and death issue, early treatment can help many more Americans live longer, healthier lives.

Barriers to Treating HIV among Adults Over 50

Many seniors are not comfortable addressing their sexual history and sexual behaviors among a generalized population age group. Seniors often are less likely to find support and comfort among family and friends, and because they are traditionally
not comfortable in support groups, they may be less inclined to join them, citing lack of shared experiences concerning different issues (NAHOF, 2007). For example, programs should be in locations where individuals over 50 convene on a regular basis, such as senior centers, recreational parks, malls, and spiritual organizations. The goal is to raise awareness of HIV/AIDS within their community, teach seniors about sexually transmitted disease, condoms, risky sexual behaviors, prevention, testing, treatment, overall health, and education on infectious diseases with special emphasis on HIV/AIDS. In many cases, seniors believe HIV/AIDS is a disease of young promiscuous youth. They often believe that they are not at risk of becoming infected.

The failure of AIDS knowledge to facilitate appropriate changes in behavior may be due in part to the type of information provided as well as the characteristics of the person who receives the information (Ross & Kelaher, 1993). Gold & Rosenthal (1998) maintained that AIDS educators should consider one-to-one counseling and peer education programs because these methods make it easier to ensure personal relevance. In addition, these methods can be adapted to reach more people. This process will also help with reducing the transmission rate and empowering infected person to take control of their lives. Treatment and prevention services are intricate components when fighting the spread and reducing the risk of new cases of HIV/AIDS. Many times our adults over 50 are left isolated, however, society and medical professionals must not forget the need and importance for intervention, reporting and clear and concise information within their communities. By increasing awareness of the need for services geared specifically
to the older population, policy makers are more incline to filter federal and state funds
for HIV/AIDS care into the states and communities who are most affected and infected
by this preventable disease. Due to the general lack of awareness of HIV/AIDS in older
adults, this segment of the population, for the most part, has been omitted from
research, clinical drug trials, educational prevention programs and intervention efforts
(NAHOF, 2007). Often this population is forgotten or not considered valuable when
studying the risk, factors, and prevention of this disease.

Due to stigmas associated with HIV/AIDS, it can be difficult for older women in
particular to disclose their HIV status to family, friends and other communities. Seniors
are often less likely to find support and comfort in support groups, they may be less
incline to join them citing lack of shared experiences concerning different issues
(NAHOF, 2007). In the effort to promote HIV/AIDS prevention, awareness and
education, researcher marketers have not been successful in conveying this message
within aging community in metro Atlanta. Through the social marketing techniques,
public health professionals are learning to listen to the needs and desire of the target
audience themselves and build from there. Rather than dictating the way that
information is to be conveyed, i.e. from the top-down (Weinreich, 2006).
Limitations of the Literature

There are many limitations after researching, access to services, policies that governs services and barriers to treating adults over 50 who are affected or infected with HIV/AIDS. As noted above, policies and policy makers have not allocated sufficient funds for programs for senior prevention, services, treatment and awareness programs specifically for this population. In researching the variety of services available within metropolitan Atlanta, there are very few programs designed specifically for individuals over the age of 50. The literature I have researched unevenly addresses the social and medical conditions of concern to people age 50 and over who are living with the virus. The literature also fails to explain the limitation on clinical trials for this population, adversity between HIV treatment medication and aging medication, issues with isolations, and support networks and resources available for this population. Indeed extensive research and additional information is needed to best assist and understand the many issues that plague adults over 50 and their connection to HIV/AIDS.

Conceptual Framework

Social marketing is widely being used by market researchers to increase the acceptability of an idea, innovation, product, or social behaviors (Kotler & Zaltman, 1971). Introduced in the 1970s, social marketing seeks to influence social behaviors not to benefit the marketer, but to benefit the target audience and the general society (Weinreich, 2006). This strategy has been used in international health programs,
contraceptive campaigns, and is being widely used in planning, design, and dissemination of HIV prevention programs. The ultimate goal of social marketing is to focus on the needs of the people by understanding their concerns and perceptions to assist them in the decision making process (Weinreich, 2006). In an effort to accurately depict or understand these factors associated with the perceptions, education, and accessibility of adults over 50 who are infected with or affected by HIV/AIDS, the concept behind the social marketing techniques will assist in providing insight in understanding their needs.

According to Nedra Weinreich, author of What is Social Marketing, there are “Four Ps, product, price, place and promotion” of social marketing must be addressed.

1. Product, ranges from tangible, physical products, to services, practices and ideas. In order for this to be effective and considered a viable product, one must first perceive that this is a genuine problem and what is being offered is a good solution.

2. Price refers to what the consumer must do in order to obtain the social marketing product. This cost may be monetary, or require the consumer to give up intangibles, such as time. Often in this effort, one may risk embarrassment and disapproval, or may not be able to afford the product.

3. Place describes the way that the product reaches the consumer. Rather tangible or intangible product, this is an effective way to inform and reach
desired population. This includes, location such as doctors office, shopping malls, mass media vehicles or in-home demonstrations and distribution systems, including warehouses, and retail outlets where it is sold or given out for free.

4. Promotions consist of the integrated used of advertising, public relations, media advocacy, personal selling and entertainment vehicles. The focus is on creating and sustaining demand for the product. Public service announcements, paid ads, coupons, media events and editorials. Nedra Weinreich (as cited in Prohaska, Albrecht, Levy, Sugrue & Kim, 1990) found that the level of belief and trust people have in the media, including government, news, television networks and print, can either negatively or positively influence perceptions of personal risk.

Visibility, understanding of product, understanding of consumer needs, and effective communication techniques are all-important elements comprising the social marketing concept. Rather than dictating how information is disseminated, health professionals are learning to listen to the needs of the targeted audience. Unfortunately, Media campaigns regarding HIV have not been effective with the African American community for two reasons: (1) the messages have not been culturally relevant; and (2) public health officials assume that there is a basic trust in the government (Machlica, 1997).

Culturally-relevant messages should include the values, norms, and beliefs that impact and influence the behaviors of individuals (Machlica, 1997). For example,
programs and media campaigns should advertise in locations where older adults convene and place their values, such as churches, senior recreation centers, senior housing complex’s, malls, and primary care physician offices. Prohaska, et al. (1990) found that the level of belief and trust people have in the media, including government, news, television networks and print, can either negatively or positively influence perceptions of personal risk. Understanding and realizing the importance of cultural competency messages and historical viewpoints, is critical when implementing social marketing strategies. By incorporating social marketing in the assessment of HIV access, treatment, and utilization among adults over 50 who are affected by or infected with HIV/AIDS, this study will serve as a vehicle in understanding the issues, and needs surrounding HIV services, prevention and education.

Summary

The HIV/AIDS epidemic in the United States is changing. Unfortunately, adults over 50 infected with HIV/AIDS face other issues associated with ageism and being infected with a sexually or intravenous drug transmitted disease (NAHOF, 2007). In several studies, routine HIV testing in the elderly was shown to be uncommon (Chiao et al., 1999). As a result, infection is not detected early at a stage when it can be most readily treated and the risk of transmission to others is increased (UNC Center for Aging & Health, 2006). Older adults often suffer from internal and external factors that make them more marginalized in the prevention and treatment of HIV. Because of their
unique positioning, a social marketing approach presents itself as a variable method to understand how to address both external and internal factors. This chapter included a discussion of the literature regarding the history of HIV/AIDS, HIV pandemic and access and utilization of treatment services. It also included an overview of the social marketing theory and its relevance to the study. The following chapter will address the methods used to collect and analyze the research question presented in this study.
CHAPTER III
METHODOLOGY

The goal of this exploratory study is to explore African Americans adults over 50 understanding of HIV/AIDS prevention education as well as their perception of accessible HIV/AIDS services within their community. The purpose is to inform and improve HIV social marketing health messages targeting adults over 50 and the communities in which they reside. This chapter details the methodology of this study including the design, sampling, instrumentation, data collection, and analysis. The rationale for this study design, specifies why a qualitative approach was deemed most appropriate for this study, is also discussed. The research questions guiding this study are as follows:

1. How did HIV infected African Americans over 50 understand their risk prior to their diagnosis?

2. How have the sexual behaviors of HIV/AIDS infected African Americans over 50 changed over time?

3. Are African Americans infected with HIV/AIDS over age 50 accessing services within their community?

4. What is adult over 50 perceptions of HIV/AIDS services geared specifically for their age group?
Design

Most of the literature discovered for this study presented findings related to the epidemiology of HIV/AIDS and limitation connected to policy, utilization and barriers regarding older adults infected with or affected by HIV/AIDS. Although there was a limited amount of studies related to HIV/AIDS among adults over 50, the researcher was unable to locate literature that discussed participants’ over 50 perception of HIV/AIDS services geared for their population. Because of limited literature regarding the relationship between perception, education, and accessibility of help seeking behaviors of HIV infected African American over 50, a qualitative methodology presents the most appropriate design. This form of inquiry serves as a vehicle to understand these factors rather than simply the result. It is a method in which the researcher uses oneself as a tool in an effort to glean in-depth information about a phenomenon of interest (Tucker-Brown, 2007). It is used to learn more about the lived experience of research participants.

Creswell (2006) defined qualitative research as “…an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. There were many factors addressed prior to engaging in a qualitative methodology. The researcher strongly considered the nature of the topic, the depth of previously recorded literature or knowledge of potential participants, and the researchers ability to serve as an active and nonjudgmental learner dedicated to presenting the participants view in their own words in hopes to inform an overlooked population regarding the effects of HIV/AIDS. After reflecting on these factors, the
researcher determined that qualitative research was the appropriate methodology to utilize in conducting research regarding the perception, education and accessibility of HIV infected African American over 50. The researcher was also interested in infected adults over 50 understanding or knowledge of HIV/AIDS, their personal perception of services, potential barriers, and policies associated with aging and HIV/AIDS.

Sample

According to Patton (2002), one of the design strategies for qualitative inquiry is purposeful sampling. This speaks to the idea that the researcher intentionally seeks participants who have a wealth of information about the topic area or issue of interest and can, therefore, shed light on it in ways that others could not. A purposeful sample is chosen over a randomly selected sample because the purpose of qualitative inquiry is to produce valuable information from each participant, resulting in a better understanding of the given trend. Statistical generalization is not a goal of qualitative inquiry, and random or probability sampling is not necessary nor does it really have a place in qualitative research (Merriam, 1998; Patton, 2002). The findings generated from this study are not generalizable to all populations; however, it does provide insight on the need for age specific services and cultural competent health providers regarding education, accessibility, and HIV services of African American adults over 50.
The sample for this study consisted of five African Americans over 50 who are infected with the HIV/AIDS virus. As the method of recruitment, the researcher used snowball sampling to identify and recruit participants for this study. Creswell (2006) suggests that qualitative inquiry requires the researcher to seek participants who will provide the richest data available. The researcher began with adults over 50 who currently receive HIV/AIDS services through ANIZ, Inc., a HIV/AIDS service organization (ASO’s) in Atlanta, Georgia. As an intern at ANIZ, the researcher had direct access and interaction with clients who expressed their concerns with the lack of age specific services within metro Atlanta and the need for supportive services that address all issues associated with aging.

Aniz is a non-profit human service organization designed to be a resource to people of color and serve as an organization dedicated to meeting their needs. Aniz provides comprehensive social service program regarding HIV/AIDS, mental health issues, children therapeutic programs, substance abuse supportive services, and health education and information. Aniz offers both individual and group therapy services. Through ANIZ, the researcher identified other ASO’s who serviced older adults who are infected or affected by HIV/AIDS. The researcher chose participants who were willing to address topics concerning sexuality, services, resources, HIV/AIDS transmission, and environmental/family support systems. The sample consisted of both male and female participants 50 years and older.
Measure

Qualitative methodology provides the most appropriate design to understand the factors that influence individual decision-making processes and perception. This form of inquiry serves as a vehicle to understand these factors rather than simply the end result (Tucker-Brown, 2007). Within this method, the researcher uses oneself as a tool in an effort to understand and gather profound information regarding a phenomenon of interest. It is used to learn more about the lived experience of research participants. In short, the purpose of qualitative research is to generate fruitful data that can lead to a greater understanding of an observed phenomenon (Berg, 2001). Because of cognitive ability, participant’s age, and possible vision concern, the researcher found the qualitative approach to be most beneficial in accurately depicting the participant concerns and perception.

The interview questions included family demographics, and family history, sexuality, competing health concerns, acceptance, informing family and support systems, accessibility of HIV resources, HIV knowledge and testing, perceived level of individual, family, and community support for HIV services and individual interactions with social workers (see Appendixes D & E).

Procedures

Initially, the researcher anticipated conducting 7-8 focus groups containing 4 to 5 participants who were infected with or affected by HIV/AIDS. However, the researcher encountered several occasions where the participants were unable to attend
scheduled group meetings because of transportation or conflicting health care appointments. Therefore, in order to create an accessible environment for the participant, the researcher conducted three of the five interviews in the participant’s home and two at Aniz, Inc.

Data collection and information regarding the purpose of this study began November 2007 at Aniz, Inc. The researcher spoke initially with HIV/AIDS, transgender and substance abuse support group leaders at Aniz, Inc, followed by a formal introduction to the participants of the support groups, addressing the purpose of this study. The researcher explained how their participation would be beneficial in addressing their needs and concerns related with accessing HIV/AIDS services within their community (see Appendix C). The researcher also explained that although this study consisted of human subjects, this study was approved by Clark Atlanta University, Institutional Review Board (IRB) (see Appendix A). Flyers were also provided for support group members to distribute to other eligible participants (see Appendix B). As previously explained by the researcher, the criteria consisted of individual over the age of 50 who identified as HIV positive, who were infected with HIV/AIDS, who are receiving services and treatment for HIV, and willing to participate in the human subject study. Over the course of 30 days, the researcher met with five individuals over 50 years of age who agreed to participate in this study and signed the informed consent form. The researcher used audio recordings and an interview guide comprised of questions relevant to HIV services, HIV status/disclosure, sexuality, social
marketing, HIV/AIDS prevention education, program accessibility and their perception of available services within their community. The use of individual interviews created an atmosphere for the participant to give detailed individual information pertaining to the topics. Upon completion of all interviews, the researcher transcribed the information and organized the data according to topic similarities and differences.

Analysis

The analysis used for this study is the interviewer ability to obtain necessary data from the participant and accurate transcribe obtain data for analysis. According to Patton (2002), "...qualitative analysis transforms data into findings" (p. 432). Unlike in more positivist quantitative research, there is no clear cut difference in the time where data collection and analysis are conducted in qualitative inquiry. The two not only occur simultaneously, but data collection is also informed by the constant fluidity of the process. In short, the purpose of qualitative research is to generate fruitful data that can lead to a greater understanding of an observed phenomenon (Berg, 2001). Through this analysis, the researcher sought to provide useful information on the importance of HIV/AIDS services geared toward adults over 50.

This study utilizes the constant comparative method developed by Glaser & Strauss (1967) in analyzing the data in this study. This method of analysis, simply put, involves the researcher "constantly comparing" the data as it is collected. Charmaz suggested when conducting analysis it is important that the researcher not wait until the
“analysis phase” to begin reviewing and making meaning of data. There should be “constant comparison” of the data collected and analysis should be ongoing throughout the study (Charmaz, 2002). As data was collected, the information was consistently analyzed to ensure accuracy of participant perception and information provided and generate the connection between categories and participant responses as received. This way if pertinent information was lost or unclear during the analysis, the researcher could immediately contact the participant for reassurance or clarity.

Summary

This study seeks to gain insight on the perception of HIV infected African American over 50 regarding available services, treatment, education, accessibility and social marketing. This chapter included a discussion of methods used to conduct participants as well as the results of this study.
CHAPTER IV

FINDINGS

The goal of this study was to explore African Americans adults over 50 understanding of HIV/AIDS prevention education as well as their perception of accessible HIV/AIDS services within their community. The study purpose is to inform and improve HIV social marketing health messages targeting adults over 50 and the communities in which they reside. The research questions guiding this study were as follows:

1. How did HIV infected African Americans over 50 understand their risk prior to their diagnosis?
2. How have the sexual behaviors of HIV/AIDS infected African Americans over 50 changed over time?
3. Are African Americans infected with HIV/AIDS over age 50 accessing services within their community?
4. What is adult over 50 perceptions of HIV/AIDS services geared specifically for their age group?

The study utilized an exploratory qualitative design. Data was collected from November 2007 to December 2007. At this time participants were recruited from Aniz, Inc support groups, and flyers were given for support group members to pass to other
interested adults over 50. Of the older adults informed regarding this study, five HIV positive African American were interviewed individually for 60 minutes. All participants were contacted via telephone in order to schedule an appointment time conducive to both the participant and the researcher’s schedule. The individual interviews took place at Aniz Inc, social services room as well as at the participant’s home. The researcher bought pizza, drinks, and serving utensils for the participants who agreed to meet at Aniz, Inc. All of the interviews were audio recorded and transcribed by the researcher.

These next two sections of this chapter present individual descriptions of the participants. In order to keep identities confidential, fictitious names were assigned. This section also presents data from the interviews to support the categories and properties. Followed by a summary of the chapter.

The Participants

Five African Americans adults over 50 who are infected with HIV and reside in metropolitan Atlanta participated in this study. Each participant engaged in individual interviews. Their ages ranged from 54-63. All participants were African American and born in the United States. All participants have high school diplomas, two participants have Bachelor’s degrees and one participant has a Master’s degree. Four participants were heterosexual and one practices a homosexual lifestyle. One participant is transgendered and three of the five participants revealed past struggles with drugs (i.e., cocaine and heroin). Below is a detailed description of the individual interview
participants. Their own words are used at times to provide a better sense of their individual perceptions.

Mary. Mary is a 63-year-old African American female who is HIV positive. Mary resides in Jerusalem House, which provides over 50% of Atlanta, Georgia's permanent housing designated for homeless persons living with HIV/AIDS. Mary rates her support system as “little to none.” For the majority of Mary life, she has cared and nurtured others. Mary proclaims to be a “self educator,” meaning she has never been formally trained in HIV/AIDS nor does she have formal educational training. She also stated that everything she wanted to know about sex she learned from a book, such as the Kinsley report. Mary was molested by her grandfather as a child, however, did not believe that had anything to do with her sexual decisions. Nor does she believe that he destroyed her self-esteem.

Mary has four children and two ex-husbands. After living a life of celibacy for 7 year she learned at the age of 57 that she was HIV positive. She contracted the virus through sexual intercourse unknowingly prior to her celibacy commitment. At the time of her diagnosis, Mary’s T-cell count was 47, however the physician gave her a HIV diagnosis instead of AIDS. Mary states, “I have outgrown my HIV peers, everyone I know who is infected is younger than me, I am the oldest person here in this program. I have no peers of my age or attend any support groups. What can I learn from kids? I feel alone, confined and overcome by depression, I hope the virus does not take over me.”
Mary stated she truly wishes there were some effective services out there for her and her peers. She describes a time when she was trying to access services in Atlanta, Georgia:

...I noticed that as I was trying to get on my feet, the system had nothing to offer me, they had nothing for me, since I wasn’t on drugs, didn’t, have any children and wasn’t prostituting...I did not fit that criteria ... and since I did not fit then the system did not have the time of day for me. I literally, sat in the food stamp office and listen to a social worker pour out accolades over a young woman who was just coming off the street ...and the same woman had to wait on me and she treated me like I was dirt under her foot. In addition, I could not understand why, why were the positive people not getting supported?

Mary considers herself very comfortable with her sexuality. She states, “I have to be very careful who I lay down with, and that I have known since I was a child, there is something very powerful inside of my vagina ...“But it is just love manifested inward.”

Norris. Norris is a 54-year-old African American male who is HIV positive. Norris has been diagnosed with the HIV for nine years. He contracted the virus through sexual contact with a male partner. Three months prior to the interview, Norris learned that he has Hodgkin’s lymphoma (cancer). Norris currently receives chemotherapy once a week and takes a 3 in 1 ARV medication regimen. Norris identifies as a homosexual...
male. He states although, he was married and fathered three children he has always known he was gay. He often felt compelled as a young adult to disregard those feelings…"I did not want to be gay, so I got married and had a family…I don’t regret any of my children I love them dearly.”

Norris manages the property at four rental homes in metro Atlanta. When asked about services, he expressed deep concern with the lack of services for adults over 50 in the Atlanta area. He currently does not participate in any support groups or programs, however, he does feel if Atlanta offered services for his peers he would be more inclined to attend groups. When asked about his knowledge of HIV, he stated,

I knew what it was but I never read up on it. I had a few friends that died from it but I was …you know…it was just something that I was not going to get, u know I was not promiscuous, I did not have a lot of sex with other people. It was just something for those people.

Norris closed by stating, “My mother made me a strong black Gay man I may fall but I am getting up, …and you know It [HIV] is not a death sentence any more.”

_Rose._ Rose a 60-year-old African American female from Charlotte, NC. Rose is HIV positive and recently learned that she has hepatitis C. Rose stated she was never promiscuous as a young adult, she said, “I was not over sexed, sex was not my life”, but does admit to heavy usage of cocaine and heroin since the age of 24. Rose was diagnosed with HIV at age 46 and consistently used drugs until the age of 51. She initially believed she contracted the virus from sharing needles, “although we flushed the needles we still shared them,” but later learned she contracted the virus through
sexual intercourse. Rose stated she has spoken with the guy who infected her and has accepted his apology. Rose a former nurse, stated, “I knew a lot about the virus (prior to her diagnosis), I had a friend who was bi-sexual and had it...so he told me a lot.”

Regarding her perception of health care professionals HIV education pedagogy, she explained,

I would not accept anything but the best from my doctors, but I am learning how to speak up for myself. If I had questions, they answered them. My social worker was the best! I will never forget her; she taught me everything about HIV and to live life regardless of HIV.

During the interview Rose famous words were, “hey I am 60 but I am still growing and learning.”

Fred. Fred a 56-year-old HIV positive African American male. Fred moved to Atlanta from Philadelphia in hopes of accessing better HIV and health care services. He stated his mother believed he would be better off near family. Fred stated he lived a life of sex, drugs, and money in his younger years. Fred has been clean for the last four years, however still attends Narcotics Anonymous groups multiple times a week. Fred believes he contracted the virus through sexual intercourse, although he does admit to sharing needles during his drug usage. He also stated that he is unsure from whom or when he contacted the virus, yet in 1999 he decided to disclose his status to his family.

Fred stated that after his initial diagnosis he continued living his life destructively, he began manipulating the system and doctors to gain access to money which in turn he used for drugs. It was not until he decided to return to school and
educate himself regarding HIV that his sexual behaviors and lifestyle changed. Fred received a Bachelor in Science and a Masters in Counseling Education. Fred credits his education for his ability to access services within the community. Fred said that as a counselor he often just tells others what he needs and knows that his voice is important. Regarding HIV services specifically for infected or affected person over 50 he stated,

I think there is a need, because there is a lot needed for those aging with HIV. I mean people are living longer and you have something going on with your body that is not HIV... that's a normal part of the aging process... in terms of support groups things like that (HIV, health, aging process, education) could address some of those concerns.”

Fred closed by saying, “I am cool, I am in good health, I don’t even count HIV... I am not on any meds, I pick good doctors and I get results.”

Renee. Renee is 58 years old HIV positive female. She was born (Ron) a male, but currently lives and identifies as a woman (transgender). Renee recalls growing up as a child not comfortable with the way she looked on the outside. She expressed never feeling as if the soul that lives within her fit into her body. Renee continued to express to her family that she feels like a girl, however, she was told, “she is a boy and God makes no mistakes.” Renee recalled attempting to remove her penis as a child, because her mother told her “you have a penis and that’s what make you boy.”

Renee has been living with HIV for six years. Renee stated she currently dates men, although, she has not had the sex reassignment surgery. Renee stated that she is a recovering heroin addict and believes she contracted the virus through drug usage.
Renee stated she has been struggling with her addiction to heroin and being HIV positive. Renee stated she never thought at her age, HIV would be an issue. She stated, she has been clean for two years now, however, attends support services regarding her HIV diagnosis, chemical dependency and being transgender. Renee stated she has never participated in services specifically for her age group but believes it would be useful. Renee stated ”we have other issues going on, health issues, life issues, dating issues, and on top of all that HIV, I need to talk to people who can understand what I go through.”

Each participant brought a significant level of insight and understanding regarding their perception of the effects of HIV within their community and lives. During each interview, the participants effectively conveyed their concerns, provided recommendations, and openly disclosed their sexual behaviors in the past and future. In listening to their own words, the researcher received invaluable information regarding HIV services, prevention education, and accessibility from African American adults over 50 who are affected with HIV.

**Overview of the Properties and Categories**

The purpose for this study was to explore African Americans adults over 50 understanding of HIV/AIDS prevention education as well as their perception of accessible HIV/AIDS services within their community. Data analysis discovered two categories in regards to participant’s understanding of HIV/AIDS prior to their diagnosis. They reported minimal individual risk and lack of formal education regarding
HIV/AIDS. Concerning sexual behaviors, two categories emerged from the analysis. The participants identified risks associated with contracting HIV and rather to live a life of promiscuity or monogamy. On accessing services within the community, one category emerged. Generally the participants reported a major disconnect with their HIV positive peers. Lastly, data analysis concerning participant’s perception of services revealed invaluable resources. Participant’s expressed a huge gap in HIV services specifically for their age group as well as ineffective media messages. From the participant’s perception, there is an education deficiency in media messages for older adults who are infected with or affected by HIV/AIDS. Table 2 below represents the categories and their associated properties. It is important to note that six of the category and property titles were extracted verbatim from the transcripts.
### Table 2

**Categories and Properties**

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Categories and Properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>How did HIV infected African Americans over 50 understand their risk prior to their diagnosis?</td>
<td>MINIMAL INDIVIDUAL RISK</td>
</tr>
<tr>
<td></td>
<td>LACK OF FORMAL EDUCATION</td>
</tr>
<tr>
<td></td>
<td>“Faggots and gays get that not me”</td>
</tr>
<tr>
<td>How have the sexual behaviors of HIV/AIDS infected African Americans over 50 changed over time?</td>
<td>PROMISCUITY OR MONOGAMY</td>
</tr>
<tr>
<td></td>
<td>“Sex was not my life”</td>
</tr>
<tr>
<td></td>
<td>RISKS ASSOCIATED WITH CONTRACTING HIV</td>
</tr>
<tr>
<td></td>
<td>“We thought they were toys”</td>
</tr>
<tr>
<td>Are African Americans infected with HIV/AIDS over age 50 accessing services within their community?</td>
<td>POPULATION DISCONNECT</td>
</tr>
<tr>
<td></td>
<td>“They are not my peers”</td>
</tr>
<tr>
<td>What is adult over 50 perceptions of HIV/AIDS services geared specifically for their age group.</td>
<td>INVALUABLE RESOURCES</td>
</tr>
<tr>
<td></td>
<td>“We need those services”</td>
</tr>
<tr>
<td></td>
<td>EDUCATION DEFICIENCY IN MEDIA MESSAGES</td>
</tr>
<tr>
<td></td>
<td>“There is nothing for us”</td>
</tr>
</tbody>
</table>
African American Adults Over 50 Understanding of HIV/AIDS

In order to accurately depict the participants' knowledge level of HIV/AIDS, the researcher asked a series of questions centered on their perception of HIV/AIDS prior to contracting and being diagnosed with the virus. The primary intent was to understand exactly at what level they perceived their risk for contracting the virus, and what form of tangible education they received regarding HIV. Participants' responses centered around two distinct themes: Minimal individual risk and lack of formal education.

Minimal Individual Risk

All participants reported having some form of understanding of HIV/AIDS prior to being diagnosed; yet, none of them believed it could happen to them. All of the participants possessed a very narrow and vague view of HIV. They believed primarily that the virus was contracted through sharing needles and homosexual lifestyles.

Comments from Fred, a 56 year old African American male from Philadelphia and a Counseling Education professional, depicts the participants' perception of their individual risk of contracting HIV:

I must have been around 35 or so, I started smoking more dope and using more drugs than ever. I knew people who were drug users and faggots got it, and since I was not gay, getting HIV was nothing I thought I could get. Yeah, even though I used drugs still it was not going to happen to me...that is what I thought...I did not hear that part about unprotected sex and all that stuff as ways of getting it...I live a fast life but my sex life was very risky...and I never knew...basically my view was very narrow.
Although, all of the participants shared a common level of perceived risk of contracting HIV, Norris, a 54 year old homosexual male introduced a very unique outlook on his risk. Although, only one participant made the statement, as the researcher, I believed the comment to be profound and awakening. Norris’ statement reminded me of several participants thoughts of early thinking in which they believed the virus would and could produce a cure to an incurable disease. In his words he explained,

I knew what it was, but I never read up on it. But what I did know was it was not a Black mans disease, yeah you can die from it. But hell…I did not have a lot of sex with other people. True drug users and gay people got it but I only ever had two partners, well with men that is, and I was always, do you hear me honey, always careful….I had a few friends that died from it but I was so…you know…it was just something that I was not going to get. It was just something for those people, ones who were not careful, I was careful…. But something I always said or thought was that I would never die from it [HIV]. I figured that if I did get it, they [Doctors] would find a cure and I would not die from it…guess I was young and had no clue. Today, I am starting to believe that maybe I can.

Like Norris, none of the participants believed HIV was a risk factor for them. Rather they contracted the virus through sexual intercourse or drug use, none of the participants felt a significant level of individual risk. Rather they were diagnosed with HIV prior to or after the age of 50; their understanding of their realm of risk was minimal.
Lack of Formal Education

Prevention education is an intricate tool in combating the rapid spread of HIV.

Four of the five participants agreed that they were never given any formal education on sexually transmitted diseases prior to contracting HIV. Participants made reference to Venereal Disease as primary disease of their time. Mary specifically stated:

I was self taught. I could not count on my parents...I really did not talk to my parents about, it...um. I didn’t listen to them because they were not as mature as I was...I started keeping a diary and um my mom found it, and unconsciously I put it where she could find it... but because of her fears and her insecurities dealing with sex...Instead of answering the questions I had in it ...she humiliated me with it, she and dad took the information and used it to humiliate me ... and the following year I had my first child...even when I asked about protection or douching, my mother got defensive, because in her mind you did not need to be douching if you were not having sex...so it was like oops...that was squashed right quick... So everything I learned I learned from a book. Meaning there were so many things I didn’t understand. I read everything I could get my hands on, like this sex book everyone was talking about...the Kinsley Report, but I never did hear about it in school. Come to think of it, they guy I contracted the virus from lived with a woman who he was caring for. She was older and noticeably dying, but I just thought she was sick...but all along, she was dying from AIDS, I didn’t know... but now I know. I was watching someone die from AIDS...a disease at the time I knew nothing about.
All four participants’ agreed that STD and HIV were never discussed in school. Renee said, “that was something they [schools] left for you to get at home, but we didn’t get it at home.” Of the five participants three confessed to learning about HIV, sex, and STD’s from peers at a young age. As stated by all three participants, but stated best by Norris,

So what real true information did we get, I learned from my friends on the street, who learned from their friends and so on and so on...and it was strictly street...so much information was never mentioned...we really did not know anything...there were no adults willing to confirm or talk to us about what we thought was right or not.

Yet unlike the majority of the participants, Rose, a 60 year old retired nurse articulated, “I was a nurse and had been a nurse for a long time, so I knew about HIV and STD we studied it in school...but some how I never thought it would happen to me. But I knew about it...and I kept doing drugs too, hell I knew about that as well.” From their words and past cultural beliefs, HIV, which is acquired primarily through sexual intercourse and drug use, was never verbally expressed. As stated by many of the participants, the conversations regarding sex and diseases was not openly discussed around children in African American cultures or families, which in my belief, perpetuates a cycle of ineptly, uninformed, uneducated, unprepared adults who in return make poor decisions.
Sexual Behaviors

Participants’ responses to questions designed to understand their past belief of sexual behaviors were relatively similar. It was evident that they all viewed themselves as active sexual beings. The participants repeatedly expressed that many people believe that just because they are older they no longer have sex or a sex drive. Yet, the participant perceived their past sexual behaviors in only one of the two categories: promiscuity or monogamy.

Promiscuity or Monogamy

Most of the participants indicated that while sexuality was never a popular topic “everyone was sex and more sex.” Four of the five participants comments pertaining to their sexual history hinted at living a life of monogamy. Rose’s statement was very similar to Renee, as it was revealed in this statement:

You know, I grew up with my grandmother and her words were you only have sex with your husband and that is it. I wanted to know why I couldn’t have sex, couldn’t see married men, use drugs or do all the things my friends did when I was younger, but all she said was it was bad...so when I got older I explored So I did not have sex with a lot of people...I wanted drugs once and sleep with a guy who I considered my trick...I later found he was also the person I got HIV from...but sex was not my life, I had other things to do...When I did marry I still did not have a lot of sex, I was never over sexed liked everyone else.
Many of the participants had a high regard for the sanctity of marriage and not living a promiscuous life. Mary in particular expressed,

I was always prepared for marriage, even as a child...my grandfather would always say, "I could have a husband but that didn't mean I would keep a husband" and years later I grew to understand that he was coming from was the fact that black men were still being lynched...so, I watched my aunts and uncles and knew that was the type of love and marriage I wanted, so by seven, I began preparing for sex and marriage, I collecting towels, sheets, pots, blankets anything...Because I believed in monogamy and marriage so much my behavior was always in support of my vision for myself... I was ready to be a bride.

Interestingly, when asked about how their sexual behaviors or decisions have changed over time, Fred candidly stated,

I do not try to screw everything(now)... when I was younger if it looked good, smelled good, felt good, I wanted it...and if they said yes then yes I was definitely trying to take it... Now (since being diagnosed) some people do not appeal to me cause once I get to know them I have found out that is a very intimate act and you can not share no closer acts than that. Plus with all the STD and HIV out here you have to be real particular about your partner... I am not jeopardizing my health or T-cells, I do not take medicine. I am healthy and will stay that way.
In interviewing the other participants’ Norris, Renee and Mary all agreed with Fred’s description that “today you have to be very particular about your partner.” Mary went further to say:

The next important thing that began to happen to me sexually was learning about um the power of my vagina they were all isolated incidence but there was a common thread... that men was effected in a really positive way when I slept with them...Although, I was full of sexual passion, I was able to keep myself under control, I was not always hopping around...I had choices ...selective partners...my vagina is powerful and I have to be real careful who I sleep with, I know there is some serious electricity going on in here that I now have to be real responsible for....you cant be fooling around laying around with everyone. You have some real responsibility these days. I am not interested in being promiscuous...I have ridged rules about sexual behaviors. There is just too much power inside of me.

Risks Associated with Contracting HIV

Participants expressed that they felt little risk of contracting HIV. While a majority of the participants stated they were never promiscuous, three of the five participants battled with drug addiction. It is important to recognize that HIV is often transmitted through drug use (intravenous). Although three participants admitted to destructive and heavy drug use, they still self identified as having limited risk associated with contracting HIV. Renee shared,
I was addicted to heroin up until 2005, I did hard core drugs all my life. I shared needles, lived in crack houses, and often did bad things for my next hit...but in all that I did not think I was at risk, I mean I didn’t know much about HIV, so I was just living out in the streets and doing whatever....being transgender I struggled at one time with my self esteem, I did a lot of things to be accepted, and not knowing really how to protect myself, I did have sex with men...you know...with nothing (unprotected). I do not consider my self to be a homosexual, cause I know I am a woman on the inside, I just still have the parts.

Listening to Renee’s perception of her perceived risk, I posed a question to the remaining participants about their experience with or knowledge of condom usage. Although, each participant gave a similar response, I think it is important to note each participant’s perception of condoms. Rose specifically stated, “You know it was not in my time to ask my partner to put on a condom. I mean condoms were jokes to us back then. We would play with them like toys...they were thick and bid and had faces on them...No one took them serious...So I would not ask them and they would not put one on.” Similar in context to Rose statement, Mary comments as illustrated next gives her perception of condom usage of her time:

Rubbers were something you saw laying on the side walk, you knew what they were for but there was no um...they did not apply. The didn’t belong in my world um...they were just something that I knew what they were for, I had no emotional um, value connection to them at all...You know I was married twice and did not think of it. but after my fourth and last baby, I became interested in
protecting myself....I could remember thinking there has going to be something out there that I can protect my self with, because white girls were having just as much sex as we were and they were not getting pregnant. I know rubbers were something I just did not use.

As a male Fred gave a similar outlook. It was the researcher assumption that since women felt they were unable or chose not to ask their partner to use protection, that the men were aware and taking necessary precautions to protect themselves. Interestingly enough, the researcher understood that women were submissive to their mate’s wants and desires, yet it never occurred to me that men were not advanced in condom negotiation either. As stated by Fred,

I was 14 or 15 when I had sex for the first time, I did it cause everybody else was doing it (laugh)....that’s how it was, I mean everyone else said it was good and shoot I didn’t want to be left out....everyone else was getting some so I wanted I some and I found it was ok.. As I got older I found out it’s not all that its cracked up to be....and sure I knew what condoms were, but I never used them....and I do not think that my friends were either. All I worried about was getting someone pregnant never about catching something like HIV...it was not until after I went back to school and starting educating myself that I started using or openly talking about it....and like I said. I did not know you could get it (HIV) from sex they never told us that.
Similar in nature to Fred’s outlook, Norris recalls his experiences with sex and the risk it held:

I was 13 (first sex encounter)... Um she thought I was cute.....no... I was a nerdy kid and um, to my self I start hanging out with my younger cousin we had a place just right outside town, were everyone hung out after school. Valerie more less seduced me, I have always been more attracted to men but at that time I was fighting it... it was not a hard task for me to ...cause you know I did not want to be gay, for a small town and that was not the to do thing, so she wanted to do it and I did not know how to do it, or protect myself and I did not care.. reason why I remember it so well, is because (sigh) Samantha (first child) was born 9 months later. Funny, my second time with a female was 17 and my second child was born then... you were never was really told what it (condom) was, but as kids I remember the first time I ever saw a condom, I must have been 6 or 7 maybe younger and we thought it was balloons...even in my teen age years they were discussed but not properly, your buddy may tell you about a condom, but your parents...my mother nor father never mentioned a condom my entire life...and when I got older and decided to date men openly, I still never knew.. Although, I did not think I could catch the virus, I still had unprotected sex with men...you know it was just not my reality.
Accessing Services

A number of questions were raised to gain insight into the participants’ behaviors regarding seeking and accessing HIV services within their communities. The participants gave similar responses regarding how they accessed services. The participants expressed concern regarding services meeting their individual needs and community needs. Three of the five participants shared the same response, while one shared a different, but noteworthy view. The researcher believes it is important to include her response, because it sheds light on how the current services are ineffective.

Population Disconnect

Three participants specifically, Rose, Renee, and Fred shared a commonality in why accessing services is important to them. Interestingly, all three participants have and continue to battle with remaining sober and drug-free. As illustrated by Renee, she needs services to keep from relapsing. Specific to services regarding HIV, Rose, just as Renee and Fred gave vivid clarity to the overall understanding of utilizing services. Rose states:

My overall health is important, I cannot afford to miss or do not try and access Services. This is what helps me stay on the straight and narrow. Now I can easily go to an NA (Narcotic Anonymous) meeting and feel just fine...In the drug world its all the same, drugs have no age or rules, or thought pattern of view...its all about getting that next high...that is it! Just getting high. But when you start talking about HIV services that different...yeah we all know how we got it and what it is, but our times are different. We did not do have the
things they do now nor did we talk about it so openly. I do not mind telling my story, if someone can learn from it and not make the same mistakes, I made, but when it comes down to me learning from them and all...it just do not happen.

Mary expresses her personal encounters or issues accessing the available services in her community:

I have taken to empowering myself - to live inside of the dimension of being HIV positive. I have outgrown my peers (meaning HIV Positive people) within the support groups. I do not go anymore...so I am on my own. I do not know a woman who is older than me. I even had female pastors who wanted to be a buddy, and she came here and took me to her church and she wanted me to redesign it for her and I told her ok let me spend the night since it was so far away...and see the service that way I can design it based on how it is used and after I said let me spend the night ... she hasn’t been back since. She has not set foot on this property, and what I learned is that people will go to class, and call themselves getting educated and take workshops about life with HIV, but they do not believe what they are being taught. I have no church home so my spiritual support system does not exist... I am my spiritual support...I am so discouraged with the services here till now. I love being able to give back or talk to younger adults, but there is a true population disconnect...I mean my issues are not always their issues...what can I learn from kids. So I don’t go to any services, so I guess accessing them is not a problem, it do not exist.
Notable to mention, Norris simply stated, “No I do not participate or access services, I mean, there are a lot of groups that I know are available for positive homosexual males, um ... but I just don’t know... but come to think of it honey, ..No... no there are none just for old people.”

Age Specific Services

Participants eagerly provided illustrations of why they perceived age specific services to be invaluable within for their community. They also gave descriptive accounts of how social marketing strategies do not target their age groups or address their concerns regarding HIV, sex education, clinical trials, or other aging issues.

Invaluable Resources

According to Mary,

The lack of personal involvement in learning about what this virus is about is amazing and yet I understand that what the underlying thought of that paradox is self-hatred, racism, abuse, and that long list of trauma. I came here traumatized and my trauma wasn’t even identified. I had to take a workshop at AIDS Survival Project (ASO), to learn I was suffering from Post Traumatic Stress Disorder (PTSD) and I had 3 counselors! If I knew where they were I would [use them], but they do not exist. The support group that I was with I had largely outgrown. I am the oldest person in this program. I was the oldest person in my support group and because ... I have outgrown my HIV peers, everyone I know who is infected is younger than me. I am the oldest person here in this
program. I have no peers of my age or attend any support groups; I feel alone, confined, and overcome by depression. I hope the virus does not take over me.

Renee added a very important point to the dynamics associated with services, “we have other issues going on - health issues, life issues, dating issues, and on top of all that HIV. I need to talk to people who can understand what I go through.” According to Fred, there is a need for services. He explains by adding:

I think there is a need, because there is a lot needed for those aging with HIV. I mean people are living longer and you have something going on with your body that is not HIV… that’s a normal part of the aging process… in terms of support groups things like that (HIV, health, aging process, education) could address some of those concerns. This can be the ticket to informing and teaching prevention education… now what I think is because of funding there may never really be services just for us. I think some (peers) know about HIV some do not, but they should. I am not getting on TV, but I talk in the community or in groups, but my peers I guess they are still ashamed. They come from a different time, the have not been in the dating game for a while. They are widows and we are still human beings - we are still sexual. We still have sex. The women are more at risk because some of them are with older guys. They go get them younger girls to come up in there and have sex. When they have money they go to the older woman who are not asking for money. They go get these girls off the street don’t know their sexual history and sometimes don’t use a condom…some think all I have to worry about is getting someone pregnant and
the women are saying I am in menopause so I can’t get pregnant and they are not worrying about that (HIV). Some peers use condom’s and some don’t. Women asking. Sometimes they will ask, but most times it’s about just someone to be close with…someone to be with…or have sex with. And if they can get it they don’t care, they don’t think bout the ramifications and consequences. Some do not think it could happen to them. They think it is out there somewhere in left field…it’s not here it is out there. So yeah they…we need those services.

Education Deficiency in Media Messages

As introduced by Mary, “I can say I have never seen any marketing or media message on HIV/AIDS for people my age...that is why I go speak wherever I can... I began going to every workshop I could get my hand on. I started educating my self on everything. I mean, I guess they think we don’t have sex or do not need to be informed about HIV and STD’s, how else are we supposed to protect our self if no one thinks it’s important?” I believe it is important that the media and marketing companies make a greater effort to inform seniors of their risk. It is paramount to enlighten them that HIV is not bound by age, but certain behaviors can put you at greater risk. Older adults often fall under the notion that HIV is a young person’s disease. Fred sheds light on social marketing strategies in his community in his response:

I live in the hood! I do see posters and billboards, but nothing for Senior citizens. But I think that’s where the church come in at, alot of those people go to church and it could be helpful in stopping the people over 50 from contracting
the virus. They think this is just for gay people and young people, they do not know that this can happen to them too! People need to get out to the churches, these high rise communities, senior centers, mall and on TV, letting seniors know that this thang is real...but know one does that all the focus us on children, women of color, gays and all...yeah that is important too but aren’t we all?

Lastly Renee states, “I do not see any thing that looks like me and there should be more signs out there. Maybe they still don’t think it affects us and that’s part of the problem.”

Summary

The purpose for this study was to explore HIV infected African Americans over 50 understanding of HIV/AIDS prevention education as well as their perception of accessible HIV/AIDS services within their community. In addition, this study purpose is to inform and improve HIV social marketing health messages targeting adults over 50 and the communities in which they reside. The research questions guiding this study were as follows:

1. How did HIV infected African Americans over 50 understand their risk prior to their diagnosis?

2. How have the sexual behaviors of HIV/AIDS infected African Americans over 50 changed over time?

3. Are African Americans infected with HIV/AIDS over age 50 accessing services within their community?
4. What is adult over 50 perceptions of HIV/AIDS services geared specifically for their age group?

In order to truly grasp the understanding of African American adults over 50 perception regarding HIV, this study focused on the participants understanding of HIV/AIDS, their sexual behaviors, their role in accessing services and their outlook on specific services for their age group.

Because of adults over 50 lack of understanding surrounding HIV/AIDS, it translated into a false impression of participants’ individual risk and further informed why their educational understanding of the virus is limited. In addition to discussing their understanding of HIV, their sexual behavior primarily, leads to two categories. Participants identified mainly with living a life of monogamy and not living promiscuously. Yet their actual behavior increased their risk of contracting the virus. Denounced to them, each participant experienced and expressed participating in events or acts that are currently categorized as the primary ways of contracting HIV. Ironically, they specifically identified and pride themselves with not having multiple partners, but did however, partake in risky sexual behaviors, or did not take necessary precautions to protect themselves.

Both accessing and utilizing services within the community and age specific services for adults over 50 were identified as major factors that African American over 50 consider when faced with an HIV/AIDS diagnosis. Participants responses ranged from accessing services as an intricate part of their recover to not accessing services because of a population disconnect. Each participant brought an important level of
insight and understanding regarding being HIV positive, over 50 and living a healthy life.
CHAPTER V

CONCLUSION

The purpose for this study was to explore African Americans adults over 50 understanding of HIV/AIDS prevention education as well as their perception of accessible HIV/AIDS services within their community. In addition, this study was designed to inform and improve HIV social marketing health messages targeting aging communities. Five HIV positive African American adults between the ages of 54-63 were purposefully selected and interviewed. All five participants were individually interviewed. Three of the interviews were conducted within the participants’ home and the remaining two took place at Aniz, INC, an ASO in metro Atlanta. This chapter includes detailed discussion regarding the general conclusion of this study and the relevance of the conceptual framework applied to this study. In addition, the limitations of this study are presented along with suggested research for future practices are discussed.

The data revealed that HIV positive African American over 50 is significantly affected by the HIV epidemic. Based on the analysis, the data generated two general conclusions. The conclusions are:

1. African American adults over 50 was born in a time when protective sexual behavior was not commonly discussed; consequently, culturally relevant prevention education materials are very much needed.
Because of their general lack of awareness about sex and sexuality, African American adults over 50 still are at high risk for becoming infected with HIV/AIDS.

2. African American adults over 50 can live longer with HIV/AIDS; age specific services do not exist within their community. Judging by the lack of support services for this population, it is assumed that African Americans adults over 50 are not considered at high risk, therefore resulting in poor social marketing strategies. This further explains why older adults are not comfortable accessing HIV services.

_African American adults over 50 were born of a different time; prevention education materials are still needed. Despite their general understanding or lack of education, African American adults over 50 are becoming infected with HIV/AIDS._

This study found that the perceptions of African Americans adults over 50 were only altered because of being HIV positive. Regardless of the format of educational learning, the participants all believed that they were not at risk of contacting the virus. According to the National Association on HIV over Fifty [NAHOF] (2007), HIV/AIDS educational campaigns and programs are not targeted at/older individuals. Each participant possessed a worldview that indicated they were immune to contracting HIV. This study also showed that growing up; African American adults over 50 were expected to not engage in sexual activities until marriage, yet no one explained to them why or ramifications such as STDs, and HIV. Seniors are unlikely to consistently use condoms during sex because of a generational mindset and unfamiliarity with HIV/STD
prevention methods (NAHOF, 2007). Unfortunately, today, there are still many
uniformed older adults. Long held beliefs about sex, risk, and prevention remains
largely rooted in issues of the 1940’s, which only serves to perpetuate repeated cycles
of uniformed older adults participating in high risk behaviors.

This study also found that many adults are becoming infected after the age of
50, which suggests that their understanding of the virus and their risk for contracting the
virus is limited and not well informed. Participants maintained that they believed HIV
to be a young persons’ disease and HIV would never affect them. Since they were never
formally educated, their knowledge and consequently, their risky behaviors place them
at greater risk for contracting and spreading the virus.

*Although African American over 50 are living with HIV/AIDS, age specific services are
obsolete within their community. In fact, often adults over 50 are not considered as a at
risk populations, therefore resulting in poor social marketing strategies. This further
explains why older adults are not comfortable accessing HIV services*

This study findings support the importance of culturally relevant HIV services.
Research supports that interventions must be culturally-sensitive, provide skills training
in condom use and sexual communication, and place emphasis on gender-based power
imbalance as well as sexual assertiveness (Barker, Battle, Cummings, & Bancroft,
1998; Nyamathi & Stein, 1997). The participants all agreed that there was a significant
lack of services for their peers. As previously stated the need for age specific services is
paramount. Participants consistently professed that they were born of a different time, and did not know half the information as young adults today.

The findings also revealed that while Americans are generally living longer healthier lives, they are not operating according to best practices when it comes to HIV education. Older adults are less likely to take precautions when they engage in behaviors that put them at risk for HIV infection (Stall & Catania, 1994, Maes & Louis, 2003). It was noted that when age specific services are being delivered multiple issues associated with aging could also be addressed. Specifically, study participants suggested that their peers can benefit from a spectrum of HIV related information, including: how to protect themselves from contracting/spreading STDs and HIV; on being newly single or dating; medical issues that can occur as a result of the normal processing of aging; and HIV related medical issues. Counterproductively, African Americans adults over 50 are not accessing services due primarily to the lack of their ability to connect with the current HIV support population or grow educationally or socially; yet, social marketing techniques do not reach this silent HIV population. As revealed by this study, this population is still sexually active and participating in high risk behaviors. Unless age specific services and better social marketing techniques are implemented, there will continue to be a raise in new cases of HIV positive adults over 50.

The theory upon which the conceptual framework for this study was based was social marketing. Social marketing seeks to influence social behaviors not to benefit the marketer, but to benefit the target audience and the general society. The ultimate
goal is to focus on the needs of the people by understanding their concerns and perceptions to assist them in the decision making process. The public often rely upon messages from media sources to gauge the importance of a cause or filter important topic, issues or information.

Like marketing, the primary focus of this study is to understand the needs of the participant. The focus of this study was to learn what African American adults over 50 want and need regarding HIV/AIDS services rather than trying to persuade them to partake in culturally imposed services (i.e. mixed-age services, limited clinical trials, limited prevention education within their communities). As noted in this study, media messages are implied to be reliable and informative, as they are prominently displayed on community billboards, radio ads, televisions, posters, or on buses. Social service providers commonly use these venues as the primary form of education. However, study participants stated that they never see or hear ads or media images that reflect their images when it comes to HIV. They often feel forgotten regarding HIV/AIDS education. Although, the participants did not feel ashamed of being HIV positive, they wanted greater outreach and service delivery to their peer group.

Inconsistent media messages may also be a culprit in the increase of new HIV cases among aging populations. For example, there are numerous billboards, television and magazine ads on erectile dysfunction and sex enhancing medications. Most ads are geared toward males and couples over the age of 50 who have the desire to be sexual active, yet because of normal aging or health issues are unable to do so. These ads often
speak to fulfillment and quality of life. What continues to perplex me regarding this advertising approach is the lack of information regarding STD and HIV prevention and education for older adults. If the media introduces the idea that there is a need for medication that promotes an active and healthy sex life, why does the myth of ‘a non-sexual’ seniors/adult over 50 persists? Why do researchers and health care providers lack information regarding the affects of HIV within this population?

As indicated in the existing literature, this study supports the notion that adults over 50 primary HIV/AIDS transmission is through sexual intercourse. This study also identifies a population disconnect between infected African American adults over 50 and infected African American youth when accessing resources. As stated in the existing literatures, older adults are not provided prevention education, health care providers and service workers do not realize that seniors are at the same risk as other age populations and media messages regarding HIV/AIDS is limited within their community. Although, the existing literature identifies resources within the community, this study exposes the multiple barriers associated with policies that govern HIV/AIDS services and older adult’s ability to access resources and services within the community. This study emphasis the perception of African American adults over 50 regarding their sexual behaviors and life experiences and why there is a great need for sex and prevention education to their peers.
Limitations of the Study

Several noted incidences posed limitations to this study. Due to the sample size of five, there were not enough perceptions or evidence to address a reputable percentage of African American adults over 50 who are infected with or affected by HIV. In addition, the single method of accessing data also presents itself as a limitation to this study. The usage of individual interviewing techniques was the only method implemented. In the future, the usage of focus groups, surveys (pre-post test) and individual interview would be more beneficial in accurately capturing the understanding, perspective and recommendations of HIV infected or affected adults over 50.

In addition, this study lacks the perceptions of health care professionals who work with the target population. This perspective can potentially shed insight as to why media and other professional are not recognizing adults over 50 as a population affected by HIV. Moreover, this study did not provide the perception of the adults over 50 who are affected by HIV. Caregivers are intricate and often overlooked regarding HIV. There were many dimensions of the caregiver aspect that were not discussed, for example grandparents raising grand children of infected parents, parents caring for children who are infected with HIV/AIDS, parents or grandparents who are still mourning the lost of a loved one from HIV/AIDS.
Suggested Research for Future Practice

More research is needed to further examine the affects of HIV among African Americans adults over 50. Research should be focused on older adults of all ethnic backgrounds. A comprehensive study should first be championed determining the different types of age related services programs and the outcome of each program. This would create a larger body of literature from which future studies can draw. Prevention educations should also be included in each study as a way to dispel any myths or fictitious beliefs regarding the spread or transmission of HIV.
CHAPTER VI
IMPLICATIONS FOR SOCIAL WORK

The purpose of this study was to examine the relationship between perception, education, accessibility and social marketing on the help seeking behaviors of HIV infected African American over 50. Even though those in the medical field primarily research HIV, social workers play an intricate part in its recommendations. As social workers, we are equipped to address the social implications associated with living a healthier life, self esteem and self efficacy issues, promote education and awareness, encourage empowerment, identify resources and link individuals with resources and services in hopes of promoting quality of life, to name a few.

Treatment and prevention services are intricate components when fighting the spread and reducing the risk of new cases of HIV/AIDS. Effective treatment for individuals over the age of 50 who are infected with or affected by HIV/AIDS begins with education. As social worker, we often work in the capacity of health educators, practitioners, evaluators, intervention and prevention specialists as well as program planners. Through these avenues, we can develop effective prevention strategies, as well as provide services and support to individuals who have already contracted HIV. As social workers our responsibilities lies in properly informing seniors of the risk associated with the virus, transmission rate, prevention methods, and ways to decrease
their risk and spread of the virus. Placing emphasis on the severity of HIV/AIDS is critical. Through education, social workers can equip older adults with the tools considered necessary to decrease them from becoming infected by this infectious but preventable disease.

The social work profession serves as a vehicle to uncover voices that were silenced, to improve the social well-beings of others, to encourage and empower and to advocate for change by bringing awareness to perspectives of individuals who have been oppressed or disenfranchised. Our role as advocates began here. In order to encompass change we need to evaluate current programs and express the need for age specific HIV services. Local agencies can promote education and awareness at all the location where people over 50 convene, inform local legislators of this growing population infected/affected with HIV/AIDS and inform legislators of the need for additional funds to increase services to defeat and combat the spread of HIV/AIDS among all populations.

As social workers, we often incorporate various theoretical frameworks to suggest or give guidance when seeking an explanation of why something happens as it does. Frustrated by existing literature and researcher’s narrow and limited view of HIV/AIDS among older adults, the researcher began identifying theories that did not solely identify with a disengagement type theory as the primary explanation of the aging process. Cummings & Henry (1961) coined the term disengagement to refer to a process whereby people respond to aging by gradually withdrawing from the various roles and social relationships they occupied in middle age. The disengagement theory
claims to be a practical process for the elderly or older adult. The theory suggests that older adults will gradually lose the energy and vitality held during younger years. Yet, this study identified older adults who were active, vital, involved in the community and concerned with the outcome of their social relationships. Society has unrealistic expectations that all adults should work and be productive; other people label older adults as incompetent or lacking in some ways; older adults accept the label and view themselves in terms of the label; they then learn behaviors consistent with the label and downplay their previous skills. As a result, they become more dependent, incompetent and feel inadequate (Zastrow & Kirst-Ashman, 2001). The social breakdown syndrome theory was conceptualized by Zusman (1966). Zusman indicated social breakdown occurs for the elderly because of the effects of labeling. Kuypers & Bentson (1973) asserts that this negative interaction between the elderly’s environment and self-concept explains many of the problems of aging in our society. According to the findings related to this study, the adults over 50 identified most with theories that encompass independence and control over their lives, social services and access to services that meets their needs (needs of an aging community) and societal norms that revered their self worth and competency rather than setting unrealistic standards and expectations. These attributes models the social reconstruction syndrome theory, which was designed to break the vicious cycle of the labeling process (Kuypers & Benston, 1973).

As social workers, we must integrate the concept of cultural competency models in health care practices. Cultural competency is a tool used to provide more care that is effective for minority groups and those affected by health disparities. Culture is a
concept that refers to integrated patterns of human knowledge, beliefs, and behaviors that depend on human capacity for learning and transmitting knowledge to succeeding generations. Culture also relates to customary beliefs, shared attitudes, values, goals, practices, social forms, and material traits of a racial, religious, or social group (Office of Minority Health [OMH], 2001). Cultural competency is important when working with HIV/AIDS clients, primarily because the HIV/AIDS epidemic has principally affected specific social and racial/ethnic groups that have already experienced discrimination and socioeconomic disparities within our society (National Minority AIDS Education and Training Center [NMAETC], 2007). This implies addressing behaviors, attitudes, and policies targeted at meeting the clients' needs.

True change relies in our abilities as social workers to effectively educate and communicate the risk of the HIV/AIDS infection regardless of race, gender, and age. The primary role is to informed, and practice safe behaviors in the fight to decrease HIV/AIDS incidence, the number of individuals infected and affected by HIV/AIDS. Although, limited research has been conducted on the effects of HIV/AIDS among older adults, seniors and HIV is not a new discover. The spread of HIV/AIDS continues to increase at an alarming rate, preventive messages and treatment should be addressed with health care providers, professionals, and individuals of all populations. As social workers we strive to dispel negative myths and stereotypes within diverse communities. As stated by Council on Social Work Education, this profession is based on the values of service, social and economic justice, dignity of all persons and the importance of human relationships.
APPENDICIES
APPENDIX A: IRB APPROVAL FORM

CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

October 19, 2007

Roshaunda R. Leopold, <rrleopold@yahoo.com>
School of Social Works
Clark Atlanta University
Atlanta, GA 30314


Principal Investigators: Roshaunda R. Leopold
Human Subjects Code Number: HR2007-10-227-1

Dear Ms. Leopold:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your protocol and approved of it as exempt from full IRB review in accordance with 45 CFR 46.101b.2. You may begin your study after October 29, 2007. Your Protocol Approval Code is HR2007-10-227-1/A

This approval is valid for one year from the date of this notice. This permit will therefore expire on October 28, 2008. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office. Any reaction or problems resulting from this investigation should be reported immediately to the IRB, the Department Chairperson and any sponsoring agency. If you have any questions, please contact Dr. Georgianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee
cc. Dr. Sarita Davis <sdavis@cau.edu>
Office of Sponsored Programs, “Dr. Georgianna Bolden” gbolden@cau.edu

223 James P. Brawley Drive, S.W. * Atlanta, GA 30314-4391 * (404) 880-8000
Are you affected or infected with HIV?

Does HIV affect your community?

Would you like to help in the fight of alleviating HIV?

If you answered yes to any of these questions, please participate in a free and confidential study geared toward Researching The Relationship between Perceptions, Education, Accessibility and Social Marketing on the help seeking behaviors of Elders affected by or infected with HIV.

If you are interested or would like additional information please contact Rashaunda Leopold at 770-635-8024 or 225.936.7056

Conducted by
Clark Atlanta University, Whitney M. Young Jr. School of Social Work
Masters of Social Work Department
223 James P Brawley Drive, SW
Atlanta, GA 30314
APPENDIX C: INFORMED CONSENT

Informed Consent to Participate in a Study addressing HIV/AIDS services among African American over age 50.

1. Why is the study being conducted? Over the past 25 years HIV/AIDS has infected/affected an estimated 38.6 million people. HIV/AIDS both attack the immune system, which is designed to fight the infections that enter the body. This study is being conducted to find out the relevance of age specific services when addressing the needs of HIV/AIDS infected/affected individuals. You have been asked to take part because you have either used the services or are capable of shedding light on the needs of your community.

2. What are you being asked to do? You will be one of 30 adults over the age of 50 who either participate in a focus group or individual interviews about their experience with accessing or receiving HIV/AIDS services within the community. You will be asked some questions about the importance of services, sexuality, treatment and previous education and awareness on the topic. You may choose not to answer any questions that you do not feel comfortable answering. However, you will be giving information on how to reach me should you have any questions pertaining to the study or your participating in the study.

The study will occur over the course of 30 days. If you decide to participate in the study, I will asked you about your perception of services and areas of growth. The interview will take approximately 75 minutes to complete. I would like for the meetings to take place at Aniz, Inc located at 233 Mitchell Street, SW Suite 200, Atlanta, Georgia 30303.

3. Is this voluntary? Yes. You are under no obligation to participate. If you agree to participate, you can ask the interviewer to skip questions that you'd rather not answer. Also you are free to stop the interviewer at any time.
4. What is the advantages of participating? As a participant your answers and perception will help inform HIV/AIDS service providers. As a participant you will help the providers better address issue that affect you and your community.

5. Will participating in this study affect the services you are receiving? No. Whether or not you agree to participate in the study will not affect the type or amount of services you are eligible or currently receiving.

6. Is this confidential? Yes. Nothing learned about you by the researcher will be told to anyone else. The researcher will remove identifying information from your demographic sheet. All records will be identified only by your initials and year of birth. Once the study is complete all records of your name will be destroyed. Everything that you say is strictly confidential, and any reports or other published data based on the study will appear only in the form of summary statistics without names or other identifying information.

7. What risks do you face if you participate? There are minimal risk to the participants. There will be sensitive subject matter discussed. Participants may feel uneasy or unsure about disclosing their sexual behaviors and understanding of the subject matter. However, there is no physical risk to the participants.

8. Are there any cost? There will be no cost to you for participating in the study.

9. Who do you contact if you have questions about the research? If you have any questions about the study, you can ask immediately or contact the researcher directly, Ms Roshaunda Leopold at 770.635.8024, or Georginna Bolden at Office of Sponsored Programs at Clark Atlanta University, 404.880.6979

Participants Contact: If you have questions about your rights as a participant in the study. The IRB directors reviews all studies to ensure the rights and protect the participants.

Your signature below indicates that you consent to participate in the focus group or be individually interviewed, that you have been given a copy of this consent form, and that you have read and understood it.

PRINT NAME of PARTICIPANT DATE/TIME
APPENDIX C: INFORMED CONSENT continued

SIGNATURE OF PARTICIPANT

DATE/TIME

I have read the consent form to the person name above. I have had a chance to ask questions about this project and my questions have been answered. I agree to be part of this study. I will receive a copy of this form

PRINT NAME OF PERSON OBTAINING CONSENT

DATE/TIME

SIGNATURE OF PERSON OBTAINING CONSENT

DATE/TIME
APPENDIX D: CLIENT DEMOGRAPHIC FORM

Client Code

Name
Date

Date of Birth Current Age

Ethnicity (circle one) African American
Caucasian
Native American
Hispanic
Asian
Other

Are you (circle one) Infected or Affected by HIV/AIDS

If YES, have you disclosed your status with family and friends (circle)

YES NO

Are you receiving HIV/AIDS services (circle) YES NO

Do you currently have support from your family (circle) YES NO

Do you feel this focus group/interview was beneficial (circle)

YES NO

Is there anything you would like to address?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________

86
APPENDIX E: INTERVIEW GUIDE

1. How did HIV infected African Americans over 50 understand their risk prior to their diagnosis?
   a. What do you know about HIV/AIDS
   b. Where you ever given any formal education about HIV/AIDS?
   c. Did you ever know anyone with HIV
   d. Have you disclosed your status with your family/support systems?

2. How have the sexual behaviors of HIV/AIDS infected African Americans over 50 changed over time?
   e. How old were you when you had your first sexual encounter?
   f. What was your sexual behavior like as a young adult?
   g. What do you do now sexually, that you did not do in the past?
   h. Where you ever given and formal education regarding sex and protection?

3. Are African American infected with HIV/AIDS over age 50 accessing services within their community?
   i. What types of HIV prevention education services are available in your area?
   j. Are these services adequate?
   k. Do you currently receive HIV support services?
APPENDIX E: INTERVIEW GUIDE continued

1. What productive role did (can) the social worker play in helping older people accessing HIV services?

4. What is adult over 50 perceptions of HIV/AIDS services geared specifically for their age group?
   m. Have you participated in HIV groups with people younger than yourself? IF so explain.
   n. Do you think your peers see HIV and STD’s as relevant to them?
   o. DO you think HIV treatment/education groups are needed for your age group? Explain
   p. Do you see any public health messages in your community about HIV and older adults (e.g. posters on buses, bus stop, bill boards, TV, radio, etc )
   q. Should HIV and STD prevention material be provided specifically to your peers?
   r. How helpful are your family members in helping you access HIV services.
REFERENCES


http://www.thebody.com/content/policy/art3377.html


Retrieved December 15, 2007 from


http://www.med.unc.edu/aging/elderhiv/diagnose.htm


http://www.social-marketing.com/Whats.html

