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An Examination of African American Women with HIV and Health Care Barriers

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This is to certify that the doctoral dissertation by

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Abstract

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MHA, Walden University, 2012

MBA, ITT Technical Institute, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Care Administration

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Abstract

For over 40 years, HIV has been seen as an epidemic and problem on health care that disproportionately affects the African American women (AAW) and population. This epidemic represents 12% of the total U.S. population, yet accounts for 37% of the commutative HIV cases, and 45% of the new HIV cases reported since 1998. Research in this case was needed for increased understanding to this health care problem, between AAW and HIV. A review in the literature indicated the problem and found new alternatives that helped support aspects on today’s health care. The purpose of the study was to help explore the experiences of the AAW with HIV and make an effort to identify the barriers in the health care system. This was by using a narrative design and qualitative approach that helped address the overall questions, on the economic and environmental risk factors associated with HIV, and how one compensates for barriers to HIV treatment and resources. The current results by the narrative provided new knowledge for AAW with HIV. They are seen as the new generation of AAW with new challenges on health care and HIV treatment. Therefore, in an effort to make further recommendations and deal with the challenges on social change, the older generation of AAW need to educate their younger generation on HIV prevention strategies. They are implementations of strategies for positive social change that will help make a difference, by educating today’s youths and correct the miss-educated, among our black population of society.

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Dedication

I dedicate this dissertation to the African American women and population who have and may still continue to experience the most severe hardship and burden of living with HIV or AIDS, while trying to seek health care access. This research study is also dedicated towards ensuring that all individuals of color have the knowledge and equal opportunity to access medical care, in regards to any contiguous disease as part of a comprehensive strategy. This will help eliminate health disparities in the health care system. Therefore, my heart goes out to the African American communities all over the world who may have experienced difficulties in the health care system, while living with HIV or AIDS or who have experienced stigma. The outcome may reduce health disparities and may make a difference by helping to create more positive social change. This is the positive social change for a better understanding of our nation’s health care system and health disparities that has existed among the African American women and people of color. These are the actions that will help make a difference to improve the fundamentals between human and social conditions that effects positive social change in the health care system.

Acknowledgments

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Table of Contents

List of Tables

Table 1 Code and Response

Table 2 Code and Response

Chapter 1: Introduction to the Study

Introduction

HIV and AIDS among African American women (AAW) has become a complex mix of economic, social, cultural, biological, environmental, and behavioral factors when it comes to health care access (Anti-Virus Emergency Response Team [AVERT] 2012). In the past, HIV statistics about African American women were often buried within the statistics of the general HIV/AIDS population or lumped together with statistics on Black men toward seeking health care treatment (The Center for Disease Control Prevention [CDC], 2012). This practice disguises compelling evidence how Black women represent a high disproportionate number of HIV cases, when compared to the overall female population in the United States. Global Information and Advice on HIV & AIDS. AVERT (2012), stated that 1 in 30 Black women will be diagnosed with HIV at some point in her life, leaving many as a health disparity, with no insurance for health care at some point. Since Black women account for 9 out of 10 new HIV infections among women, it is important to understand how social and gender inequities and cultural dynamics shape the perceptions and realities of the disease among health disparities (CDC, 2012).

According to Black Women's Health Imperative [BWHI] (2012), more than 34% of the 45 million Americans who lack health insurance are African American and women of color. The reality is that they live in federally designated, underserved, and underresourced communities, lack appropriate access to primary health care, and endure more chronic illnesses and diseases that are diagnosed and treated inadequately, resulting in shortened lives and unnecessary deaths (World Health Organization [WHO], 2013). This has been a very important factor in health inequality that leaves millions of women of color unable to participate fully in social, civic, and political affairs in their respective communities, and more importantly, in the lives of their families (BWHI, 2012).

Another important factor has been the significant barrier between politics and discrimination which goes hand-in-hand and created these disparities. In many ways, discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status (Stratford, Mizuno, & O'Leary, 2008). In other ways, social stigma and discrimination were found to be inherent and laid between several different races, cultures, or minorities among people of color. According to WHO (2013), stigma is inherent with the social and health inequities that result from the human immunodeficiency virus HIV-related social stigma and continue to be a significant barrier to health care access in an effective global response to the HIV epidemic.

One way this barrier was created and still exists was from the past research and data on how it was overly diagnosed and reported by the information to the CDC for the past 50 years. According to the CDC (2012), factors such as heightened levels of poverty, lack of access to adequate healthcare, and stigma surrounding men who have sex with men shaped the epidemic among African Americans. Addressing issues such as poverty, poor access to healthcare, and unemployment was seen as an integral part of tackling the disproportionate impact of HIV on the African American population (AVERT, 2012). Among the factors that have affected health care access and status among African Americans—such as inadequate health insurance and limited quality care of preventive care—poverty appears to be a primary underlying factor and barrier that highly contributed to the risk for HIV infection among African American living in the South (Stratford et al., 2008). Collins, K. Tenney, &. Hughes, D. (2002) stated that despite the rising rates of preventive care, health outcomes have been known to remain the worst for African Americans compared with white adults, and these disparities will require an examination of other points of access and quality in the health care system. Furthermore, even for many African Americans who are working, high poverty rates and high insurance rates have continued to erode their basic access for health care for AAW who live with HIV.

In many cases, health care has been considered a multispectral issue that involved access to care and services, transportation, health insurance of some type, education, individual and family well-being, housing, and community-level issues—such as neighborhood safety (Stratford et al., 2008). In some cases, African American, Hispanic, and Latino cultures who live with or without HIV have become much more vulnerable. Roger (2008), stated that vulnerable is a word commonly used to describe certain individuals, and being more vulnerable leads to complications while trying to receive health care for HIV prevention. Since 2012, the Affordable Act Care (ACA) provided a number of opportunities to help improve the health of vulnerable Americans—primarily by expanding insurance coverage or even commonwealth the health care safety net (Commonwealth Fund, 2012).

One first important step to improve health care access was to provide the opportunity for health care insurance to all who live in the United States. According to

BWHI (2012), many advances have supported the efforts to improve health outcomes for black women–most recently in 2010, with the passage of the ACA, known in the vernacular as Obamacare. Since 2010, ACA has had the potential impact of broadening Black women's access to affordable health care by lifting barriers that previously limited their choices on how they received coverage and care (BWHI, 2012). Therefore, much work has and still remains to be done toward ensuring that fair opportunities are met and barriers are identified with support for many AAW who live with HIV. According to Messer (2013), while some research identifies a range of barriers to HIV care exists, few researchers have explored these barriers at various stages in the HIV-care engagement process, specifically among one of the most vulnerable populations, African Americans.

Therefore, it was important to focus and understand the population of the study to find and address the barriers and gaps to this disparity problem. One way was by exploring the lives of the vulnerable AAW using the vulnerable population model (VPM). The VPM helped define three strategies for the study: (a) ensure how coverage provides care, (b) strengthen the health care delivery system, serving many cultures, and (c) coordinate medical care for African American and black minority groups (Commonwealth Fund, 2012).

The results of the VPM were shown to help address and give some clarity to answering the research questions about health care access for the 10 AAW participants. This was when asking and examining their living conditions and their behaviors by the data analysis step in regards to the repeated themes and codes. These were themes and codes, repeated constantly, on their living conditions and arrangements, and their levels of low-income or being uninsured. These important answers and results played some part in the racial and ethnic minority populations in the health care system. As part of The Commonwealth Fund's mission was to promote delivery system improvement and innovation. The Program on Vulnerable Populations helped support the efforts to ensure that low-income, uninsured, and racial and ethnic minorities are able to obtain care from high-performing health systems with the capacity to meet their special needs (Commonwealth Fund, 2012). Therefore, the research on the background of the problem on HIV and health disparities of the African American culture are identified and addressed in Chapter 2.

Background of the Problem

For the past 40 years, HIV has been seen as an epidemic and a problem that disproportionately affects the African American population. This is a population that represents 12% of the total U.S. population, yet accounts for 37% of the commutative AIDS cases, and 45% of the new AIDS cases reported since 1998 (CDC, 2014; MMWR, 2014). According to AVERT (2014), the African American population has had the highest HIV case rate per 100,000 of all ethnic and racial groups studied. The current rate of HIV cases is 66.4 per 100,000 of the African American population, when compared to 8.2 per whites (CDC, 2012).

The HIV rate has doubled in the African American population while remaining fairly constant in the white population (Newsweek, 2009). Thus, African Americans have consistently consumed a higher percentage on health care treatments and experience a higher mortality rate when compared to white patients (Berkman & Mullen, 1997). Such differences on the higher numbers and facts on the African American and health outcomes have brought up many unanswered. These are the questions that were addressed and brought up in the research study. They are seen as the mechanisms today, which may have caused such an unequal balance, in the medical and health care field for many black races and cultures and the African American population. According to Williams and Jackson (2005), these disparities in health and health care are rooted in a deeper and larger historical, geographic, sociocultural, economic, and political context with the overall consensus being the indirect and direct effect of socioeconomic status (SES). They are rooted in deeper within the resources and treatment that come with each of these serving as the mechanism by which health disparities operate and causing an imbalance of distribution.

This imbalance of distribution of the African American and health care disparities were seen as an overall consensus of an indirect and direct effect of SES, during interviewing the 10 AAW who live with HIV. This imbalance is part of the problem that served as a negative mechanism upon which health disparities operated and hindered the access to health care for AAW with HIV. This SES is known for the social standing of an individual and has been described within terms of their living arrangements, income, education, and occupational status. Individuals who have a SES face proportionally more challenges in life when it comes to effectively accessing health care and preventative services (Davis, 2013).

This is very challenging for the subgroups and minorities who live at poverty level when seeking or gaining any access to health insurance plans or plans sponsored by state governments which were affordable at the low end cost minimum. Williams (2012), stated how SES has predicted many variations in health and healthcare within minority and white group populations and has been responsible for the racial differences in health and health outcomes. According to the American Psychological Association [APA] (2012), 26% of African Americans are currently living in poverty as compared to only 8% of non-Hispanic whites. This was seen as a huge disparity that lack's someone's motivation and knowledge or resources, between both racial and minority groups, as to living with HIV and seeking treatment. According to Williams and Jackson (2005), social motivation, knowledge, and resources are required to reduce or eliminate the disparities of health and diseases.

In many other ways, someone's SES affects their residential area and living conditions of an African American woman who has HIV and this was proven by their environment where they live and environment exposed to as well (APA, 2016). Furthermore, someone's SES with HIV affects their community benefits and educational resources available to them. According to Williams and Jackson (2005), the residential concentration of African Americans leads to inequalities in neighborhoods, SES, and quality of medical care.

In this chapter, I preview major sections of the barriers in the health care system for AAW who live as HIV positive. They are seen as the barriers that have discriminated or denied an AAW the health care and treatment while living with HIV. According to Davis (2013), racism and discrimination therefrom has been around for centuries and seems to find unique ways to interfere with the lives of those who are African American and afflicted with HIV. Racial discrimination against African Americans in health care has existed directly and indirectly through perceived racism by patients in the quality of care, lower SES, and the resources that are available and unavailable to its members (Davis, 2013). The problem of discrimination is expressed and emphasized in the following chapters.

Problem Statement

Many different studies have been conducted on racial discrimination and racial segregation in health care, all which operated under the notion that African Americans have a higher disease rate as compared to Caucasians (Davis, 2013; Williams, & Jackson, 2005). This problem and rate has been current and persistent and segregated within time for many AAW who live with HIV. Theoretically, racial segregation that does not deny equal opportunities, as may be observed in middle-and upper-middle-class Black communities, might portend a positive health benefit in Black communities (Airhihenbuwa & Liburd, 2006). Therefore, additional research for increased understanding to this health care problem between AAW and HIV was needed to confirm that this was the case. Further research about the problem of health disparities and HIV was done to explore new alternatives and to help support and improve aspects of the AAW who live with HIV and the United States' health care system. The research study was done by using the VPM that helped examine and measure how levels of low-income, poverty, and being uninsured played a role of the racial minority populations.

According to Welch (2011), any ethnic group, family social structure and influences, geographic distribution, environmental risks, communication patterns, and lifestyle preferences have influenced the health beliefs and behaviors of African Americans. This was noticed where the repeating patterns and behaviors where shown, and where HIV has been seen as a social, cultural, biological, and environmental issue when seeking health care for this population (Welch, 2011). This is a problem for many AAW with HIV that has been buried by the statistics or media on how AIDS has generally shaped the society, by creating barriers today from the past. According to Welch (2011), an increase in a population with HIV has created barriers when seeking the right health care and treatment, especially in the black segment of American society.

Purpose of the Study

The purpose of the study was to explore the experience of 10 AAW living with HIV upon making an effort to identify and address the barriers to health care access and treatment. Evans and Swan (2014), explained how African Americans have disproportionately higher rates of HIV in the United States, and there is no biologic, as opposed to sociological, reasons for these disparities upon incidence and no single reason why these disparities have existed. According to Davis (2013), for centuries African Americans have faced the consequences and daily struggles of discrimination and racial inferiority in every stroke of life. In this case, the VPM and the following research questions helped address the barriers in the health care system for AAWs who live with HIV.

Research Questions

RQ1: What are the economic and environmental risk factors associated with African American women with HIV/AIDS?

Subquestion: How do these risk factors influence overall health status?

Subquestion: How do these risk factors influence access to health care services?

RQ2: How do African American women with HIV/AIDS compensate for barriers to treatment and community resources?

Subquestion: What measures do the African American women use to deal with the stigma associated with the diagnosis of HIV/AIDS?

Subquestion: How do these measures enable the African American women with HIV/AIDS to overcome or adapt to the risk factors associated with vulnerable populations?

Conceptual Framework

The VPM was used as a conceptual framework for the research study. The population was defined as vulnerable based on three characteristics: resource availability, relative risk, and health status (Flaskerud & Winslow, 1998). Flaskerud and Winslow's VPM was the appropriate and suitable conceptual framework for the study. This is because VPM helped focus on many of the characteristics of AAW with HIV. According to Flaskerud and Winslow, other vulnerable groups have been investigated by using the VPM as a conceptual framework for vulnerable women and children and ethnic and minority groups. The VPM helped address the study by exploring the attitudes and behaviors and explored the life experiences of AAW living with HIV. The special components to the VPM are: (a) SES and resources, (b) environmental status and resources, (c) relative risk of activity, (d) lifestyles, (e) health choices, (f) disease onset, and (g) HIV/AIDS and/or diabetes, morbidity— all of which were centered on one’s vulnerability.

Nature of the Study

The nature of the study was addressed by a qualitative focus using a narrative design. The rationale for selecting the narrative strategy of inquiry was based on its effective way of “a story telling history” of each individual participant. Creswell (2013), stated how a narrative design and inquiry helps explore people of color and provides a better understanding to work together with the problem statement. The key concepts and elements of the narrative strategy of inquiry was one method that has been known for its accuracy in explaining something specific. This was about a protected class or minority group, or a special purpose for a research study. According to Creswell (2013), narrative research is a strategy of inquiry in which the researcher “studies the lives of individuals” and asks one or more individuals to provide stories about their past experiences.

Other concepts for the narrative strategy of inquiry were used as a tool of social learning. This concept as being the right tool in narrative design and inquiry helped rely on storytelling from AAW. As the narrator or sample participant told their story or talked about their past experiences on how they live as HIV positive, or with the stigma of having HIV, another felt their pain or confusion. From eliciting their emotions and recollection upon one’s similar experiences, these narratives became a link that allowed the participants to understand how they were potentially vulnerable to living with HIV infection and seeking health care treatment.

Sampling Method

The sampling methods were based on the snowball and single stage cluster sampling method. According to Crossman (2015), cluster sampling is used to find a specific race or targeted population. The cluster sampling method works best for small groups in a big city, where HIV is overly rated or populated. According to Explorable (2016), the snowballing sampling method works like chain referral, where after observing the initial subject, the researcher asks for assistance from the subject to help identify other people with a similar trait of interest. Creswell (2013), expressed how identifying whether the sampling methods for a population or people with a similar trait of interest may be either "single stage" or "multistage" called clustering. This meant that the small sample was recruited in a small area and population within a cluster of their surrounding black communities. This population consisted of 10 women participants, who are adult AAW and diagnosed as HIV positive followed by the recruitment process.

Recruitment Process

The recruitment process was done after identifying the sample of participants, who were AAW with HIV, while using the snowball and cluster sampling technique. The strategy of combining snowballing and clustering sampling together was used to recruit participants in small rural area clusters of local communities. After participants were recruited, I conducted a 45 minute, one-on-one interview with 10 HIV positive AAW. The recruiting method used to attract the participants was by hanging fliers, word of mouth, friends of friends, and other clinics and shelters that fit the criteria on the participants. According to Nunn, Yolken, Cutler, Trooskin, Wilson, Little, & Mayer.

(2014). HIV infection often clusters in neighborhoods that already experience significant social and economic burdens. Once the recruitment methods were used and combined, the data were collected.

Data Collection

The data collection tool consisted of 10 open ended questions that helped answer and address the final outcome by a face to face interview. The open ended questions were considered the right tool that worked well with a qualitative approach for collecting data on a small sample of AAW living with HIV. This approach helped the participants open up and express their feelings on their experiences about health care access, medical service, and treatment. In many ways, a qualitative inquiry procedure employs and demonstrates a different approach on scholarly inquiry than methods of quantitative research. Creswell (2013), stated how qualitative inquiry employs different philosophical assumptions, strategies of inquiry, and methods of data collection upon analysis with interpretations. Therefore, I paid special attention and kept focused on learning what participants experienced in health care problems or issues. One important issue in writing a scholarly manuscript was to not exploit the labor and provide authorship to individuals who would contribute to publication during data collection and interviewing (Creswell, 2013). This was very important because being highly focused released the special details of myself and the research design which helped the readers determine for themselves the credibility of the data. This helped to avoid unethical assumptions of the study and helped the data be analyzed correctly.

Data Analysis Procedure

The purpose of this section is to introduce the data analysis procedures that were used in the research study. The qualitative data analysis process helped answer the research questions surrounding the research the participants. This process helped identify the common themes about health care and health disparities, as well as social stigma and discrimination by the open ended questions. According to Richards (2009), qualitative data analysis is an open-ended process in which coding categories can evolve and new information can emerge, and this is a start to organize and prepare the data analysis. In this case, each 45-minute individual interview was transcribed and analyzed by using qualitative data analysis computer program software.

Transcription

In the first step, I examined and got to know the data by transcribing each interview individually. Transcription involves the interpretation of oral language into a written format with different rules and standards (Kvale & Brinkmann, 2009). Therefore, I made choices about what to filter out or include and what should be further guided by the needs of the study. According to Kvale and Brinkmann (2009), a researcher who transcribes his or her own interviews might preserve more of the social and emotional aspects of the interview due to being reminded of the context in which the words were spoken.

Once the data were transcribed and organized, I reviewed and evaluated the overall data of each transcript to get a better understanding on what was discovered. This was by reading each individual’s transcript within its entirety, or by gaining a general and overall sense of the gathered information. This was the first step and goal to understand the type of information and data I needed to convey. The conveying step process involved myself to transcribe each interview by constantly scanning and filtering the material, writing up field notes, and arranging and sorting the data into different types of categories, depending on each source of information and data. Furthermore, this step called myself to read through every transcript and piece of data and obtain a general sense and idea of what each individual participant has said in the 45-minute interview.

Software for Analysis

In this step, I used qualitative data analysis software that has been known to be highly effective in many research fields of qualitative research to categorize information. In this study, I used a program called NVivo10 (QSR International) that helped in analyzing the background and demographic of the AAW attitudes and behaviors, who live as HIV positive. They are the 10 AAW participants who provided important and valuable information in a 45-minute face to face interview. According to Bazelt (2007), NVivo10 has many unique features that can create coding pieces of text, memos, and searching some relationships between codes to enhance the researcher’s ability and help to recognize different patterns and themes of qualitative data.

One ideal purpose for using software helped me identify the themes as one of the most fundamental tasks in qualitative research. Bazelt (2007), expressed how using software to analyze qualitative data is a helpful tool and technique to discover hidden themes in the qualitative data analysis and text. Therefore, qualitative content analysis software was used to help analyze data and describe the past experiences of AAW living with HIV. In many past studies, qualitative data analysis software was recommended and used to manage data, organize themes, and confirm ideas. I used this process to generate an idea and description of the setting or participants as well as categories or themes for coding the data analysis.

Through the research study and narrative design, I attempted to extract themes or statements on an understanding how AAW have experienced barriers to health care because of their health status and living as a health disparity.

Identifying Patterns and Themes

After I coded the narrative data, they were grouped into organized clusters, labeled themes, and coded within the following steps during the data analysis process. I coded the relevant 45-minute interview data within broad categories. This was indicated by the existing literature of the 10 participants by their narrative story, their attitudes and behaviors, and their past experiences with HIV. The initial topic and helpful categories included African American personal and religious beliefs, health care barriers and issues, and reference or literature of some research variables to poverty, stigma, and discrimination. This was the step that helped advance how the description and themes were represented in qualitative narrative research by clustering, summarizing, and extraction of general and unique themes from all interviews for development. This was the process I used to identify common and repeating themes about the 10 AAW who were interviewed.

Results and Discussion

Towards the end, I concluded on writing a composite summary that transformed and interpreted the end results of the interview data into the expressions that were appropriate for the scientific discourse. This step supported the research between health disparities and health care access. By this, I repeated the analysis steps again to thoroughly examine all data collected by the in-depth interview sessions. Furthermore, it was the final step to make special interpretations or meaning of the data analysis procedure. However, I attempted to recheck the transcripts several times to make sure qualitative validity and qualitative reliability and mistakes were not made during transcription.

Definitions of Key Concepts--Constructs

Defining certain terms and wording used occasionally in the study helped provide concise word choice and areas on unbiased information. The concise definitions and terms throughout the study provided the key concepts and constructs on the valuable resources about the African American race and culture. Such words were repeated often in the study like “adult African American women,” “stigma,” “coping attitudes and behaviors,” “AIDS,” “HIV/AIDS stigma,” “HIV,” “poverty and poor,” “socioeconomics,” “health disparity and health inequality,” and “vulnerable population.”

Other terminology like *African American*, *healthcare*, *health disparities*, and *living with HIV* were used for the general search terms. General search terms as *stigma* and *discrimination* were used repeatedly, throughout to help identify and address the root or gap for making sense among all inquiries. According to Braveman (2006), repeated definitions and key concepts throughout any study have very important meaning with practical consequences that determine the measurements being monitored within governments and international agencies. Such activities that are supported from the resources earmarked that help address the health disparities and health inequalities by the research. The definitions below helped narrow down the topic of the research and information about AAW living with HIV as part of the vulnerable population. This population was seen as a vulnerable group of people with the coping attitudes and behaviors among today's society and socioeconomic.

AIDS: AIDS is and has been seen as an infectious disease, caused by HIV. The HIV disease has been known to take two variants parts within the HIV virus, HIV-1 and HIV-2, which both can ultimately cause AIDS (CDC, 2015).

Discrimination: Discrimination happens in an obvious or direct manner. It may be someone making false accusations or negative remarks on another's mental capacity or illness, or for a service or treatment. Discrimination can be subtle or unintentional as someone trying to avoid someone else, as the person may assume the other may be violent, unstable, or dangerous because of their race, mental health, sickness, or condition. Discrimination and racism may be seen under an umbrella of terms that refer to someone's beliefs and practices by their attitudes of denigrate protected minority groups (Tigawalan, 2010).

Health disparity: Health disparity(s) are seen as inequalities that may occur within the provision and area of access to healthcare and healthcare within an ethnic or minority group and racial or socioeconomic groups. According to the Health Resources and

Services Administration (2001), health disparities are defined as population-specific differences in the presence of disease, health outcomes, or access to healthcare.

Health inequality/equity: A health equity is about the study on differences within the quality of health care and health across different races and populations. A health equity is known to be different than a health equality because equality will refer only upon the absence about disparities in remediable and controllable aspects of one's health care and health status (Braveman, 2006).

HIV: HIV is a contagious virus that may lead to further stages of acquired immunodeficiency syndrome, other known as AIDS. Unlike other contagious viruses, a person's body will not get rid of HIV (CDC, 2015).

Socioeconomics: Socioeconomics, or social economics are issues or concerns in regards to one's living factors that may have an impact on a family or individual economic and social standing by economic status. The questions or concerns may include factors of their ethics, and fairness and results on policies, theories, and institutions, and this can result in different standards of health care treatment opportunities that are based upon SES. In many cases, poverty and education are seen as the major socioeconomic factors and as being the major source for one's socioeconomic concerns (William, 2016).

Stigma: Stigma is the actions on viewing someone in a poor or negative way. This negatively action may be on one's personal trait, or distinguishing characteristics, thought to be, or by a negative and disadvantage stereotyping that can lead to discrimination (Brown, 2011)

Vulnerable Population: A group or population who may be economically disadvantaged because of their racial and ethnic minorities, and who may be uninsured, low-income, elderly, homeless, or those with HIV, or other chronic health conditions with lack of health care. The vulnerable group or population may reside within rural or populated areas and clusters of a race, individual, and minority group who may often encounter barriers to accessing healthcare services (American Journal of Managed Care [AJMC], 2006). The vulnerability of the individuals is enhanced from their race, ethnicity, age, sex, and factors on their income, while their health problems intersect by their social factors, like housing, poverty, and inadequate education (AJMC, 2006).

Assumptions and Limitations

The purpose of the study was to identify and address the barriers on health care access and the experience of AAW who live with HIV. The assumptions and limitations were addressed before and after the information was reported by each participant during each interview. The first assumption from the current literature was made by a participant's private and confidential information on past documentation, where they have experienced difficulties, because of their race, when dealing with HIV or death in their family. This assumption was limited or out of the question.

Another assumption from the literature was on the actual participant's attitude and behavior regarding bias opinion or perception on HIV and stigma experiences. According to Harris (2011), HIV positive participants could have also had a previous bad experience with a primary care physician and therefore had an overall bias perception of the research study as well. However, there were several limitations associated with this study based on the themes. The content in the literature review has certain questionable theories and limitations because the participants are part of the vulnerable population or were not fully open upon interview.

This assumption from the content was on interviewing a participant by asking her the questions, on how they live with HIV and not being entirely open and honest. A questionable theory on a protected class on health disparities was based on the theory that being Black and being HIV positive has prevented someone to seek health care. According to Sequist and Schneider (2008), there are four methodological issues to consider before using federal data: (1) validity classification of race, (2) sample size limitations, (3) smallest analyzable geographic unit, and (4) availability of data on other cultural characteristics. However, there have been several studies that investigated certain risks and limitations on HIV for not only AAW, but for other races and cultures that showed an unbalanced and limited trend, not only between their life style or gender, but their choices made in life. This assumption for such an unbalance between genders was because women have always outnumbered men in the United States, irrespective on their race and ethnicity which spread the virus openly.

One last assumption from the content and literature to consider was the language barriers of the African American language and beliefs. This limited my ability to read and interpret the interviews and data. In some cases, my own personal beliefs and/or cultural beliefs can affect the administration of the initial study, whereas I could have illustrated unconscious biased behavior towards certain individuals.

Significance of the Study

This research study adds to the existing body of literature that helped identify and address the barriers and gaps of AAW who live with HIV. The significance of the study was to explore the experience of the adult AAW who lives with HIV and seeks health care. According to the CDC (2011), despite the fact that health of the United States population has improved significantly over the last 50 years, data on African Americans still continue to lag behind the white population—experiencing substantial barriers from health outcomes. Therefore, important data and information about HIV were collected and analyzed and narrowed into research questions by interviewing participants. These data helped address the questions and the significant indicators on the barriers in regard to AAW who are either seen as a disparity or who lacked health care access. The research questions also helped identify and address the barriers and gaps and helped contribute to the implications for positive social change in the health care system.

This helped promote positive social change by (a) identifying the barriers that played a role in health care for many AAW and other individuals who live with HIV/AIDS and (b) identifying the gaps that hindered the access to health care on people who live with some other life-threating disease. Since beginning of the HIV epidemic, stigma and discrimination have been identified as the major obstacle in the way of affective, responses to HIV. HIV-related stigma and discrimination is a complex social process that interacts with, and reinforces, the preexisting stigma and discrimination associated with sexuality, gender, race, poverty, and HIV (Ajibade, Adeleke, Olagunju, Kolade, & Ladoke, 2013)

Chapter 1 Summary

The summary and conclusion is followed by a review of the content and literature ads to the following Chapter 2. Chapter 2 contains the introduction, literature review, conceptual framework VPM, and review related to key concepts, followed by the ending summary and conclusion. Chapter 2 is about related previous qualitative research study that examines AAW living with HIV and how they received health care. This is the research that provided a fair opportunity to health care access and health care treatment for all. This was seen as the opportunity that will make a difference and improve the fundamentals on the human and social conditions that effects positive social change in the health care system.

Chapter 2: Literature Review

Introduction

This qualitative study was focused on the problem of health disparities and having access to health care and treatment for AAW patients who live with HIV. The purpose of the study helped identify and address the barriers and gaps in the health care system on an older generation of AAW who live with HIV. According to Harris (2011), HIV/AIDS is a disease of the human immune system caused by an infection with HIV. In the United States, the AIDS epidemic is seen as a health crisis for African Americans (Harris, 2011).

The literature review and strategy for searching the literature address a synopsis of the problem on how one's race and ethnicity has interfered with HIV prevention and treatment for AAW who live in the Boston, Massachusetts area. The content and literature review establishes and addresses the current and past statistical data and trends on HIV treatment and prevention vis-a-vis racial and economic disparities within the African American and black communities. According to Nunn et al., (2014), addressing racial and economic disparities on HIV requires an implementation program that assesses impact of HIV prevention interventions that focus on increasing HIV testing and treatment in more heavily affected neighborhoods.

Since the discovery of HIV, the disease has been known to have a major impact and presents a burden for health disparities of the African American communities and population. According to the CDC (2013), genetic research has indicated how HIV first originated and has impacted west-central parts of Africa during the late 19th or early 20th century; this timeframe was the beginning of the HIV problem.

A preview of the major sections of Chapter 2 show in detail how the problem between health disparities and AAW who live with HIV, has not only attracted international medical and political attention, but much controversy in the health care system. This problem has affected the AAW in almost every black community where HIV and AIDS has been growing and spreading fast and rapidly, since the beginning of the AIDS epidemic. Corbin and Trammel (2006) stated how these statistics of the HIV disease affects many Black women as a health disparity, and this deters those with HIV to seek proper health care. According to the Henry Kaiser Family Foundation [HKFF] (2014), other statistics about the health disparities and AAW who are HIV positive have shown that AIDS is the Number 1 cause of death for Black women ages 25 to 44, above heart disease, cancer and homicide. The CDC (2013), stated how Black women made up 67% of AIDS diagnoses among women in 2004, and of all women living with AIDS, 64% are estimated to be black. According to Corbin and Trammel (2006), in Delaware, 79% of the reported HIV cases in New Castle County were Black women, as cited in the 2002-2004 Delaware Comprehensive HIV Prevention Plan. In 2003, women constituted 28% of HIV/AIDS cases in the United States, and approximately 69%of those cases were among non-Hispanic black women (Corbin & Trammel, 2006).

However, rates and statistics on heterosexual transmission were seen as a commonly reported mode of HIV transmission among Black women. The CDC (2013), noticed how in 2004, a dramatic increase of blacks accounted for 49% of the estimated number of HIV and AIDS cases diagnosed in the United States, although they represented only 12.3% of the U.S. population. Corbin and Trammel (2006), stated HIV was among the top three causes of death for Black men aged 25 to 54 years and among the top four causes of death for Black women aged 25 to 54 in 2002. This was the most recent year for which those data are available. Black men experienced a shorter life expectancy than any other ethnic group, a higher mortality in every group up to age 65, as their death rate for heart disease was one and one-half times greater (Airhihenbuwa & Liburd, 2006).

However, race and ethnicity were not found to be the only risk factors for HIV infection in this study. Blacks were more likely to face certain risk factors for HIV infection and experience the barriers to testing and treatment and were more vulnerable to living in poverty with limited access to health care (Corbin & Trammel, 2006). Of African American and Hispanic women who represented approximately 83% of new U.S. cases between 2001 and 2004, younger women were particularly vulnerable (Corbin & Trammel, 2006). Therefore, the health disparity and the African American community issue was a very important topic to understand when looking at someone diagnosed as being HIV positive and diagnosed with AIDS. In this case, the qualitative research topic was important because it helped address what special type of health care access 10 AAW received, while professions have feared their respective illnesses HIV, as contagious. However, the health disparities in the African American communities have played an important role in today’s social and gender inequities and cultural dynamics for AAW who live with HIV. Addressing ethnic and racial health disparities was an important issue because it affects the way AAW receive proper treatment and prevention care.

In this chapter, I explain how HIV and health access and health disparities, played a very important part that contributed to the biological factors, for 10 AAW who live as HIV positive and experienced stigma. According to BWHI (2012), biological factors have shaped perceptions for not only HIV but new barriers in health care that relates why more than 34% of 45 million Americans who lack insurance are African American or people of color. Women of color are at an increased risk of dying from HIV/AIDS, a disparity that may be partially explained by the health care barriers they face (Messer, 2013).

One reason for these barriers was shown by the interviews in the reality of living in underresourced communities that lack the appropriate access to primary health care. This was also seen as a problem that leaves millions of women of color, unable to fully participate in their social lives within their respective communities with their families or loved ones, with full self-esteem or full self-confidence. However, many factors of self-confidence were shown by the themes to degrade self-esteem, which made matters very difficult while seeking the fair opportunity on receiving proper access to health care for almost any fatal disease. These factors were seen on the end results by the themes, as having the opportunity to make a difference. This is the difference on improving the fundamentals upon human and social conditions that effects the positive social change in the health care system.

Literature Search Strategy Terminology

Since 1980, HIV has been known to affect many races and cultures within the African American population, especially relative to adult women who are African

American and who live with no insurance. These women today, are noticed as those being affected by the barriers and obstacles that hindered health care access and treatments available while living with HIV. Throughout this research study, the term African American and Black and people of color was used as interchangeable. This term helped to refer on the broad spectrum of people who are of African descent, and who are known as the people from the United States, South America, the Caribbean, Central America, and Africa.

With the selection on certain terms and wording helped provide concise areas for writing the unbiased information and helped provide the concise resources, which are the valuable words and themes. However, several words and themes were useful and gave meaning for the research study. They were words such as “ adult African American women”, “beliefs about mental illness”, “attitudes about mental illness”, “stigma”, “coping behaviors”, “AIDS”, “HIV” “stigma “, “HIV”, “poverty and poor”, and “depression”. They were identified as themes and codes that helped provide and narrow down the topic of the qualitative research and information about AAW and health disparities. This was handled be various themes and current research and from there, helped address and display the proceeding and study results by using the qualitative and narrative method. The themes were the repeated themes on the end results on health disparities and HIV, with the use of the NVivo10 software, qualitative research, and the conceptual framework. Creswell (2013), states that qualitative research is a means for exploring and understanding the meaning of individuals and groups ascribed to a human or social problem.

Conceptual Framework

Vulnerability Population Model (VPM)

The explorations on the vulnerability of populations as a conceptual model began in the 1990s (Flaskerud & Winslow, 1998). The choice of the vulnerability population model (VPM) was used as the conceptual framework and the narrative approach that helped analyzed the stories with the African America participants and research study. A concept of the vulnerable population was defined as vulnerable based upon three characteristics: resource availability, relative risk, and health status (Flaskerud & Winslow, 1998). Inventors and key theorist Flaskerud and Winslow’s invented the vulnerable population model as an appropriate model and method with the right components and conceptual framework for this study. This may be, because the VPM focused its attention on many characteristics of the African American women (AAW) who have acquired HIV and live as a health disparity.

Other vulnerable groups that VPM investigates with its conceptual framework were best known among women and children, ethnic and minorities, people of color, gay men and lesbian, immigrants, homeless persons, and elder persons. With special components of the VPM helped address the research study upon exploring their attitudes and behaviors, and experience as being part of adulthood, and being African American. They are seen as AAW who either live with HIV, and/or experienced stigma that all required attention on health care and health disparities. The special components known to make up the VPM and help insist the research and study were: (a) socioeconomic and environmental resources, (b)) relative risk, (c) lifestyles and health choices, (d) diseases onset HIV/AIDS and/or diabetes, and (e) morbidity that are all common and centered around and on one’s vulnerability on health disparities. Roger (2008), stated how African American women who have been vulnerable over the years, created higher stress and anxiety with issues on trust since HIV, which has been well known to affect their physiological, psychological and social functioning. However, the behavior and attitude of vulnerability affected some personal factors as well as factors within the health care environment, allowing a number of vulnerable people to create additional demands on an already over-burdened health care system (Rogers, 2008).

The use of Flaskerud and Winslow's (1998), conceptual model for vulnerable populations—such as African American women, helped guide new meaning and development, when experimenting with their vulnerability model for many diseases, within the health care system. According to Flaskerud and Winslow, vulnerable groups may have limited resources, and may be at higher risk for disease—such as HIV/AIDS, morbidity, and premature death (1998). These vulnerable groups typically include women and children, ethnic minority people of color, immigrants, gay men and lesbians, the homeless, and the elderly (Flaskerud & Winslow, 1998).

Together, the VPM and conceptual framework helped define the research on a vulnerable population. This was research on health and medical research that related to resources availability and relative risk to one’s health status living with HIV. The conceptual framework, such as the VPM has a population-based focus that places much burden and responsibility upon the collective health status and citizens with the community (Flaskerud & Winslow, 1998).

Another model with some similarity is the Women's Vulnerability Model (WVM). The WVM took root from extremely convincing reasons like—biological, epidemiological, sociocultural and structural that indicated that heterosexual women are more susceptible than are heterosexual men to HIV infection (Flaskerud & Winslow, 1998; Winslow & Betty, 2008). One vulnerable population like the African American were seen as a protected minority social group, who experience limited resources and much consequent high relative risk—when it came to disease, morbidity, premature mortality, and HIV prevention (Flaskerud & Winslow, 1998). According to Tsasis and Nirupama (2008), for many years most HIV prevention literature has very much portrayed the African American woman as especially vulnerable relative to HIV infection. This was because of the biological susceptibility and men's sexual privilege and power, when we look at health disparities over politics.

Since the first cases studies related on HIV were diagnosed more than 30 years ago, the depiction of women in the scientific and political discourse of HIV and AIDS has dramatically transformed (Tsasis, & Nirupama, 2008). According to Flaskerud and Winslow (1998), the vulnerability population model was adopted by global health policy leaders which contributed to an increased concern for women in the worldwide HIV/AIDS epidemic. The subordination of African women has increased vulnerability to HIV infection through economic dependency, lack of assets, and lack of protection against abuse and exploitation.

In some cases, studies related on women in African societies were subjected to discrimination right from their youth and denied access to education and gainful employment, and it was not fair that women end up being engaged in subsistence farming or low paying jobs. Flaskerud and Winslow (1998), stated how the vulnerability model helped point out discrimination and recognize the ways of African American women at HIV risk, but not those of men and this was shaped by attitudes and behaviors and their gender norms. The other major role of the vulnerability model ascribes women's greater likelihood of encountering an HIV-positive partner to gender-based social inequalities.

In other cases, studies on gender roles and dimensions were affected by age, class, race, ethnicity and religion, as well as geographical, economic and political environments of that race, when the topic is about HIV. According to Tsasis, & Nirupama (2008), the gender dimensions that are relevant to HIV and AIDS include economic, legal, cultural, religious, political and sexual status of women. However, some of the gender inequalities did not only increase vulnerability of women to HIV, but may soon become factors that help fuel the spread of the epidemic. This may be true, as gender referred to differences in social roles and relations between men and women which are learned through socialization and vary widely amongst cultures (Tsasis, & Nirupama, 2008).

According to Tsasis, & Nirupama, (2008), areas of someone’s socio-cultural factors, like the fear and stigma on African American women were seen to increase vulnerability on many black women, who not only have HIV— but who may not. This subordination of African women has created the vulnerability to HIV infection through economic dependency, lack of assets, and lack of protection against abuse and exploitation (Tsasis, & Nirupama, 2008). However, most women in African societies were somehow subjected to early discrimination and labeled right from start—by their early youth which led them to be denied access to health care facilities. This led them to the unfair education and unfair gainful employment later on in life. All of this information and past experiences were told by a storytelling interview and with the use of the narrative design and inquiry.

Over time, researchers in the HIV health discipline and with a greater clinical understanding of HIV helped make HIV-positive women visible. This was from the development and use of the VPM that helped mobilize a prevention discourse—and in turn, reframed women's risk within terms of the gender inequalities (Flaskerud & Winslow, 1998). Such health disparities and health inequalities were shown to be multitude of socio-cultural factors that increased the vulnerability in women to HIV and AIDS (Flaskerud & Winslow, 1998). By reviewing the studies related to the research questions were very meaningful to proceed in this qualitative research study. Since we now had the opportunity, we can now appreciate the VPM designed for the HIV vulnerable population of African American race and culture living with HIV.

Background of the Problem

Human immunodeficiency virus infection / acquired immunodeficiency syndrome (HIV/AIDS) is a relatively newly discovered illness and disease. The HIV disease has not been old when compared to other illnesses active in today’s society that require special health care and medical attention and treatments, or in some cases, require quarantine steps. Manda (2014), explained how there have been other types of serious infections like malaria, plague, leprosy, tuberculosis, ebola, measles and cholera that affected a vast majorities of humanity over many centuries, and develop into barriers for health care.

However, the history of HIV slowly surfaced and originated sometime during the early period in 1960, then surfaced as a fatal epidemic in 1980. According to (Morbidity and Mortality Weekly Report. [MMWR]; CDC (2013), since the early stages of the 2000 census, about 36.4 million persons, approximately 12.9 percent of the U.S. population were seen and identified as black or African American and people of color. This accounts for 35.4 million of the populations who are identified as either black or non-Hispanic. According to MMWR and CDC (2015), for many health conditions like HIV, non-Hispanic blacks have beard a disproportionate burden of disease, injury, disability, and death because of not having access to the right health care.

By the mid-1970s the spread of HIV and a rise on health disparities had begun to increase awareness as a new epidemic in the population and medical community as well. Manda (2014), expressed how the HIV/AIDS epidemic became such a major concern and awareness within many medical communities and organizations and became soon aware and alerted how HIV was spreading from one country to another. Thirty-one years into the domestic HIV epidemic, communities of color remain disproportionately affected, particularly black and Hispanic communities (Sutton, Lanier, Willis, Castellanos, Dominguez, Fitzpatrick…Miller, 2013). This epidemic was a concern that has taken its toll and sharp turn upon new hope and development for many racial disparities that soon focused on highly effective antiretroviral drugs, which made it costly and unaffordable for many African Americans and black populations entering hospitals. According to Bachhuber and Southern (2014), hospitalization rates among people living with HIV in the U.S. have been higher than have been previously estimated.

Therefore, substantial gender and racial/ethnic disparities in hospitalization rates exist, suggesting that the benefits of antiretroviral therapy have not been realized across all groups equally. Certain obstacles, because of HIV has produced the cultural barriers and racism on the black society and community to seek access to the availability on experimental and FDA-approved antiretroviral drugs. According to Malebranche (2005), despite the availability of over 20 FDA-approved antiretroviral (ARVs), African Americans have still been suffering from disproportionate HIV-related morbidity and mortality rates when compared to their white and Hispanic counterparts. The reasons for the racial disparity was multi-factorial and categorized into two distinct camps of thinking: one suggests that inherent genetic racial differences account for the disparity, while the other emphasizes the role of social issues (Malebranche, 2005).

Such factors have produced many health disparities and a cultural barrier upon the availability for new experimental drugs that help lead a normal life with AIDS. According to AVERT (2014), a region like Sub-Saharan Africa, are more heavily affected from HIV than any other region in the world and the African American and in the U.S. have experienced the culture and racism barriers to health care. According to Sutton et al., (2014), the US National HIV has one of its major goals on the reduction of HIV-related health disparities and notes that to achieve this goal we must diversify the HIV workforce and increase HIV prevention interventions.

According to Baptist Global Response [BGR], (2014), since the beginning of the AIDS epidemic, about 14.8 million children have lost one or both parents to HIV/AIDS. According to MMWR and CDC (2014), three of the 10 leading causes of death for non-

Hispanic blacks are not among the leading causes of death for non-Hispanic whites: homicide (sixth), human immunodeficiency virus (HIV) disease (seventh), and septicemia (ninth). Messer (2013), stated how the consequence of this delay is the death rate differential experienced by African American compared with white women in 2009. The death rate among adult and adolescent African American females with an HIV infection diagnosis was 23.8, compared with 1.1 for white women the same year (Messer 2013).

The background and history of the African American culture is only a small portion and background of the American history. This is just some background and history that may specifically be spoken upon the African American and black American or other related ethnic and minority groups living in United States, who experienced barriers to health care because of HIV. They have been seen as the ethic and minority groups who live as HIV positive or with AIDS, and who seem to suffer and pay because of their origins and are treated unfairly because of their disease. According to Tahirah (2013), since the past history on the African American culture, much has been edited and changed on the Black culture, subgroups and minorities, by more openness to disclosing problems to others who live with AIDS. Because of this openness, there was good reason to raise the questions and draw some conclusions to study, and research the African American race and culture, on their past experiences with HIV and health care access once received.

One experience included the treatments and availability of new innovative medicine and medical service technology and other experiences on experimental drugs and available medications. One fundamental question that was raised as part of the research was to ask: Why are ethnic and racial minorities with HIV less inclined than whites to seek some or the same type of health care treatment? According to Grossman, (2013), African Americans who were identified later as a health disparity in their course of HIV disease and were less likely to be engaged in medical care than are white persons living with HIV. Braveman (2006), expressed how a particular type of difference in health and a difference in disadvantaged social groups—such as racial/ethnic minorities, systematically experience worse health or greater health risks than more advantaged social groups.

In some cases, a diverse effect of the African American community and society toward treatment for some diseases were different and difficult. This was seen as being difficult when diagnosed with AIDS, Hepatitis, Diabetes, and a mental disorder. According to NASTAD (2008), African American women with AIDS were one fifth more likely to lack insurance, and three times likely to be insured by Medicaid, and are nine times as likely to have Medicare and become a disparity. According to Department of Health and Human Services DHHS and CDC (2013), early stages to begin eliminating these health disparities will require culturally appropriate public health initiatives, community support and equitable access to quality health care.

However, a better understanding was gained by the study objectives, the logical connections, and key elements of the conceptual framework—all which helped reference upon the findings towards treatment for AAW who have HIV. These findings helped enable more responsiveness to the African American community and other cultural and social contexts as well. The strategy and researched facts I used to provide answers on such health disparities were based on their sociological factors, by being rich vs. poor, educated vs. uneducated, or the demographics factors of the individual or culture itself. NASTAD (2008), expressed that several key elements and factors create disparities that include biological vulnerabilities, unique characteristics and nuances of heterosexual relationships in African American communities, employment, education, incarceration, and structural influences. This, which I found in the end results that had an impact on issues from poverty to discrimination barriers of which created a stigma barrier, for someone who is black seeking health care on contagious disease.

Stigma and Discrimination Barriers

One barrier that has existed for years was the significant barrier on stigma. The stigma barrier lies between politics and discrimination and seem go hand-in-hand in many black races and culture. In several ways, discrimination has always followed the stigma and the fear in the black community and has always seemed unfair, especially for AIDS treatment for many black individuals for known HIV status. Stigma is an increasingly acknowledged reality today that throughout the world those most deeply affected by the HIV epidemic are the most severely disadvantaged, whether on grounds of race, economic status, age, sexual orientation or gender (Bharat, 2002). In addition, stigma and fear was shown to be inherent within the social and health disparities and inequities that continue to be the significant main barrier for health care access, among effective global response to the HIV epidemic. Furthermore, politics and discrimination has caused much tension and has led to many health disparities between the African

American community and society for people who have live with many diseases like HIV or AIDS. However, for many AAW living with a disease such as HIV found themselves degraded and discriminated, and they became easy targets or victims, as a health disparity by their race within the health care system.

This is why the research study was very important and why it was done. This was to know how and why—stigma and discrimination by fear of HIV, can inadvertently tend to downgrade or divide the African American race and culture. This was one important factor and health care barrier, or open link for disparities and inequalities, for those who may or may not even have HIV, and who became easy targets of a health disparity.

Health Disparities - Health Inequalities Barriers

The research study includes information about health disparities and health inequalities when dealing with HIV, stigma, and discrimination. In the past, stigma has made it very difficult for many AAW to seek a fair opportunity at health care access. In many ways, stigma was shown in the study as the main barrier that hinders someone who lives with HIV the available resources and health care by the practicing physician who fear contracting the disease. According to AVERT (2013), for forty years' stigma in real life has been a barrier that caused physicians and society to either neglect or decline the black population, and ever since to have human contact with people with HIV.

Other barriers that affected access to health care among AAW were questions of either having inadequate or limited health insurance and limited quality health care. Without health insurance, the economics of poverty is in itself, a barrier to both acquisition of medical advice and access to prescription drugs. According to Stratford et al., (2008), factors that affect health status among African Americans—such as inadequate health insurance and limited quality care—poverty appears to be a primary factor that contributes to HIV for African American women. African American women who live in poverty have caused and triggered some considerable panic or hysteria within the news media, leaving HIV comparatively overlooked from the media and press (Be Safe, 2014). The actions on many people of color who are living in poverty alone, with or without AIDS—have painted a negative image, making it harder for many African American women to be treated fairly with HIV (AVERT, 2013).

Another access barrier that has contributed to health disparities that was found in the study and considered a multispectral issue, was the need for good transportation particularly in areas where public transportation such as trams or trains is lacking. According to Stratford et al., (2008), health may be considered a multispectral issue, involving access to care and services, transportation, health insurance of some type, education, individual and family well-being, housing, and community-level issues such as neighborhood safety. Furthermore, a health care disparity not only involved having a ride to and from treatment, but good health insurance, some type of education, good housing and community. Therefore, one first important step to start eliminating health disparities would be to improve the system with the health care access and provide health care insurance to all, each and every, who live in the United States. According to U.S. Department of Health and Human Services [DHHS] (2001), the problem is well documented that African Americans generally, who live in United States, are either less fortunate or less likely than whites, to seek health care treatment. One reason for being less fortunate is in spite how the HIV epidemic has gotten out of control since 1980. CDC (2005), stated how the AIDS virus disease was the third leading cause of death for African American females between ages 25-34, in 2004.

This age bracket and rate was shown by the research study to be one of the high factors for AAW who are more prone to higher risk of infection. According to National Alliance of State and Territorial AIDS Directors [NASTAD] (2008), a high risk and infection through heterosexual contact and injection drug use were a primary mode and reason on HIV transmission. On the other hand, African American women were less likely than other women to date men outside their racial and ethnic group which provide higher rates of HIV infection (NASTAD, 2008).

The answers were found by the results of a qualitative research study that helped focus on the AAW and their experience with HIV. This research study helped answer and address the barriers and gaps, on what special type of health care access one received, while health care professionals have feared their respective illnesses as contagious. According to Bharat (2002), race, class and gender, were been found to serve as important determinants of a person's health and well-being status affecting his/her perception of illness, health-seeking behavior, accessibility to services and coping mechanisms. This was the chance and opportunity to make an effort and understand the experiences of the AAW of how the health care system worked since 1980. This was an effort that explored the AAW with the use of the narrative design, conceptual framework and the VPM.

This helped explore three strategies: (a) ensure how health coverage provided adequate access to care; (b) helped strengthen health care delivery system serving vulnerable populations; and (c) helped coordinate medical care with other community-based services (Commonwealth Fund, 2012). In addition, the VPM helped me examine how levels of low-income or non-insurance played some part or role on the racial and ethnic minority populations in the health care system. According to Commonwealth Fund (2012), the Accountable Care Organizations (ACOs) represented a model of integrated care delivery with the potential to provide comprehensive, coordinated, and efficient care that meets the needs of vulnerable populations. Therefore, the correct behavior model was suited as the right standard and model which helped examine a small sample of 10 African American women, upon one’s wisdom, religious beliefs, and life experiences. Using the conceptual framework and the right model helped support answers for those underinsured, or those who may not always be sufficient or fortunate in receiving adequate medical care and relevant available treatments in the ever-growing HIV positive population.

Literature Review Related to Content

The literature review and related content was chosen because they were concise with the research methodology. The studies related to the constructs of interest shown to be up to date and consistent on the chosen research, on health disparities and health inequalities for AAW living with HIV. Braveman (2006), stated how there was little consensus about the meaning of the terms “health disparities, “health inequalities,” or “health equity.” The definitions have important practical consequences, determining the measurements that are monitored by governments and international agencies and the activities that are supported by resources earmarked to address health disparities/inequalities or health equity (Braveman, 2006). The content and literature were found by using several research articles and journals from the Walden Library and Walden Research Center, ProQuest, PubMed, published books and Medscape. This was the first step that provided me with a draft and portion of the biography and sources on the authors.

Researching the main sources on the discipline and the topic on health disparities, HIV and health care access and barriers were found through other additional strategies by using Google, and other college libraries. The web-based strategy was very helpful for finding accurate articles and sources that added to the first and general resources that the Walden Library may have missed or not found. The content on the qualitative research study was drawn from the peer reviewed journals. Other sources helped put together and provide the clear literature review with a theory in contrast on the past experiences of the AAW and black population and different races and cultures.

Therefore, with the exceptions and the approval by the Walden University Research Board (URB) and by reaching out too many audiences who were interested in this topic, provided a better understanding on the AAW and experiences with HIV. Creswell (2013), states how researchers write for their audiences who are interested in a topic and that will accept such research. Such audiences to reach out to were journals editors, journal readers, graduate committees, conference attendees, or colleges. Literature and important information with the media field has written about access barriers for today's health care system and health care disparities with the correct terminology.

The words and terminology of African American, healthcare, health disparities and living with AIDS, or having HIV, were used for the general search terms. Other terms were used as "unfair" and "discrimination" may help to find the root or gap for making sense among all inquiries which will make a difference in creating more positive social change.

Previous and Past Related Research Studies

There are many challenges that lie ahead for researchers to address and many reasons behind the adverse health outcomes how a researcher has approached this discipline and problem of AAW who either live or do not live with HIV. The comparisons with key concepts from other related research studies, when synthesized under some investigation, described some similarity and rationale. The comparisons below, explained the strengths and weaknesses about the health care system and the stigma and discrimination, due to AAW with HIV.

Comparisons

In one study for comparison, the rate of perceived racial discrimination was constantly compared in health care among women who are African American and white women patients. According to Davies, Diclemente, Hardin, Harris, Hook, McCree, Mikhail, Saag, Wingood, (2007), the study showed how African American women with HIV are vulnerable to discrimination because of stigma associated with HIV, as well as their race, gender, and class status. This study investigated an association between the characteristics of black women who self-reported HIV discrimination and health outcomes among African- American and white women living with HIV. The study provided how 366 women who live as HIV positive were recruited from AIDS clinics in Georgia and Alabama. In the study, the participants completed an interview that assessed self-reported HIV discrimination and depressive symptomatology, suicidal ideation, self-esteem, stress, quality of life, sexual health and HIV related health care seeking. According to Davies et al., (2008), women who reported HIV discrimination or stigma had higher rates for stress, suicidal ideation, depressive symptoms, number of unprotected sexual episodes; they had lower rates for self-esteem, and quality of life. The study showed how they were more likely to have not sought medical care and treatment for fearing their HIV status. However, the study provided information of separate race-specific analyses that indicated when compared to white women, how African-American women were markedly more likely to experience the adverse effects of HIV that led to high rates of discrimination.

Another study done in 2007, revealed how the estimated HIV and AIDS case rates among adult and adolescent African-American females, who live with HIV or AIDS often have no choice but to face many complex social issues and problems. Such issues or problems have enhanced or inhibited them from accessing the right resources for healthcare services that helps to assist them within coping with HIV. According to Amutah, (2012), the study provided the in-depth interviews and observations by utilizing open-ended note taking, and conducted at an HIV service provider’s office to help determine the unique needs that develop, specifically among HIV positive black women.

The study used ethnographic methods to address the research questions among 10 HIV infected AAW of different ages and backgrounds in group settings at a non-profit organization. These methods provided the qualitative results that indicated how the AAW who are HIV positive, dealt with a myriad of social and mental issues related to their HIV diagnosis, instantly. The study also revealed issues from fear of HIV disclosure, for family and friends, may reveal how African American women with HIV were in dire need of mental health services, because of their disclosure (Amutah, 2012). This was the mental health service and HIV counseling to address and speak about their unresolved issues regarding their HIV diagnosis.

Another study showed how older African Americans have more co-morbidity and lower physical function than European Americans of similar ages. According to Ryder (2007), older African Americans are more likely to have been exposed to a lifetime of unfair race-based treatment and to live in deprived neighborhoods. This showed that a majority (69.5%) reported a history of unfair race-based health care and most frequently at work (43.0%), or while shopping (40.4%), while forty-four (46.3%) were classified as having an active response to unfair treatment (Ryder, 2007). Furthermore, the study revealed how HIV and one’s self-esteem can be a critical and unique element of their overall mental health for African American women, or person of color’s racial esteem to seek treatment. According to Hatcher (2006), the study provided an overview and a close look at the factors influencing the inequitable mental health and self-esteem of African American women. Self-esteem is a critical and unique element of their overall mental health that showed differently for African American women that included racial esteem (Hatcher, 2006).

The study also investigated how positive black women's perspectives and their concerns about effective HIV prevention for information on access to health care and receiving the correct treatments. Melton (2007), expressed how a past study showed that people living with AIDS may have found themselves arbitrarily discriminated against at some point in time when seeking treatment to stay healthy. The threat of stigma is like a shadow—it is invisible but lurks behind every comer for women already living in the margins, outing themselves as women with HIV and has potential to relegate them beyond borderlands (Melton, 2007). In many cases, many living with HIV have experienced the complications and consequences as a health disparity in a healthcare setting while trying to receive health care access. Melton (2007), states how the study investigated the positive black women's perspectives and concerns on effective HIV prevention that was informed by their experience and situated knowledge. According to Melton (2007), a threat of being associated with factors of HIV intersectional stigma can cut off African American women from their survival systems. This was seen as their survival system that helped them subvert oppression, and seek an opportunity to get proper health care, living with AIDS. According to Tigawalan (2010), women were more subjected to HIV stigma—vulnerability upon labeling African American women to HIV and cannot be explained from one’s biological factors alone—leaving gender inequalities that still exist in the African American society.

In the last study, Messer (2012), stated how research was conducted in an academic medical care clinic in North Carolina (NC), where the medical clinic provided HIV care to 1700 HIV infected people in 2010. This whom 58% were African American, 10% were Hispanic or otherwise not white, and 31% were women (Messer, 2012). However, of the women who were seen in the medical clinic, almost all were minority women (82%), of whom the majority (69%) was African American (Messer, 2012).

Since 2004, HIV has taken an increasing toll among the entire black population and has become the worst health disparity in the health care system for almost every person living with HIV. The toll has also precipitated a higher increase of health care utilization for the AAW and the black population, with a significant impact on stigma, between health care access and medical treatment and dealing with the HIV disease. According to AVERT (2013), stigma not only made it difficult for people trying to come to terms with HIV and manage their illness on a personal level, but stigma interfered with the attempts to fight the HIV epidemic. A problem with stigma alone has always been associated with fear and anxiety on HIV by gossip which has remained to this day a main barrier.

AVERT (2013) found that

> Stigma remains the single most important barrier to public health care and public action, and has become the main reason why too many people are afraid to see a doctor to determine whether they have the disease, and seek treatment. Stigma is a chief reason why the AIDS epidemic continues to devastate our societies around the world— increasing health disparities. (para 3)

However, HIV related stigma was not shown by the participants to be a straightforward or out spoken phenomenon when observing their behavior or attitudes about the HIV epidemic, during interviewing. Reactions to HIV will vary between individuals and groups of people—by either religion, gender, sexuality, age and levels of AIDS education, all may affect how somebody feels about AIDS (AVERT, 2013). In some cases, stigma was enacted with discrimination on different cultures or even an individual population that differs from African American. (AVERT, 2013), explains how HIV-related stigma and discrimination severely hampered the efforts to effectively fight the HIV and AIDS epidemic. This was an under-representation that may have been experienced among other individuals and subgroups as African American, Latino, Hispanic or other black minorities with a disease like AIDS and hepatitis.

Research Questions

RQ1: What are the economic and environmental risk factors associated with African American women with HIV/AIDS?

Subquestion: How do these risk factors influence overall health status?

Subquestion: How do these risk factors influence access to health care services?

RQ2: How do African American women with HIV/AIDS compensate for barriers to treatment and community resources?

Subquestion: What measures do the African American women use to deal with the stigma associated with the diagnosis of HIV/AIDS?

Subquestion: How do these measures enable the African American women with HIV/AIDS to overcome or adapt to the risk factors associated with vulnerable populations?

Labeling the African American

One scenario that has led to such changes within the African American culture may be by years developing and changing their attitudes and behaviors. Such changes have taken their toll by leaving such a negative impact which today, has developed into a negative weakness among labeling the African American race with HIV. This weakness has also “painted a negative picture” that led to their related labels, and therefore—is viewed today by public health and medical perspectives. Agyemang et al., (2005), uses the appropriate terminology on the African descent populations that may conclude: (a) it describes the African American population under consideration is of paramount importance. Other simple wording like “African American” origin may be a necessary prefix and appropriate upon the ethnic label, and the label “Black” should be phased out. (Agyemang et al., 2005).

Still, much of the research on one’s ethnicity, race, and health status, has been taking much of a spotlight in health care sector, when we dealt with health disparities and HIV. According to James, Thomas, and Lillie-Blanton (2007), health status is a function of several factors in the African American culture, including access to care and insurance coverage, socioeconomic conditions, education, occupation, income, and place of residence, genetics, and behavior. While poor or low-income people of all races report worse health statuses than higher income people, differences in overall health status by race and ethnicity persist even within income groups (James et al., 2007).

Therefore, much on the concepts and terms on the African American ethnicity will still need to be explored or explicitly defined in future research. This action will permit a better understanding on the research and labeling, in order to facilitate the international and regional comparisons of the black culture. This today, has caused a label or mark, upon one’s race or ethnicity and may be very difficult concepts to talk about. Agyemang et al., (2005), stated, that while there is a conceptual distinction between African American race and ethnicity, such terms may be often used interchangeably or as synonyms.

However, labeling someone has always been seen as a unilateral argument—given that, the other side never has any say. If this was the fact, society has labeled and marked our cultures, of who we are, and labeling someone by her past, can be seen as unhealthy behavior. This action today, has created barriers for almost anyone who seeks health care when diagnosed, especially for those who are HIV positive. According to Tahirah (2013), labeling has been an unfair promotion that plays an important part in society, as well as an unequal part upon fearing the African American culture and is seen to produce or create barriers and stigma in the health care field and society. Although African Americans endorse more stigmas on HIV than those with mental illnesses, Americans may be quite susceptible to stigmas which have not been studied for mental health problems (Agyemang et al., 2005).

Therefore, given that stigma was found to the main and key barriers toward labeling and obtaining health care access for people living with HIV— it will be known to increase medical problems for African American women in society. According to Tahirah (2013), several past studies that used experimental design and vignettes to examine the influence of acculturation and labeling African Americans without AIDS, but with stigmatization of depression, social phobia, alcohol dependence, and schizophrenia were most common.

Barriers and HIV

One barrier that has taken its toll on the African American culture was shown to be the barrier that lies between healthcare training and HIV. According to AVERT, (2014), barriers between health care and training professionals within affected countries have been known to not only put strain on their infrastructure, but between this country and the health sector in America as well. Therefore, the HIV epidemic has had a very costly impact, especially when faculty and staff employers have to train other staff and by replacing those at the workplace, who become infected or too ill with AIDS to work.

Another barrier on the African American culture and HIV that has had great effect on health care system was the impact on schools. This was true, because schools were found to be greatly affected by AIDS. Many public schools have become a major concern through HIV education and HIV information and support—since lower level schools may play a vital role upon reducing the impact of the HIV epidemic. The HIV education and HIV information barrier was found as a negative barrier and impact on African American productivity. According to Los Altos Rotary AIDS Project, [LARAP] (2009), AIDS dramatically affects labor, setting back economic activity and social progress, and vast majority of people with AIDS are between age 15 and 49 - in their prime working lives. Furthermore, employers, schools, factories and hospitals have to train other staff to replace those at the workplace who become too ill to work. This was seen by the research, as the barrier that has a negative impact on economic growth and development, and employment and income.

However, there has been a seemingly endless range of different individual variations and subgroups of a culture that have been seen as being very important disparity. One reason was because this bears on what every person may bring to the table in a health care and clinical setting and/or may account toward minor variations and aspects on how people of different color have communicated to their physicians about their symptoms and sicknesses that may or may not be confidently reported and documented. According to Airhihenbuwa and Liburd (2006), the problem of physicians not having relevant skills to adequately communicate with people of color, or diverse patients with HIV was very important. But acquiring such skills encompasses only one aspect of the complex web of social, political, and economic structures and policies needed to more fully address cultural insensitivity in particular and health promotion more broadly, when we talk HIV and health disparities on the African American culture.

African American Barriers

The barriers in health and health care settings was shown to vary within the AAW population. The articles and journals were selected to find these barriers in the health care system that hindered health care access for the African American population who dealt with health disparities on HIV. However, there were several factors in the study that were found to limit access to care. Such factors were by causing women to postpone care, preventing them from receiving quality care, or inhibiting access to care and treatment altogether. Other factors were shown by how the system had initially failed on access to health care, by not fighting or combating AIDS. Furthermore, public health specialists and health care providers have been challenged in gaining the trust of reaching and maintaining relationships with those most impacted by HIV (Grossman, 2013).

Because the system failed, many black cultures, like African American have lost faith and trust in the American health care system in several ways. According to NASTAD (2008), the health care system failed upon considering the problems on social and economic which are embedded within society, and public institutions and never attempted to target the black community in any culturally specific way. This action was ignored because their initial prevention strategy was to aim at the population and community of white gay men. Henderson (2014), expressed how a 2006 study in the Archives of Internal Medicine found that African Americans are less likely to report a trusting relationship with their health care provider.

The research articles and journals had common information that explained and addressed several other factors why the system failed. The articles showed important information about an AAW or individuals, who was seeking access to health care for AIDS. This article was about one or multiple parts or types of common health care barriers. According to NASTAD (2008), the three main health care barriers are known as the primary, secondary, and tertiary barriers—which in terms block someone’s access to health care. They were proven in the article to be the three major disparity barriers that helped service gaps upon health disparities that needed further explanation and research, on the HIV and health disparities topic.

The primary barriers were found to focus on direct obstacles for health care service and treatment when dealing with health disparities According to NASTAD (2008), primary barriers included the health insurance barriers, between lack of insurance or having incomplete coverage. The primary barriers were found as dissatisfaction of service providers and health care plans that hinder access to care by preying on some part of the African American population (NASTAD, 2008). The primary barriers were also found to develop into the financial restrictions which include the high health care costs, and the out-of-pocket medications and expenses for AIDS. Sutton et al, (2013) expresses that health inequities among blacks and Hispanics accounted for $218 billion (2008 dollars) in excess annual direct medical costs and by reducing health inequities, including HIV health inequities, could realize substantial savings.

The secondary barriers were found in the research as the structural barriers that were internal for most organizations and service providers, when dealing with health disparities and AIDS. The secondary barriers include the limitations from public programs and the limited eligibility restrictions that lack the comprehensive coverage (NASTAD, 2008). The secondary barriers have been known to lack important information for available services and the inconvenient hours of operation which all leads to difficulty to make an appointment (NASTAD, 2008). The tertiary barriers were found in the research to reflect the ability of the health care provider in the health care system, when dealing with health disparities and HIV. This was the ability that helped address most needs for the AAW who are seen as a health disparity, while seeking health care for HIV. According to Braveman (2006), health disparities/inequalities include differences between the most advantaged group in a given category—e.g., the wealthiest, the most powerful racial/ethnic group—and all others, not only between the best- and worst-off groups.

Some of the needs included low cultural competency and limited social-cultural sensitivity by the staff, toward the female clients. This cultural competency has gained attention as a potential strategy to improve quality and eliminate racial/ethnic disparities in health care (Betancourt, 2014). Cultural competence has gained attention from health care policymakers, providers, insurers, and educators as a strategy to improve quality and eliminate racial/ethnic disparities in health care, which create limitations and territory barriers. Such limitations have been based on the type of health care and treatments they have experienced while living with HIV or HIV related stigma.

Therefore, HIV related stigma and discrimination have remained the enormous barrier to the fight against AIDS. According to AVERT (2013), stigma and discrimination will continue to exist so long as societies as a whole have a poor understanding of HIV, and the pain and suffering caused by negative attitudes and discriminatory practices. However, the fear of discrimination has been known to prevent people from getting tested, or has slowed much progress on people seeking treatment, when opening up, disclosing, or admitting their HIV positive status when going public about their disease. Compounding the fear of disclosure was the added burden of social and economic marginalization of being African American that can be greatly increased by being labeled HIV positive (Braveman, 2006). Despite advances in HIV prevention, African Americans remain at much higher risk of acquiring HIV, and are more likely to be unaware of their HIV-positive status, and retained in care than Whites (Grossman, 2013). This has come from the fear of prejudice that still lies at the core of HIV discrimination and needs to be tackled— at both community and national levels.

Upon the research findings and the questionable areas in health care system, were more than grateful to discuss or question any areas on racism and discrimination. This was by asking two general questions on ways that were helpful or proposed for research in regard to their life experiences, while living with HIV and stigma:

Question: can racial stereotypes and discrimination be internalized by adult African Americans with or without HIV, and can stereotyping and discrimination degrade an individual’s self-worth and self-esteem?

Question: can racism and discrimination among the societal institutions have somehow resulted in minorities having lower socioeconomic status and poorer living conditions, which today have led to poverty, crime, and violence, and hindered health care treatment for many African American women with HIV/AIDS?

African American Beliefs

One key element about the beliefs of the African American culture was shown to underlie their situation—their ethos of religion and culture-bound syndromes as a belief while seeking treatment. According to DHHS (2001), some aspects were seen as a set of conditions that are much more seen than common within few societies, when compared to other cultures in society. Other races or cultures of a color are the situations, wherein there was the question, of whether people would even seek some kind of health care or treatment of any form or kind of medical help in the first place. According to Malebranche (2005), medical and public health officials have also speculated about specific cultural and individual behavioral factors that may influence healthcare utilization, adherence patterns, and other variables influencing HIV morbidity and mortality among African Americans. Some behavior factors included, but not limited to religiosity, beliefs regarding complementary and alternative medicine practices, mental health status and substance abuse. According to DHHS (2001), the African American culture takes pride or active approaches in facing personal problems, rather than avoiding those, and rely more on spirituality or religious to help them cope with the symptoms on mental illness.

Another key element of the African American culture found that their beliefs would depend on the type of disease or sickness one is faced with and type of coping styles that society may support U.S., (DHHS, 2001). This seen and based on the style of disease and depended on how much stigma may be attached on their disease or mental illness. However, a race or culture may influence meanings how other people may impart, attract, and deny upon their illness by HIV stigma and fear. According to Henderson (2014), stigma was highly portrayed as the most formidable obstacle to future progress within the arena of fear and mental health. Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public on and about fear, reject, avoid, and discriminate against people with any kind of mental illness and disease (DHHS, 2001).

The last key element of the African American cultures found that stigma and fear may vary from one culture to another or may be studied from either of two perspectives. First perspective, was by the perspective on the targets upon the fear of stigma (i.e., people who may have the symptoms, AIDS, Hepatitis), seen as the members in an ethnic or racial minority group, who are much likely than the white population to experience a form of the stigma. Second perspective, was by the perspective on how the public reacts vis-vis its beliefs and attitudes as to being married, raising a family, and family being oriented from a foreign culture. In other perspectives, stigma was found to lower the participant’s access to resources and opportunities, such as housing and employment, and leads to diminished self-esteem and greater isolation and hopelessness (DHHS, 2001). Furthermore, stigma was shown to also be against family members; and this damages the consumer's self-esteem and family relationships. Henderson (2014), stated that there have been numerous barriers that prevented African Americans from seeking health care and wellness promotion: socioeconomic status, masculinity, prejudice, not knowing or understanding the need for a physician, peer influences, and religious beliefs. According to Henderson (2014), the lack of education, unhealthy behaviors, and barriers to seeking health promotion played a large part in seeking health care and wellness promotion. However, African American women were found to be less likely than women of other ethnicities, to get married because an imbalance of the number of African American women and men results in fewer available partners. This meant that women had less interpersonal power in the relationships as men have more options available to them.

With such unfair answers for these cross-cultural questions may seem far by definitive. With the end results by the research outcome and putting the important facts together about the AAW who live as HIV positive, provided and shed new insight. This new insight not only improved or offered new alternatives in the health care system, but suggested how these minorities hold a similar and stronger stigmatizing attitude, toward a disease than do whites. The societal stigma was shown to keep minorities from seeking needed health care and this can be very potent by not only affecting individual self-esteem, but also derive limits upon a family tree or member (Henderson 2014; DHHS, 2001).

Since the AIDs epidemic in 1970, the United States has been making a demographic transformation among the ethnic and racial composition on the African American culture and population. Many organizations involved in health care and health delivery have been connected to financial cost and hospital services, and funding that provides the services and treatment plans available that go hand in hand with the AIDS epidemic (NASTAD, 2008). This, along with the broader social issue, began with discrimination and racism that now, ended up by living poor and in poverty. NASTAD (2008), expressed how living in poverty with lack of education resulting from racial and gender discrimination—has often impacted African American women in many positions where they are forced to make choices that negatively impact their health.

This impact on living in poverty became a burden that influence and affected many AAW in society, especially who live with HIV. This burden has created the disparities in almost every community, making it difficult to receive health care for almost any disease or sickness because of their race. According to DHHS (2001), where cultural influences end and larger societal influences begin, there are contours not easily demarcated by social scientists, society and culture which recognizes how they overlap on ways that are difficult to disentangle through research. A cultural misunderstanding may lie between the individual patient and the clinician, clinician bias, and the fragmentation of health treatment and services deter minorities upon accessing and utilizing care (Henderson, 2014). This today, has created a barrier on stereotype with cultural characteristics that has somehow prevented many AAW from receiving the appropriate health care, while living as HIV.

However, some of the past general statements on any cultural characteristics has played upon many given minority groups that invited some kind of stereotyping. This stereotyping was by recognizing the individual's infection and living in poverty, by their demographic or geographic location and their HIV infected areas. The CDC's approach to reducing HIV infections called for high-impact HIV prevention through a combination of interventions that were scientifically proven, cost effective, and scalable and targeted toward the African American populations (Hall, Holtgrave, Tang, & Rhodes, 2013). According to DHHS (2001), the cultural characteristic of location has caused more diversity within that culture than there is between populations in terms of level of acculturation, age, income, health status, and changes on social class.

Over the years, on health care and social change, America has seemed to struggle with the ways and handling of the matters that have been related to ethnicity, race, and immigration. The history on each racial and ethnic minority group has attested to long periods of legalized discrimination, and has become subtler forms of discrimination—within U.S. borders (DHHS, 2001; Tigawalan, 2010). Furthermore, discrimination and racism were seen under an umbrella of terms which refer to someone's beliefs and practices by her attitudes of denigrate protected minority groups (DHHS, 2001; Tigawalan, 2010).

One reason for such actions were because of the phenotypic characteristics (e.g., skin color and anthropomorphic features generally) and by the ethnic group in common (DHHS, 2001). However, despite the United States low moderate level on the black community, improvements on health care that African American's have received from the last three decades continues to be documented on much more racial discrimination (DHHS, 2001). This type and level of discrimination and racism has been shown to play some part and documented in the administration on medical care and health. This type of discrimination has been carved in stone and manifested when we read or hear about cases on health disparities in any race. According to Bharat (2002), race is a form of `group identity' and arguably the basis of some of the most extreme and serious acts of discrimination and violations of human rights globally.

In one case, several minority groups reported how they experienced some racism and discrimination and were considered as being stressful experiences (Clark, Anderson, Clark, & Williams, 1999); DHHS, 2001). These differences were greatest for two specific types that were: financial stress and stress from racial bias. However, some African Americans reported a much higher level of stress and a much higher level on stress from racial bias and the sampling methods did not permit statistical comparisons from other racial or minority groups (Williams, & Jackson, 2005).

In another case, African American women perceived much higher form of discrimination that was associated with psychological distress, self-reported ill health, lower well-being, and the number from sick days confined to bed (DHHS, 2001; Williams et al., 2005). This type of racism and discrimination was termed as being major discrimination with reference by some dramatic event. This was an event, as to being harassed by police or fired by employment which was reported within a lifetime prevalence of 50 % of African Americans, compared in contrast on 31 % of the whites (DHHS, 2001).

The other forms of discrimination were termed as the day-to-day perceived discrimination. This discrimination was reported as an experience to often from at least 25 % of the African Americans than compared to 3 % of the whites (DHHS, 2001). When focusing on the African Americans communities, there was few studies on racism's impact within other cultures from racial and ethnic minorities on health disparities (DHHS, 2001; Williams, & Jackson, 2005). However, the VPM helped me address and investigate how this impact on HIV experiences have changed an African America woman’s perspective and behavior.

Chapter 2 Summary

In summary, the findings from the major themes in the content and literature clearly indicate on how much we know, and found out, and how racism and discrimination has been known to be clear and very stressful events. This was shown in the research to be true upon some connection by several past and present studies, and what the future holds by future findings of this research study and the African American community. This was seen by the present study on filling the gap within the adversely and stressful effects which were heavenly related to receiving unfair access and treatment to health care since the AIDS epidemic. This was true upon findings and bridging the health care gap, on what we now know so far, for many of today's African AAW They are seen today, as an old generation of AAW, who still seem to struggle and live with the fear of rejection by their health care professionals, while living as HIV positive.

This was seen as the stress and rejection that highly contributed to an unhealthy and unstable environment and a shorter life. According to Airhihenbuwa and Liburd (2006), to better understand the root causes of these disparities, we need to examine the social environment, social economics, and risk factors, on the past experiences and living conditions since the AIDS epidemic. This research study was an attempt to find the barriers and gaps. The research study provided a better understanding of the experience of AAW with HIV. This was an important step that helped address and answer, what special type of health care access AAW received, while health care professionals have feared their respective illnesses as contagious.

The research helped find and bridge the gaps upon the ethnic and racial health disparities in medical and primary care settings among this vulnerable population and community. Many of the barriers in the study were found to be complex which included social stigma and discrimination, income and poverty, and inadequate access to healthcare, followed by the distrust of medical services and physicians, and high risk behaviors. Harris (2011), expressed how the recognition of bias and discriminatory behavior has contributed to the lack of trust in healthcare providers within the African American community. Research studies done by the U.S. Department of Health and Human Services (2010), found that most women who are HIV positive live in poverty and were already poor when they learned their sero-status; socioeconomic status of women negatively influences access to health care. Therefore, income, and social stigma, were found to be the true factors and barriers that remain heavily within urban communities with regard to many HIV issues.

In conclusion, the qualitative research study helped local communities and state health organizations establish more effective treatment and prevention programs. These are the programs that are geared toward creating an opportunity upon positive social change for the African American women and their infected partners. This was an opportunity to make a difference and improve the fundamentals within the human and social conditions that effects positive social change in the health care system. This research study provided the research that addressed the barriers and gaps, for those with limited or no access to health care, of the African American culture, living with HIV.

Chapter 3: Research Method

Introduction

Chapter 3 contains the introduction, design and rationale, methodology, and instrumentation. The chapter includes the process and procedure for participant section and recruitment, data collection, and data analysis. The chapter includes issues of trustworthiness, ethical procedures, and a summary leading to Chapter 4. Chapter 3 also addresses the conducted qualitative research study that examined the AAW who live with HIV and having access to good health care.

Through this research study, I helped identify the barriers and gaps in the health care system of 10 AAW who live with HIV. They were barriers and gaps were identified as the main themes and codes that pertained to each individual participant's health care treatment, stigmatization, and economical and environmental risk factors during interview. The main purpose of this chapter is to explain the research design, methodology, and strategies that were used to conduct the face to face interviews on 10 participants, who were AAW with HIV who live in the Boston Massachusetts area. The narrative design and approach was employed as an inductive mode for gaining a better perception and perspective on the disparity rate of HIV. The research study also provided a better understanding and opportunity of the past experiences of the 10 AAW. This research experience was found to be an opportunity to make a difference on improving the fundamentals between human and social conditions that effects positive social change in the health care system.

Evans and Swan (2014), stated how African Americans and Hispanics of both sexes have disproportionately higher rates of HIV and health disparities in the United States. One main reason was by a number of contributing factors to a health disparity, including (a) health disparities linked to socioeconomic conditions, (b) distrust of the healthcare system, based on historical abuses of people of color, and (c) difficulty communicating health education in culturally appropriate ways to diverse communities (Evans & Swan, 2014). According to Collins et al., (2002), numerous research studies have documented the relatively poor health and health outcomes of African Americans, reflecting a long history of economic deprivation by the barriers to health care. According to BWHI (2012), it was well documented that African Americans over age 50 are living longer, with higher rates of chronic diseases who do not have healh care for HIV.

Therefore, more research was needed to better understand the AAW who have HIV and who live as a health disparity in the Boston Massachusetts area. The research study also helped combat the phenomena of stigmatization and discrimination upon HIV related conditions for AAW, Black communities, and people of color. According to Bharat (2002), to understand how race is relevant to questions of public health care and treatment issues, it is important to first examine the phenomena of stigma and discrimination as related to illness and diseases on HIV. Therefore, the research and results of the study has shed new insights upon new intervention toward health care access and health disparities, by using the qualitative method and the narrative inquiry.

The following major sections of this chapter provide the major framework of the research study and include the research design and rationale, instrumentation, issues of trustworthiness, followed by the qualitative research questions and the summary and conclusion.

Research Design and Rationale

The rationale for the qualitative research was based on a process of narrative inquiry that helped to better understand the nature of the problem between AAW with HIV and health access and treatment. Therefore, I employed the central concept of a narrative design and approach with a storytelling tradition. I explored a social and human problem about HIV and health care by interviewing a protected minorities and a vulnerable population of the African American race and culture. The interviews were done by face to face and a natural setting and natural observations, with qualitative research. According to Harris (2011), qualitative research involves the studied use and collection of a personal experience, introspective, life story interview, observational, historical, interactional, and visual texts that describe routine and problematic moments and meaning in individuals' lives.

In addition, another rationale for choosing the narrative design and approach was because it is known to be very effective and appropriate for its storytelling history in past HIV studies. This is based on each individual by their participation in a story on their past experiences, while I asked the questions. According to Creswell (2013), one of the main reasons why narrative design has been so effective and appropriate is because of its past storytelling experiences which provides a better understanding in every race and culture when researching a problem.

One storytelling experience and scenario included problems regarding racism and stereotyping and its effect on African American people. This was difficult for participants when trying to receive or manage their own health care status while living with HIV. Beatty, Gaiter, and Wheeler (2004), used an example by the Institute of Medicine report in 1988 on how HIV and disparities in health care had an impact not only individually but on people who practiced racism, stereotyping, and discrimination. These actions shaped the health care system for the African American society. This action must not only be acknowledged but eliminated if HIV interventions among African Americans are to be effective. This action has also been connected to AAW with HIV and their communities to health care access, by their lifestyle, language, race, education, and living in poverty. With poverty and health needs so concentrated among older women of the African American culture, benefit programs must overcome access barriers arising from language limitations and culture (Burke & Hsiao, 2009).

The following research questions addressed the researcher's role and responsibility to the AAW participants with HIV. They were the questions used to help find and address the health care barriers and gaps on a young generation of AAW who live with HIV. They were the research questions that helped address the economic risk factors and barriers to treatment in the health care system for 10 AAW with HIV.

Research Questions

RQ1: What are the economic and environmental risk factors associated with African American women with HIV/AIDS?

Subquestion: How do these risk factors influence overall health status?

Subquestion: How do these risk factors influence access to health care services?

RQ2: How do African American women with HIV/AIDS compensate for barriers to treatment and community resources?

Subquestion: What measures do the African American women use to deal with the stigma associated with the diagnosis of HIV/AIDS?

Subquestion: How do these measures enable the African American women with HIV/AIDS to overcome or adapt to the risk factors associated with vulnerable populations?

Role of the Researcher

The primary role of the researcher was to remain unbiased when asking personal questions about a participant's health status, during a 45-minute face to face interview. The personal questions were asked by myself, by using a 10 question protocol in a personal storytelling interview and atmosphere. The interview protocol was developed in accordance to the qualitative research and narrative design and may be viewed in (Appendix C). According to Rudestam and Newton (2007), a narrative design may be either oral or written or derived by a naturally occurring conversation of storytelling in an interview. In some cases, narrative storytelling may be being very sensitive—not only to the AAW participants, but too many other races and cultures as well. Melton (2007), explained how one of the main functions of the narrative account was to assist people or participants to make sense of their lives, especially if they have experienced a traumatic event or adverse life changes.

By choosing the qualitative method for the research study was best suited to relate to a better understanding—why certain barriers have hindered some of the AAW as a health disparity, while seeking health care because of HIV. The qualitative method and narrative design was the best approach that allowed myself, a connection between a health disparity and minority group, or race, who are vulnerable and living with HIV. According to Creswell (2013), narrative research has always been a strategy of inquiry in which the researcher “studies the lives on individuals” and asks one or more individuals to provide stories about his past and present lives.

Methodology

Participant Selection Logic

The qualitative method was used in the study because it has been known for precise data collections, analysis, and participant selection procedures. According to Rudestam and Newton, (2007), using a qualitative method has always been helpful when evaluating and completing a study, whether or not the selected method is sufficiently rigorous and appropriate to the research questions. In this case, a selected sample size of 10 AAW who were HIV positive, in small rural communities, and a 50-mile range, was an appropriate way to provide answers by a face to face interview. According to Grayson (2015), geography and rural impacts the research sample when the collection takes place in remote or rural areas.

By selecting the sample of 10 AAW with HIV to participate in a face to face interview and tell their side of their experiences, helped provide a better understanding, between living with HIV and having a fair opportunity to health care access. This was the qualitative research understanding that was gained on the boundaries between health disparities and HIV and our health care system. According to Rudestam and Newton (2007), the boundaries between qualitative research and quantitative research have become increasingly blurred, as various disciplines have adopted their own perspectives, when it comes to staying unbiased and researching different cultures. According to Melton (2007), narrative analysis allows for systematic study of personal experience and meaning: how events have been constructed by active subjects. This experience helped African American and positive black women relate and construct their experience about HIV and health care access, and that gave meaning within each and every narrative interview.

Advantages of Narrative

The narrative inquiry method was used because it helped reveal the essence of the AAW participants past experiences while living with HIV. In many cases, narrative researchers have had considerable training in interviewing skills, drawing out and listening to the thoughts, feelings, and interpretations of the narrator—as he or she constructs and organizes previous life experiences, on what they went through over the years. Some life experiences were based on the participant's past experience and knowledge by their narrative story that was told and shared. Melton (2007), used storytelling among black women to make their point or message, because storytelling has always had the potential that tends to sway a person to make changes in their life, or see their situation from different perspectives. In some cases, as the participants or narrators told me their stories and talked about their relationships, I felt their joy, pain, or confusion.

By participants eliciting their emotions or recollection of similar experiences, the narrative stories became the link which allowed the AAW to understand how they were potentially vulnerable to HIV infection. However, the narrative approach seemed to develop relevant true statements, ones that may serve to explain the situation of concern or describe the casual relationship on a subject interest (Creswell, 2013). Other choices of method and approach below would not have been best for the research topic and process, especially when interviewing a vulnerable group of people face to face, who have been living with HIV and lacked health care or treatment.

Other Methods of Inquiry

The phenomenological method would have helped by either revealing the essence of the participants past experiences, or by coping on the lack of health care access and the medical treatment received. The results and answers from the phenomenological method may have provided ways of how others cultures may relate to some unified meaning when living with an HIV experience. The phenomenological method would have been second best to describe the “experience” of the African American women, who were placed within a position or environment as being in a black culture, on more feedback and a special purpose than case study.

The case study method has always been based on cases of patients, who have been treated for illnesses or sickness in the medical or health field. Rudestam and Newton (2007), used their term on case studies by usually referring to a study that focuses on a single individual, organization, or event program, called a “specific, unique bounded system”. Furthermore, case studies would have been more suitable or commonly associated with qualitative designs, on which there is an intensive effort to understand a single unit of study within a complex content of interview data (Rudestam and Newton, 2007). However, the case study method was designed to study some social phenomena on ways to draw some conclusion on problem solving decisions. Rudestam expressed how the case study had more of a strategy, than the method, wherein the narrative approach may have been appropriate when comparing images to various groups. These are groups like people who have a story to tell, about a specific subject, trauma, or event in life experience.

Sampling Method and Recruitment Process

The snowball and cluster sample method was used to seek and recruit a small population of 10 AAW who met the HIV criterion. The criterion for selecting the sample was based on their past life experience, as to living with a disease particularly HIV. According to Sequist and Schneider (2008), there has always been at least four methodological issues to consider before collecting and analyzing data to assess racial or ethnic disparities in health care. These methodological issues are: (a) the validity of the classification of race and ethnicity, (b) sample size limitations, (c) smallest analyzable geographic unit, and (d) the availability of data on other cultural or socioeconomic characteristics (Sequist & Schneider (2008)

The participants who met these criteria were selected and identified within a 50-mile range of the Boston, Massachusetts. Metropolitan area. However, if a participants knew someone with important information that was very helpful to me for the study, they were given a referral by snowballing that adding such data for future information. In the past, the snowballing technique was highly exercised by someone knowing someone else to refer for a study by written referral or word of mouth.

Recruitment for Small Sample

The recruitment process and sample size for the qualitative research study was based on narrative observations and narrative interviews. Therefore, I used a qualitative method and narrative design and a sample size of 10 participants. According to Crouch and McKenzie (2006), a smaller sample size has often helped to penetrate social life beyond appearance and manifest meanings upon the actions of the participants or subjects upon observation in a narrative study. By using a smaller sample size, helped establish the continuing, fruitful relationships with the participants, through theoretical contemplation and observations, both approaches were shown to help address the research problem more in depth (Crouch and McKenzie, 2006).

Therefore, I highly considered the status of participants to recruit, who were subject to HIV within local and surrounding communities of the Boston, Massachusetts Metropolitan area. This was the status that depended on each participant’s socio-economic status, educational background, religion, sex, age, and past and present living conditions, upon considering the right match, while meeting the research and HIV requirements. This was also the status in regards to each participant’s characteristic that influenced their past experiences, leading to natural discussion for a 45-minute interview. Therefore, I determined the rigid qualifications and availability for how many HIV participants for the research in the surrounding Boston areas. According to Grayson (2015), setting rigid qualifications for study subjects or participants has been known to reduce the sample size due to the limited number of people with HIV who met the standards and qualifications. In general, the participant's qualifications opened the research study to a smaller number of people and was based on their geographic boundaries that impacted the research sample when the collection took place in a rural area (Grayson, 2015).

Therefore, I choose and considered to recruit a small sample of 10 AAW participants because of the following reasons: (a) the surrounding population parameters on HIV positive black women who one might want to estimate; (b) cost of sampling (importance of information); how much was known about HIV in that area; (c) (variability) of HIV and African American women in the cluster or population, and (d) how hard it was to collect the data, or how precise and reliable the data and information will be. A common (and simplest) method for selecting only 10 AAW participants for this research study, was subjected and limited to the cluster and snowball sampling method. By just recruiting a small sample of 10 AAW participants who are HIV positive, provided the valid and reliable information by a 45-minute interview. In this case, a small sample was highly acceptable when it came to collecting the data, or when simply getting feedback to enhance validity in a narrative interview. According to Crouch and McKenzie, (2006) by allowing a small number of participants (less than 15), facilitated the researcher's close association with the participants, and this added or enhanced the validity of fine-grained, and in-depth inquiry in naturalistic settings. This sampling method was where and why smaller was better, and where validity and reliability played a big part on collecting and analyzing data.

The participant selection and recruitment method was done by pin-up fliers, organizations, newspaper advertisements, Internet, and snowball referrals for an interview. By putting fliers in professional clinics and hospitals, advertisement by media and newspaper, word of mouth, friends of friends, clinics and shelters, provided good results on recruiting and selection. This step helped filter out participants within certain clusters who were HIV positive for interviewing. According to Nunn et al., (2014), HIV and AIDS infection often clusters in neighborhoods that already experience significant social and economic burdens.

The participant was contacted by phone or email for a quick conversion about meeting criteria and qualifications to proceed to the next step. Next, a conversation over the phone was based on matching criteria, and to see if a participant would like to be interviewed by either, face to face or internet cam, by a 45-minute interview. This interview was scheduled after phone discussion took place and consent form was signed. The 45-minute interview process was the important research data and information collected on each AAW who live with HIV.

Instrumentation

Data Collection

The procedure and instrument for the data collection was based on asking questions from a protocol and recording the outcome by a 45-minute face to face interview. The procedure for data collection has been known to be highly effective as the tools that work well and easy with a qualitative approach and narrative design, when collecting data on a small sample of 10 AAW participants with HIV, and talking about their experiences with HIV. The interview questions and narrative storytelling method helped the AAW participants open up and express their feelings, about their past experiences on health care access and treatment and HIV. In many ways, the qualitative method and inquiry procedure, helped employ and demonstrate a different approach on scholarly inquiry than methods of quantitative research. According to Creswell (2013), qualitative inquiry employs different philosophical assumptions, strategies of inquiry, and methods of data collection, upon analysis with interpretations. Therefore, I payed special attention and kept focused on learning the meaning that the participants held about their health problems or issues which they experienced with HIV in their past.

At the end of a 45-minute interview with a HIV participant, they were free to leave with compensation of $35.00

Assurance of Volunteerism - Right to Withdraw - Privacy

During each interview with a participant, my role and responsibility was to provide assurance of volunteerism to each and every participant upon ensuring how their information was kept anonymous by using a consent form. In every case, the participants were more than free to choose whether or not to participate, before, or during the interview. The participants were at no or minimal risk and were more than free to choose whether or not to discontinue their participation. In a concern with participants upon any event who may have experienced some anxiety or stress, during the interview participation, they may have chosen at any time to terminate their full participation, within any time or moment of the interview. Therefore, a participant could have refused to answer any personal questions that would have been stressful or invasive to their privacy.

The information that was collected and provided at the interviews by the AAW participants are strictly kept private and confidential. Each interview was either done at a participant's own location, or participant's a choice and would last approximately 45 minutes in length. Therefore, with respect, I fully understood and participated in the 45-minute interview and the decision was strictly voluntary. This was the participant's own made decision as to whether or not to fully cooperate and participate at any time. Therefore, each interview and procedure was strictly voluntary and had no effect on a participant's future or currant relations with Walden University or with a participant's health status. However, if for any reason a participant presently decided to initially participate, they could have withdrawn at any time later without penalty or consequence, and withdrawing will not have affected any relationships. By doing this research study has provided a positive outcome and has contributed to certain advantage and benefits.

One benefit for participating may have helped contribute to some form of inclusive health care support services, for our future loved one's who live with HIV. This was the opportunity that made a difference and improved the fundamentals within the human and social conditions which effects positive social change in the health care system.

Data Analysis Procedure

The purpose of this section was to introduce the data analysis procedures that were used in the research study. This was the qualitative data analysis process that helped answer the research questions surrounding the research of the AAW participants. Renner (2003), describes the narrative data analysis process by the open ended questions, individual interviews, observations, and narrative stories. This process helped identify the common themes about health care and health disparities, as well as stigma and discrimination by the open ended questions. Richards (2009), stated how qualitative data analysis is an open-ended process in which coding categories can evolve and new information can emerge and this is a start to organize and prepare the data analysis. In this case, each 45-minute individual interview was transcribed and analyzed by using qualitative data analysis computer program software called NViv10.

Transcription

In this step, I got to know and understand the data by transcribing each interview individually on what information was important to convey. According to Richards (2009), researchers who transcribe or convey their own interviews helps participants feel more comfortable during interviews. Kvale and Brinkmann, (2009), expressed how the conveying process involved the researcher to transcribe each interview by constantly scanning and filtering the material, writing up field notes, and arranging and sorting the data into different types of categories. These categories highly depended on each source of information and data that I read through, and every transcript and piece of data. This was to obtain a general sense and idea of what each individual participant has said in the interview. This step helped to express the tone and overall depth, credibility, and the use of reliable information I was looking for, before the step of software which helped categorize the information. According to Kvale and Brinkmann (2009), a researcher who transcribes their own interviews will preserve more of the social and emotional aspects of the interview due to being reminded of the context in which the words were spoken. This process helped myself to make better choices about what had to be filtered out, or included and further guide the needs of the qualitative research study.

Software for Analysis

In this step, I used a qualitative data analysis software that has been known to be highly effective in many research fields of qualitative research to categorize information. In this study, I used a program called NVivo10 (QSR International) which helped assist in analyzing the background and demographic of the AAW attitudes and behaviors, who live as HIV positive for years. They are seen as the 10 AAW who provided the important and valuable information by a 45-minute face to face interview. According to Bazelt (2007), NVivo10 has many unique features that create coding pieces of text, memos, and searching on some relationships between codes to enhance the researcher’s ability and help to recognize different patterns and themes of qualitative data. Richards (2009), expressed how qualitative data analysis software has helped create documentation of the process by organizing data and forming ideas, and hence increases the validly of research.

However, one ideal purpose for using software helped identify the themes as one of the most fundamental tasks in qualitative research. Bazelt (2007), expressed how using a software to analyze your qualitative data can be a helpful tool and technique to discover hidden themes in the qualitative data analysis and text. These techniques were based on: (a) an analysis of words (word repetitions, key-indigenous terms, and key-words-in contexts); (b) a careful reading of larger chunks or segments of text (compare and contrast, social science queries, and searching for missing information); and (c) an intentional analysis of linguistic features (metaphors, transitions, connectors). According to Creswell (2013), coding has been a process of organizing the material into chunks or segments of text before bringing meaning to information. In this case, qualitative content analysis was used and helped me analyze data and describe the past experiences of 10 AAW participants who live with HIV and received health care and treatment.

Therefore, qualitative data analysis software was highly recommended and used to manage data, organize themes, and confirm ideas. According to Bazelt (2007), qualitative data analysis is best suited for many studies because the researcher can formulate a comprehensive description of the past experience by the context of the descriptions and meanings. This was the step where I started to list statements and highlighted the text, that had specific meaning, or relevance to the problem or phenomenon that was studied. Furthermore, I used this process to help me generate an idea and description of the setting or participants as well as categories and themes for the data analysis. Description involves a detailed rendering of the information about people, places, or events in a setting (Creswell, 2013).

At the end, the research study and proposed narrative design attempted to extract themes or statements on an understanding how AAW experienced barriers to health care, because of their HIV health status and living as a health disparity. Beyond identifying the themes during the coding process, qualitative researchers can do much with themes to help build additional layers of complex analysis (Creswell, 2013).

Identifying Patterns and Themes

After I coded the narrative data, it was grouped into organized clusters, labeled themes, and coded within the following steps during the data analysis process. The interview data were coded by myself and was the relevant step and process, within the broad categories. The categories were indicated by the existing literature of the 10 AAW participants by their narrative story on their attitudes and behaviors and their past experiences with HIV and health care access.

The initial topic and helpful categories included African American personal and religious beliefs, health care barriers and issues, and reference or literature of some research variables to poverty, stigma, and discrimination. This was the step that helped advance how the description and themes were represented in qualitative narrative research by clustering, summarizing, extraction of general and unique themes by all interviews for development. Groenewald (2004), recommends the following steps during the data analysis: (a) clustering units to form themes together where the researcher identifies significant topics, (b) summarizing each individual interview data and validating it and (c) extracting general and unique themes. This was the process, where I looked for the common and repeating themes about the 10 AAW participants who were interviewed.

Results and Discussion

Towards the end, I concluded on writing a composite summary that transformed and interpreted the end results of the interview data, into the expressions that were appropriate for the scientific discourse. This step supported the research between health disparities with HIV and health care access. By this, I repeated the analysis steps again to thoroughly examine all data collected by the in-depth interview sessions. This was the final step that involved myself to make special interpretations or meaning and discussion of the data analysis procedure. This was the procedure where I asked what was the lesson learned and what was gained from interviewing the 10 AAW participants for the qualitative study. This was the lesson and discussion on the results where I had the chance to voice their own personal experience or opinion in regards to the African American women's past experiences. Therefore, I double checked the transcripts to make sure qualitative validity and qualitative reliability and mistakes were not made during transcription.

Issues of Trustworthiness

The research context and literature involved my knowledge and experience to build a friendly and trustworthy atmosphere and relationship while interviewing the 10 participants with HIV. The literature review stated how the qualitative method and narrative design strategy has successfully built the trust for a credible relationship. The qualitative research study was seen by taking the appropriate first step on building new trust and new development, upon finding the health care gaps and eliminating the barriers. They were seen as the barriers of a lifetime for the 10 African American participants who may have denied or prevented them from receiving fair medical treatment and health care in the past. However, by building this trust, built and established the appropriate strategies of rapport that broke the ice, and helped facilitate the participant’s confidential dependability to eventually sign a consent form.

The confidential information of the consent form included the reconstruction of participant’s early years and experiences. This information included their immediate families, education and school, and relationships, with friends and neighbors who live in their neighborhood. Other confidential information was gathered during the interview process to provide the insight on what type and culture among family structure that existed in their past childhoods. This step helped provide a better understanding from a participant’s credibility and point of view on their values and norms that lied between the context of health disparities and HIV, and access to health care. According to Rudestam and Newton (2007), the criteria commonly proposed for determining whether or not a special research study is ethical are “grounded in norms”, and values reinforced by the scientific community upon the five norms on interviewing. They are the five norms that are particularly noteworthy such as: (a) validity of research, (b) competency of the researcher, (c) beneficence of the researcher, (d) special population, and (e) informed consent (Rudestam & Newton, 2007).

However, during the beginning and end of each interview, the context and questions where directed to describe the nature of the study, and where I had an opportunity at the beginning to share their own “personal experiences” about the health care system. This opening and closing opportunity helped upon building rapport and credibility. This action on building rapport developed into the credibility and trust with the participants, and helped them listen to their own stories and experiences, with ease, comfort, and objectively. However, during the interviews, I had a chance to participate on their own personal thoughts that helped address certain types of concrete information. This concrete information opened up their voices on their past experience. This was the information based on asking the additional focused questions that stemmed between the research questions and the interview process. The interview process was conducted in an environment and location that was selected by each participant upon being distraction free and ensured privacy. As each interview was transcribed, notes were taken to further document the nonverbal communication, upon distraction free environment.

Finally, the data was organized by creating individual files by my transcribed interviews. This was the first step and the beginning toward creating and organizing the data analysis process. At the time the data processes were transcribed—the data analyzing process on collected data on the participants began. The choice on data collection was my choice, of which data made sense and appropriate and ethical while being coded within standards of race and diversity. According to Sequist and Schneider (2008), the collection of data on race, ethnicity, and health must reflect the growing diversity of our population so it can also be useful to local health care leaders and policy makers. These health care leaders and policy makers have strived to reduce racial and ethnic disparities and improve care for all of the citizens of the United States.

Therefore, all files and documents by the interviews have been maintained with the privacy of a locked filing cabinet that are either in my office or home.

Ethical Concerns and Procedures

The ethical issues between myself and the participants in a proposed research study did not stop before and when collecting and analyzing data. According to Creswell (2013), in some cases, an ethical issue or mistake may mistakenly or unaware apply by accident to the actual writing and dissemination of the final research report and full study. This is why I was fully aware, when gaining access to take strict precautions, and when going over the agreement and forms with each participant. Therefore, an agreement to gain the access to interview participants for their story and important information was first finalized for permission by Walden Institutional Review Board (IRB), and a consent form was signed by each participants before the interview. This was based on final approval by the IRB application form which was based on the treatment on human (subject or participants) when a protected class or subgroup was being interviewed with minimal risk. The special steps on institutional permission were approved and met before recruitment even begins. (IRB approval # is 11-16-15-0229933)

The first step was where the ethical concerns and considerations had addressed the research study. This step was maintained in accordance with the Walden (IRB). The Walden (IRB) played an important role in this qualitative research study. The second step was to ensure the safety and the ethical protection and treatment, of human research and participants and their private and confidential records. These specific steps on considerations were related to the recruitment and how to exercise caution by ensuring there was no exploitation or personal gain, within vulnerable populations being researched. This especially on a protected class or minority group of AAW with HIV.

Therefore, the concerns and considerations were based on not using my own influence, over participant, to compel or persuade them to participate in any research when collecting data. Any ethical consideration related to the recruitment and myself, were mindful on religious, cultural, religious, gender and had significant differences in the research population, when conducting, planning, or reporting on their research role. However, with ethical concerns and considerations on today’s day and age, I had to communicate upon findings, and the practical significance of their research making it clear, straightforward, using the appropriate language to any relevant and vulnerable research populations, especially upon recruitment.

Therefore, I used the language and words that were not biased against participants or people who may be sensitive outside the study. According to Creswell (2013), the language or wording from the data collection must be planned as unbiased against gender, sexual orientation, disability and age, or any racial or ethnic group. Furthermore, I showed an unbiased plan before and after the study or any standard procedure. This helped anticipate and provide authorship upon dealing with the future consequences. According to Dowd (2015), biased writing can impugn a writer's integrity and competency toward finding a professor who is willing to serve as a job reference when the student graduates. A writer with a reputation for overly biased writing may face alienation, ridicule, and consequences. Letting personal views slant writing creates distrust, according to the Walden University Online Writing Center.

This was known as standard procedure when conducting the research, or by reading the manuscript out loud—with certain audiences present. The plan for qualitative procedures should end with some comments about the narrative that emerges from the data analysis and manuscript (Creswell, 2013). According to Creswell (2013), one important issue in writing a scholarly manuscript is to plan not to exploit the labor and provide authorship to individuals who may contribute to publication during data collection and interviewing. This was very important because it released the details of the researcher, on the research design that helped the readers of the audiences determine for themselves the credibility of the data of the study. According to Harris (2011), to avoid unethical assumptions from happening, the researcher may withhold any and all bias and keep an open mind point on his view throughout the study to aid in validity and reliability of the study.

Other important details that emerged by the data collection plan and process, added some life to the study, by the historiography unstructured qualitative observations, and interviews. Qualitative interviews and observations are those where a researcher takes field notes on the behaviors and actives of the individuals at the site, and qualitative interviews are those in which the researcher conducts face-to-face interviews with participants (Creswell, 2013).

Last, the ethical concerns and considerations focused on the data collection procedure of my role. In some cases, a participant may have not felt like participating, or have change of thought at the moment. This may have led to participant refusal or withdrawal from the study and the researcher was aware to back away. By backing away and not putting pressure on a participant had an advantage to both sides which allowed an open gate for trust to the participants. According to Creswell (2013), researchers engage in multiple observations during the course of a qualitative study by using a protocol for recording information, while observing participants, and this helps indicate the type of data on their experiences and background. (Approval # is 11-16-15-0229933)

Treatment of Data

The results and outcome of data transcripts and records for the interview study are kept confidential and private. Within reason, any report and information from the study that may be published, I with respect of the participants, will never include any information that can make it possible in any way to ever identify a participant. The research on the treatment of data of records and transcripts from the study and interview, has been kept locked in a file cabinet. The only one to have access to this information will be me. In the future, these records will be shredded or destroyed upon the interview completion within one year. Therefore, the participants have experienced no risk that was associated for contributing and participating when being interviewed.

If a participant upon any event or time, felt or experienced some anxiety or stress while and during the interview participation, they could have chosen at any time to terminate their full participation any time or moment of the interview. Furthermore, a participant could have or refuse not attempt to answer upon any personal questions that they may consider answering, as being stressful or invasive to your privacy. During the interview, a participant could have terminated the interview if they felt it would violate their space or environment, or may be a conflict of interest to their church or community.

Potential Negative Risk and Vulnerable Population

The sensitivity and privacy of the subject and topic may have had some potential to make participants feel uneasy or ashamed on sharing their experience and information. The vulnerable populations of the research study, were African American women who live with HIV and who were appropriate for the study. According to Israel, Laudari, and Simonetta (2008), it has been well understood that particular minority groups like African Americans are more susceptible and vulnerable to HIV infection because of their behavioral, cognitive, and programmatic environments. African American's are among the most stigmatized and discriminated against health care and in society.

To better understand the influence of vulnerability among the participants and have a better understanding of HIV and health disparities, it was more adequate to apply better prevention strategies. Mann and collaborators defined three interdependent and interactive vulnerability components for prevention strategies: (a) Individual vulnerability, (b) Programmatic (or political) vulnerability, and (b) Social (or collective) vulnerability (Israel, et al., 2008).

First, individual vulnerability that derives from personal behaviors, knowledge, and attributes that affect the possibility of preventing HIV infection. Such behaviors and attributes are linked to the social environment where individuals live, and they reflect a level of self-awareness and the potential power to change one's personal behavior (Israel et al., 2008). Second, programmatic vulnerably that can increase or reduce vulnerability to HIV among those people most susceptible. Programmatic vulnerability relates to the quality of information, education, and communication in a program, as well as the existence of quality medical and social services that are easy to access to health care (Israel et al., 2008). Last, social vulnerability that incorporates those social factors that influence the capacity to reduce individual vulnerability, as it focuses on policies and laws, like the criminalization of SW, MSM, and IDU in some countries (Israel et al., 2008). However, I had announced that before the start of the interview session, a participant may stop or not participate, if there are any feelings of emotionally vulnerable or physical uncertainty anytime during the interview process. This was also noted in the consent and discloser form before the start of the interview process.

Chapter 3 Summary

Verification and Findings

The proposed research findings and interpreting of results was the final step in the process. This was the step to consider upon the findings in the light of the research questions that were set forth in the beginning by conducting a face to face interview, with the sample of 10 AAW who live with HIV. They were known as the findings and results that helped indicate the social implications, by the results by the sample and population that was chosen and studied for future research on HIV. This was the important future research that helped answer and address the special type of health care access that a sample of 10 AAW with HIV received, while health care professionals may have feared their respective illnesses as contagious. This was the opportunity that has made a difference upon improving the fundamentals on the human and social conditions that effects positive social change in the health care system.

Therefore, no exploratory study was or will be conducted. The next phase and chapters on 4 and 5, explains the future outcome on the data that were collected, the results about the interview and procedure, and results and data about the qualitative study on AAW, living with HIV and health disparities.

Chapter 4: Results

Introduction

Chapter 4 includes the findings related to the research questions from Chapter 1. A summary of the 10 AAW participants and their characteristics is presented. This is followed by the demographics, data collection, data analysis, results, trustworthiness, themes, and discussion. This also includes the themes and patterns of responses that emerged by the experiences of the 10 participants, AAW living with HIV.

The purpose of this qualitative research study was to explore the health care experiences of AAW who live with HIV. The information from the research study helped identify and address the barriers that still exist in the health care system. They are barriers among the disproportionately higher rates of women who are African American with HIV. These barriers are shown to either hinder or prevent the process to health care access and treatment for many who live as a disparity. Evans and Swan (2014), stated how barriers of the African American seem to have disproportionately higher rates of HIV in the United States, and there are no biological, as opposed to sociological, reasons for these disparities to exist. Therefore, the narrative approach was used to help explore how older AAW who live with HIV received health care and treatment.

In this case, I collected data from each face to face interview with 10 AAW participants who live with HIV. For the data and analysis step, I used NVivo10 software that helped analyze and understand qualitative data. The Nvivo10 software assisted in the data analysis process by translating the words and phrases into themes as the end results and findings.

The study was aimed toward a protected class and special minority group. They are people of color who have found to face much social stigma when opening up or disclosing their HIV status. In the qualitative research study, I investigated and explored the lived experiences of 10 AAW who have HIV in a primary care setting. A specific purpose for this research was to help me explore many of the various factors on ethnic health and racial disparities which have had an impact and effect on the health system, among the target population of the African American. The data were gathered by myself as the sole researcher who interviewed 10 AAW participants, who shared their own occurrences with narrative interviews. Each narrative interview provided rich feedback of description through open-ended questions that ascertained meaning on their ethnicity, race and culture.

Within all the individual interviews, the findings of the participants, revealed the true logic of information and data that addressed the final research questions and subquestions. These results were by the transcript data of the recurring themes and patterns and data entry that were analyzed by computer-aided software Nvivo10. The evidence of quality showed and assured the accuracy of data to be genuine and trustworthy when analyzed. This was by credibility, transferability, dependability, and conformability of data, when using the framework of the VPM. By using VPM and the following research questions, helped to identify and address the barriers in the health care system for the 10 participants.

Research Questions

The questions followed the purpose and design of the research study. The questions helped identify and address the gaps and barriers that are associated with the health disparities, regarding those who live with HIV and social stigma of being from a black culture.

RQ1: What are the economic and environmental risk factors associated with African American women with HIV/AIDS?

Subquestion: How do these risk factors influence overall health status?

Subquestion: How do these risk factors influence access to health care services?

RQ2: How do African American women with HIV/AIDS compensate for barriers to treatment and community resources?

Subquestion: What measures do the African American women use to deal with the stigma associated with the diagnosis of HIV/AIDS?

Subquestion: How do these measures enable the African American women with HIV/AIDS to overcome or adapt to the risk factors associated with vulnerable populations?

Setting

Each participant was interviewed in a private setting of her choice. The private settings provided comfort and convenience to help ensure an uninterrupted environment and full success for the outcome and results. Out of 10 participants, six were interviewed face-to-face on-site in a meeting room at a shelter and four of the other participants were interviewed privately in a quiet place and setting in a local restaurant at the respective participant's request and choice.

Demographics

Six of the participants were selected from Dorchester Massachusetts. One reason for targeting this area was because of its overly proportioned black population and black neighborhoods with the highest HIV rate in the Boston, Massachusetts area. The busy city neighborhoods of historic Dorchester are comprised of approximately 6 square miles in Boston, Massachusetts, especially the main road that runs through the busy city called Blue Hill Avenue. Blue Hill Avenue in Dorchester is from Roxbury to Mattapan. These sections of Dorchester are overpopulated by distinct ethnic, racial, and socioeconomic compositions. A great many of the residents are from down south. According to the Dorchester Anthem (2006), the central and western areas of southern sections of the surrounding neighborhood have been home to the predominantly African American race and culture. In 2010, the Dorchester population was up to 92,115. This makeup was seen by the subgroup and ethnic groups that counted for 37% of the Black or African American culture (Dorchester Anthem, 2006).

Dorchester today is the largest working class community in the Boston area and home to many African Americans. This covers the wide geographic area seen equivalent to the nearby busy city of Cambridge, Massachusetts. However, most people do not drive or own a car; transportation for the black communities is provided by railroad and streetcar lines. According to the Dorchester Anthem (2006), Dorchester demographics is seen as a separate municipality that ranks among the top five Massachusetts urban and overly crowded and populated cities next to the big city and capital, Boston. This today, makes Dorchester a diverse mix of African Americans, European Americans, Irish American immigrants, Caribbean Americans, Latinos, and East and Southeast Asian Americans, as well as the corporate headquarters of the Boston Globe newspaper.

According to Dorchester Anthem, by the early 1990s, the city of Dorchester, Mattapan, and Roxbury had the highest percentage rate of victims of violence-related injuries and high comorbidity of sexual transmitted disease of many black race and ethnic groups. This race and ethnicity in the Dorchester area is known as risk markers that correlate with other more fundamental determinants of one’s health status (Dorchester Anthem, 2006).

These are risk markers, such as low income and poverty, welfare assistance, access to quality health care, illicit drug use, and vulnerable health care seeking behavior, and this adds to the higher prevalence for sexual transmitted diseases. Statistics in these Boston metropolitan areas show that Black/African Americans accounted for 46% of new HIV infections in 2013, and made up 43% of the total number of people with HIV, despite only 13% living in Boston, Massachusetts. (AVERT, 2015).

Because of these high HIV prevalence and statistics factors in the Dorchester and surrounding communities, it increased the likelihood of black/African Americans to only have sexual relations with others in their community and this heightens their risk (Avert, 2015). The CDC (2015), expressed how African Americans have the most severe burden of HIV of all racial and ethnic groups when compared with other races account for a higher proportion of new HIV infections, those diagnosed and living with HIV. A wide range of factors like social, economic, and demographic factors—such as stigma, discrimination, income, education, and geographic region—have been added to such markers, and these affect the African American women at risk for HIV (CDC, 2015). Because of this, Blue Hill Avenue today has become occupied within every block, with either multiple clinics, homeless shelters, community health care, or homes, for many people with HIV and/or AIDS.

Data Collection

The 10 participants in this study were identified as AAW who live with HIV and/or AIDS. The recruitment approach to attract the 10 participants was done independently by myself. This was by hanging fliers in the surrounding sites of the Dorchester neighborhoods. These sites are noticed as community services for health care and shelters for women, who are abused or who live with HIV and AIDS. Therefore, once a participant saw the flier and was willing to participate in the interview, I was contacted by her, via telephone for further details. Each participant was then contacted via telephone to set up a time and place for an interview and was interviewed on the spot. However, before being interviewed, each participant was asked if she met the HIV criterion for the interview.

Once a participant was identified, a letter to the participant would either be mailed if address was made available, or given to a participant face-to-face, at the time of interview for letter to participant (Appendix B). However, each participant was required to sign a consent form for permission to discuss anything about her health that was confidential and private (Appendix C). One of the methods to recruitment of participants was by means of hanging fliers and snowballing (Appendix D). Each location to hang a recruitment flier was approached with mannerism and permission of each facility. This was done, upon first introducing myself to a director, or someone in charge, as a Walden University student who is seeking participants for a good cause in the health care field, and as nonprofit. The nature of the study was to interview at least 10 African American Women, who live with HIV and their experience with health care.

All participants were asked the same questions using the identical protocol questionnaire by each interview. All participants, who were interviewed were compensated for their time with $35 cash at the end of the interview. All data were finally collected by face-to-face interviews by a narrative story with a protocol questionnaire and written into individual interview transcripts. See an example of a participant’s interview transcript (Appendix E). The process of the data collection in the interview transcripts began on November, 28, 2015 and ended on December 18, 2015.

Data Recorded

Data were recorded by an interview protocol by 10 participants who were African American women living as HIV positive. The instrument consisted of a least 10 questions and one additional question at the very end. The question at the end was an open ended question for the participant to speak freely on what should be done about more HIV education in their community.

Data Analysis

After each individual face-to-face interview with a participant, the data were fully transcribed within a 24-hour period. The data were then stored in a private and secure computer and a locked filing cabinet at my office. The data were then pre-coded to help provide several of the parameters that assisted in defining of the data quality and amount on what should be collected of the coding process. This step helped to filter and emphasize the results of the specific themes by the collected data and to help answer the two research questions by each participant. This was done by having uploaded the data transcripts into the NVivo10 software.

This was a process that took several attempts and multiple steps. The first step of the data analysis and process step involved some hand-coding and repeatedly reading, over and over each and every individual word and transcript. This process was done entirety throughout each interview transcript. This was to gain a general and better understanding on each participant, on what was said, and what was provided in each transcript. The second step of the data analysis and process step involved highlighting the statements that were made by each participant. This step and process provided specific relevance of a participant on their past experience of being HIV. The third step of the data analysis process involved putting each transcript into the Nvivo10 software. This step helped produce the results and pick up the repeated themes in each individual interview. They are the themes from all the transcripts that emerged from all 10 AAW who were interviewed about their experiences with HIV and healthcare access.

Data Collection and Storage

Each participant was interviewed in person after consent was given by signing the form. The consent form was reviewed at the beginning of each interview and a true copy was handed to each participant in person on site. Each individual interview was later hand-transcribed at my home. The transcripts were then stored in a filing cabinet and locked in my office. From the results of the software, each individual thought was filtered and separated by coded units. This was based on its occurrence and repeated frequency on each thought expressed by each participant.

The first research question was about finding the economic and environmental risk factors, with African American women with HIV. To address this research question each of the 10 participants were asked the same questions from the protocol.
(See Table 1 below).

(Continued)

Table 1:

What are the Economic Risk Factors Associated for African American Women with HIV

Code	Response (%)
Was stigmatized by doctors	70
Stigma is the worse reason you do not bother to go to the doctor	60
Stigma lowers your self-esteem and is very stressful	80
Stigma discouraged people	70
Stigma can lead to discriminate	70
Stigma is the worst enemy when you have “the thing”	70
Stigma is the worst and discriminates for a black woman with HIV	80
Stigma and income is a major barrier and risk factor	80
I was in denial and depressed	70
Denial had such a big economic impact	80
I start treatment right away	60
I was embarrassed I got HIV “The Thing”	60

Note: Codes developed from participant responses to data collection instrument by Questions 4, 5, and 6. Data that were collected from RQ1, were generated into the responses that are shown in Table 1.

The second research question asked how African American women with HIV compensate for barriers to treatment. (See Table 2)

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Table 2:

How do African American Women with HIV Compensate for Barriers to Treatment

Code	Response (%)
Community church and organizations	90
HIV Support groups	90
I make money in my community	60
My HIV status to my church	70
Friends support in my community	70
I do not disclose my HIV status	70
Support SSI and Public Assistance	60
Low income and unemployed-prostitution	70
Friends provide transportation	80
I quit my job	70
More HIV Information	100
More HIV Education	100
Provide HIV Education and Prevention Programs	100

Note: Codes developed from participant responses to data collection instrument by Questions 7, 8, and 9. Data that were collected from RQ2, were generated into the responses that are shown in Table 2.

Emerging Themes Identified

The following themes and codes emerged by the interview questions and presented in Table 3 below.

Table 3:

Themes	**Corresponding Codes**
Stigma barrier	Was stigmatized and discriminated due to my illness Stigma is the worse reason you do not bother to go to the doctor Stigma lowers your self-esteem and is very stressful Stigma discouraged people Stigma can lead to discriminate Stigma is the worst enemy when you have "The Thing" (another name for HIV*)* Stigma is the worst and discriminates for a black
Denial barrier	I was in denial and depressed Denial had an impact I started treatment right away Denial is a barrier I was embarrassed I got "the thing"
Community support	Community and organizations HIV Support groups I make money in my community My HIV status and my church Friends support in community I do not disclose my HIV status
Income barrier	I get support SSI- Public Assistance Friends provide assistance- transportation I quit my job No or low Income and no access to health care Income is a major barrier
HIV education	Provide more HIV Information Provide more HIV Education Having no, or lack of HIV Education is a barrier

The research protocol was selected as the tool and primary instrument that helped a participant answer each question. They were the questions based on and inquired about the AAW and their lived experience with HIV and health care and treatment. These questions were asked on site and in person, in a quiet and private setting for at least 35 minutes in a narrative story interview session. After this step, the responses from the interview questions and data were finalized and clustered into five of the major themes and were then generated by the codes.

The five major themes were seen as: stigma and discrimination, denial and depression, community and support, income and assistance, and HIV education.

Theme 1: Stigma-Barrier

According to the responses in table 3, stigma relative to HIV was frequently experienced by participants. The stigma was found to be a main barrier in the study and results. The stigma also followed some discrimination when a participant was seeking health care and treatment and by opening up and telling someone about their HIV status. This stigma was expressed and seen by almost every one of the ten African American women who were interviewed. In some cases, the transcripts showed how their experiences with the stigma was prior to their initial first doctor visit, and/or while being seen or tested for their HIV diagnosis.

Participant 1 told me about being stigmatized: “I was stigmatized and discriminated based on my diagnosis. And stigma discourages people as main reasons why people do not bother to return to see the doctor.” Participant 2 told me about being stigmatized:

> At one time there was a break where I did not bother to go back for treatment, because I was fed up with how the system and application process works, and another reason, because I felt no need to as I was feeling healthy and I was sick of being ridiculed and stigmatized.

Participant 3 told me about being stigmatized: “when you’re known to have *the thing*, there is the fear and conflict of stigma and mistrust when you seek or receive health care outside the black communities.” Participants 5 told me about being stigmatized: “stigma discourages people, especially who are of color, and stigma does not make them patient, and this makes people afraid to talk about HIV which discourages them from getting heath care, when they are dispirit and really need it.” Participant 7 told me about being stigmatized:

> The barriers that has made such an impact that I have faced is the one by being black and not being a citizen in this country, and the another barrier where I was stigmatized and discriminated like any other person who aren’t even African American, but black and not even living in the Boston area.

Participant 9 told me about being stigmatized: “stigma is ridiculing and discriminating and effects almost every black person with HIV, and HIV patients with stigma on top, is not fair for those who have the AIDS sickness, and people really desperately need the medication during AIDS.”

When looking at the stigma in percentages, eighty percent of the participants expressed some concern as to being discriminated by stigma at some place and time due to their HIV status or disclosure thereof (80%). The eighty percent of the participants who were interviewed also recalled in some way that sigma can be a major risk factor, especially if they disclose their HIV status, when and if they need urgent heath care, hospitalization, and/or medication (80%).

However, twenty percent of the participants recalled that when people do not know about how HIV is transferred, they worry they will catch it, and this is why they do not disclose their HIV status anymore (20%). Sixty percent of the participants recalled being stigmatized, after being tested and received ongoing health care right away, and they were happy they disclosed their HIV status out in the open (60%). The sixty percent recalled that when they found out, they did not want to get sick and come down with AIDS because they were afraid they would die without the proper health care and treatment and be stigmatized. However, seventy percent of the participants still experienced some barriers to health care and felt some form of stigma like any other person who is black, when living in the Boston area (70%).

Theme 2: Denial-Depression Barriers

According to the responses in table 3, denial and depression was highly experienced by several participants about their past experiences with HIV. The denial or depression was found to be a mid-level barrier to health care and treatment, for the HIV study. The participants who experienced the denial or depression barrier were shown to be aware and present in the results, when participants had to face the fact, the reality of being HIV positive. Participants 3 told me about her denial and depression:

> After I was tested I was in denial and depressed for more than 2 years and mad at my boyfriend for giving me HIV and being in denial made such a big impact on me that I had to make life changes and go on medication or I would die.

Participant 6 told me about her denial and depression barrier: “after testing positive I was very depressed and ashamed at myself and I was in denial for a long time, but managed to start treatment and care right away at Boston Medical Center.” Participant 8 told me about her denial and depression barrier: “When you’re told you have *the thing* or HIV, it changes your whole life and you need to make some changes very fast, and because of these fast changes, you live day by day.” Participant 10 told me about her denial and depression barrier:

> I was devastated and depressed when I found out about my HIV status and I was mad at my husband and in denial and I had to self-medication myself by using many illegal drugs, because I was very depressed and suicidal and could not live with myself or accept the answer about my health and coming up with AIDS.

When looking at the denial and depression barriers in percentages, sixty percent of the participants told me that they found out through a different source that their “other half” was sick (or died) and they should be tested (60%). The sixty percent of the participants told me in some way that after they found out they were HIV positive, they became depressed and started treatment within months and were stigmatized because it was HIV (60%). Eighty percent of the participants told me in some way that they were in denial and depressed and/or at some time, some had wanted to die (80%).

However, seventy percent of the participants told me in some way that they did not talk to anyone for a long time and were mad or in denial at their respective husband or boyfriend’s HIV status (70%). Sixty percent of the participants told me that they were so embarrassed and depressed that they would not disclose it to anybody except the Task Force (60%). However, forty percent of the participants told me at some time how health care is very important and very difficult with barriers, when you are black, especially when you are a depressed separated mother and live in this poverty area (40%).

Theme 3: Support Networks

According to the responses in table 3 for support networks, the participants told me about their HIV experiences in regard to their community and neighborhood and support networks. Participant 1 to me:

> My community and church members are my HIV support groups and my support organizations and a very important part of my life, and I wouldn’t feel right if other people beside them knew or found out about my HIV status in my city, because I may probably be discriminated and lose my friends and job.

Participant 2 told me about her support network:

> My pastor and church people and friends support me for the past 15 years, no matter what, and this HIV is something I don’t disclose to anyone or talk

> about, and this could have a big impact on my insurance and job, because health care is very hard to get, especially when you have HIV.

Participant 3 told me about her support network: “my church is located down the street and this is where I get my support, and my HIV status to my church and community is no surprise—I am open for advice for HIV treatment and counselling.” Participant 5 told me about her support network: “My church is very supportive because they don’t judge me for who I am by having HIV and my church members of my organizations and HIV support groups have been supportive by accepting me for disclosing.” Participant 8 told me about her support network:

> No one knows but my church pastor about my HIV status, and I attend the Grace of All Nature Baptist Church, which also has an AIDS support group with free health care for the black people and surrounding communities and neighborhoods, and anyone can go there and they won’t get turned away for HIV or AIDS help.

However, participant 9 and her support and community network is from the outer parts of Dorchester. She described herself as being very church-oriented and her church and pastor knows it, and there is not much support in their community, because she does not disclose her HIV status to anyone.

When looking at the participant support and community network in percentages, seventy percent of the participants expressed in some way that they do not receive any support, when they disclose their HIV status to anyone, because of the possible repercussions or consequences (70%). Thirty percent of the participants told me that their HIV status in their neighborhood is still no surprise, because when they found out they had HIV, they opened up and disclosed it by telling people right away (30%). The thirty percent told me that their friends and/or family are supportive in the community and they described them as family and/or sisters.

However, sixty percent of the participants told me that people are not supportive until they get involved and do functions such as AIDS walk, AIDS day in the world, church gatherings, and support group at the local churches (60%). The sixty percent of the participants also told me that this is another way how people know and find out that they are HIV positive, and that their community is the place where they work and make money. This is by walking the streets and selling sex to men for money-- sometimes without a condom (60%). However, to this day seventy percent of the participants get a lot of community and emotional support from friends either who have HIV or who are sick with AIDS (70%).

Theme 4: Financial Barriers

According to the responses in table 3, the participants told me about their HIV experiences and their financial barriers. Most of their experiences with the financial barriers were due by the stress and burden of having no money, while living with HIV. The financial barriers for public assistance and income, also showed and played some role to hinder or prevent the health care access and treatment, and was due to being black with HIV. The financial barrier was seen by the end results to act like the stigma barrier, but not as bad, when seeking health care and treatment due to their HIV status.

Participants 1 told me about her financial barriers:

> I have a part-time job as a HIV volunteer social worker, but I still get some get public assistance and emotional support and the transportation from my friends and HIV partners, and they help me with transportation sometimes to go to a doctor or HIV specialist appointment out of town.

Participant 3 told me about her financial barriers: “I do and don’t have close friends because of my past drug use, and I told my friends and family about my HIV condition and what I do for money, and they sometimes accept me.” Participant 4 told me about her financial barriers:

> My respective family is emotionally supportive and my boyfriend with HIV is supportive as well, by helping me with some financial burden and financial support, like health care transportation, which is a big problem, to and from a health care facility, when you have AIDS.

Participant 5 told me about her financial barrier: “I use public transportation and receive social security and sometimes work the streets for extra income, because I am disabled, and this is my financial barrier, which helps me keep a roof over her head.”

Participant 7 told me about her financial barrier:

> I have no income assistance and no health care insurance and I have experienced, not only the stigma barrier, but the financial burden and difficulty of getting health care, and because of my HIV status, I having given up and I can’t find a job.

Participant 10 told me about her financial barrier: “I have no health care coverage and I cannot get insurance and I still have to prepay, and I still can’t find a job, because I am too honest about my HIV diagnosis upfront.”

In regard to financial barriers in percentages, seventy percent of the participants told me that at one time they had to quit their job and were unemployed and had no income for a long time (70%). The other thirty percent remain employed with steady income (30%). Furthermore, sixty percent of the participants told me that they are on disability or public assistance program and have no car--and having no car adds to the stress (60%). Eighty percent of the participants told me in some way that their family or siblings are supportive and provide transportation and assistance and that they are all they got and part of the family (80%). In one case, eighty percent participants told me, if they lived on the outskirts of Boston, the emotional and community support they get would entirely be more difficult and different, and sigma would be higher in the white communities (80%).

However, ninety percent of the participants told me that they had family support (90%), while participant 1 told me: “my family don’t bother with me and they disowned me.” However, all sixty percent of the participants praised the women’s center and support groups that provide the assistance and transportation to their needs, which helps control some financial and income problems (60%).

Theme 5: HIV Education

According to the responses in table 3, all ten participants told me about their HIV experiences and how HIV awareness and education is clearly needed. Most of their experiences on HIV was to send out a word or advice to the future generations on what information and education, and measures the black community must take. All 10 participants told me at the end of each interview, how they contracted HIV and that more information and education on HIV is needed (100%).

Participant 1 told me about HIV education: “be patient, things will come your way; it’s a good thing we have some HIV education, because it’s a package that definitely is needed for people living as a disparity, especially with HIV.” Participant 2 told me about HIV education:

> People should have been more informed back in the 80’s and we need to be more educated and informed on how HIV is spread, and if my daughter knew she was HIV, she may have gotten the treatment and help instead of dying at 20, and people need to be more educated and informed on how HIV is transform and spread.

Participant 3 told me about HIV education: “to eliminate HIV and other STD disease, we need to all work together, no matter what color you are to prevent health disparities for the black communities and educate the black people.” Participant 4 told me about HIV education:

> We need more education about HIV and more education on how it is contracted and spread, not just for our black communities, but for the white communities as well, and we need to educate today’s black and white communities, about drug use and not ignore it.

Participant 5 told me:

> You need to eliminate HIV, because it is getting worse on young people, real young, and the younger are getting it, and this is not their fault, because many black women in this area are dispirit and eager to meet older men, who are HIV positive and offer to buy them stuff and prey on them like a sugar daddy.

Participant 6 told me about HIV education: “more support is needed and more information on HIV needs to be available for the public in the black and white communities and neighborhoods.” Participant 7 told me: “HIV education is the best advice to receive, because I don’t know anyone in the health care system, who can get what they want, because it’s all about politics and who you know today.” Participant 8 told me: “I think that we need more information on the internet about AIDS, and we should be made more available to educate people and our kids.” Participant 9 told me about HIV education:

> We need to provide more local help for the young people, who are not educated about drug use, and we need to get people off the streets, and we need to help them with drug addiction, and educate them, by first giving them a roof, and most of all, care for them— because no one is going to do it but us.

Participant 10 told me about HIV education: “we should look at ourselves first and not only educate people about who they are, but about their color.” All 10 participants, told me in some way in the last open question, HIV education and information is what we need in the sense of the black communities for the people who are poor and living in poverty with HIV (100%).

Data Verification

After each individual interview was completed, the process for transcribing and analyzing the data took place for each verification: The information and data for this research study were verified by peer review, member checks, and researcher bias. This is by the description that has been demonstrated with the use of direct quotes by each transcribed interview. This was done to help provide support by the expressions that were listed by each group description. This follows on the section of evidence of trustworthiness that is credibility, reliability, transferability, dependability, and confirmability.

Evidence of Trustworthiness

At the beginning of each interview, each participant was given a true copy of the consent form that I signed for the participant to look over and sign to. Each interview consent form also came with a participant letter that had a welcome and introductory statement that introduced myself and why the research was important and why it needs to be done.

At the very end of the participant letter was the consideration in the amount of $35.00 cash which was paid to each participant at the end of the interview. However, after each individual interview, each participant was asked in some way to look over and review her transcript and to contact me if she felt her transcript required corrections or changes. This was also the information about myself, who provided a contact number for questions about corrections or changes of the study.

At the end of the interview, each participant was provided with a copy of the transcripts that were made on site by the office copier after each interview. Each participant was treated with empathy and respect. This was the trust and openness that was slowly developed between each participant and the researcher, by being honest, open, and upfront. This openness was shown during the introduction of the study and before and after each interview, and provided them with important information about myself and dissertation background. This is the background that showed some sincere interest in the African American culture who experienced the HIV stigma and discrimination in the health care system, during interviewing and data collection.

Next, the data collection was transcribed at my home during the first 48-hour period after each interview. In one case, most of the data collected and transcribed were shown to be very significant and accurate--except for some hesitation or blank areas. This might have been where a participant was telling her personal story, was embarrassed, or was just trying to open up and share thoughts about her past HIV experience. In other cases, certain phrases (e.g., foul and obscene language), about their boyfriends or husbands, who gave them HIV, were eliminated from transcripts to help improve the readability and credibility of each transcript and the process.

Credibility

For the study, I used the narrative interview protocol as the instrument. This instrument helped assist and guide myself to ask identical questions to each participant for same or similar credibility of data (Appendix E). The observations of each participant's experiences were captured in the data, along with how being a black or an African American with HIV either hindered or denied health care coverage due to HIV illness. This is the data collected by the 35-minute face-to-face interview sessions and the field notes in a quiet and private setting. Furthermore, taking field notes helped myself to benefit and enhance each interview and allow more accurate, believable and dialogue to the end of the interview process. Therefore, the information and data collected during the interviews were reviewed several times for accuracy and because all participants were asked the same identical questions.

Reliability

The reliability of data for this study was enhanced by quality of the data collection, when gathered and collected from each individual transcript, during participant interviews and data collection. This included the 10 open-ended questions, recording, transcribing, and data collection process directed to 10 AAW participants. These open-ended questions helped guide myself at a slow pace, by providing an opportunity to collect data face to face about each participant's experiences with HIV and health care access.

Transferability

Transferability of the data relates to the social stigma associated with having the disease and the shared experience of the participants. Readers of this research may be able to draw upon the participants lived experience in that of their own. These experiences were captured through a systematic data collection process. This process was repeated multiple times for accuracy. In each case, each participant had shared their loved experience regarding social stigma during their conversation and interview, when each asked the same 10 question about HIV and health care access.

Each of the participants participated in a face-to-face interview to include discussion about their community to break the ice before delving into the sensitive nature of the interview questions. This was the one-on-one conversation for the six participants who were interviewed at the Dorchester Community Women's Health Center, which is located in Dorchester, Massachusetts. However, the other four participants were interviewed in a local restaurant of their choice, with some one-on-one conversation about the HIV topic. Furthermore, I was the only researcher who gathered the important field notes and information and data collection from the interviews. Each face-to-face interview lasted 35 minutes in length over the four-week period.

Dependability

As the researcher, I constantly rechecked the data collection and transcripts for accuracy and quality to increase the dependability. I also provided an opportunity for each participant during the interview, to ask any questions before and after we started. I explained and reviewed the consent form to each participant prior to the interview process, by letting them know they could stop at any time--with full compensation. During the interview process, each participant was asked the same 10 questions using the same protocol and interview guide.

Confirmability

There were several techniques and strategies used to enhance the confirmability. First, I documented each interview procedures by checking and rechecking the data throughout the study. Second, I actively searched for negative instances, phases, and themes that may have contradicted prior participant observations. Last, I reexamined the data collection and data analysis procedures and made a judgement on the potential for bias and distortion. In addition, several field notes that were taken were re-read and compared, and adjustments and modifications were made for consistency and confirmability as needed. At the end, each transcribed interview was compared to the recording data and were mailed to each participant to review and for their feedback.

Results

Research Question 1

In addressing the first research question, about what are the economic and environmental risk factors associated with African American women with HIV.

Answer: The economic factor of low income, and environmental risk factors associated with the AAW, were found to highly enhance the spread of HIV. This association was seen by their vulnerable behavior between the distribution of injecting drug abusers and young people forced into commercial sex work. Other economic factors were seen in the middle age group, who experienced social stigma, being of single parent status, do not meet requirements for public assistance, and living arrangements by a shelter residence in a depressed community.

These living arrangements are dangerous risk factors and risk behavior indicators. They showed a relationship of this specific vulnerable sub-group and population for a higher rate of HIV transmission. However, most of the data collected showed how being stigmatized within their surrounding environment played some role as a significant risk factor. The data analysis showed higher economic hardship and vulnerable, risky behavior as the main economic factors, in their neighborhood environment which highly contributes to such behavior on its complications and consequences with stigma.

Subquestion 1: How do these risk factors influence overall health status?

Answer: Social determinants and risk factors can have a big influence on someone’s overall health status, especially when she is an African American woman and living with a health disparity. Such risk factors can have an influence upon many inequalities in today’s health care structure. This is seen as— who or what squeaky wheel gets the oil. However, looking at these inequalities or disparities in people living with HIV or AIDS can mean a difference.

Subquestion 2: How do these risk factors influence access to health care services?

Answer: Such differences by these risk factors can have an impact on someone’s economic hardship and access to health care services. Being an African American or black woman, and having very little education about HIV transmission is seen as a major risk factor. In many cases, employment, income, community and family support are all major risk factors that can easily influence a participant’s health care status. These factors may become some of the determinants which, in turn, can have had an influence on whether or not someone qualified for any health care or treatment for HIV.

Research Question 2

In addressing the second research question, the goal was to find out how African American women with HIV/AIDS compensate for barriers to treatment and community resources.

Answer: African American women who are infected with HIV may be not as fortunate to have access to the best health care or resources available to them. This may be due to the stigma and economic hardship. Someone who may be black and HIV positive may have access to fewer financial resources and health care resources in the community. From the information that was collected and analyzed, social stigma, unemployment, poverty, and lack of HIV education and HIV information, were shown to be barriers among the growing HIV problem of the African American women interviewed.

These barriers not only affected the black communities, but the city’s poor neighborhoods as well. This has made it hard to compensate for their poor health status and conditions, while being in denial or depressed. These barriers are known to prevent someone from a fair shot at health care for HIV prevention or treatment. However, while the vulnerable and risky sexual behaviors have been shown to play a role in the spread of HIV, their model of behaviors of irresponsibility have created and added to this over time. Within time, this action has created a feedback loop on urban poverty in surrounding black communities. This is a loop that has made it dangerous and fatal— a vicious, never ending cycle. This is seen as a repeating cycle of the participants’ risky sexual behavior and their risky partners.

Subquestion 1: What measures do the AAW use to deal with the stigma associated with the diagnosis of HIV/AIDS?

Answer: From the data collected, fear of AIDS stigma and denial and depression, can indefinitely harm many lives of the African American. In the past, African American women who dealt with some HIV-related social stigma and some discrimination, had a negative impact on their self-esteem—once their status was known and disclosed. AAW, who had experienced some form of social stigma by a professional, got some social support by friends and family and felt less perceived of the HIV stigma. Other AAW perceived higher HIV stigma because of their drug abuse and prostitution and sexual activity. This included more stigma when showing current symptoms of major depression and denial, after seeing and telling their doctor what they do.

In some cases, HIV-positive participants seem to manage certain measures of social stigma to some extent by their social resources. Some social resources were by close friends, family, or others, who provided emotional support to the African American women, already with HIV. This in turn helped to increase their self-esteem and self-confidence. Therefore, the emotional support question was very important because this had an effect on how the individual felt the impact and burden thus associated.

Subquestion 2: How do these measures enable the AAW with HIV/AIDS to overcome or adapt to the risk factors associated with vulnerable populations?

Answer: Overcoming vulnerability involves race and poverty as well as the related issues of discrimination and social stigma. These social factors are highly and indefinitely related to lack of HIV education and HIV information and low income. This is the relation between someone’s early years and often over their life course. This relation was found to be more common among black than white Americans. Such factors today may have interacted in complex ways. Therefore, the low social status and early developmental experiences have very much contributed to a poor future for this vulnerable population living with HIV. However, an understanding was based on these underlying sources by how vulnerability may be critical. This was from the results of study that showed AAW, who are HIV positive. This was by a population, who are more vulnerable on mistrust, and who are strictly limited in terms of good health care quality.

To overcome or adapt to the risk factors and problems, more availability to insurance programs, like Medicare and Medicaid, and public assistance programs need to be made available to this population and group. Furthermore, work-study programs for single mothers should be made available to help with income. This is mostly where people with HIV do not carry any insurance, as this will help insure a disproportionate share of this vulnerable population. This action should continue right away and support and leadership in the development on the health care quality and measures. This action will help assess the health care delivered, to the African American population who live with HIV.

Chapter 4 Summary

Chapter four ends by providing the final results and information in regards to the 10 participants who are AAW and who shared their experiences and stories with HIV. They are of a special minority group who experienced social stigma and barriers in the health care system because of their race and diagnosis. This chapter provided the data collection and development into the five major themes and codes. The themes and codes that emerged by the end results were: stigma and discrimination, denial and depression, community and support, income and assistance, and HIV education and HIV information.

The results on the first research question and subquestions were related to economic and environmental risk factors associated with AAW with HIV. The results to the second research question and subquestions were related to how AAW with HIV compensated for barriers to treatment and community resources. The answers to both questions were answered and generalized by the data analysis.

The answer to the first research question suggested that participants had low or no income and little to no HIV education and little to no HIV information about HIV. Their vulnerable behavior ranged between the injecting drug users and young people forced into commercial sex work. These are dangerous risk factors and risk behavior indicators. This showed a relationship of the vulnerable sub-group for a higher rate of HIV transmission.

The answer and results to the second research question suggested that participants who are infected with HIV might be not as fortunate to have access to the best health care or resources available due to the social stigma barrier. Because of being black and HIV positive, fewer financial resources and health care resources are available. In addition, social stigma has made it hard to compensate for their poor health status and conditions. Stigma and depression has prevented some from accessing health care for HIV prevention or treatment.

Chapter 5 provides a discussion of the interpretations of the key findings and limitations of the study. They are followed by the recommendations for further research and implications for positive social change and a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this narrative research study was to explore and to have a better understanding about the experiences of 10 AAW who live with HIV and received health care access and treatment. They are women who took place in my research study by each participating in an interview about their past experience with HIV. They are seen as women of a protected race and minority who are seen less fortunate to available resources, while living with HIV. The study was based on the narrative approach and qualitative data that were obtained by the 10 women participants who fit the criterion of the African American race and culture. The data collected on site for this study were by face-to-face interviews and were analyzed by the final steps and process with Nvivo10 software by the coding and theme formation.

Key Findings

During the research and interview process a protocol was the tool and instrument that I designed to help gather the data by the 10 participants. The protocol also helped guide myself to answer the research questions where five of the themes and phrases emerged upon development. These themes were finally analyzed by the Nvivo10 software as: stigma and discrimination, denial and depression, community and support, income and assistance, and HIV information and education.

Interpretation of Findings

Advancing Knowledge

The current results of the narrative research study provided new knowledge and insight which helped address the research questions of 10 participants who are AAW with HIV. They are seen as the new generation of women with new past experiences and new knowledge about heath care for HIV treatment. However, the information by transcripts found how several participants may have survived without income and HIV education and HIV information, with very much stigma within their community.

Therefore, the narrative story interviews helped address and answer the research questions on the past and present living conditions for this vulnerable group and population living with HIV. This vulnerable group and population with HIV are seen as middle age older generation of AAW who still struggle till this day, with stigma by their illness and treatment. These facts were proved and provided by the narrative research, literature, and themes, how stigma is still present till this day in the health care system. This literature was analyzed and expressed into themes and phrases from Nvivo10 software for the end results and confirmed findings.

Confirmed Findings

The interpretations and confirmed findings from the narrative interviews were found to provide new knowledge and insight from the results by each participant. This is the new knowledge and insight that helped answer the research questions addressed during each interview. However, in almost every interview, social stigma and discrimination was confirmed and shown as the main barrier. This social stigma barrier prevented or hindered the fair access to health care, either by living poor or in poverty and in unhealthy conditions with HIV. This social stigma was shown as the overall barrier and the theme that was repeated constantly by the transcripts and data analyses. However, some studies, when reviewing the peer-reviewed literature, found some similarity of topics and comparisons on social stigma and discrimination.

In one study relevant to social stigma and discrimination relative to African Americans, observed a higher social stigma than whites. According to Malebranche (2005), African Americans are less likely to receive medications for HIV and AIDS and are more likely to suffer disproportionately from high rates of HIV-related morbidity and mortality than whites.

In another case, a study showed a dramatic decrease in opportunistic diseases and deaths among Whites with HIV and a dramatic increase in these events were observed among African Americans during the same period between 1991 and 2001 (Cargill, Robinson, & Stone, 2014). However, despite the availability and proved efficacy of current AIDS medication, the study expressed how many African Americans with HIV did not receive regular health care treatment, including highly active antiretroviral therapy and drugs (Cargill, et al., 2014). According to Cargill, et al., (2014), many have claimed that this distrust stems from a history of racism and discriminatory health care and medical research practices, including experimentation, involuntary sterilization, and unethical and lawful practices. Furthermore, the study expressed a concern how many have believed that the intergenerational transmission of medical care mistrust among African Americans with HIV while seeking health care access, has led to the formation of conspiracy theories regarding HIV infection and treatment. Therefore, these attitudes of the African American culture, become today’s formidable social stigma barrier, when engaging African American women with HIV the prevention and medical health care.

In another study that was relevant to social stigma and discrimination, Neuman, Obermeyer, Cherutich, Desclaux, Hardon, Ky-Zerbo, Namakhoma, and Wanyenz, (2013), argued that HIV/AIDS-related social stigma is a persistent force that discouraging those at risk of infection from HIV testing, and creates barriers to HIV-related care and support. However, the study was shown to agree that social stigma and discrimination is a product of social power structures that will always exist at multiple levels, within the Black community. According to Neuman, et al., (2013), stigma affects multiple domains of an individual’s life, including home life, employment, and health care.

The study expressed how discrimination and social stigma could act on an individual’s wellbeing, by increasing one’s vulnerability to harmful, discriminatory behavior and feelings of low self-worth. While many studies have investigated the prevalence of HIV-related stigma or discrimination, broadly defined, fewer studies differentiate between internalized feelings of self-worth (Neuman, et al., 2013).

Much of the research in the study showed and indicates that factors such as provider mistrust and the perception of racism and discrimination in health care settings play a significant role in medical care by HIV-positive African American patients. According to the CDC (2015), the number of women diagnosed with HIV has remained stable in recent years, but black women are 18 times likely to be diagnosed with the disease than white women, and five times than Latinas. This study confirmed how the

African American community has long looked to the Church as a central resource for information on many issues, including healthcare or mental illness.

In the last study stigma and African Americans with mental illness confirmed that stigma compounds problems faced by those with mental disorders and leads to strained relationships, depression, social exclusion, low self-esteem, and poorer health outcomes (Egbe, 2015). According to Egbe (2015), past studies have shown that social stigma has led to many people refusing to seek help for themselves or their relatives and friends who are suffering from mental illness (Egbe, 2015).

Conceptual Framework

For this study, I used the VPM for the conceptual framework. The VPM was the appropriate model and conceptual framework that helped meet the goals upon exploring the past experiences of the African American culture. For this narrative strategy and qualitative research design, the Flaskerud and Winslow’s VPM was a highly suitable conceptual framework for observations on this race and culture. According to Flaskerud and Winslow (1998) the VPM is appropriate because it has special components which focuses attention on an array of the special words and characteristics of African American race and culture. These are the special components are such as children, ethnic minorities, people of color, gay men and lesbians, homeless persons, and elder persons.

Other special components that the VPM focuses on relate to HIV and health care in some other way. The special components are: (a) socioeconomic status and resources, (b) environmental status, (c) relative risk of activity, (d) lifestyles, and health choices, (f) disease onset, and (g) HIV or diabetes, morbidity, centered on one’s vulnerability (Flaskerud & Winslow, 1998).

Behavioral Beliefs

Several of the participants who were interviewed believe that silence and social stigma of HIV in their community, will always remain the most significant and main barrier to HIV prevention, testing, and treatment. However, the participants believed that it was their responsibility to talk to people on how to educate and protect themselves from contracting HIV. This was by talking about their past and present behavior and beliefs, and by their church and community, about what to do when they are tested and diagnosed.

Normative Beliefs

For several participants, a question about their normative beliefs and family support was asked and few did not want to answer or talk to about it. This question was about their loved ones and their family who found out about their positive HIV status. However, a few participants believed that their friends with HIV were supportive enough and would always be there for them. In other cases, most participants believed that their local community church and pastor was their savior, support, and lifeline.

Control Beliefs

Several of the other participants seemed to have control of their lives and most were certain where their respective lives were heading. Almost all the participants interviewed, had some kind of positive attitude in some way about HIV, as they took charge and control of having this disease for life.

Conceptual Considerations

Based by the previous conceptual applications from the VPM and previous and past research studies, the Flaskerud and Winslow's conceptual model for vulnerable populations—such as African American women--helped guide new meaning and development for people living with HIV. According to Flaskerud and Winslow (1998), vulnerable groups such as African American women have limited resources, and are at higher risk for disease—such as HIV and AIDS therefrom. These vulnerable groups typically included ethnic minorities, people of color, immigrants, lesbians, the homeless, and the elderly.

However, based on the end results and findings from the research study there were many other barriers found to either hinder or prevent obtaining health care, which may seem out of the reach of the African American communities.

Methodology

For this research study, the narrative research approach was selected and used. This approach was selected because it first determines if the research problem or questions best fit the narrative research and qualitative topic. According to Creswell (2013), narrative research is best for capturing the detailed stories or life experiences of a single life or the lives of a small number of individuals. Another reason for this selection, because individuals with stories and life experiences spent considerable time with them gathering their stories by multiple methods. Creswell (2013), refer to the narrative stories as “field texts.” because, research participants may have recorded their narrative stories in a journal or diary, or the researcher might have observed the individuals and recorded field notes. After examining the sources, the researcher collects certain data about the specific context of these narrative stories about their personal experiences, their culture (racial or ethnic), and their historical contexts, and time and place (Creswell, 2013).

For this, the narrative research strategy and inquiry was determined to be the appropriate approach for this qualitative research study, because it facilitated the questions that were in-depth with 10 African American women participants who live with HIV.

Limitations of the Study

The qualitative research study had several limitations. One limitation may have been where the questions asked at interview, had limits on how far to push a participant to answer the questions—such as information that was too confidential or very personal.

Another limitation may have been where words or feedback were limited where mistrust might have been created during the interviews. If this was the case, this could have been improved by an additional follow-up interview, with some one-on-one discussion, or a follow-up phone call to each participant. This follow-up would have been to talk via telephone and to meet for a second interview in person, or over the phone for additional compensation.

One last limitation may have been by a participant’s credible feedback and interview information. This was where she was rushed to speak because of business elsewhere, someone waiting outside, or complications of personal issues that may have diminished her full thinking capacity at the time. However, the study had no limitation on the recruitment due to the use of snowball sampling.

Recommendations

To make further recommendations and deal with these challenges on social change, the older generation of AAW needs to educate their younger generation, about HIV education, HIV information, and prevention strategies. This is the HIV education engaged with both the black woman and her steady sexual partners in their local neighborhood or community. According to El-Bassel, Caldeira, Ruglass, and Gilbert, (2009), African American women are more likely to become infected with HIV by a steady sexual partner, who less likely uses a condom, when they are in relationships within their own community.

In addition, HIV education and HIV information was another one of the biggest findings in this qualitative research study. This was about taking the steps to make these changes and by learning how to mutually protect and support and communicate with each other. HIV education and HIV information prevention is the tool that the African American race and culture must use for social change. This social change will help educate today's youths and help correct the miss-educated, among our black population in the black community.

Implications

Social Change

The research in the past about the AAW with HIV, shown to be disadvantaged and disproportionately affected for health care by the AIDS epidemic. This is by receiving health care or insurance coverage that may have been unavailable to so many poor black women. Today, progress is being made for health care and insurance coverage available for everyone for today’s preventive services, and for many subcultures and people with HIV or other disease. El-Bassel et al., (2009), stated how the progress of the past 35 years of cumulative AIDS research and demonstrated how these challenges on behavioral and precautious interventions may have helped curb HIV risks. Therefore—social change must still and always be our number one goal and priority.

Therefore, to make a difference and an impact on social change in the African American community, we must first ask the questions about these alarming discrepancies. First, what has been driving this high quantity and population of the HIV epidemic among many young and older generations of AAW to become today’s health disparity? Second, what were the unique prevention challenges these women faced or future generation’s children face? And third, how well may these available prevention and challenged strategies be considered on the everyday realities in these lives of women who are African American and who are infected without sufficient health care access or treatment?

Vulnerable Population Model and Methodological Implications

The VPM was the appropriate model and conceptual framework to adopt when collecting data by 10 individual interviews about past experiences and implications for health care access while living with HIV. The VPM was appropriate and suitable conceptual framework for the study because, it helped focus on attention of many of the characteristics of AAW and other races and cultures with HIV.

In other cases, certain implications and constructs found the VPM very appropriate, because it effectively provided new meaning and insight and the structure of the logic by its conceptual framework. Other reasons were because it helps investigate and utilize with its conceptual framework the women and children, ethnic and minorities, people of color, gay men and lesbians, immigrants, homeless persons, and elder persons.

This is the right framework that was needed to gain the answers behind the research questions and to better understanding the participant's and their past experiences who live with HIV and seek health care access.

Chapter 5 Conclusions

In conclusion, the qualitative research study brought new meaning which helped address the issues that AAW still face, while they live and experience the barriers between HIV and health care access. Second, the study brought new meaning by showing more ways for people with HIV to seek HIV health care and treatment and follow up on HIV education and HIV information and prevention programs. They are results and findings geared toward creating an opportunity upon improving positive social change for the AAW and their infected partners.

And last, the study sought out the most valuable information of a sub group and race, who have suffered serious consequence or struggled with the barriers due to HIV. They were found to be the barriers that hindered and still hinder those with HIV and AIDS from obtaining the full array of health care. This is the array of health care from HIV education and treatment, to hospitalization within some time and period, and where the health care system seemed very fragile in today's world. This is the world that will make a difference to human and social conditions by bringing positive social change in today's health care and society.

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Appendix A: Letter of Collaboration

Name: Date:

Organization:

Address:

Re: Recruit Participant for Interview

Dear (Name of person in charge),

My name is Robert Petralia and I am a doctoral student at Walden University. I am conducting my dissertation research on a small population of African American women, who live as HIV positive.

At the moment, I am in the process of recruiting participants, who may be familiar with the subject of being HIV positive for an interview. I am interested in interviewing women who are African American who are HIV positive, and who may have experienced the barriers to health care access and medical opportunities, due to this disease, because of their race or color.

As we know, there have been a vast number of research studies in the past which detailed how someone's race can create barriers to health care. These barriers may have some effect by being African American, or from a race or culture of color. Because of this, I feel that I need to address the gap and links which created the barriers which may have hindered, a woman who is African American, of seeking the available health care in their community.

If you and your organization is willing to cooperate, it would be very helpful if you would help me identify these participants, who may be associated with your organization. They should be willing and available to spend at between 30 and 45 minutes being interviewed, either face to face, or by Skype internet, and to talk about their experiences as being HIV positive.

Once you have identified participants, I would like to meet with them to discuss the process, steps, and nature of the study. With respect upon your permission and organization, I would recommend at least 6-7 participants upon going forward with this interview and research. One again, the participants should be women who are African American and diagnosed as being HIV positive.

(Continued)

The participants are at no risk and may be more than free to choose whether or not to participate at their own will. They may choose at any time during, before, and after, to discontinue their participation. Information that is collected and provided at the interview by the participants, will strictly be kept private and confidential.

As my chair person, Dr. Kimberly Dixson-Lawson, at Walden University has requested and recommended, it would be to best and beneficial, if you would sign below and agree to participate in this study. This is to help me recruit the participants and go forward with the delicate and important information, and help our future African American culture, find the gaps and improve our health care system.

You may contact Dr. Kimberly Dixson-Lawson, At Walden University anytime for any questions regarding this study at Kimberly.Dixon-Lawson@waldenu.edu

Furthermore, I would be more than happy to welcome a telephone call from you to further discuss any questions and concerns you may have about the interview and about your role on identifying the participants. I can be reached at XXX

Thank you,
Sincerely,

Robert Petralia
Doctoral Student and Candidate
Walden University

Contact information:
Robert Petralia,

Date: ________________________________

Print Name: ____________________________

Sign Name: ____________________________

Organization representing: ____

Address: ____

Appendix B: Letter to Participants

Date:

Name of Participant:

Address:

Dear (Name of Participant),

My name is Robert Petralia, a doctoral student at Walden University.

I am in the process of conducting my dissertation and research on how some African American women received health care while being HIV positive.

As we may know in the past, there have been several studies that detail the negative effects by being HIV positive, and this may prevent someone a fair opportunity to seek the proper health care and treatment.

I am very confident that my research will provide new leads and insight for finding the gaps and links, and ways to receive the treatment in the future that our kids deserve from the health care system.

I realize that your time is very valuable and important to you. Therefore, I do appreciate your consideration by participating in a narrative face to face interview. The results and important information, by your story and experiences, will definitely help me fulfill my understanding. This understanding, on your experience, on what it was like over the years being HIV positive.

Therefore, I would like to meet with you on a separate occasion for about 45 minutes. You may choose to hold this interview at any location you wish and you will not be required to do, or say anything you may not feel comfortable about. This meeting would be simply designed to get to know you, and listen and learn about your experiences. All information which will be gathered at our interview is strictly kept confidential.

I would appreciate if you would contact me at your earliest convenience. We can schedule a time and date to set something up to meet. Please feel free to email me at Robert.Petralia@waldenu.edu. I will wait and look forward and more than happy to hear from you.

Robert S. Petralia,
Doctoral Student at Walden University

Appendix C: Consent Form

Date:

Dear Participant:

You have been invited to participate in a research study as someone who has experiences living with HIV and someone who meets the participant criteria. To participate, you must meet the following criteria: women who are of African American descent, aged 21 and older, be HIV positive, and live within a 50-mile radius of Boston Massachusetts area. To participate, you will be asked to voluntarily or willingly talk about your experiences of living with HIV.

You may share your story or experiences, in a 35 to 45-minute interview, as someone, who may have experienced any different opportunities, or someone who may have experienced any disadvantages of the health care system. Your story or experiences, may be something that you experienced, about health care access, transportation, social economics, or the health care system, in regards to your HIV experience.

Therefore, you are more than welcomed, and invited to participate in this research study and interview. You are invited because the information you provide, may help examine the race and culture of African American women and their experiences with HIV. The information by your interview, will be beneficial on finding the barriers and closing the gaps, in the health care system. The research and information you provide, will be very beneficial and shed light on other races and cultures, who live with HIV and AIDS as well.

You may still participate if you feel you cannot sign this informed consent form and you may still proceed in the interview and answer the questions. Therefore, you must read this consent form and carefully ask any questions before accepting this this interview invitation and be comfortable with this research study. The study is being conducted by Robert Petralia, Doctoral Student at Walden University. The participant will receive a true copy of this form by the researcher.

Background Information:

The main purpose for this study is to have a better understanding of your experience as an African American woman who is HIV positive, who may have experience the barriers and milestones, while seeking health care and treatment because of their race**.**

(Continued)

Interview and Procedures:

You may agree to respectfully participate in the interview and be informed to proceed in a narrative interview at your own location preferred at your own choice. This interview would last approximately 35-45 minutes in length.

Voluntary Participant and Nature of the Study:

I Robert S. Petralia, is the researcher, who will respect your corporation and participation in the interview and this decision must be strictly voluntary. This may be on your own decision as to whether or not to fully cooperate and participate at any time. This is strictly voluntary and this will not have any effect on your future or current relations with Walden University or with your health status. However, if for any reason you presently decide to initially participate, you can withdraw at any time later without penalty or consequence, and still be compensated with 35.00, and withdrawing will not affect any relationships.

For this research study and participant interview there are no risks, which are associated for contributing and participating when being interviewed. Therefore, only the potential and benefit for participating can help and contribute by some form, and provide more inclusive health care support services, for our future loved one's who live with HIV.

In concern with participants upon any event, you may experience some anxiety or stress while and during your interview participation, you may choose at any time to terminate your full participation, and receive full compensation, within any time or moment of the interview. Therefore, you can refuse or not attempt to answer upon any personal questions that you may consider answering, by being stressful or invasive to your privacy.

Compensation:

The form of compensation for an approximately 35-45-minute interview is $35.00 for participation in the study interview.

Confidentiality:

The following results and outcome records for this interview study will and must be kept confidential and private. Within reason, any report and information from this study which may be published, the researcher with respect of the participants, will never include any information that can make it possible in any way to ever identify a participant. Therefore, any research and records from the study and interview, must be kept locked in a file cabinet. Furthermore, the only one to have access to this information will be me, who is the researcher.

(Continued)

The interview will be audio recorded for the purpose to provide the accurate description of your experiences. In the future, these records or audiotapes will be shredded or destroyed upon the interview completion, within one year.

Questions and Contacts:

I Robert S. Petralia will be conducting this interview and study. My chair person is Dr. Kimberly Lawson. If you have questions now or later, you can contact a representative at: irb@walden.edu

The participant will receive a true copy of this form by me.

Statement of Participant Consent:

I am a participant who will be voluntarily interviewed by Robert S. Petralia, who is the interviewer and the researcher. I have read all of the above information. I have and still may asked questions before, during, and after the interview, and receive answers, while and during the process.

I the participant, voluntary consent to be interviewed and audio recorded and participate in this research study.

Name Printed of the Participant

____

Signature   Date of Interview

____   ______________

Signature from Interviewer   Date of Interview

_______________________________________   ______________

Approval # is 11-16-15-0229933

Interview Protocol

An Examination of African American Women with HIV and Health Care Barriers

Date: ____________________________

Location of Interview: _____________________________

Name of Interviewer: ______________________________

Name of Interviewee: ______________________________

Age: ____________

Gender: _________________

Education: _______________

Marital status: ____________

Opening Statement

My name is Robert Petralia and I am from the Walden University. At this time, I am working on my research which is part of my dissertation. The research concerns the topic of the African American women, who live in local and surrounding communities of the Boston area.

This research will help find new answers and alternatives to improve health access in many areas for the Black women and African American culture and the people of a different race of color.

Therefore, I am very interested in the African American culture and Black women who live with HIV/AIDS. Other interests to my topic are African American women who may have experienced the stigma or fear because of their race or color.

The form of compensation for the approximately 45-minute interview is $35.00 for participation in the study interview. Your knowledge and your experiences will be very helpful and appreciated, and very valuable on making a difference for creating positive social change. This is also the opportunity to make a difference and improve the fundamentals within the human and social conditions that effects positive social change in the health care system.

(Continued)

Interview Questions

1) Can you please tell me something about yourself and the community where you live as it pertains to your HIV status?
2) How long have you known about your status and where did you get tested? What led to your decision to be tested?
3) After testing positive, how long did it take before you started to receive ongoing care?
4) Please describe any barriers or obstacles in obtaining treatment? Of these barriers, which one had the most impact?
5) From your experience, do you feel obtaining access to healthcare is more difficult as an African-American woman? If so, why?
6) Did you feel comfortable notifying friends, family, and partners about your status? Where they supportive? Are they willing to provide assistance with emotional support, visits to the doctor, and/or transportation?
7) Have you ever been stigmatized due to your diagnosis? From your experience, do you believe the stigma to be worse due to being an African American Woman?
8) What support do you wish were available to you that you are not currently not receiving either from the healthcare providers or family/friends?
9) Please tell me from your own opinion, what can and should be done to eliminate health disparities among many African American women living with HIV/AIDS.

Is there anything else you would like to add to what we have discuss?

(Continued)

Research Primary and Secondary Questions

Below are the primary and secondary (sub-questions) that will be asked during the interview process with a narrative approach. Other questions may emerge beyond the study that may lead to information on the African American women (AAW) who may have experienced being turned away, or denied, while living with HIV, or the fear and stigma of being marked base on color, as having AIDS.

The purpose and main focus of the study would also help identify and address the gaps and links that are associated with barriers for the AAW who are diagnosed with HIV/AIDS. The questions follow the purpose and design of the study which will help identify and address the gaps and links that may be associated with the AAW and health disparities living with HIV/AIDS, or stigma.

Questions:

RQ1—: What are the economic and environmental risk factors associated with African American women with HIV/AIDS?

Subquestion: How do these risk factors influence overall health status?

Subquestion: How do these risk factors influence access to health care services?

RQ2—: How do African American women with HIV/AIDS compensate for barriers to treatment and community resources?

Subquestion: What measures do the African American women use to deal with the stigma associated with the diagnosis of HIV/AIDS?

Subquestion: How do these measures enable the African American women with HIV/AIDS to overcome or adapt to the risk factors associated with vulnerable populations

Approval # is 11-16-15-0229933

Appendix D: Procedure for Participant Selection, Recruitment, and Size

The purpose of this qualitative study is to identify the experiences of the African American women who live the experience with HIV. By selecting a small sample of 10 African American women who meet the HIV positive criteria and by interviewing them one on one individually would help identify and address the gaps and barriers on health care access, and who are noticed as a health disparity in society. Participants are at no risk to be interviewed and may sign a consent form at the beginning.

Participants Selection

The participants were selected according to of their HIV status and who meet the sampling criteria. Participant selection began after Institutional Review Board approval (# is 11-16-15-0229933). The participants are African American women and may be seen as being vulnerable because they are living with HIV and/or who are from a protected race or minority group.

By using the snowball and cluster sampling methods helped narrow down the important participant sampling characteristics and sampling criteria. This criterion is a list of elements from the characteristics that I was determined beforehand as being essential to the study, and who may be eligible to be part of the recruited sample and study. In this case, the snowball and cluster sampling methods were highly suitable and recommended to recruit a small sample of 10 participants from the small rural areas within the black communities.

Participants Recruitment

The methods for recruitment will be done by providing fliers, advertisements, and referrals for recruiting participants for an interview. An interview s will be by narrative design and face-to-face which will last approximately 45 minutes with informed consent.

Sample Size

The sample size coincided for the 10 women are African American women who matched the criteria and the topic about being HIV positive. They must be willingly to talk and express their past experience living with HIV. The selected and qualified participants for these criteria was selected within a 50-mile range of the Boston Massachusetts, metropolitan area for the qualitative research study and interview.

However, a participants during the interview may know someone they may recommend with important information with HIV. This was someone who may match the HIV criteria who can be very helpful by adding another participant, with more information about someone with HIV. Participants who are adult African American women and who are experiencing the stags of AIDS, are more than welcome and appreciated to participate in a 45-minute interview.

Participants are at no or minimal risk to be interviewed and are free to not participate in the interview. They may sign a consent form at the beginning.

Thank you!

Appendix E: Recruitment Flier

SEEKING Volunteers for a HIV Research Study

Volunteer participants who are African America women and who live as HIV positive are needed

- You must be an African American woman between the ages of 21 to 80
- You must be willing to open up and talk about your experiences being HIV positive
- The information you provide will be strictly kept private and confidential
- The information will be beneficial to help find the barriers and close the gaps in our health care system.
- The information will be very beneficial for others who live with HIV and AIDS as well

There is minimal risk or harm for this Interview. You are more than free to choose whether or not to participate during or after the interview with full compensation. You may choose to discontinue your participation at any time.

Participants will receive $35 for an interview and/or story about their past experience with HIV

This research is conducted by a 35-45 minute (note-taking or tape-recorded) interview by Robert S. Petralia. You may contact me for more info at: (978-747-6624)

Call Bobby for info: 978-747-6624 603-512-4198	Call Bobby for info: 978-747-6624 603-512-4198	Call Bobby for info: 978-747-6624 603-512-4198	Call Bobby for info: 978-747-6624 603-512-4198	Call Bobby for info: 978-747-6624 603-512-4198	Call Bobby for info: 978-747-6624 603-512-4198	Call Bobby for info: 978-747-6624 603-512-4198

Appendix F: Sample Interview Transcript of Participant

A 31-year-old African American female who was born in New York. She lives in Dorchester for the past 2 years and is the mother of 2 daughters, who are 6 and 13 years old, who don't live with her. Her education is 10th grade. She lives in Dorchester. She answered me on the first question about her community, as people not judging her about her HIV status. She said, they welcome her at the welcome center, because of her health condition. This is a private and confidential place for the rest of the women who are infected.

Interviewer: Can you please tell me something about yourself and the community where you live as it pertains to your HIV status?

Participant: "The people in the community and my church are supportive. They don't judge people for what or who they have."

Interviewer: How long have you known about your status and where did you get tested? What led to your decision to be tested?

Participant: "I have known about her HIV status for 2 years prior to being tested in community health clinic in New Bedford Massachusetts."

Interviewer: After testing positive, how long did it take before you started to receive ongoing care?

Participant: "After I found out about being HIV positive, I started treatment with 2 months of the outcome. During the treatment, I was in denial and depressed at the time and wanted to die. I did not talk to anyone for a long time and was made at my boyfriend"

Interviewer: Please describe any barriers or obstacles in obtaining treatment? Of these barriers, which one had the most impact?

Participant: "One of the biggest impact and obstacle that led me to be tested was being a drug user. Because if you disclose that you are a drug user, they look at you differently with less respect and can discriminate. They look at you; as other ways you earn or get your money to survive out there."

Interviewer: From your experience, do you feel obtaining access to healthcare is more difficult as an African-American woman? If so, why?

Participant: "I feel that obtaining health care and treatment for HIV on being African American women has not had much difficult. This may be because of the area is full of people, like me who use drugs and have a boyfriend that is very pushy to make money. They know you are not going make a recovery, like most people do who are just HIV, because you do drugs, and that's dangerous to each other to change"

Interviewer: Did you feel comfortable notifying friends, family, and partners about your status? Where they supportive? Are they willing to provide assistance with emotional support, visits to the doctor, and/or transportation?

(Continued)

Participant: “I do and don’t have close friends because of my past drug use. I told my family and family about my condition, and I am comfortable about letting them know I have HIV and a drug user. This made me feel better and at ease about further support. Most of my support comes from people in the health center. They give me the transportation and I hang out with the girls. We stick together as a group in the shelter and home.”
Interviewer: Have you ever been stigmatized due to your diagnosis? From your experience, do you believe the stigma to be worse due to being an African American Woman?
Participant: “I really haven’t been stigmatized outside the black communities. Most people don’t want nothing to do with me, or a person who is HIV, especially if they are black and a drug user.”
Interviewer: What support do you wish were available to you that you are not currently not receiving either from the healthcare providers or family/friends?
Participant: No comment!
Interviewer: Please tell me from your own opinion, what can and should be done to eliminate health disparities among many African American women living with HIV/AIDS.
Participant: “We need to have more information and education about HIV and how it is spread by using drugs. This is what we need in many areas and communities outside the poor and poverty areas, not just the black communities. Things are much better than what they were years ago. We need to education today’s black communities, about drug use, and not ignore this.”