A SIGN OF THE TIMES: AFRICAN-AMERICAN SEMINARIANS' ATTITUDES,

PERCEPTIONS AND KNOWLEDGE ABOUT HIV AND MUTAL HIV TESTING IN

INTIMATE RELATIONSHIPS

by

TIFFIANY M. CUMMINGS AHOLOU

(Under the Direction of Jerry E. Gale)

ABSTRACT

Whether dating, cohabiting, engaged or married, the AIDS epidemic continues to increase at startling rates amongst heterosexuals in the African American community. This suggests that partners in sexually, intimate relationships are unaware that they have been exposed to HIV and may underestimate their risk. Though HIV testing has historically focused on individuals, the sign of the times calls for a greater focus on strategies to promote and normalize mutual HIV testing (MHT) with couples in intimate relationships. Using a Basic Qualitative Research design and Symbolic Interactionism as a theoretical perspective, this exploratory study sought to understand the attitudes, perceptions, and knowledge about HIV and mutual HIV testing within intimate relationships amongst new generation faith leaders. Ten African American seminary students were recruited from three seminaries in Georgia. Data was collected using semi-structured interviews, a participant profile, and an HIV Knowledge Scale. The data was analyzed using constant comparative, thematic analysis and descriptive statistics. The analysis revealed seven overarching findings. **First,** the seminarians had moderate factual knowledge yet were perceptive about the complexities of HIV in the African American community and intimate relationships. **Second,** the vast majority of the seminarians perceived HIV testing as beneficial and a vital part of HIV prevention. **Third**, most of the seminarians perceived MHT as a positive

gesture with many benefits; yet they were also cognizant of the barriers associated with MHT, as well. **Fourth,** in general, the seminarians agreed that MHT should occur within intimate relationships; however, context played a significant role. **Fifth**, to promote and normalize MHT, the seminarians identified a number of strategies to include the use of the Black Church, media, policy, and schools. **Sixth**, the participants identified several tensions, referred to as crossroads and roadblocks, which may impede the Black Church from being actively involved in promoting MHT. **Lastly,** the seminarians discussed the need for more formal training, continued education, and external partnerships to aid them in promoting and normalizing MHT. Implications and recommendations for seminary curricula, practitioners who work with couples, policy that impacts couples, and future research were also discussed.

INDEX WORDS: African American Seminarians, Intimate Relationships, HIV Prevention,

                         Mutual HIV Testing, Qualitative Research

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DEDICATION

I would like to dedicate this dissertation to my parents,

Natalie Cummings and the late Warren Cummings,

who instilled in me a tenacity to press towards my goal.

To my husband, Komi A. Aholou,

who stood by me and prayed through every step of this journey.

To the late Dr. Harriette McAdoo,

who changed the trajectory of my life and encouraged me to make a difference

To all of you, I give thanks!

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How befitting that the number seven signifies the 'year of completion' in the Bible. Seven years ago I started this journey and I am glad to say, IT IS FINISHED!! However, this journey would have never been possible without the love and support of so many. I begin by giving all honor and glory to my Lord and Savior Jesus Christ who gave me the strength and grace to endure when things seemed impossible. To my parents, Natalie and Warren (deceased), who always believed that I could do anything that I put my mind to. And, to my husband, Komi Aholou, who has rightfully earned the title, "Co-Doc," for the countless sacrifices he made throughout our marriage and whose prayers have kept me afloat.

Next, a special thanks to my major professor and fried, Dr. Jerry Gale, whose patience, encouragement, advice and witty sense of humor balanced me over the years and helped to cultivate my 'inner-scholar.' To my dissertation committee for their guidance, wisdom and flexibility. I value their gifts and talents and the learning experiences that I have received from each of them.

I am extremely appreciative for the outpouring support that I have received in different ways. To five special women - Tanisha, Pinky, Tonia, Denise, and Pastor Mary - whose eyes and ears, prayers, and that gentle push helped me make it to the finish line. To all of my friends and church family, whose names are too many to mention, for their constant encouragement. To my SPFy folks, my Emory family, and the RCA crew for their sensitivity to this process and for having my back through it all. Also, to Father (Dr.) Abraham and SREB as well as Dr. Tera Hurt and the ProSAAM/ProSAAF programs who helped to finance this journey and also afforded me wonderful learning opportunities along the way.

Last, but definitely not least, I thank the seminaries that allowed me to recruit from their institution and to all of my awesome participants whose rich experiences and lively insight gave birth to limitless possibilities.

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FORWARD

In 1995 my journey to join the movement to eradicate the AIDS epidemic began. My first 'real' introduction to the epidemic was in sub-Saharan Africa where over 30 million people are living with HIV, primarily through heterosexual transmission or mother-to-child (MTC). More specifically, I went to Zimbabwe, in the southern region of Africa where I lived for three months to study people's behaviors and attitudes about HIV. Since that first introduction nearly two decades ago, I have been committed to reducing the spread of HIV/AIDS through research and prevention education.

Most of my practical experiences in HIV prevention have been in the area of Health Education with African American girls and women. As a health educator, time and time again, I have witnessed women empowered and encouraged along with their peers in the class setting to change or adopt a new behavior such as secondary abstinence, the use of condoms, or HIV testing. While many women left my classes encouraged to make healthier decisions to maintain their sexual health, all too often, some of them later expressed challenges or low self-efficacy when attempting to persuade their male partners to adopt and embrace their newly learned behaviors.

As a woman, I believe that it is essential to empower women and increase their self-efficacy regarding their sexual health. However, as a result of the challenges expressed by women I have encountered personally and millions of women worldwide who share a similar plight, I also believe that there is an urgent need to employ HIV prevention strategies that educate and empower intimate partners together on the mutual benefits of maintaining healthy relationships, particularly when learning their HIV status.

Although HIV testing data does not clearly indicate relationship status, there is ample research available to demonstrate that HIV is not limited to the young and the careless. The epidemic has spread to those who perceive themselves to be at low-risk - namely those individuals in, dating, committed, and marital relationships. Consequently, those who tend to perceive themselves at low risk for contracting HIV are also the same people who are least likely to test for HIV. This fact led me to ask two questions: "What can we do in the US to increase HIV testing between intimate partners?" and "What strategies can we employ to make testing for intimate partners a normative behavior?" These questions inspired my research.

CHAPTER 1

INTRODUCTION

Background of the Study

In 2011, the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) epidemic reached the 30 year mark globally. At the start of the epidemic, AIDS was thought to be largely confined to gay and bisexual men and intravenous drug users (IDU) (Shelp & Sunderland, 1992; Weatherford & Weatherford, 1999). However, the Centers for Disease Control and Prevention (CDC) recently reported a dramatic shift in the distribution of the epidemic, particularly concerning the modes of transmission (CDC, 2011a). In 1985, men who have sex with men (MSM) accounted for 65% of all AIDS diagnoses (CDC, 2011a). In 2009, while still the largest transmission category for HIV and AIDS, MSM transmission represented just 49% of all AIDS diagnoses (CDC, 2011a). Likewise, IDU transmissions accounted for 29% of AIDS diagnoses in 1985 and sharply declined to 15% in 2009 (CDC, 2011a). Therefore, the two populations responsible for the largest portion of all AIDS cases in the 1980s and 1990s have had significant declines over the course of the epidemic. However, the converse is true for heterosexual transmission. In 1983, heterosexual transmission accounted for only 3% of AIDS diagnoses, but in 2009, this category accounted for 31% of all AIDS cases and 28% of all people living with HIV (PLWHA) (CDC, 2011a).

Most HIV prevention efforts, including HIV testing, continue to focus on individuals (Burton, Darbes, & Operario, 2008). The emphasis on individuals alone is problematic given that HIV transmission does not occur in silos; instead it occurs through interpersonal encounters (i.e. sexual contact with an infected person or sharing infected needles) between at least two people (Cline, 2003). Fortunately, there is an emerging focus in the literature on HIV prevention strategies and approaches that specifically aim to reach partners in intimate relationships (see N.

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El-Bassel et al., 2010; Karney et al., 2010; NIMH Multisite HIV/STD Prevention Trial for African American Couples Group, 2008; Slater & Aholou, 2009)

Given the increasing prevalence of heterosexual transmissions and the estimated number of people living with HIV yet unaware of their positive serostatus, US researchers and policymakers could learn from strategies used in other countries where heterosexual contact is the primary mode of transmission. For instance, in sub-Saharan Africa heterosexual transmission amongst couples is the leading cause of HIV/AIDS. As a result, the faith community and others have begun to place an emphasis on strategies aimed to increase HIV testing between partners in those countries (Akani, Erhabor, & Babatunde, 2005; S. Allen et al., 2007; Umeora & Esike, 2005).

This focus on HIV prevention in couples could begin to dismantle misperceptions about risk behaviors. For example, one misperception is a low perceived risk for contracting HIV among partners in intimate relationships. This misperception can be attributed to researchers' initial focus on risk groups rather than risk behaviors. Also, relational factors such as love, trust, intimacy, and commitment are considered the cornerstone of relationships; yet these protective factors have also been associated with a low perceived risk of contracting HIV (Emmers-Sommer & Allen, 2005; Misovich, Fisher, & Fisher, 1997; S. M. Noar, Zimmerman, & Atwood, 2004). For these reasons, many people in intimate relationships do not practice strategies aimed at eliminating or reducing HIV transmission (Hammer, Fisher, Fitzgerald, & Fisher, 1996; Harman, O'Grady, & Wilson, 2009) such as HIV testing. Unfortunately, these misperceptions about risk and behaviors not only contribute to a sense of invulnerability, but also to the alarming increase in heterosexual transmission of HIV.

For intimate relationships in the African American community, the risks posed by the AIDS epidemic are further confounded by a constellation of factors (i.e. structural, environmental, and cultural) that facilitate and heighten the spread of HIV. Some of the overarching social determinants of these risks include issues of racism, poverty, stigma,

homophobia, knowledge inequality, and limited access to health care (Fenton, 2007; McNair & Prather, 2004). In addition, there are several individual, social, and contextual factors that have been shown to exacerbate the spread of HIV in the African American community: early age of sexual debut (Hill, 2005; Staples, 2006), inconsistent condom use (Bowleg, Lucas, & Tschann, 2004; CDC, 2010a), low sex ratio (Adimora & Schoenbach, 2002; McNair & Prather, 2004), marital patterns (Adimora & Schoenbach, 2002; Hill, 2005), multiple and concurrent sexual partners (Adimora, 2005; Carey, Senn, Seward, & Vanable, 2008; CDC, 2010a), sexually transmitted diseases (Adimora, 2005; CDC, 2010a; Farley, 2006) and incarceration (Adimora & Schoenbach, 2002; Lichtenstein, 2000; Maruschak & Beaver, 2010). These factors are particularly germane to the formation, maintenance, and sexual health of intimate relationships and therefore increase the vulnerability of contracting or transmitting HIV amongst African Americans intimate partners. A look at the epidemiology of HIV/AIDS in the African American community helps to further contextualize many of these factors.

HIV/AIDS Epidemiology and African Americans

Since the first cases of AIDS were reported in the US in 1981, the social impact, as well as the mortality rate of the epidemic, has been devastating. Although this disease impacts people of all races, ethnicities, genders, and ages, African Americans have carried the burden of the epidemic (CDC, 2010a, 2011d; McMickle, 2008; Weatherford & Weatherford, 1999). When AIDS was in its infancy, it was primarily found amongst white gay males (CDC, 2011c). However, by the second decade of the epidemic there was a remarkable distribution to people of color, with African Americans being hardest hit (McMickle, 2008; Weatherford & Weatherford, 1999). To put this into perspective, according to data from 2009, African Americans made up approximately 13% of the total US population (CDC, 2011d). However, according to the CDC[1],

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[1] Among the 40 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting since at least January 2006.

African Americans accounted for 50% of the approximate 172,000 HIV diagnoses made between 2006 and 2009 (CDC, 2011d). They also accounted for 64% of the total number of women diagnosed with HIV; 66% of all cases attributed to heterosexual transmission; and 68% of all children under 13 (CDC, 2011d). Furthermore, since 1996, African American children, adolescents and adults exceed all other race/ethnic groups in terms of new and cumulative AIDS diagnoses as well as AIDS-related deaths (CDC, 2011a).

The transmission data clearly indicates that for both African American women and men, HIV is largely transmitted through sexual intercourse with an infected male partner (Fenton, 2007). In 2009, there were 42,793 new HIV diagnoses reported of which African Americans accounted for 50% (CDC, 2011c). Of the new HIV cases in males, African Americans accounted for 47% with the modes of transmission being MSM (68%), heterosexual (20%), and IDU (9%) (CDC, 2011d). From 2006-2009, the age ranges with the largest estimated numbers of diagnoses in the MSM category were 25-34 and 35-44; however MSM between 13-24 had the highest percentage increase during this same time frame (CDC, 2011e). During the same reporting period in 2009, the CDC indicated that 10,255 females were newly diagnosed with HIV (CDC, 2011c). African American women accounted for 66% of the total new HIV cases for women with 87% attributed to heterosexual transmission and 13% to IDU (CDC, 2011d). For women, heterosexual transmission was highest in the age ranges of 20-24 (81%) and 25-34 (83%) (CDC, 2011f). To further punctuate this burden, it has been estimated that 1 in 16 African American men and 1 in 30 African American women versus 1 in 104 white men and 1 in 588 white women will receive an HIV diagnosis at some point in their lifetimes (Sutton et al., 2009).

The AIDS Epidemic in the South

In 2002, the Current Population Survey (CPS) reported that 55% of African Americans (36 million) resided in the Southern region of the United States (McKinnon, 2003) which is comprised of 17 states beginning from Delaware and extending around to Texas (CDC, 2009a). In 2007, the southern region was estimated to have the highest percentage of adults and

adolescents living with AIDS (CDC, 2009a). More specifically, 46% of the newly diagnosed AIDS cases were in the South, 40% of PLWHA resided in the South, and 50% of PLWHA that died from AIDS-related causes died in the South (CDC, 2009c).

The AIDS Epidemic in the Deep South

Within the southern region is another sub-population known as the Deep South. The Deep South is made up of six states: Alabama, Georgia, Louisiana, Mississippi, North Carolina and South Carolina (Reif, Geonnotti, & Whetten, 2006). In 2000, African Americans represented less than 13% of the US population, yet from 2000-2003, they represented 29% percent of the Deep South region compared to 19% of other Southern states (Reif et al., 2006).

The Deep South has historically been known for its association with slavery, racial injustice, Jim Crow laws, and segregation (Reif et al., 2006; Whetten & Reif, 2006). The region is also characterized for a host of social and health disparities that directly impact the African American community. For example, many African Americans living in this region experienced higher rates of unemployment (McKinnon, 2003; Reif et al., 2006) which has been shown to correlate with increased crime and consequently higher rates of incarceration. All of these factors – unemployment, crime, and incarceration – have contributed to low rates of marriage (Adimora & Schoenbach, 2002; Sampson, 1995). From a sexual perspective, African American females residing in the Deep South have had higher rates of sexually transmitted infections, teen pregnancy and unwed childbirths than their Caucasian or Hispanic counterparts (Johnson & Dye, 2005). Furthermore, in 2003, this region accounted for 36% of the newly reported AIDS cases in the south, compared to 4% in other southern states and 5% nationally (Reif et al., 2006).

HIV/AIDS in Georgia. Georgia is a state in the Deep South region that has demonstrated a high prevalence of HIV/AIDS cases. Georgia ranked sixth in the highest number of AIDS diagnoses and sixth in the number of cumulative AIDS cases through 2009 (CDC, 2011g). In 2009, Georgia Department of Community Health's (GDCH), Georgia HIV Surveillance reported an estimated 2,250 new HIV/AIDS cases, with 61% diagnosed with HIV and 39% diagnosed with

AIDS (GDCH, 2011). Like the racial distribution of the epidemic nationally, Georgia also experienced similar trends with African Americans being disproportionately represented in the number of people diagnosed with HIV/AIDS. For example, despite the fact that African Americans represented only 30% of Georgia's population, the Georgia HIV Surveillance data reported that in 2009, 74% of the newly diagnosed HIV cases were amongst African Americans compared to Caucasians and Hispanics, 19% and 6% respectively (GDCH, 2011). Nearly half (47%) of the PLWHA in Georgia were between the ages of 30-39 (24%) and 40-49 (23%) (GDCH, 2010).

The transmission data from 2009 for those persons newly diagnosed in Georgia was remarkable. MSM represented 49% of all men newly diagnosed with HIV that year, and 16% of all women diagnosed that year contracted it through heterosexual contact (GDCH, 2010). However, the Georgia HIV Surveillance data also reported on another risk category called No Identified Risk Factor/No Risk Reported (NIR/NRR). This category represented individuals who reported without a CDC-defined HIV risk factor such as men who have sex with men (MSM), high risk heterosexual (HRH) and IDU (GDCH, 2010). Interestingly, a large percentage of newly diagnosed HIV cases in Georgia fell into this category, with nearly 81% of females and 46% of males (GDCH, 2010). There is not a definitive explanation for the large percentage of newly diagnosed individuals in the NIR/NRR category. Perhaps some individuals intentionally withheld information concerning their risk factors. Others may have actually been unaware of their risk for contracting HIV. Also, the alarmingly high percentage of women and men. Unfortunately, the national data from neither the CDC nor the Georgia HIV Surveillance captured information regarding relationship status, which poses a challenge in accurately describing the roles that intimate relationships play in the rising rates of heterosexual transmission.

Statement of the Problem

As evidenced by the epidemiological data, the unyielding presence of the AIDS epidemic threatens the health of intimate relationships, and therefore underscores the importance of

prevention approaches that are relational in nature. One prevention strategy that considers individuals in committed partnerships is mutual HIV testing (MHT), where both partners in the relationship seek an HIV test together and learn their results together (Exner, Hoffman, Parikh, Leu, & Ehrhardt, 2002). However, for this approach to be actualized in intimate relationships requires a paradigm shift, which may entail a change in the way risk is perceived as well as the social norms regarding couples testing together.

One way to begin to change norms amongst African Americans is to engage the Black church. The Black church, arguably, is the most prominent institution in the African American community (McMickle, 2008; Weatherford & Weatherford, 1999). According to Poole (1990) the Black church is considered "one of the few organizations that is owned and governed and is accountable to the African-American community" (p. 43) In recent years, the Black church has been influential in promoting healthy behavior change regarding various health disparities that continue to affect African Americans. In fact, a growing number of African American faith leaders and faith-based organizations, considered by many to be the gatekeepers in the African American community, have been instrumental in promoting HIV testing within their congregations and community (Balm in Gilead, 2011; Eke, Wilkes, & Gaiter, 2010).. This is evidence of their willingness to help influence and change the social norms and acceptability about HIV testing in general. This raised the question of whether African American faith leaders could also help to influence mutual HIV testing within intimate relationships.

Purpose of the Study

The increasing rates of heterosexual transmission coupled with the individual and contextual factors that facilitate the spread of HIV between intimate partners in the African American community prompted the need for exploratory research dedicated to the promotion and normalization of mutual HIV testing in the context of intimate relationships. While it is important to explore the perceptions and attitudes of individuals and couples regarding their HIV testing practices, this research identifies a pathway to prevention within the Black church. More

specifically, this study looked to the influence of African American seminarians, the next-generation of faith leaders, to gain their perspective on mutual HIV testing. Hence, the purpose of this study was to explore African American seminarians' attitudes, perceptions and knowledge about HIV and mutual HIV testing within intimate relationships. The questions that guided this research are as follows:

1. What knowledge do African American seminarians have about HIV/AIDS?

2. What attitudes do African American seminarians hold about HIV testing as a form of prevention?

3. What meaning do African American seminarians ascribe to mutual HIV testing?

4. What attitudes and perceptions do African American seminarians have about normalizing mutual HIV testing with intimate partners?

5. What are the perceived tensions within the Black church associated with promoting mutual HIV testing with Intimate partners?

6. What are the perceived needs of African American seminarians to facilitate mutual HIV testing with intimate partners?

Significance of the Study

This study is significant for numerous reasons. Firstly, faith leaders, existing and emerging, play a pivotal role in the African American community. As the future leaders of churches and in communities, seminarians have accepted the call to minister to the needs and issues concerning today's generation. Therefore, having faith leaders engaged in finding solutions for our modern day dilemmas is a benefit to the African American community. Secondly, this study fills a gap in the literature regarding attitudes and perspectives of African American faith leaders in regards to HIV prevention, with a focus on mutual HIV testing. Thirdly, as previously mentioned, the Black church is an influential institution; therefore, the positions of faith leaders have the ability to shape their congregation's views about HIV/AIDS and influence their behaviors. Hence, this research also sheds light on the roles, tensions, and

complexities involved in the promotion of mutual HIV testing. Lastly, this study has implications for seminary curricula, policy, and the development of culturally sensitive practices and strategies specifically aimed at reducing the spread of HIV/AIDS amongst intimate partners yet sensitive to the views and needs of African American faith leaders**.**

Overview of Methodology

Using a Basic Qualitative Research design and Symbolic Interactionism as a theoretical perspective, this exploratory study sought to understand the knowledge, attitudes and perspectives about HIV and mutual HIV testing within intimate relationships from the vantage point of 10 African American seminarians. The participants were recruited from three seminaries in Georgia. The primary method used to collect the data was the semi-structured interview and a participant profile questionnaire was used to describe each participant. In addition, to compliment the qualitative data and get a more accurate assessment of the seminarians' knowledge about HIV/AIDS and HIV testing, a HIV/AIDS Knowledge Scale adapted for the study was also included.

Delimitation

The research was bound to seminary students in Georgia. Given the number of seminaries within Georgia and the small target sample size, it was deemed unnecessary to recruit outside of the state. Also, because the participants were both, existing and emerging church leaders, it helped to situate many of the discussions.

Definitions

Black/African Americans - The term ''Blacks'' is used in this study to include African Americans, Caribbean Americans, Africans, and other persons of Black race who may not self-identify as ''African American'' yet included in the epidemiology (Sutton et al., 2009).

Black church- The term "Black church" in this study refers to an institution where the majority of the congregation is made up Black/African Americans (T. Aholou, Gale, & Slater, 2011; Sutton et al., 2009).

Heterosexual Transmission - CDC refers to heterosexual transmission as heterosexual contact which defined as "heterosexual contact is with a person known to have, or to be at high risk for, HIV infection" (CDC, 2011c).

Intimate relationships/couples – In this study, the term "intimate relationships" and " intimate couples" are used interchangeably to refer to sexually active heterosexual couples who are dating, engaged, cohabitating, and married couples, regardless of length of relationship (World Health Organization, 2011).

Mutual HIV testing – A strategy where both partners in a relationship learn their HIV serostatus via HIV testing, whether conjointly or concurrently, and share their test results with each other (Exner et al., 2002).

Seminary – A theological or bible institution that provide post-baccalaureate education to students preparing for careers as ordained or licensed religious functionaries. Careers may include, but not limited to, pastors, ministers, and pastoral counseling (Conklin, 1997).

Seminarian – A student who attends a seminary, theological, or bible institution.

Serostatus – Refers to the presence or absence of HIV antibodies (AIDS Info, 2008).

Seroiscordant – A couple in which one partner has a positive serostatus and the other partner has a negative serostatus (AIDS Info, 2008).

Seroconcordant – Both partners in a couple unit have the same serostatus, whether positive or negative.

Summary of Chapters

Chapter 1 provided a background to the study including its purpose and significance. A list of the key terms were identified and defined to ensure a proper understanding of the information to follow. Chapter 2 reviews the relevant literature regarding the role of HIV testing in prevention and barriers and facilitators of HIV prevention with intimate partners. The role the Black church has played in preventing the ADIS epidemic as well as the preparation of seminarians is also discussed. Chapter 3 provides a discussion about the research methodology

and the theoretical perspective that situated the study. Chapter 4 presents a descriptive analysis of the findings. Chapter 5 concludes with an interpretative summary and discussion of the findings, and implications and recommendations.

CHAPTER 2

LITERATURE REVIEW

The purpose of this qualitative study was to explore a sample of African American seminarians' attitudes, perceptions and knowledge about HIV and mutual HIV testing within intimate relationships. The research questions that guided this study were as follows:

1. What knowledge do African American seminarians have about HIV/AIDS?

2. What attitudes do African American seminarians hold about HIV testing as a form of prevention?

3. What meaning do African American seminarians ascribe to mutual HIV testing?

4. What attitudes and perceptions do African American seminarians have about normalizing mutual HIV testing with intimate partners?

5. What are the perceived tensions within the Black church associated with promoting mutual HIV testing with intimate partners?

6. What are the perceived needs of African American seminarians to facilitate mutual HIV testing with intimate partners?

The chapter is outlined as follows: an overview of the role of HIV testing in HIV prevention, factors that may hinder or help intimate partners to seek mutual HIV testing, the role of the Black church in the African American community with specific attention given to its role in HIV prevention and preparation of seminary students to address HIV prevention with intimate couples. The chapter is concluded with a synopsis of the gaps in the literature.

Role of HIV Testing in Prevention

HIV testing has been identified as vital strategy in the arsenal of HIV prevention interventions (CDC, 2009b; KFF, 2010). There are several benefits that can be attributed to HIV testing. To begin with, HIV testing has been determined as necessary for individuals to learn their

HIV serostatus and is associated with early detection of HIV (Fenton, 2007). This is especially important from an epidemiological standpoint to follow and track the trends of the epidemic (Fenton, 2007). Secondly, HIV testing presents an opportunity for people who test positive to be linked to medical and psychosocial care (Weinhardt, Carey, Johnson, & Bickham, 1999) as well as new advancements in antiretrovirals therapies that help to prolong and improve the quality of life (Branson et al., 2006). Lastly, when coupled with personalized counseling, HIV testing serves as a platform to educate people about risk reduction strategies to prevent the acquisition and spread of spread of HIV (Denison, Higgins, & Sweat, 2009; Irwin, Valdiserri, & Holmberg, 1996). It is for this reason that the CDC has devoted a significant amount of resources to expand and extend their current HIV testing initiative (CDC, 2011b).

At the end of 2008, the CDC estimated nearly 1.2 million people ages 13 and older to be living with HIV (CDC, 2010b). Approximately 21% of people living with HIV are unaware of their HIV status (KFF, 2010). Research has shown that PLWHA yet unaware of their HIV serostatus are unlikely to change their behaviors and consequently, may unknowingly transmit the virus to others (T. M. C. Aholou, Hou, & Grimes, 2009; Weinhardt et al., 1999). Conversely, when persons who test positive become aware of their status, they are more likely to change their behaviors in order to reduce the transmission of HIV to others (KFF, 2010; Weinhardt et al., 1999).

Despite the numerous benefits of HIV testing, the HIV testing data communicates mixed views. For instance, in 2011, the Henry J. Kaiser Family Foundation (KFF) conducted the *2011 Survey on Americans on HIV/AIDS* (KFF, 2011a)*,* a national telephone survey based on a representative random sample of 2,583 adults 18 through 64 years of age. The results revealed that *54*% of the total sample indicated they had ever been tested. These findings present a dichotomy. On the one hand, it is commendable that over half of the sample reported they were tested at some point in their lives. However, these data also revealed only one-fifth (21%) has

been tested within the past 12 months, and that nearly half (44%) of the participants had never been tested (KFF, 2011a).

There are a few plausible explanations regarding the low percentages of HIV testing in the US population – low perception of risk and stigma. First, early in the epidemic, HIV was perceived as a disease people in high-risk groups such as men who have sex with men (MSM), intravenous drug users (IDU), and people who traded sex for drugs or money (McMickle, 2008; Shelp & Sunderland, 1992). By the early nineties, it was evident that the virus was disproportionately infecting people of color, especially women (McMickle, 2008). Though the rates of heterosexual transmission were rising, the perception was that it was often linked to promiscuity and the unsafe sexual practices of men and women who were part of the drug culture (i.e. crack or IDU) (Shelp & Sunderland, 1992). The over emphasis on risk groups rather than risk behaviors contributed to a low perception of risk.

A second related explanation is stigma. As mentioned, the association of AIDS with marginalized populations such as homosexuals and substance users led to increased stigma and discrimination against people living with HIV and people who had similar lifestyles (Chesney & Smith, 1999). The religious sector, in particular, was very dogmatic in their proclamation that AIDS was a punishment from God (McMickle, 2008; Shelp & Sunderland, 1992). Research has shown that as people began to internalize shame and judgment with a positive HIV status, that fear of being rejected or ostracized became a barrier to learning one's HIV status (Chesney & Smith, 1999). In particular, for African Americans, social stigma has been documented as a significant barrier to HIV testing and disclosing risk factors (CDC, 2010a; Isbell, 2009). These two overarching factors, while not exhaustive, have been largely associated with the trends and indifference concerning HIV testing.

HIV Testing Trends

Targeting HIV testing has its advantages and disadvantages. Some would argue that a targeted focus on individuals who engage in high-risk behaviors (i.e. drug treatment facilities, patients of STD clinic), there is an increased likelihood of reaching individuals who may have been exposed to the virus (Bond, Lauby, & Batson, 2005; Irwin et al., 1996). Other scholars have argued the danger of focusing only on certain subsets of the population implicitly perpetuates stigma and discrimination which can further polarize the epidemic between *them* versus *us* binaries (T. M. C. Aholou et al., 2009). Furthermore, it has been documented that risk-based approaches to testing typically miss individuals who contract HIV in the course of low level risk behaviors (Isbell, 2009).

As evidenced by the testing patterns where 44% of US residents reported that they never have been tested for HIV, it appears that many people did not perceive themselves to be at risk (KFF, 2010). Several studies that have examined HIV testing patterns have found binaries between those who were more likely to test compared to others particularly in to the areas of race/ethnicity and marital patterns.

Race/Ethnicity

HIV testing is most polarized by race/ethnicity. For example, in terms of race, the survey conducted by the KFF indicated that 50% of Caucasians reported they have never been tested compared to 22% of African Americans. The gap widens to 15% and 43%, respectively for Caucasians and African Americans who have tested in the past year. Other studies have also found that Caucasian populations report lower rates of testing compared to other race/ethnic groups (Inungu, 2002; Rountree, Chen, Brown, & Pomeroy, 2009). In contrast to Caucasians, African Americans reported the highest percentage of HIV testing (KFF, 2011b). Interestingly, while African Americans report higher testing than other race/ethnic groups, research has concluded based on years of HIV testing data collected from KFF that the number of African

Americans under the age of 65 who reported having a recent HIV test has roughly remained at roughly 40% for a decade (Isbell, 2009).

Despite their frequency of HIV testing compared to other race/ethnic groups, African Americans are more likely to be classified as "late testers" (Fenton, 2007). Late-testers is an indication that people manifest an AIDS diagnosis within a year of testing positive for HIV (KFF, 2010) or receive a simultaneous concurrent diagnosis of HIV and AIDS by a physician (T. M. C. Aholou et al., 2009). The three potential dangers in late HIV testing is (a) the possibility of others being exposed; (b) late-testers are unable to benefit from the new technology in terms of antiretroviral treatments that help to decrease the viral loads in the body; and (c) their immune system is compromised and therefore risk progressing to AIDS within 10 years (Shouse, Kajese, Hall, & Valleroy, 2009).

Marital Status

Marital status was another area where studies have found a difference in testing patterns. For example, even with HIV increasing at alarming rates amongst heterosexuals, studies have shown that testing trends are lowest for people who identified as married or cohabiting (Brown, Taylor, Mulatu, & Scott, 2007; Inungu, 2002; Rountree et al., 2009). For instance, Rountree et al. (2009) conducted a study to examine the rates of HIV testing within certain racial-ethnic groups in which case they used the 2005 BFRSS data set. The data consisted of 147,361 married individuals with the majority being Caucasian. From least to highest rates of HIV testing percentages amongst married individuals was Caucasian (n=120,641; 35%), Hispanic (n=11,132; 44%), and African Americans (n=6,961; 57%). Based on the findings from this study, irrespective of their marital status, race-ethnicity appeared to play a factor in the perception of risk and rates of HIV testing.

Misperceptions about HIV Testing

Research has also found that some testing patterns are also influenced by misperceptions about HIV testing. The foremost concern regarding misperceptions is related to negative test

results. For example, based on a meta-analysis, HIV testing is supported as an effective secondary prevention strategy that leads to behavior change and subsequently, a reduction in the spread of HIV for persons who test positive (Weinhardt et al., 1999). Therefore, for persons who test negative, the research indicated that a negative test result does not necessarily lead to behavior modification (Weinhardt et al., 1999). A negative test result presents a barrier for routine testing recommendations. Similarly, Irwin et al. (1996) review of literature indicated that for people who tested negative, they believed that they were at low or no risk for reasons such as marriage. For this reason, it was determined that married individuals may deem regular HIV testing as unnecessary or raise unwarranted suspicions. However, unlike blood types that remain static over one's lifetime, a person's HIV serostatus can change, unbeknownst to them, if exposed to the HIV virus.

Another misperception is the belief that one person can test on behalf of both partners. In a study conducted by Morrill and Noland (2006) they identified an issue where partners' were 'testing by proxy' rather than by presence. This concept suggested that some partners assumed that if one partner in the relationship were to test negative, then the non-tested partner would also have a negative serostatus. Also, in their research, Morrill and Noland found this notion of "testing by proxy" was common most among the men as they relied on their female partners to share their results. This is a dangerous assumption given that partners' can have serodiscordant results.

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HIV Testing Recommendations

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In the past few years, public health agencies have endorsed several revised testing guidelines. In 2006, there were two important revisions made to the existing testing recommendations. The first revised recommendation required mandatory HIV testing for pregnant women for early detection of HIV in order to prevent the perinatal transmission of HIV (Branson et al., 2006)This recommendation has been recognized as a major success in reducing the transmission of HIV to infants The second revised guideline recommended all people between

the ages of 13-64, regardless of risk level, to have the option to opt-in for HIV testing in medical settings. The opt-in process required pre-test counseling and written consent before an HIV test was administered. However, the opt-in guideline was found to be a barrier to HIV testing in medical settings and resulted in a change in recent years, the recommendations from 'opt-in" to an "opt-out" HIV testing process (Isbell, 2009). Therefore, rather than consenting to test, the consent is to not test for HIV in health care settings (Branson et al., 2006). The new recommendations for "opt-out" HIV testing are promising in terms of reaching populations that do not typically seek HIV testing as well as reducing the stigma associated with the HIV testing process (Fenton, 2007).

In summary, HIV testing is important to reduce the spread of HIV. However, the testing trends revealed a number of barriers to HIV testing such as stigma, low perceived risk, and misperceptions. Also, while the new testing recommendations show promise, the trends also reveals the need for a more coordinated effort to endorse, promote, and normalize of HIV testing within the context of intimate relationships.

HIV Testing Recommendations for Intimate Partners: A Historical Perspective

In the US, HIV testing specifically aimed at reaching couples have been inconsistent and not widely promoted. As previously mentioned, when the AIDS epidemic was in its infancy, it was thought to be confined to gay, White males and intravenous drug user (Emmers-Sommer & Allen, 2005; McMickle, 2008; Millett, Peterson, Wolitski, & Stall, 2006; Shelp & Sunderland, 1992). By the late eighties, the virus began to emerge into the heterosexual community, which prompted greater involvement at the federal and state level.

There are three well-documented responses spurred on by the federal and state governments aimed at addressing the sexual transmission of HIV, particularly among persons' in heterosexual relationships. During the first decade, the uncertainty about the epidemic, particularly in terms of transmission among heterosexuals, led to both messages of caution and prevention as well as fear and discrimination (Cline, 2003; Shelp & Sunderland, 1992).).

The first national response came approximately five years into the epidemic (Cline, 2003). In 1986, then, Surgeon General Everett C. Koop issued a multi-page brochure called "Understanding AIDS" to every household (US Public Health Service, 1986) (US Public Health Service, 1986), estimated at 170 million homes (AEGIS, 1988). The brochure was a first attempt on the national level to educate the general public about the epidemic (Cline, 2003). Koop included four prevention recommendations that were aimed specifically at couples. He started with emphasis on being in mutually faithful relationships. Second, he strongly urged couples to "know your partner" before engaging in sex. Next to use condoms if partners were not *absolutely certain* about their partner's risk behaviors. Last, to get tested if person's had been involved in any high-risk sexual activities or IDU (US Public Health Service, 1986). A major criticism of this response was that instead of promoting sexual HIV testing for all partners, the "know your partner" advice led some people to rely on superficial attributes to assess their level of risk rather than on learning each other's HIV status (Cline, 2003; Seal & Ehrhardt, 2004).

Also around this same time period (1986-1993) was the controversial fear-induced, legislation introduced by 35 states requiring mandatory premarital HIV testing (Closen, Gamrath, & Hopkins, 1994) (Closen et al., 1994). This particular legislation received a great amount of attention and debate. According to) Closen et al. (1994) proponents of mandatory premarital HIV testing were mostly politicians, while those who opposed were mainly people in the legal and health professions. For those who were proponents of the legislation, there were two schools of thought. Some saw the legislation as a means of helping couples make informed choices before entering into marriage and also to prevent perinatal transmission from mother to child. However, others used this approach to expose those who were HIV-positive as a means to protect the society at-large and to prevent marriage. Conversely, the opponents of the legislation argued against it stating that it violated people's rights to marry, fostered stigma and discrimination (Closen et al., 1994) and that anticipated mandatory premarital HIV testing would yield minimal HIV-positive results (Mockler & Kleiman, 1988). Furthermore, the CDC and other public health

agencies were not in agreement with mandatory, compulsory HIV testing (Cleary et al., 1987; Closen et al., 1994).Notwithstanding, two states, Illinois and Louisiana, did enact the legislation in their states only to later have it repealed due to low incidence amongst the targeted population and debates about cost-effectiveness (Closen et al., 1994; McKillip, 1991; Turnock & Kelly, 1989).

By the second decade, it was evident that the sexual transmission, particularly heterosexual contact, was by far the predominant mode of HIV transmission worldwide. As a result, in 2003 the Bush Administration launched the US President's Emergency Plan for AIDS Relief (PEPFAR, 2008), which ushered in the ABCs of HIV Prevention - *Abstinence, Be faithful, and Correct and consistent use of condoms.* This approach was highly publicized, promoted, and adopted by many countries as the most effective approach to reduce the sexual transmission of HIV (PEPFAR, 2008). However, when the approach is examined in the context of intimate relationships, there are several limitations. First, although extensive funding has been spent to promote the "A" through abstinence-until-marriage programs and encourage sexually active partners to adopt the "C" - the correct and consistent use of condoms, the research indicates that most intimate couples – dating, engaged, cohabiting, or married – assume monogamy, the "B," as their choice of protection (Emmers-Sommer & Allen, 2005; Misovich et al., 1997).

Second, the "B" component of the ABC model does not take into account several important conditions (Collins, Coates, & Curran, 2008; Hageman, Tichacek, & Allen, 2009). For example, many people in intimate relationships who profess to practice monogamy may actually engage in serial monogamous relationships (i.e. one monogamous relationship after another), which is risky and does not reduce the risk of HIV (Hammer et al., 1996). Another important consideration is that monogamy as a prevention approach requires a mutual commitment from both partners as well as the need for partners to know each other's HIV status *before* eliminating the use of condoms (Collins et al., 2008; Hageman et al., 2009; Misovich et al., 1997). To this point, there needs to be a balance of power in the relationship. Research has shown for many

people worldwide, particularly women, they are unaware of their partner's unfaithfulness or lack the power to insist on the use of condoms when there has been a breach of fidelity (Collins et al., 2008).

Lastly, is in regards to the muted emphasis on voluntary counseling and testing for intimate partners. For instance, a guidance document issued by the Office of the US Global AIDS Coordinator regarding recommendations for the implementation of the ABC approach actually encourages HIV testing as a risk reduction strategy in the "B" and "C" components of the approach. Unfortunately, the intent to oversimplify the approach into ABC's failed to explicitly endorse the importance of HIV testing in the context of intimate relationships and therefore diminished the significance of HIV testing as a key to prevention.

In summary, this section briefly examined responses to the sexual transmission of HIV from a relational perspective. Although HIV testing it is vital tool for understanding the epidemiology of HIV/AIDS, the research suggests that HIV testing in the context of intimate relationships has been overlooked.

Barriers and Facilitators of Mutual HIV Testing

One of the most critical contemporary issues facing individuals and couples is the HIV/AIDS epidemic (Slater & Aholou, 2009). Being in an exclusive or monogamous relationship is perceived as 'ideal' for couples in intimate relationships (Hammer et al., 1996; Misovich et al., 1997; Swann, Silvera, & Proske, 1995). As evidenced by the ABC's of HIV Prevention (PEPFAR, 2008), monogamy is promoted as the social norm of our culture by religious leaders and politicians,), yet not necessarily the reality of our culture (Emmers-Sommer & Allen, 2005). Under most circumstances, a couple who pledge faithfulness and practice fidelity in their relationship, whether in an exclusive relationship or in marriage reduces one's likelihood of contracting HIV and therefore is considered a safe relationship (PEPFAR, 2008). However, the caveat that is often overlooked is that fidelity in an exclusive relationship or marriage does not exclude the sexual history and potential risks that one or both partners may have been exposed to

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prior to the onset of the union (Slater & Aholou, 2009). With serial monogamy being a common practice within our culture (Hammer et al., 1996), Hageman and colleagues (Hageman et al.) assert that it is misleading to promote monogamy alone as an effective prevention strategy unless both partners are knowledgeable of each other's HIV serostatus. To promote this strategy, it is important to understand the barriers that are relevant to intimate relationships.

Barriers of Mutual HIV Testing

Low perceived risk factor. It is well documented that sexual intercourse is a socially normal activity that occurs between most people in intimate relationships – dating, engaged, cohabitating, and married (Emmers-Sommer & Allen, 2005). Reasons for engaging in sexual intercourse may include intimacy, affection, a demonstration of love, or for reproduction purposes (Christopher & Sprecher, 2000). Unfortunately, in the age of AIDS, the very act connected with intimacy and life, is also associated with the transmission of a life-changing disease – HIV. Although intimate couples today live in an era where the sexual transmission of HIV is the predominant mode of transmission, the HIV testing trends suggested that, many partners have a low perceived risk of contracting HIV.

There is a growing body of literature regarding HIV prevention practices for couples in intimate relationships (Emmers-Sommer & Allen, 2005; Hammer et al., 1996; Misovich et al., 1997; S. M. Noar et al., 2004). Most of the research concludes that many of the constructs that are intended to be protective factors in intimate relationships such as love, trust, and commitment have actually become an antithesis to effective HIV prevention for intimate partners (Emmers-Sommer & Allen, 2005; Misovich et al., 1997). A discussion of each follows.

Trust. Trust is often believed to be a powerful protective factor in the development and maintenance of intimate relationships (Misovich et al., 1997; S. M. Noar et al., 2004). The request of an HIV test or the use of condoms has been shown to raise suspicion between partners and is often viewed as a sign of mistrust in most relationships (Billy, Grady, & Sill, 2009; Emmers-Sommer & Allen, 2005; Hammer et al., 1996; McKoy & Petersen, 2006; Misovich et al., 1997; S.

M. Noar et al., 2004; Seal & Ehrhardt, 2004). In fact, according to the literature, 'trust' is best demonstrated when the need for safer sex precautions such as condoms or HIV testing is no longer necessary (Billy et al., 2009; Emmers-Sommer & Allen, 2005; Hammer et al., 1996; Misovich et al., 1997). Likewise, the elimination of condoms in exchange for contraception to prevent an unplanned pregnancy is a further indication of trust between intimate partners (S. M. Noar et al., 2004). Research has shown that partners tend to place a greater emphasis on maintaining their relationship rather than being concerned about sexual health matters (Bowleg et al., 2004; Hammer et al., 1996; S. M. Noar et al., 2004). Hence, the notion of trust has been associated with increased invulnerability to sexually transmitted infections (Emmers-Sommer & Allen, 2005).

Length of relationship. The length of a relationship has been shown to have implications on perceived safety in relationships as well as the use of safer sex practices. Research has found that feelings of love led partners to assume their relationship was exclusive in a short timeframe which often resulted in partners engaging in sexual activity at a fast pace; sometime as quick two-three weeks (Harvey et al., 2009; S. M. Noar et al., 2004). Some partners may have chosen to adopt safer sex practices at the outset of a relationship such as using condoms, however as the relationship continues to progress the tendency for intimate partners to associate the length of a relationship with trust, greater commitment and sexual exclusivity increases and therefore justified the elimination of prevention strategies (Emmers-Sommer & Allen, 2005).

While this may be true in some relationships, Forste and Tanifer (1996) found contrary results when they examined the concept of sexual exclusivity among a multi-racial national sample of dating, cohabiting, and married women (n=1235). Like most intimate partners, the sexual exclusivity construct was used as a proxy of commitment. Their hypothesis was that familiarity or boredom in the relationship would increase the probability of having a secondary sex partner. The results revealed the length of the relationship was positively associated with a greater likelihood of having a concurrent sexual relationship for 10% of the women in the sample.

Although cohabiting women (20%) reported being in concurrent sexual relationships more frequently, it is noteworthy to mention that 4% of the women were married. Other demographic indicators related to the lack of sexual exclusivity were having a higher educational background than the primary partner; having a history of multiple partners; and being women of color, particularly African American.

Assumed monogamy. Partners in monogamous relationship are generally founded on the ideology of trust, commitment, and sexual exclusivity which results in a heightened sense of invincibility towards contracting HIV (Crowell & Emmers-Sommer, 2001; Cummings, Battle, Barker, & Krasnovsky, 1999; Emmers-Sommer & Allen, 2005; S. M. Noar et al., 2004). While a relationship that possess these protective factors are important to the formation and development of relationships, monogamy without knowing the partner's HIV status is dangerous (Hageman et al., 2009). Nevertheless, the existing research concludes that HIV prevention in relationships with assumed monogamy is considered a violation of relationship norms (Cummings et al., 1999; Emmers-Sommer & Allen, 2005; Misovich et al., 1997). In research conducted by Sobo (1993) she spoke of the "monogamy narrative," in which case women tell themselves their relationship is monogamous. Therefore, when one perceives to be in a monogamous relationship, they also perceive that they are safe. Further, if one thinks that she in a monogamous relationship, to imply the necessity for safer sex practices such as mutual HIV testing would signify that infidelity is possible (Sobo, 1993). This in turn challenges their illusion of safety and therefore could undermine the relationship (Misovich et al., 1997). Moreover, it has also been asserted that HIV prevention, such as mutual HIV testing poses internal doubts about the partner's ability to select a safe partner (Sobo, 1993; Swann et al., 1995).

Unknown risk factors. There are several studies that point to the unknown risk factors of partners as a contributor to the rising rates of HIV within the heterosexual community. In fact, most of the newly diagnosed cases of HIV in Georgia were categorized as unknown risk for women and men, 81% and 46%, respectively. Unknown risks place the unsuspecting partner(s) in

a vulnerable position that deprives them of the right of informed choice (Lucchetti, 1999; Slater & Aholou, 2009). Examples of unknown risk factors include but not limited, substance abuse history, deception in communication, lack of disclosure, and extradyadic relationships.

Deception ~~in~~ sexual health communication. Trust in intimate relationships is predicated on partners being honest with one another in the relationship (Karney et al., 2010). While rare amongst adolescent couples, there were some instances where couples, prior to initiating sex, may actually choose to adopt the safer sex practice of engaging in a discussion about their sexual history at the outset and even inquire about their HIV status. In doing so, partners are attempting to gather risk assessment information.

Although sexual communication and risk assessments are important, Swann and colleagues caution that reliance on an individual to be transparent about their sexual history may not be a reasonable expectation . In fact, research suggests that people are not always forthright with providing honest information about their sexual history. For example, Lucchetti (1999) explored the dialectical tensions that couples experience regarding the disclosure of sexual history when forming a new sexual relationship. The findings described three dialetectics. The first was the dialectic of trust and risk which implies that some partners may want to share things about their past in order develop trust, yet afraid to risk sharing what many perceive as "taboo topics" in fear of being rejected (Misovich et al., 1997). Next, is the dialectic regarding the need to reveal versus conceal information about their sexual history. The final dialectic was the lie of omission and lie of commission. Whereas the lie of omission refers to when a person chooses not to reveal their sexual experiences, the lie of commission is when a person alters their sexual history. The overarching finding was that the students preferred to conceal information about their past in order to maintain the relationship.

Marelich and Clark (2004) provide another key example where deliberate deception poses a threat to the sexual health of partners. In this study, the researchers explored false disclosures of having a negative HIV test with heterosexual college students. Of the 246 students

in the sample, only 5% in this sample (n=12) admitted to deceiving their previous partners about having a negative HIV test when in fact they had never been tested. The motivation behind the false disclosure was to facilitate sexual intimacy.

Both of these illustrations are examples of deceptive sexual communication. Although Lucchetti's (1999) work reveals the dilemmas that couples experience in terms of adopting safer sex practices, the information that is not revealed could place the other partner at risk . Likewise, the low percentage in Marelich and Clark's (2004) research may seem marginal, it too is detrimental to intimate relationships given that people often rely on the information shared with when making sexual decisions. Notwithstanding, it is important to note that sexual health communication alone is insufficient to prevent HIV. However, it is important for negotiated safety strategies that include partners having honest sexual health communication coupled with mutual HIV testing (Kippax, 2002).

Lack of disclosure. Since the beginning of the AIDS epidemic, there has been a preponderance of studies conducted to understand the sexual practices and risk behaviors associated with homosexuality and bisexuality. For example, a growing body of literature exists that seeks to understand the practices and behaviors of African American men who secretly have sexual relationships with other men, yet maintain a heterosexual relationship (MSMW) (Montgomery, Mokotoff, Gentry, & Blair, 2003; Sandfort & Dodge, 2008; Wolitski, Jones, Wasserman, & Smith, 2006). This phenomenon otherwise known as the "down low" or "DL" differs from bisexuality in that men on the DL typically do not disclose their involvement in same-sex relationships with their female partners (Sandfort & Dodge, 2008). Although living dual sexual lifestyles is not unique to African American men, several scholars argue that this secret lifestyle among African American men is fueled by the cultural stigma associated with homosexuality in the African American community. Hence, rather than face the stigma and ridicule, many men who are homosexual succumb to the pressures of cultural expectations to

maintain a heterosexual lifestyle with a women, even marriage, while at the same time maintain their homosexual behaviors (Fullilove & Fullilove III, 1999; Montgomery et al., 2003).

In a literature review conducted by Millett et al. (2006) on African American MSM, the findings suggest that African American MSM are less likely to identify as gay or to disclose their same sex behaviors. Furthermore, the review indicated that African American k MSM had higher rates of STDs and tested for HIV less frequently. Similar findings were concluded in studies conducted with non-disclosed Black bisexual men as well as self-identified African American DL men (Sandfort & Dodge, 2008; Wolitski et al., 2006). While there have been strong assertions that the DL phenomena serves as a bridge to the higher rates of HIV in African American women, the secretive nature of this lifestyle makes it difficult to make definitive generalizations. Albeit, what is known is that when people make sexual decisions under false pretenses, they are not armed with the information to protect themselves.

Besides the DL, other studies have been conducted with heterosexual couples who were unaware of their partner's risk (Drumright, Gorbach, & Holmes, 2004; Witte, El-Bassel, Gilbert, Wu, & Chang, 2010). For example, Witte and colleagues (2010) conducted a study with 217 couples to determine how accurately they described their risk for sexually transmitted disease. Both partners were asked to report on their risk and their perceptions about their partners risk factors. The findings indicated revealed several areas where there was low agreement such as non-monogamy, history of intravenous drug use, and recent STD diagnosis including undisclosed HIV positive status. Drumwright had similar findings, in which 96 heterosexual couples reported on their partner's concurrent behavior. Of the 61 individuals who reported they engaged in concurrent behavior, only 26% of their partner's accurately reported they were aware (Drumright et al., 2004).

Extradyadic relationships. Despite the disapproval of most Americans about sexual infidelity, research reports that nearly of one-fourth of people who are married, cohabiting or dating report engaging in an extradyadic relationship (E. S. Allen et al., 2005; Forste & Tanfer,

1996; Treas & Giesen, 2000). Research has also indicated that the length of relationships is a factor associated with increased extradyadic experiences. Furthermore, attributes such as being male, African American (Hill, 2005; Treas & Giesen, 2000),and having numerous lifetime sexual partners prior to marriage (Forste & Tanfer, 1996; Treas & Giesen, 2000) are also associated with an increased likelihood of infidelity. These findings are particularly important given that couples who may have adopted safer sex practices (i.e. condoms, mutual HIV testing) at the start of their relationships, may actually discontinue this practice as the relationship continues under the semblance of exclusivity.

Often times the attention placed on the DL phenomenon as well as the infidelity of males tends to overshadow the risky behaviors that women also engage in. Chapman (1986) outlines details about a phenomenon referred to as "man-sharing." She describes "man-sharing" triangles, which occurs when one woman is usually aware that she is sharing a man with another woman; however, the other woman is typically unaware of this arrangement. As with the DL phenomena, 'man-sharing' is not restricted to Black communities, however it appears to be particularly pronounced in the African American community as a consequence of the low sex ratio of men to women.

There is research that has aptly addressed the implications of the low sex ratio of African American males to females (Adimora & Schoenbach, 2002; Hill, 2005; McNair & Prather, 2004).The research has shown that the low sex ratio is correlated with a decline in marriage and rise in divorce (Adimora & Schoenbach, 2002; Hill, 2005). Furthermore, low ratio is also related to gender power. Therefore, when there are more women to men, men are less inclined to remain faithful in their relationship (Adimora & Schoenbach, 2002; Hill, 2005). For women, the sex ratio has implications on the power and choices they make. Furthermore, when women lack interpersonal power, their choices are limited, thus causing them to compete and compromise to have their desires met (Staples, 2006).

Chapman's research reveals that some women who are the secondary partner are willing to accept some element of risk, while many primary partner are deprived the opportunity to make an informed choice. Conversely, research also purports that some women become aware of their partner's sexual indiscretions yet choose to remain in the relationship despite the betrayal (Bowleg et al., 2004; Chapman, 1986; Witte et al., 2010).

In summary, the literature provided in this section regarding low perceived risks and unknown risk factors help to explicate factors from a relational perspective that exacerbate the AIDS epidemic in intimate relationship. Each factor, individually and collectively pose barriers to the practice and adoption of mutual HIV testing. Moreover, the literature further substantiates the need to identify strategies that can help to facilitate mutual HIV testing with couples in intimate relationships. This is especially important for partners in long-term relationships such as marriage where the norm is to assume fidelity, thus being the default HIV prevention strategy.

Facilitators to Mutual HIV Testing

Several scholars have asserted that the best way to promote HIV prevention with couples, such as mutual HIV testing, is to educate and empower both partners together (Nabila El-Bassel et al., 2001; Misovich et al., 1997; Slater & Aholou, 2009). Misovich et al. (1997) posits that prevention programs that seek to change the behavior of one partner in a relationship without the inclusion of their intimate partner can be problematic. For example, in the context of mutual HIV testing, research suggest that many women tend to be hesitant about raising the issue regarding HIV testing in fear that it will imply infidelity or may provoke unwarranted suspicions.

Hageman et al. (2009) advocates for strategies that integrate a couple-based approach to HIV prevention may be effective in mitigating the implicit and explicit relational barriers that couples encounter. In doing so, couples can make informed decisions in their relationship. For example, a CDC, evidenced-based intervention for couples that has been implemented in many developing countries where the heterosexual transmission of HIV is rampant, is Couple Voluntary Counseling and Testing (S. A. Allen, Karita, N'Gandu, & Tichacek, 1999). According

to Hageman et al. (2009),some of the noted benefits to this approach include support for open communication between partners; removes the barrier of partner notification; and encourages couples to take steps to maintain their health as a couple.

Although the literature has focused primarily on research conducted in the US, it is imperative to note that globally, HIV is spread predominantly via heterosexual transmission. Hence, as previously mentioned, it is important to glean from strategies that have been employed in other countries. For instance, one way to change the norms of a particular issue is to engage influential stakeholders to encourage and educate their constituencies. This strategy was employed by Allen and colleagues (2007) in their efforts to promote CVCT in Rwanda and Zambia. They found that working with influential networks in the community, to include religious leaders, was an effective approach to encourage couples to seek testing together. In like manner, most religious leaders are regarded as influential in their respective churches and communities (Edelheit, 1994; Lincoln & Mamiya, 1990). Given the escalating heterosexual rates of HIV for women in the African American community, it is important to enlist the influential power of the Black church.

The Black Church and the African American Community

The Black church is arguably one of the most powerful institutions in the African American community (McMickle, 2008). The Black church has historically been champions for African American in all facets of life to include spiritual, social, political, and education. In addition, social justice and social activism has been the hallmark of the Black church. For instance, the Black church and its clergy has a long history of standing up against the many injustices that African Americans have endured to include the effects of slavery, Jim Crow laws, civil rights, and segregation (Lincoln & Mamiya, 1990).

Although the Black church as an institution is very diverse, it is not a monolithic institution. Nevertheless, it has also played an integral role in shaping the values, norms, and

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beliefs in the African American community (Eke et al., 2010). This historical foundation has defined for many the role and expectations of the Black church and its clergy.

The hallmarks of the Black church may account for their high commitment to religious practices in general, and the Black church particularly. According to the U.S. Religious Landscape Survey, conducted in 2007 by the Pew Research Center's Forum on Religion & Public Life, African Americans are the most religiously loyal race/ethnic groups in the United States (Sahgal & Smith, 2009). This designation was based on indicators such as attendance at religious services, frequency of prayer, religious importance to one's life, and religious affiliation (Sahgal & Smith).

Role of African American Clergy in Health Promotion

African American clergy serve in various capacities within the Black church. As the pressing needs of the African American community continue to emerge, clergy are often faced with transitioning into new roles. For example, while clergy generally serve in preaching roles, there is evidence that their role of clergy that have evolved from preacher, teacher to counselor, change agents for health promotion. For example, research has shown that many African Americans often seek out their clergy for mental health concerns such as substance abuse, marriage and family issues, bereavement and other personal matters rather than seeking mental health services from a secular counselor (Blank, Mahmood, Fox, & Guterbock, 2002; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; D. Watson et al., 2006).

From the public health standpoint, the influence of the Black church and clergy in the African American community has proved successful in promoting health messages and programs aimed improving the quality of life for African Americans (Campbell et al., 2007; Peterson, Atwood, & Yates, 2002; D. Watson et al., 2006).

The Black Church and HIV

The historic presence and role of the Black church in the African American community explains the criticism that has been echoed throughout the literature over the past three decades

pertaining to the Black church and the AIDS epidemic. Some scholars have vehemently argued that due to the initial silence, denial and delayed response of the Black church to confront HIV at the outset has contributed to the rising rates of HIV in the African American community (Douglas, 1999; Fullilove & Fullilove III, 1999; Sommerville, 2008). For example, when the gay community realized that the AIDS epidemic affected their community, they went into action. They pooled their power, influence, and wealth together to influence policy and demand additional resources for their community. Because of the activism, there has been a remarkable decrease in the new infections amongst White men who have sex with men.

Unfortunately, the converse is true in the Black community. The mere association with what many political and faith leaders considered as "immoral behavior" stagnated the advocacy for African Americans affected by the AIDS epidemic (McMickle, 2008; Shelp & Sunderland, 1992).

In spite of the resistance of the Black church as a whole, research has shown that as members of African American faith community began to grasp the enormity of the issue in the Black community, several responded accordingly (Billingsley, 2002; McMickle, 2008). During the early years of the epidemic several grassroots efforts were birthed to break the silence, the Balm in Gilead, Gospel for AIDS and Affirming a Future with Hope (Francis & Liverpool, 2009; Martin, Younge, & Smith, 2003). These initiatives were some of the forerunners to mobilize and increase the knowledge and readiness of the Black faith community to begin combating the AIDS epidemic in the Black community (Martin et al., 2003). Other organizations, such as the National Black Leadership Commission on AIDS was established to advocate and educate on behalf of the needs for African Americans affected by AIDS (Billingsley, 2002).

Thirty years into the epidemic, there is greater mobilization in the Black faith community around issues pertaining to HIV/AIDS prevention (Berkley-Patton et al., 2010; Francis & Liverpool, 2009; Martin et al., 2003; McMickle, 2008). While there is a paucity of outcome-based research regarding faith-based initiatives, there have been several recent studies conducted

with the Black faith community. One area that has emerged is in community-based participatory initiatives where faith leaders are often the target community aimed at greater involvement in church-based HIV/AIDS education and support services as well as reducing stigma (Berkley-Patton et al., 2010; Griffith, Pichon, Campbell, & Allen, 2010; Lindley, Coleman, Gaddist, & White, 2010). While the advancements demonstrate evolving attitudes about HIV/AIDS coupled with greater involvement of the Black church and its leaders, it is not without tension.

The Tensions of the Black Church and HIV Prevention

For many faith leaders, HIV is still a very difficult subject to address. The quandary that exists for many faith leaders is not whether to get involved in preventing HIV/AIDS, but more about what should be their level of involvement. There have been several studies conducted that have explored African America faith leaders perspective on topics related to HIV/AIDS prevention and the best approach to tackle the epidemic (T. Aholou et al., 2011; Alder et al., 2007; Barnes, 2009; McKoy & Petersen, 2006). The literature suggests that faith leaders are not oblivious to their members' involvement in risky sexual behaviors. However, for many faith leaders, their willingness to provide HIV prevention is dictated by the boundaries of church doctrine, theology, or biblical tenets (Barnes, 2009; Eke et al., 2010; Khosrovani, Poudeh, & Parks-Yancy, 2008). For example, in studies where both female members and clergy were the target populations (Khosrovani et al., 2008; McKoy & Petersen, 2006), the members, which were majority unmarried women, reported their involvement in unprotected sexual relationships. The clergy, however, acknowledge the need for HIV prevention in the church, yet they expressed tensions regarding education and distribution of condoms (Khosrovani et al., 2008; McKoy & Petersen, 2006). Further, some clergy have also expressed discomfort and distinctions about addressing the issues surrounding HIV (i.e. risk behaviors and prevention) from the pulpit versus one-on-one counseling sessions (Alder et al., 2007).

HIV Testing in Black Churches

It is evident that many churches and clergy, particularly in the African American community, are polarized on their approach to address HIV/AIDS prevention. While some clergy are proponents of abstinence-until-marriage, others advocate for safer sex. However, HIV testing has been recognized as essential first step in reducing the spread of HIV (CDC, 2009b; Grinstead, Peterson, Faigeles, & Catania, 1997). Therefore, it seems plausible that faith leaders may be willing to encourage church members and the community to learn their HIV status by way of HIV testing.

The Balm in Gilead, a faith-based CDC funded initiative, is one of several grassroots efforts that has remained consistently on the front lines since early in the epidemic (Eke et al., 2010). In 1999, the Balm in Gilead launched its "Our Church Lights the Way" (OCLTW) HIV testing campaign (Balm in Gilead, 2011). The campaign was designed to mobilize the faith community in articulating the importance of people learning their serostatus (Balm in Gilead, 2011; Eke et al., 2010).

Several studies have demonstrated greater interest and involvement of Black churches and faith leaders in promoting and providing HIV testing (Berkley-Patton et al., 2010; Griffith et al., 2010).In addition, Lightfoot et al. (2001)found that trained church volunteers were actually effective in diffusing HIV testing messages to the church body. Likewise, there is existing popular literature where Black clergy have encouraged their congregations and community to learn their HIV status. Others have shown clergy who publicly test for HIV in their congregations to demystify the stigma surrounding the HIV test. Lastly, clergy who works with premarital couples is another context in which research has shown that clergy have been able to promote HIV testing within intimate relationships (T. Aholou et al., 2011)While there is merit to these strategies, little is known about the attitudes and perceptions that faith leaders have about HIV testing.

In summary, the research continues to show the importance of the Black church and its faith leaders in every aspect of the lives of African Americans. Despite the delayed response of the Black church, the emerging body of literature coupled with the long-term efforts of grassroots endeavors is imperative. Nevertheless, while the struggle about HIV prevention continues to serve as a barrier for many faith leaders, the heterosexual transmission of HIV continues to rise. Therefore, the endorsement and influence of Black faith leaders (i.e. clergy) is instrumental to the acceptance of health promotion, and considered an integral strategy for faith-based approaches. This warrants the question, how prepared are the next generation of clergy (i.e. seminarians) to address this modern-day social and health crisis with their future congregants?

Clergy and Seminary Preparation

Studies and reviews have explored the preparation of seminary students to address issues relevant to relational concerns that many congregants encounter to include, yet not limited to marriage preparation (Buikema, 2002), sexuality (Conklin, 2001; Ott, 2009), and family planning (Goodson, 2002). An overarching theme in the literature is the lack of adequate training to address the pressing concerns brought to them by their congregants. For example, in the area of sexuality, Ott (2009) surveyed seminaries on the *Criteria for sexual healthy and responsible seminary* and found that of the 36 institutions included in the sample, some schools (9 out of 10) do not require seminarians to take a course in sexuality prior to graduation. Of the institutions that offer courses, however, courses are not offered every semester, and are optional depending on the program. More specifically, Ott (2009) states,

> Seminaries are not providing future religious leaders with sufficient opportunities for study, self-assessment, and ministerial formation in sexuality. They are also not providing seminarians with the skills they will need to minister to their congregants and communities, or to become effective advocates where sexuality issues are concerned. p. 4

While the focus of Ott's study was to address sexual health and responsibility in a very broad sense, there was no mention of HIV/AIDS in the executive summary.

With the exception of the work conducted by Barnes, very few studies have sampled African American seminary students. Barnes (2009)work is important for two reasons. First, she studies an underrepresented segment of the African American faith community, African American seminarians. Second, she specifically addresses HIV/AIDS. While preparation was not the focus of the study, like many other current faith leaders, the future leaders in this study also announced their sexual conservatism and their tensions regarding the HIV prevention discourse. The sexual conservatism has been a major critic of the Black church (Douglas, 1999; Fullilove & Fullilove III, 1999; Gould-Champ, 2008). Douglas (1999) argues that the Black churches stance on issues of sexuality, namely homosexuality was the basis for the ambivalence to confront the HIV AIDS epidemic.

Preparation has also been questioned in regards to the amount of counseling hours that seminarians are required to complete (Firmin & Tedford, 2007) study conducted by . Of the 31 evangelical Baptist seminaries included in their study, Firmin & Tedford found that the maximum number of credit hours that students were required to take was six hours; however, the majority was only required to take up to three hours.

Challenges for Clergy/Seminary

Research has shown that the direction for a church or ministry is often set by the pastor (Gould-Champ, 2008). Education level, particularly the completion of post-secondary or seminary training, has been found to be an important indicator of a pastor's willingness to address or promote HIV prevention with their congregants (Billingsley, 2002; Gould-Champ, 2008). Early in the epidemic, Edelheit (1994) admitted that most of the clergy serving in churches or in some aspect of church ministry were trained and ordained prior to the onset of HIV/AIDS as a social and major health crisis; therefore asserting a lack of training and preparation to address the complexities of the epidemic. Gould-Champ (2008) and Edelheit (1994) both recognize the influence of church leadership. This is true especially amongst African Americans (Martin et al., 2003). With that understanding, seminarians are urged to receive the appropriate education and

training to adequately address, while appropriately influence and mitigate the complexities that the previous generations were not faced with.

The combined concerns expressed by clergy about feelings of inadequacy to address marriage preparation; the lack of sexuality and counseling course requirements prior to graduation, followed by limited discussions about HIV raises questions about current seminarian students' readiness to address and intervene with couples regarding sexual health matters, to include HIV.

Gaps in the Literature

There are a number of gaps in the literature that this current study seeks to address. First, HIV testing has focused primarily on individuals, with little to no coordinated efforts to promote HIV testing for couples. Next, while there are several recommendations outlined to help couples address HIV, there is a gap in the literature about the perspectives of practitioners, namely clergy who work with couples. Another gap is the dearth of research that speaks to the clergy's attitudes and perceptions about HIV testing as a strategy to promote HIV prevention. Furthermore, there is existing research about HIV testing in church settings (see Lightfoot et al., 2001) and literature in the popular press that has demonstrated Black Clergy's influence to encourage congregants to test for HIV. Notwithstanding, there is little known about Black clergy's position on promoting HIV testing in the context of intimate relationships. Finally, this research fills a gap and gives voice to African American seminarians by exploring their attitudes and perceptions on an issue that is gravely impacting the African American community.

CHAPTER 3

METHODOLOGY

This chapter discusses why basic qualitative research was the most appropriate research design for the study. Next, the chapter describes the sample selection, methods, and procedures used to conduct the study. Finally, the chapter details the data analysis and steps taken to ensure trustworthiness, including the researcher's subjectivity.

The purpose of this qualitative study was to explore a sample of African American seminarians' attitudes, perceptions and knowledge about HIV and mutual HIV testing within intimate relationships. The research questions that guided this study were as follows:

1. What knowledge do African American seminarians have about HIV/AIDS?

2. What attitudes do African American seminarians hold about HIV testing as a form of prevention?

3. What meaning do African American seminarians ascribe to mutual HIV testing?

4. What attitudes and perceptions do African American seminarians have about normalizing mutual HIV testing with intimate partners?

5. What are the perceived tensions within the Black church associated with promoting mutual HIV testing with intimate partners?

6. What are the perceived needs of African American seminarians to facilitate mutual HIV testing with intimate partners?

Design of the Study

Although growing support for the Black church and its faith leaders' involvement in promoting HIV testing has been demonstrated in the literature, little is known about their attitudes and perceptions about HIV testing, particularly from the vantage point of seminarians. Moreover, due to the overwhelming focus on individual testing, there is much to learn about existing and

emerging Black faith leaders' views towards promoting HIV testing in the relational context, otherwise referred to as mutual HIV testing throughout the study. Given my interest in exploring and discovering the next generation of faith leaders, knowledge, attitudes and perceptions, I employed a qualitative research design, more specifically basic qualitative research.

At the heart of qualitative research is an acknowledgement that individuals socially construct meaning. As stated by Sharan B. Merriam (2002) "Qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences" (p. 15). In addition to the focus on meaning and understanding, qualitative inquiry is also characterized by (a) utilizing the researcher as the primary instrument for data collection and analysis; (b) a willingness to remain flexible with the research design; (c) an inductive process throughout data analysis; and (d) the use of rich description to express the views gleaned during data collection (Sharan B. Merriam, 2002; Patton, 2002).

Basic qualitative research is most appropriate when the overarching goal is to "uncover and interpret" the meaning that a phenomenon has for those involved (Sharan B. Merriam, 2002, p. p. 24). Hence, a basic qualitative study is the most appropriate research design to explore and understand the perspectives of African American seminarians regarding the promotion of mutual HIV testing within intimate relationships.

<center>**Theoretical Perspective**</center>

An epistemology "is a way of understanding and explaining how we know what we know" (Crotty, 2003, p. 3). Constructionism is the epistemology that sets the foundation for this study. Crotty (2003) stated this about constructionism: "Truth, or meaning comes into existence in and out of our engagement with the realities in the world" (p. 8). This knowledge of how meaning is derived and interpreted is further explained by symbolic interactionism, the theoretical perspective that guides this research. Williams (2008) defines symbolic interactionism as the "study of the meanings that people learn and assign to the objects and actions that surround their

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everyday experiences" (p. 849). In short, symbolic interactionism emphasizes the significance of meaning and interpretation (Patton, 2002). Moreover, Crotty (2003) stated, "only through dialogue can one become aware of the perception, feelings, and attitudes of others and interpret their meanings and intent" (pp. 75-77). Therefore, from a methodological standpoint symbolic interactionism both informs and supports the use of qualitative methods and underscores the significance of discovering and interpreting meanings prior to predicting behavior.

Although there are numerous scholars who have contributed to the development of symbolic interactionism as a theoretical perspective, the philosophical underpinnings of symbolic interactionism stems primarily from the works of George Herbert Mead and his student, Herbert Blumer (Blumer, 1986; S. Smith, Hamon, Ingoldsby, & Miller, 2009). Blumer (1986) established three central tenets for symbolic interactionism:

1. Human beings act towards things on the basis of the meanings that the things have for them.

2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.

3. These meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters (p. 2).

Essentially, the first tenet asserts that human behavior cannot be understood without first taking into account the meanings that a particular matter has for that person (S. Smith et al., 2009; White & Klein, 2002) . Furthermore, the meanings and subsequent interpretations come into existence through our experience and interactions with people (S. Smith et al., 2009). Based on this premise, in order to understand whether mutual HIV testing can and will be promoted by African American seminarians and future church leaders requires an understanding of the experiences and interactions that shapes their definitions, attitudes and perceptions about HIV, individual HIV testing, and mutual HIV testing.

The second tenet highlights the importance of self and mind (S. Smith et al., 2009).In their explanation of Mead's notion of self, Smith et al. (2009) described the "I' as our "immediate reactions to something" whereas the "me" is "the learned roles that are determined by interactions with others" (p. 12). This is further explained by the notion of "role taking" wherein individuals take on "the role of the other" (Blumer, 1986; p. 13; White & Klein, 2002; p. 66). For example, Bogdan and Biklen (2003) wrote, "In constructing or defining self, people attempt to see themselves as others see them by interpreting gestures and actions directed toward them and by placing themselves in the role of the other person" (p. 26). Another important stage of role taking is the *generalized other*, where individuals anticipate through the lens of norms, roles and expectations how others will respond or react to a gesture or interaction (Blumer, 1986; S. Smith et al., 2009; White & Klein, 2002). It is in this role taking process that individuals' perceptions are further illuminated.

The last tenet takes society into consideration (Smith et al., 2009). Within any culture or society, there are values, beliefs, traditions, and norms. As a result of being part of societies, cultures and sub-cultures, individuals learn the expectations that are germane to that particular environment and context, which in turn, influences their thoughts and actions. Nevertheless, while individuals may develop shared perspectives, meanings are socially constructed and negotiated through our interactions. Therefore, as suggested by Bogdan and Biklen (2003) people do not necessarily act or respond according to what is "supposed to be," they act or respond based on how they perceive things to be (p. 26). Furthermore, Williams (2008) posits, "people are autonomous, interpretive beings who have the ability to negotiate, modify, or reject the meanings they learn, thus actively shaping culture" (p. 848).

Therefore in this study, in addition to its methodological utility, the tenets and concepts of symbolic interactionism provides a lens to explore how African American seminarians' interactions with the culture as a whole and the sub-culture of the Black church, specifically

informs their understanding about HIV in the African American community, the relevance of HIV testing, and their interpretations about promoting and normalizing mutual HIV testing.

Approval to Conduct Research

The University of Georgia's Institutional Review Board (IRB) granted permission in September 2010 to proceed with data collection for this study under project number 2011-10092-0.

Sampling Selection and Recruitment

The sampling strategy employed for this study was purposeful sampling. Purposeful sampling entails being intentional about identifying and selecting individuals who can provide information-rich data with the goal of gaining a greater understanding about the phenomena understudy (Patton, 2002). This is in contrast to probability sampling that is characteristic of quantitative studies where the goal is to generalize to the larger population (Creswell, 2007; Sharan B Merriam & Associates, 2009; Patton, 2002) For this study, I employed three purposeful sampling strategies - criterion, snowball/network and emergent.

Sampling Strategies

First, a criterion sampling approach served as the basis for my recruitment efforts. Criterion sampling requires the researcher to identify a predetermined set of attributes as inclusion criteria to participate in the study (Palys, 2008; Patton, 2002). This approach is often recommended by qualitative scholars as a way to engage participants who can provide rich detail about the phenomena (Creswell, 2007; Sharan B Merriam & Associates, 2009; Patton, 2002). The five original criteria and rationale for selection of participants were:

1. Identified as an African American or second generation Black American seminarian.
   Rationale: I recognize African American faith leaders are often viewed as change agents in the African American community. As such, it was important to learn and understand future faith leaders' knowledge and attitudes about HIV/AIDS in general, and their perceptions about HIV testing in the context of intimate relationships.

2. Pursued a graduate degree in Divinity or Pastoral Counseling. Rationale: These degrees are required preparation for ministerial duties in communities, mostly through local churches.

3. Attended seminary in the state of Georgia. Rationale: This was necessary to maintain the context of the social and relational determinants of Georgia's HIV epidemic.

4. Enrolled in the second or third year of their graduate program. Rationale: This criterion was included to ensure that students had been exposed to coursework or nearing the end of their program.

5. Expressed an interest in leading or serving in a ministerial capacity. Rationale: There are numerous degrees that a person can seek while in seminary, yet not all degrees lead or prepare students for leadership in ministry or counseling. For example, some may attend seminary with the sole intent to teach in the academy instead of having direct interaction with the community-at-large. Therefore, the criteria for divinity or pastoral counseling as well as an expressed interest in serving or leading a ministry were important.

Next, I used a snowball/network selection approach. This strategy relied heavily on identifying information-rich individuals to help spread the word or refer other information-rich people to the study (Hutchenson, 2004; Patton, 2002). Finally, I utilized the emergent sampling approach. As previously stated, one of the strengths of qualitative research is the ability to be flexible. According to Patton (2002), emergent sampling is an approach which entails " on-the-spot decisions about sampling to take advantage of new opportunities during the actual data collection"(p. 240).

Recruitment and Enrollment

The recruitment phase started in October 2010 and went through the end of November 2010. While there were three sampling strategies, the actual recruitment techniques occurred primarily via snowball or face to face visits. Recruitment began at the beginning of October with the launch of the first phase of the snowball/network selection. During this first phase, I contacted

approximately 15 people within my own collegial and professional network that had an affiliation with a seminary in Georgia (e.g. alumnus, student, professor, or employee). Though these individuals were not included in the study, they were asked to forward the recruitment materials – an email invitation (**Appendix A**) and recruitment flyer (**Appendix B**) – to individuals within their networks who could be eligible for participation. The recruitment materials instructed interested persons to contact me for more information and to determine their eligibility for participation.

While the first phase of the snowball/network sampling was underway, I also contacted five Georgia seminaries that offered at least one of the two programs included as part of the inclusion criteria. During each contact, whether by email, phone or in face-to-face meetings, I requested an opportunity to visit a class on their campus to discuss the study and extend an invitation for students to participate. Once the recruitment materials and consent were reviewed, I was granted permission from three seminaries to recruit students from their campus It is noteworthy to mention that while permission was granted to recruit, one seminary instructed me to not use their name in the dissertation manuscript. Therefore, for confidentiality purposes, I assigned pseudonyms and a brief descriptor for each institution: Beacon, known for its diversity; Torch, for its global influence; and Freedom, for its scholarship.

As prospective participants began to hear about the study via snowball they contacted me by email, or phone to get more information. During face-to-face visits, the students provided their contact information and granted me permission to contact them to determine their eligibility. To ensure a balanced sample of male and female participants and to determine eligibility, I created an eligibility script and screener based on the original criteria (**see Appendix C**). However, in an effort to remain open to unanticipated opportunities for rich data, some exceptions were made during recruitment. As mentioned in the sampling section, there were a few instances where the emergent sampling approach seemed appropriate. For example, while talking with prospective participants during the eligibility screening, I realized that an interest in "leading and serving in a

ministerial capacity" as indicated in the original criteria, had different meanings to each person. As several people shared their intentions after seminary, I decided to extend the inclusion criteria to seminarians who desired to serve or minister in nontraditional community settings including urban ministry, youth outreach, and community-based organizations; otherwise considered as ministry that extended beyond the four walls of the church. The second occasion where emergent sampling occurred was during recruitment at the third and last seminary. An exception to the original criteria was made for an existing clergyman who had 10 years of ministry experience, yet only in the first year of his Master of Divinity program. After a brief conversation, he was deemed an information-rich case due to his years in ministry, his role in his church, and because he came from a different seminary and he could potentially offer a another perspective.

Once the seminarians were determined eligible or an appropriate, information-rich case and agreed to participate, I provided details about the interview process to include the estimated length of the interview. Enrolled participants were asked to choose an interview location and were told they would receive a one-time $20 gift card for their participation in the study from one of four locations: Target, Wal-Mart, Barnes & Nobles, and Ruby Tuesday, for their participation in the study.

Phase two of the snowball/network sampling occurred concurrently with data collection. After each interview, participants were asked to forward the recruitment materials to their peers. This approach was particularly useful to identify additional males for the study.

Overall, the different sampling approaches and recruitment techniques yielded 17 seminary students with whom I spoke with to determine their eligibility[2]. Of this number, 10 were enrolled and completed the study; one enrolled yet cancelled due to an emergency; and six were

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[2] An additional six prospects recruited via phase 2 snowball approach expressed interest, yet were not enrolled because saturation was achieved with 10 participants.

ineligible based on the original inclusion criteria[3]. Since interviews were conducted simultaneously with recruitment, once saturation was reached with 10 participants, recruitment ended. Table 1 charts the participant pool in terms of sampling and recruitment strategy.

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[3] Two expressed interest during the beginning of recruitment, yet indicated they were first year students. Therefore, no additional contact information was collected.

Table 1

Participant Pool and Enrollment Chart

	Participant Pool	Criterion	Emergent	Face-To-Face	Snowball: Phase 1	Snowball: Phase 2	Ineligible
ENROLLED	Female Participant 1	✓			✓		
	Male Participant 2	✓				✓	
	Male Participant 3		✓		✓		
	Male Participant 4	✓				✓	
	Female Participant 5		✓	✓			
	Male Participant 6	✓				✓	
	Female Participant 7	✓		✓			
	Female Participant 8	✓		✓			
	Female Participant 9		✓			✓	
	Male Participant 10		✓	✓			
NOT ENROLLED	Female/ 1st Year Student			✓			✓
	Female/1st Year Student			✓			✓
	Female/ Theology			✓			✓
	Female/ Theology			✓			✓
	Male/ Theology					✓	✓
	Male/Lived Too Far			✓			✓
	Male 3rd Year Cancelled	✓				✓	

<center>**Data Collection Methods**</center>

This study utilized three data collection methods: participant profile survey, interviews and an HIV/AIDS Knowledge Scale. The methods were selected to gain greater insight and understanding of the participants' background, views regarding HIV, prevention, and mutual HIV testing, and knowledge about HIV. A description of each method in the order by which it was conducted is provided below.

Participant Profile Questionnaire

A participant profile questionnaire was created to collect demographic information about the participants as well as their respective churches (**see Appendix D**). According to Bloomberg and Volpe (2008) demographic information is useful to "help explain what may be underlying an individual's perceptions, as well as the similarities and differences in perceptions among participants" (p. 70). The questionnaire requested participants' demographic data, current academic focus, church involvement, estimated demographic data of the church membership where they attend services as well as information in reference to HIV testing services offered at their respective place of worship.

Interviews

In order to generate information-rich, perceptual data (Bloomberg & Volpe, 2008), interviews were conducted as the primary data collection method to engage the participants in conversations about their background, attitudes, and perceptions regarding HIV, prevention, and mutual HIV testing. Interviews are commonly used in qualitative research "in order to discover and explore the range of variation among individuals and to find patterns of similarity and difference" (Schensul, 2008, p. p. 524)). The most common interview formats are unstructured, structured, and semi-structured. With unstructured interviews, the participant has the latitude to speak freely about a topic while the researcher follows their lead. As a result, the researcher has little control over what will emerge in their data set (Patton, 2002). On the other end of the spectrum is the structured interview, which is typically a standardized, close-ended interview

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protocol where the questions are derived from the literature with fixed responses. Due to the intended structure of this format, all participants are asked the same questions in the same sequence, thereby making it easier to aggregate the data (Patton, 2002). However, one significant shortcoming is that the fixed responses limit the participants' ability to respond in a manner that accurately reflects their beliefs or experiences (Patton, 2002).

For this study, a semi-structured interview format was selected. As suggested by the name, a semi-structured interview includes a predetermined set of questions, which served as the interview guide to "increase the comprehensiveness of data" (Patton, 2002, p. 349), and remain flexible enough to ask the questions in an unstructured format (deMarrais, 2004). The interview protocol was organized according to the research questions (see **Appendix E**). Moreover, since the researcher is the primary instrument, the semi-structured format afforded me the opportunity to probe and ask additional questions to gain further insight, as needed (Sharan B Merriam & Associates, 2009). Aside from the strengths of this format, the limitation was the potential to ask questions differently from one participant to the next, which could change the interpretation as well as pose challenges in terms of comparability across interviews.

The interview guide was comprised of different question types to elicit a rich understanding about the phenomena. Demographic and background questions including "What prompted you to attend seminary?" began the interview. These questions served a three-fold purpose:

1.   Put the participants at ease before delving into the topic of HIV/AIDS.

2.   Participants were able to reflect at the level that they felt most comfortable.

3.   Allowed me to learn more about each participant, beyond what the participant profile could capture.

The background questions were followed by a mixture of "opinion and value questions," such as "What does mutual HIV testing symbolize to you?" According to Patton, "opinion and value" questions are generally asked to gain insight into the participants' attitudes and

perceptions about the phenomena under study. Therefore, given the purpose of the study, this was the most frequent question type solicited. Lastly, "ideal" questions were included, which allowed participants to brainstorm suggestions, such as "What strategies could be used to promote mutual HIV testing?" (Sharan B Merriam & Associates, 2009).

HIV/AIDS Knowledge Scale

The last data collection method was an HIV/AIDS Knowledge Scale. Although the study was primarily qualitative, an HIV/AIDS Knowledge Scale was included as a secondary method for two reasons. First, in a recent study that closely resembled the current study, Aholou and colleagues (2011) explored the perspectives of seven African American clergy regarding sexual health dialogue and HIV testing in premarital counseling with an entirely qualitative research design. Aholou et al. (2011) suggested that the use of an objective HIV Knowledge Scale may have offered additional insight into the clergy members' level of HIV knowledge. As a result of these findings, the HIV/AIDS Knowledge Scale was added as a data collection method to assess the participants' 'factual' knowledge. Furthermore, it supplemented the information gained during the interview regarding the participants' perceived about HIV.

The HIV Knowledge Scale used for this study was adapted from a cross-sectional, faith-based study with a sample of 1,615 African American clergy and church members in South Carolina (Lindley et al., 2010). The original instrument measured HIV Knowledge and Stigma and was split into three sub-scales. For the purpose of this study, the second scale which consisted of 20 items that measured knowledge about HIV was adapted. The statements were presented in a forced-choice style, with response choices of "True," "False," and "Don't Know." In its original state, the sub-scale reported a Kuder-Richardson alpha of 0.756. However, four additional items were included based on research conducted by Morrill and Noland (2006), which specifically addressed HIV testing with a focus on testing between intimate partners. The inclusion of the

additional items changed the instrument to a 24-item measure[4] (see **Appendix F**). With the adaptations made to the instrument, the psychometric validity data also changed. However, due to the purpose of the study and the sample size, my dissertation committee and two peer panelists determined the instrument had high face and content validity.

Historic Contextual Events

Throughout the data collection phase of the study, there were two notable events in the media that was relevant and made an impression on the participants. First, in late September 2010, a prominent African American bishop and televangelist allegedly used his power and influence to coerce four, young, former male members of his church into sexual acts. This issue profoundly impacted the African American community and the Black church as an institution. While this event started a community discourse around issues pertaining to sexuality, it also led to debates and gossip that eventually caused divisions in the African American community. The second event was the movie release of "For Colored Girls." The movie addressed a plethora of issues that plague the lives of many African American women. Some of the more salient topics included low self-esteem and self-worth, intimate partner violence, abortion, the effects of sexually transmitted diseases, and a wife who contracted HIV in her marriage. Although the two media events did not directly address mutual HIV testing, the surrounding issues of sexuality, the church, sexual health and relational risks intersected with the research.

Data Collection Procedures

After receipt of approval from the Institutional Review Board, the instruments were pilot tested with a seminarian colleague, who also served as a peer panelist. The pilot test was conducted to ensure that the questions generated the type of responses that were expected. Based on his responses to the questions and subsequent feedback, the instruments were refined to include additional opening questions. For example, because of our friendship, it was easy to go

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[4] See notes in data analysis for additional information about the changes made to the HIV Knowledge Scale.

directly into the interview without concern of being too abrupt. However, the sensitive nature of the topic of HIV warranted the inclusion of a few background questions for introductory purposes. Also, the pilot test provided an estimated time to conduct the face-to-face interview from start to finish.

After enrollment into the study, the face-to-face meeting was scheduled to take place at mutually determined times and locations including restaurants, a bookstore, and in one participant's home. Upon meeting the participants, I provided an overview of the study and reviewed the informed consent, with emphasis placed on the voluntary nature of their participation (see **Appendix G**). Once reviewed, all participants signed two copies of the consent and kept one for their records. All of the participants granted me permission to audio record the interview for transcription purposes.

Each participant completed the participant profile and selected a pseudonym that was used throughout the face-to-face meeting to maintain confidentiality. In addition, participants were asked to create a unique identifier code that was based on their Gender, Initials, and Date of Birth (e.g. FTMA010172). Once completed, the profile was used to segue into the semi-structured interview. To minimize bias during the interview, participants completed the HIV Knowledge Scale after their interview, which allowed them to ask questions and for me to respond, as needed.

The 10 initial face-to-face meetings, ranged from one-and-a-half to three hours, with the average being one hour and twenty minutes. At the close of each interview, participants were given a $20 gift card to one of four locations depending on their preference. Follow-up phone interviews were completed with four participants, to get additional clarity or input on topics that emerged during subsequent interviews with other participants. The average time for the follow-up interviews was one-half hour.

Data Analysis and Procedures

The different methods of data collection required different analysis strategies. A description of each data analysis strategy and procedure are discussed below.

Interview Data Analysis

To manage the data and aid in the data analysis process, the Atlas.ti 6.2 Computer Assisted Qualitative Data Analysis (CAQDA) software was used (Scientific Software Development, 2010). Several qualitative scholars have highlighted the various functions and advantages of using CAQDA (Creswell, 2007; Sharan B Merriam & Associates, 2009; Miles & Huberman, 1994; Patton, 2002). The features that influenced my decision to proceed with the Atlas.ti CAQDA were (a) the ability to store the data associated with the study in an organized database; (b) create codes; (c) code segments of the data; (d) retrieve segments of data; (e) compare across the data set; and (f) categorize the data (Miles & Huberman, 1994; Patton, 2002). However, the disadvantage of using any new software, including a CAQDA program is the learning curve associated with running the program (Creswell, 2007). Despite the relatively small project and learning curve, the process was beneficial.

The constant comparison method, thematic analysis and Spradley's universal semantics were used to analyze the qualitative interview data (Braun & Clarke, 2006; Glaser & Strauss, 1967; Spradley, 1979). The constant comparison method was initially described as a component of Grounded Theory; however it is now commonly used in qualitative research as a stand-alone form of data analysis without the need to build theory (Sharan B Merriam & Associates, 2009). Using constant comparison method, segments of data were coded and compared within and between transcripts to identify similar patterns and categories. The aforementioned constant comparison method was also coupled with aspects of thematic analysis. Braun and Clark (2006) describe thematic analysis as "a method for identifying, analyzing, and reporting patterns (themes) within the data" (p. 79). Furthermore, they suggest that "a rich thematic description" is most appropriate for "under-researched" topics or with participants whose voice on the matter is

unknown (p. 83). Finally, Spradley's universal semantic relationships were used to refine overarching themes and thematic categories into subsequent properties.

Interview data analysis procedures. In the tradition of qualitative research, data collection and data analysis occurred simultaneously (Sharan B Merriam & Associates, 2009; Miles & Huberman, 1994). After each interview, memos regarding the immediate impressions about the interview were captured in my dissertation journal. Next, the interview data was transcribed verbatim into written format. Of the 14 transcripts, I transcribed three and hired a transcriptionist to complete the remainder. While the data was being transcribed, I repeatedly listened to the audio recordings (a) to determine if there were any additional questions that needed to be asked of new participants or clarified with the current participants; (b) to become immersed in the data, (c) to generate a list of preliminary codes; and (d) to record audio memos to track musings as they occurred. As transcripts were completed, each was checked against the audio recording for accuracy. The accuracy checks allowed me to become further immersed in the data.

To begin the coding phase, the transcripts were uploaded into the Atlas.ti 6.2 software and I proceeded to select segments of the data that were relevant to the study. Initial coding started with a list of a priori codes derived from the research questions and literature. This was followed by a more inductive, data-driven approach, which included the generated code list as well as new codes that were derived from the written text. This recursive process continued throughout the entire data set. Similar codes were collapsed and codes that were no longer related were deleted.

I then used the codes to develop categories using components of Constas' (1992) category development framework. Constas argues that "categories do not simply "emerge" from the data. In actuality, categories are created, and meanings are attributed by researchers…" (p. 254). Moreover, he advocates for qualitative researchers to document the category development process.

Based on Constas' framework, the specific procedural components that informed my category development process were origination, nomination, and temporal designation. Although Constas' used the same label types to describe origination and nomination, the components are distinctly different. Origination "identifies the locus of category construction" (Constas, 2001, 257), whereas nomination is specific to the source by which the name of the category was derived. The four labels for origination and nomination used in this study were adapted from Constas (2001, pp. 257, 260):

- 1 – Theme/Category derived by the research questions/interviews questions

- 2 – Theme/Category derived by the participants/in vivo

- 3 – Theme/Category derived by the investigator

- 4 – Theme/Category derived from the existing literature/theories

Temporal designation places emphasis on when the category was assigned such as before, during, or after data collection or some aspect of the research process (i.e. data analysis). The three designations defined by Constas (2001) were also used for this study:

- A – A priori – Before the data are actually collected

- B – Posteriori – After the data have been collected

- C – Iterative – Created at some point in the analysis

Categories derived from the participants and assigned iteratively were most frequent. **Appendix H** charts each of the categories including the properties; however, a more detailed discussion of the categories is included in Chapter 4.

After the categories were developed, each were grouped to determine relevant patterns and potential themes. During this phase, Spradley's universal semantics were used to create the categories and properties associated with the overarching themes (Spradley, 1979). For example, the semantic domain, "Means-end" "X is a way to do Y" was used to determine strategies (X) to promote and normalize mutual HIV testing (Y) (for additional examples see **Appendix I**).

Although I noted the prevalence of various themes, prevalence did not determine importance. Once the thematic categories, sub-categories, and properties were organized to correspond with the respective overarching theme, I named each to reflect the "essence" of the theme or actual phrases from the data and also assigned brief descriptors for each theme (Braun & Clarke, 2006). As a final step, rich exemplars were selected that best captured the essence of the topic under study.

As with all qualitative research, there was an abundance of data. Some of the data was interesting, yet not related to the topic under study or it did not correspond directly to research questions. When appropriate, I retained some of this data in the participants' summaries.

Participant Profile Data Analysis Procedures

After each interview, the information provided on the Participant Profile was entered into an excel spreadsheet to manage the data. Pseudonyms and their unique identifier code were entered for confidentiality purposes. Once all the data was entered, descriptive analysis in the form of means, frequencies, and percentages were used to provide an aggregated description of the sample, describe the composition of the church, and HIV testing information (Bloomberg & Volpe, 2008). In addition, the information gathered from the Participant Profile was composed into a brief Participant Summary.

HIV Knowledge Scale Data Analysis and Procedures

The data management spreadsheet was also used to store the data from the HIV Knowledge Scale. A score of '1' was assigned for correct responses and a '0' for all incorrect responses and items marked as "Don't Know" (Lindley et al., 2010). The raw scores were summed to get an individual HIV Knowledge Score. It is important to note that while the scale was reviewed prior to data collection for face and content validity, once the data was collected and reviewed with a peer panel member (an HIV Prevention Behavior Scientist), it was decided to disregard one item from the original scale due to poor wording ("*It is possible, but unlikely, to get HIV from an HIV test*"). This resulted in a 23-item forced-choice HIV Knowledge Scale. The

items from the scale were grouped into six categories with a brief narrative included for each category. It is also important to note that the data obtained from the knowledge scale was only used to describe and contextualize, where appropriate, the qualitative data. Therefore this research did not project any hypothesis regarding the participants' knowledge and attitudes.

Issues of Trustworthiness

As the primary instrument for data collection and data analysis, it was imperative for the research to be conducted in a trustworthy manner. There are several strategies that are recommended to increase the rigor and accuracy of qualitative research. The following is an explanation of the steps applied to demonstrate credibility, consistency, and transferability in this study (Creswell, 2007; Sharan B Merriam & Associates, 2009).

Credibility

Bloomberg and Volpe (2008) described credibility as "whether the participant's perceptions match up with the researcher's portrayal of them" (p. 77). There were several strategies used to ensure credible findings. First, I remained engaged with the data for a significant amount of time, also known as *prolonged engagement* (Bloomberg & Volpe, 2008). For example, I listened to the recordings while the data was being transcribed and then again as transcripts were checked for accuracy. In addition, with the multiple readings of the transcripts, I developed a deeper understanding about the topic under study (Creswell, 2003). I used the member-check technique with one participant to determine if the participant's voice was accurately reflected in the preliminary findings. I also intentionally identified negative or discrepant information that challenged my way of thinking about the data and offered an alternative explanation (Sharan B Merriam & Associates, 2009). Finally, I made my biases known.

Consistency

Consistency in qualitative research does not aim to replicate findings. Rather, the goal is to determine whether there is a sense of agreement by the reader about the findings conveyed in

the data (Sharan B Merriam & Associates, 2009). To achieve consistency in this study, a number of strategies were utilized. First, I used a journal to keep an audit trail of the study. I used the journal to write memos and musings as well as decisions regarding data collection and data analysis (Bloomberg & Volpe, 2008; Sharan B Merriam & Associates, 2009).Also, I conducted method triangulation to increase the consistency. As Bloomberg and Volpe (2008) wrote, "surveys and questionnaires, which are traditionally quantitative instruments, also can be used in conjunction with qualitative methods to provide corroboration" (p. 73). To this point, as posited by many qualitative scholars, the inclusion of the HIV Knowledge Scale helped to triangulate the participants' knowledge about HIV (Creswell, 2007; Sharan B Merriam & Associates, 2009; Patton, 2002) .For example, both the semi-structured interviews and HIV Knowledge Scale explored participants' stance on HIV testing. The combined methods helped to convey their factual and perceived HIV knowledge.

The last approach involved the formation of a peer debrief panel to ensure that I remained true to the data. The peer panel consisted of two seminarians, one HIV Prevention Behavior Specialist, one Health Communication doctoral candidate, and a pastor. Members of the panel were consulted to discuss themes and my initial interpretations of the data. Some also served as readers and provided input on the presentation of the findings.

Transferability

Transferability is often discussed in comparison to the generalization of findings to other studies or settings (Sharan B Merriam & Associates, 2009). While the goal of qualitative research is not to achieve generalizability, it is important to present findings in such a way that the results could be transferred to another setting (Sharan B Merriam & Associates, 2009). Rich, thick description is one strategy used to enhance transferability of research findings. In this study, descriptions of the participants were included to contextualize the findings and add transferability value.

Researcher's Subjectivity

According to Williams (2008), symbolic interactionism acknowledges that "all science is done from a particular standpoint" (p. 849). Symbolic interactionist are also encouraged to make known the biases, values, interests, and assumptions that impacts the research process in order to ensure that research findings are credible (Williams, 2008; p. 849).

As a Christian who has been actively engaged in preventing the spread of HIV for nearly 20 years, it is my belief that the faith community has a role to play in promoting HIV prevention. While I am not a pastor or clergy member, I do serve in ministry as a missionary. That being said, I am not oblivious to the polarized discourse - no sex vs. safe sex - that divides religious circles concerning their role in HIV prevention. Admittedly, as a Christian, over the years, I too have engaged in both implicit and explicit debates regarding the role of the church in the fight against HIV. It is because of these polarities that my previous and current research has focused on finding a pathway to engage faith leaders, particularly the Black church, in promoting HIV testing, with an added emphasis given to intimate relationships. Given that the epidemic has reached the 30 year mark, it is my assumption that seminaries are being prepared to face and address the challenges concerning the AIDS epidemic, and therefore making seminarians fertile ground to begin an exploration of how this can be done.

Also, as an African American woman, it is devastating to see how rampant the AIDS epidemic is in the African American community, especially for women. As I shared in the Forward to this document, many African American women find themselves in a vulnerable position when it comes to protecting themselves. Having this knowledge has influenced my interest in targeting couples. I believe that HIV prevention that targets both partners in a relationship, benefits both the union, but especially the woman in the relationship.

While these biases and beliefs have influenced the lens through which I go about this research process, I am careful not to dismiss or lead the participants. My research experiences

coupled with the various aforementioned strategies helped me suspend these biases such that I remained open minded to the process of discovery.

Chapter Summary

This chapter included a discussion regarding theoretical perspective that guided the research process. Also, included was a detailed discussion about the research design, including the sampling criteria, methods, data collection and analysis, as well as the process taken to ensure trustworthy research. The following chapter introduces the participants and provides a detailed and rich description of the findings related to this study.

CHAPTER 4

FINDINGS

This chapter provides a detailed description of the findings gathered during interviews and an HIV assessment scale with 10 Black seminarians. The purpose of this study was to explore their knowledge, attitudes and perceptions about HIV, prevention and HIV testing within intimate relationships (also referred to as mutual HIV testing in this study). The research questions that guided this study were:

1. What knowledge do African American seminarians have about HIV/AIDS?

2. What attitudes do African American seminarians hold about HIV testing as a form of prevention?

3. What meaning do African American seminarians ascribe to mutual HIV testing?

4. What attitudes and perceptions do African American seminarians have about normalizing mutual HIV testing with intimate partners?

5. What are the perceived tensions within the Black church associated with promoting mutual HIV testing with Intimate partners?

6. What are the perceived needs of African American seminarians to facilitate mutual HIV testing with intimate partners?

The remaining chapter includes a description of the participants, an overview of the thematic categories, and follows with numerous exemplars, with thick description extracted from the interviews to give voice to the participants regarding the topic under study as well as to support the various categories and subsequent sub-categories. The chapter concludes with a summary of the overarching findings.

Description of the Participants

Ten African American seminarians recruited from three seminaries in Georgia participated in this study. The sample included an equal number of males and females. The mean age was 38.4 (range=24-56). Although the participants were homogenous in terms of race/ethnicity and their pursuit of the Master of Divinity (MDiv), as depicted in Table 2, there was a significant amount of diversity in other areas. There were five third-year students, four second-year students, and one first-year student. Two participants were married with children; two divorced; one self-identified as "committed" in a same-sex relationship with a child; and the remaining five indicated they were single. Almost all of the participants were from parts of the south with five specifically from states within the Deep South region; only one participant was from the northeast region.

There was also variability in terms of their denomination and religious beliefs: two identified as nondenominational; two as Baptist; two as United Methodist; one as Church of God in Christ (COGIC); and one as African Methodist Episcopal. One was part of "The Fellowship" denomination. Also, there was one participant who did not identify with a denomination, yet instead identified with metaphysics and traditional African faith traditions. Lastly, the participants were categorized into three groups, based on their intentions after seminary: four existing clergy (EXC), two emerging clergy (EMC), three who seek to minister or serve in settings outside of the church, Beyond Four Walls (B4W) and one who declared both, emerging clergy and Beyond Four Walls. Following Table 2 is a brief summary of each participant.

Table 2

Participants-at-a Glance

Pseudonym	Gender	Age	Self-Described Marital Status	Region of Origin	Year in Seminary Program	Denomination	Post-Seminary Intent
Chris	M	24	Single	Deep South[5]	3rd	United Methodist	EXC
Jack	M	25	Single	Deep South	3rd	United Methodist	B4W/ EMC
Jake	M	31	Single	South[6]	3rd	Non-denomination	B4W
Lillian	F	34	Single	Deep South	2nd	Baptist	B4W
Justice	F	36	Divorced	South	2nd	Baptist	EMC
Jaybird	M	40	Single	South	2nd	AME[7]	EMC
Zoey	F	42	Divorced	Deep South	3rd	Metaphysics	B4W
Denise	F	46	Committed	Northeast	3rd	The Fellowship[8]	EXC
Son	M	50	Married	Deep South	1st	COGIC[9]	EXC
Goddess[10]	F	56	Married	Deep South	3rd	Non-denomination	EXC

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[5] The following six states make up the Deep South: AL, GA, LA, MS, NC, and SC

[6] The southern region is comprised of the following: AL, AR, DE, GA, FL, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV and D.C.

[7] AME stands for African Methodist Episcopal

[8] The Fellowship is a pseudonym for the name of a particular denomination.

[9] COGIC stands for Church of God in Christ

[10] Goddess has been an existing clergy for many years, yet not active at current place of worship.

Participant Summaries

Chris, a 24-year-old single African American male is originally from the Deep South. He received his calling to ministry when he was 18 years old. Though he resisted initially, after finishing his bachelor's degree, Chris began pursuing a career in ministry. As a third-year Master of Divinity student, Chris expressed his reason for attending seminary was, "the need for young, effective leadership in our generation." As a result, Chris often ministered to youth and young adults.

Chris served as the "Pastor-in-Charge" in a rural, predominantly Caucasian United Methodist Church. He described most of the congregants as female (70%) with approximately 30% of the congregation unmarried. Upon graduation, Chris mentioned aspirations to become an ordained pastor with an emphasis on teaching biblical principles in the context of the 21st century. He also indicated his plans to seek his doctorate.

In regards to HIV, Chris was transparent about his own personal HIV testing experience. He mentioned how the experience influenced his subsequent decisions to wait until marriage to have sex. In terms of his attitude about HIV prevention, Chris endorsed abstinence, yet also advocated for sexually active persons to use protection. His views about HIV and the topic under study were informed by his knowledge about the disease and its implications. Furthermore, he stated, "my own test…I think it just opened up my eyes to 'this is real; this is serious.'"

Jack, a 25-year-old single African American male was born and raised in the Deep South and has lived in the same state all of his life. Jack started preaching at the young age of 14 and has been actively involved in ministry ever since. In recent years, Jack indicated that he felt called to community outreach ministry. After he earned his bachelor's degree, Jack went straight to seminary. He stated that seminary was "a step to pursue my call…" As a third-year Master of Divinity student, Jack stated that while graduation from seminary would permit him to pastor a local congregation in the UMC, Jack expressed that he first would like to conduct inter-faith, urban ministry focused primarily on community outreach and counseling with teen mothers. Jack

also served as the Sports Minister Director in a rural, predominately African American UMC with approximately 250-500 congregants. Based on his description, approximately 60% of the congregation was female and unmarried individuals, respectively.

Regarding HIV, Jack conveyed immense compassion. While the media informed most of his views about HIV, Jack also recalled the support he offered to a friend who was in a serodiscordant relationship as being pivotal regarding his attitudes about the topic of MHT. Jack strongly supported safer sex practices.

Jake, a 31-year-old single African American male is originally from the Southern region. After his undergraduate studies, Jake worked in the nonprofit sector for several years when he received his call into the ministry. Nearing the end of his third-year in the Masters of Divinity program, Jake shared that rather than serving as a clergy person, he intended to remain in the nonprofit sector, to act as a bridge between the church and community. He hoped to create and maximize resources that in turn benefit the community. Jake attended a large (>2000), predominantly African American non-denominational church in a suburban community and described the congregation as mostly (60%) unmarried females. Jake did not hold a position in his church or any other church.

Jake voiced strong opinions about HIV. He self-identified as a "conspiracy theorist" who firmly believed that a cure for AIDS already exists. He endorsed the use of condoms and actually considered abstinence as a "token response," especially in today's culture. Besides making references to the media and having a distant cousin infected with HIV, Jake stated that most of his information about HIV was obtained through interactions with people who conduct research pertaining to HIV.

Lillian, a 34-year old single African American female came from a city in the Deep South region. Lillian admitted it took her 12 years before she answered her call to ministry because she felt unworthy and because the Baptist church did not accept women in ministry at the time. Nevertheless, after she completed her bachelor's degree and several personal encounters

with God, Lillian answered the call. She is now a second-year Master of Divinity student. Her aspirations after seminary involve community outreach to encourage and assist girls and women.

Although Lillian identified with her Baptist roots, she attends a large (>2000), predominantly African American, nondenominational church in the urban community. She estimates the congregation to be 70% female and 40% unmarried. While she did not hold a position in the church she attended, Lillian indicated that she served as a teacher in Children's Ministry elsewhere, in the urban community.

Lillian spoke passionately as we discussed HIV. Different things influenced her views about HIV and the topic under study. First, she was influenced by her own personal research about HIV and the Black church. She also had two close friends who died from HIV, both of whom were the sons of her former pastor. Most importantly, her personal experiences as a single African American woman have also influenced her views. In fact, Lillian disclosed during the interview, "For the first time in 34 years, I really want to know my status." As far as HIV prevention, her attitude is to meet people where they are; hence, she does not oppose the use of condoms if that is needed to keep people safe.

Justice. Justice is a 36-year old divorced African American female. While she is originally from the Southern region, she has lived on the west coast and more recently moved to the Deep South. Prior to seminary, Justice completed her Juris Doctorate and worked in the law field. Her legal background evoked a passion for social justice. This interest inspired Justice to combine her seminary training with law. As a result, Justice aspires to demonstrate a balanced view of what it means to be a woman pastor in the 21st century. In addition, she would like to teach in seminary with an emphasis on social justice. She is currently a second-year Master of Divinity student.

Justice attends a predominantly (>2000) African American Baptist church in the urban community. She described the congregation as 60% female with 40% as unmarried. At the church

where she attends, she serves as the praise and worship leader and Youth Minister of Music. Justice is also a student intern at another local church.

Justice has been impacted by HIV on many levels. First, she recounted how her mother received a blood transfusion while giving birth to her sister during the early years of the epidemic; neither was infected with HIV. Second, she mentioned several relatives who died from HIV. Third, and most importantly, she expressed, as a divorced African American woman, the epidemic has caused her to become "leery" about dating. Regarding her attitudes about HIV prevention, Justice strongly encourages people to wait until marriage to have sex; however, she also believes that it is equally vital to use protection if sexually active. Justice indicated that her views about HIV and the topic at hand were influenced by her personal experiences as well as her interactions with the homosexual community, education, and other heterosexual couples.

Jaybird. Jaybird is a 40-year-old single African American male originally from the southern region. Although Jaybird served in the Armed Forces and earned his Bachelor's degree, he admitted to having a rough upbringing including a history of drug use, drug dealing, and being shot. He indicated that this lifestyle led to his "call to repentance" and his eventual call to ministry. Jaybird has served eight years as a pastor for two small African Methodist Episcopal (NIMH Multisite HIV/STD Prevention Trial for African American Couples Group) churches in his home state. He made the decision to stop serving as a pastor to attend seminary and is currently a second-year Master of Divinity student.

Although Jaybird most identified with the AME denomination, he currently serves as Youth Pastor of a rural United Methodist Church with a congregation of approximately 250 African American members. He described the congregation as comprising mostly unmarried females. Despite his years of experience, he considered himself to be an emerging clergy member. Nevertheless, upon completion of seminary, Jaybird wants to serve as a Senior Pastor again, with hopes for a larger congregation in the AME denomination.

Jaybird has a real passion to reach people who engage in high-risk behaviors such as active drug users and is very committed to people from rural communities. His previous experience as an HIV testing counselor informed his views about HIV and HIV testing. Jaybird's attitude about HIV prevention is foremost abstinence and education. However, he believes that it is crucial for people, regardless of sexual orientation, to be sexually responsible.

Zoey. Zoey is a 42-year-old African American female and is originally from the Deep South. In fact, she has lived in three of the six Deep South states for most her life. Zoey has been married twice; however, both marriages ended in divorce. She currently holds a bachelor's degree. Zoey described her call to the ministry as "unconscious" because it came after she was sexually harassed by a clergy person. Despite the resistance, difficulties and stress she encountered during the experience, it led her to realize her passion to fight against "abuse and injustice." Her commitment to social justice along with other work experiences led her to pursue of the Master of Divinity degree program, where she is now a third-year seminarian. Upon completion of seminary, Zoey plans to continue working in urban ministry and wants to collaborate with Black churches to address many of the social ills in the African American community. Aside from her position as a Chaplain Intern, Zoey does not attend a church nor does she identify with any Christian denominations.

HIV has personally affected the way Zoey views intimacy. She often used terms like "scared" and "terrified" to describe her hesitance about dating and sex. Surprisingly, while she was quite feisty in discussions about HIV, Zoey shared, towards the end of the interview, she had never been tested for HIV but expressed intentions to do so. In terms of prevention, Zoey supported risk reduction approaches to include strategies that reduce risks for incarcerated populations, drug users, and even the use of female condoms. Her education, the media, and her heterosexual and homosexual friends have influenced her views about this topic.

Denise. Denise is a 46-year old African American female. She is in a committed same-sex relationship and has a teenage son. Although Denise was born in the northeast, she spent a lot

of time in the south where she eventually moved. Growing up in the Baptist tradition and being same-sex attracted at an early age caused Denise to struggle with her call to the ministry. Once she moved away from the northeast, Denise eventually became affiliated with her current denomination, "The Fellowship". This denomination affirmed her same-sex attractions and fostered her call to the ministry. Before she enrolled into the Master of Divinity program, Denise had several years of graduate school experience as well as a background in law and nonprofit management. Both her personal and professional experiences led to her commitment to address social justice issues. This commitment along with her interest in being challenged and learning different perspectives led Denise to attend seminary where she is a second-year Master of Divinity student.

In addition to being a student, Denise holds the position of Assistant Pastor of a small (<100) African American church that affirms same-sex relationships. The congregation was described as 50% female and 35% unmarried. Upon completion of seminary, Denise plans to continue in her role as a pastor; however, she is not opposed to branching out if an opportunity presents itself.

HIV has affected Denise in several ways. Firstly, her denomination, "The Fellowship" was birthed in response to the AIDS epidemic. Secondly, she has a brother who is living with HIV, yet because of his denial does not adhere to his medication regimen. Lastly, she has several friends and congregants who are either living with HIV or have lost their battle to HIV. These experiences have given her a heightened sense of compassion to marginalized populations. As for HIV prevention, Denise advocates for risk reduction strategies including the use of condoms and needle exchange programs for intravenous drug users.

Son. Son is a 50-year-old African American male, married for 24 years with four children. He has lived in the Deep South all of his life where he also completed his Bachelor's degree. Throughout the interview, Son spoke candidly about his faith in Christ and trust in God's Word, the Bible. Son recalled, as a young man, being extremely passionate about learning the

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things of God. This passion led to his eventual call to the ministry. Although he grew up in the Church of God In Christ (COGIC) denomination, Son is a pastor of a small (< 100) nondenominational church that he founded 10 years ago. He described the congregation as being made up predominantly of African American females (60%), with an equal amount of married and unmarried congregants. He primarily attended seminary for practical purposes – he needed to be seminary trained in order to get insurance for his ministry. Upon completion of seminary, Son intends to remain the Senior Pastor of his church. In addition, he plans to expand the ministry to include a 24-hour transitional center that addresses a number of spiritual and social issues. He is a first-year Master of Divinity student.

HIV first affected Son when he and his wife were required to test for HIV as part of an adoption process. Although neither tested positive, he indicated that they still make a habit of being tested on an annual basis. Son also mentioned that education about HIV, his encounters with family members whose drug history placed them at risk for HIV, and the sexual behaviors he has observed in the culture and church has influenced his views about HIV and the current topic. Son's attitude about HIV prevention is foremost in support of abstinence and education.

Goddess. Goddess is a 56-year-old African American female, married for 38 years with five children. Although she is originally from the southern region, she has lived in many different states, with the Deep South being her principal place of residence. She was called into the ministry in her early 20s, yet resisted the call due to the negative attitude of various denominations about women in the pulpit. Nevertheless, she earned her bachelor's degree and found other ways to minister to women and served in the church in other capacities. Once she started having children, Goddess postponed the desire to attend seminary. After many years, with her children now grown and the support of her husband, Goddess moved forward with her pursuit of the Master of Divinity where she is now a third-year student.

Although Goddess is an ordained minister and has served in ministry for over 30 years, she does not have a 'church home' in Georgia because she plans to relocate after graduation.

Instead, she attends the campus ministry where she goes to seminary and serves as the Campus Worship Leader. The campus ministry is made up of mostly unmarried females. Once she graduates and moves to her new location, she plans to re-engage with her ministry endeavors.

HIV has affected Goddess in many ways. Her brother-in-law died from HIV early in the epidemic. At her former church where she served in the ministerial leadership of the church and provided HIV prevention services with the older members of her congregation. Also, in this capacity, she indicated that provided pastoral counseling to countless couples who engaged in risky behaviors including extramarital affairs. These experiences have informed Goddess' views about HIV and especially about the topic under study. Goddess' views about HIV prevention include a comprehensive approach that deals with the spiritual, physical, and behavioral aspects of people's lives. Essentially, she supports abstinence until marriage, but she also believes that people need to be educated about prevention.

Overview of Overarching Themes and Thematic Categories

The findings described in this chapter are organized thematically to correspond with the research questions into six overarching themes. Table 3 provides an Overall Thematic Outline of the findings. As depicted in Table 3, there are six overarching themes; each includes several thematic categories and sub-categories. Eight of the sub-categories were further reduced into subsequent properties; one sub-category included sub-properties as well.

Table 3

Overall Thematic Outline

I.   Knowledge about HIV
        A.   Factual Knowledge
                1.   Basic facts about HIV
                2.   HIV testing
                3.   Medical advancement
                4.   Myth & misconceptions
                5.   Risk reduction
                6.   Transmission risks
        B.   Perceived Understanding
                1.   Behavioral factors
                        a)   Drug use
                        b)   Unprotected sex
                                (1)   Age
                                (2)   Gender
                                (3)   Concurrent sex
                                (4)   Same sex practices
                2.   Relational factors
                        a)   Lack of sexual communication
                        b)   False sense of comfort
                        c)   Blind eye
                        d)   Blindsided
                3.   Socio-cultural factors
                        a)   "Superman effect"
                        b)   "We just don't talk"
                        c)   Stigmatizing views
II.   Testing as Prevention
        A.   By Any Means
                1.   Easy access
                2.   Routine testing
                3.   Encourage your circle
        B.   "A Gateway"
                1.   Wake up call
                2.   Knowledge is power
                3.   Teachable moments
                4.   Beating the odds
        C.   Promoting HIV Testing at the Church
III.   Meaning of Mutual HIV Testing (MHT)
        A.   It Takes Two
                1.   Testing between intimate partners
                2.   The tester/testee relationship
                3.   Testing between two people
                4.   An internal agreement

Overarching Theme 1: Knowledge about HIV

Overarching Theme 1**, Knowledge about HIV,** set the foundation for the study. The findings associated with this theme provided insights into what the participants knew about HIV. There were two thematic categories revealed. The first addressed their ***Factual Knowledge*** about various aspects of HIV based on six sub-categories. The second is ***Perceived Understanding*** which explored the seminarians' comprehension of the perceived factors that contribute to the spread of HIV in the African American community. This thematic category is comprised of three sub-categories, each with several properties and one with sub-properties.

Factual Knowledge

Factual Knowledge refers to the accurate responses on the HIV Knowledge Scale. The statements, also referenced to as items, were organized into six sub-categories pertaining to (a) basic facts about HIV, (b) HIV testing, (c) medical advancements, (d) myths, (d) risk reduction, and (e) transmission risks. As seen in Table 4-Participants' Overall Scores, revealed that out of 23 questions, the range of correct responses was 15-23, with a mean score of 18.8. It is noteworthy to mention that only one participant in the study, Justice, answered all the items correctly. Refer to Appendix J for a review of the participants responses' to each item. Table 4 is followed by an aggregated summary of each sub-category.

Table 4

Participants Overall Scores

PARTICIPANT	NUMBER OF CORRECT ITEMS
Justice	23
Chris	20
Denise	20
Jaybird	20
Goddess	19
Jack	19
Lillian	18
Son	18
Zoey	16
Jake	15
MEAN	18.8

Basic facts about HIV. The *basic facts about HIV* category included statements about HIV and prevention that have been widely publicized since the early years of the epidemic. There were five items in this category (2, 3[*], 4, 6, and 11), which included one statement, as indicated by the asterisk, that was added to the original Knowledge Scale. The overwhelming majority of participants were knowledgeable about the basic facts. One exception was with Jack who indicated that he did not know that HIV is often asymptomatic for 10 years or longer (item 3).

While the vast majority of participants (8) were knowledgeable that no cure currently exists for HIV, both Jake and Zoey responded otherwise. In the case of Jake, a self-described conspiracy theorist, he stated, "I'm a firm believer that a cure already exists. It has been in existence for years... I don't believe it can ever be released, because it creates a lot of ethical

problems." He reiterated his belief with a forced choice response of 'false.' Likewise, while not expressed during the interview, Zoey also responded with 'false'.

HIV testing. This category refers to information specific to *HIV testing* including testing recommendations. There were four statements included in this category: two original statements from the Knowledge Scale (items 23 and 24) and two additional statements (items 7[*] and 15[*]). All of the participants correctly answered three of the four statements (items 15, 23 and 24). Interestingly, as implied in item 15, everyone understood that "testing by proxy," is not an acceptable way of testing partners. In contrast, several participants responded incorrectly (2) or were uncertain (2) about the recommended window period (item 7) for determining a negative HIV test results.

Medical advancements. There was one survey statement (item 18), which specifically addressed recent *medical advancements* that significantly reduce mother-to-child transmission of HIV. Only Justice, Jack and Denise were knowledgeable about these advancements. Most either incorrectly responded or did not know. It is interesting to note that those who responded 'true' to a cure responded 'false' to this statement.

Myths & misconceptions. The *myth & misconceptions* category referenced the false beliefs that have been propagated in the community as true. Six statements were in this section (items 1, 5, 8, 10, 16 and 17). All the participants correctly answered items 5, 16 and 17. All but one person, Zoey, knew that birth control pills (item 1) are not a form of protection against HIV.

Most of the participants (6) knew that a vaccine is not currently available to protect against HIV (item 10). Unsurprisingly, Jake answered true, which aligns with his belief that a cure exists. However, there were three participants, Chris, Denise, and Son, who were uncertain. With the exception of Chris, Justice, and Jaybird, all of the other participants thought it could take 10 years or more for someone to test positive (item 8).

Risk reduction. The *risk reduction* category includes two statements (items 13 and 22[*]) that directly corresponded to recommendations to reduce HIV transmission. Only four

participants, Justice, Denise, Jaybird, and Goddess, knew that bleach could be used to clean dirty needles for injection drug users. Others either answered incorrectly or did not know. Item 22 specifically addressed the importance of both partners testing negative before engaging in unprotected sex. Interestingly, only Lillian disagreed with this statement, which suggests that she does not think partners should have unprotected sex, even with HIV testing.

Transmission/risks. The *transmission/risk* category refers to statements that speak to the risk factors that can lead to the transmission of HIV. Five statements fell into this category (items 9, 14, 19, 20, and 21). All of the participants answered both items 9 and 19 correctly. Majority (8) of the participants understood the connection between STDs and the increased risk of contracting HIV. Likewise, everyone except Jake knew that HIV could be transmitted through unprotected oral sex. Most (6) participants also knew that HIV can be transmitted via breast milk.

Perceived Understanding

Perceived Understanding was comprised of the seminarians' perceptions of the factors and situations that contributed to the acquisition and transmission of HIV. At the outset, the participants were asked what they knew about HIV/AIDS in the African American community. All of the participants made reference to the high prevalence of HIV amongst African Americans. This comment, stated by Justice, exemplifies typical responses provided by the participants: "I know that African Americans are the highest number of people who are currently infected with the disease." More specifically, several participants were knowledgeable about the growing rates of HIV in certain sub-populations such as youth, elderly, women and men. Denise spoke specifically about the trends in Georgia:

> Oh, it's crazy here [in Georgia]. I know that we're one of the highest areas of infection for black women all over the country. Our rate of infection is way disproportionate to our numbers in the population. And the teens are really contracting it a lot.

Their understanding of the perceived factors was further captured in the following three

sub-categories: (a) Behavioral Factors, (b) Relational Factors, and (c) Socio-Cultural Factors.

Behavioral factors. Behavioral factors referred to the actions that were perceived to

heighten the risk of contracting or transmitting HIV in the African American community. The

behaviors were discussed in the context of drug use and sexual risks.

Drug use. Almost all of the participants' referred to drug use as a factor that leads to

HIV. In this case, drug use referred to the drug-related behaviors and environments that facilitated

the spread of HIV. Jake discussed drug use from the standpoint of alcohol and recreational drug

use and how engagement in such behaviors can impair one's judgment:

> Alcohol and drugs have direct links to it (NIMH Multisite HIV/STD Prevention
> Trial for African American Couples Group). …if you've been drinking a lot and
> a situation happens, you're not able to really process ...what's happening in the
> moment and you can really get caught up in the moment…things happen. And
> so… I'm quite sure with various types of drugs that whether it's ecstasy or
> anything like that probably multiplies, or heightens the probability that
> something like that [risky sexual behaviors] will happen.

Others spoke about drug use and the subsequent risks involved in relation to intravenous

drug users. Son mentioned the risk posed by "dirty needles." Denise shared her experience as a

chaplain in a facility for incarcerated women where approximately 200 were infected with HIV:

"…a lot of them have been intravenous drug users...participated in lots of unsafe [sex]…some of

them have been in prostitution." Likewise, Zoey, who has volunteered with an agency that

provides targeted HIV prevention to active drug users, recalled a poignant example she heard

from a speaker that opened her eyes to the dangers associated with drug use and the culture:

> [A former male addict] had made a connection with someone who was going to
> bring [him]-either money or drugs-and he said, 'I knew he had HIV, he had
> AIDS… but I didn't care, I was going to have my hit.' And he said whether he
> had the condoms or not, he was going to do it… He said, 'But what I want you to
> know, is I could be sleeping with any of your daughters.' And I was like, damn.
> But I'm glad he told the truth and that's just one story.

Unprotected sex. All of the participants perceived sexual risk factors as the primary mode

of transmission. The comment captured by Goddess stressed the importance of focusing on the

leading cause of HIV, "We know about one, IV drug use. We know about all of the stuff from the transfusions and all of that. Those are not the largest numbers. The largest numbers are the sexual contact." More specifically, discussions about sexual risks were particularly positioned around unprotected situations that were perceived to directly impact the acquisition and transmission of HIV in heterosexual and same-sex encounters. For example, Denise stated, "I think people still, even though we now have teenage or young adult populations that have grown up with this information --people still are not using condoms. People are still not practicing safe sex." Chris echoed this notion about the lack of condoms and suggested that people tend to rationalize risk taking:

> Folk just don't wrap it... folks just don't use condoms...what I hear from youth and what I hear from young adults are things like that… 'It just feels better to not use protection. It feels better, it feels more natural.' You know we feel as if that's perfectly okay that because a person looks great and they look healthy and that everything is going well, that it's okay for me to do that, because 'we're just having fun.'

The majority of the participants discussed factors that they perceived to facilitate the spread of HIV in the context of age, gender and same-sex behaviors.

Age. Some participants (4) expressed concerns about youth and their sexual behaviors. Chris was particularly knowledgeable about the growing trend of youth and their early sexual debut. He offered the following as an explanation of what he perceived as a contributor to the rates in youth:

> Our kids are having sex younger and younger now, they know more at a younger age… eight- and nine-year-olds are a lot different when we were eight or nine [laughter]… I don't know what they know but they probably know more than what we think they know. And so, I think their level of knowledge about the act of sex is there, but the implications of sex, I don't think they know about.

Denise and Lillian were also disturbed about the sexual behaviors of youth. Both were particularly concerned that the messages youth receive may actually lead to greater risk:

> A lot of them[youth] who have been taught, abstinence, or for the girls, just don't get pregnant --- are engaging in riskier kinds of sexual behavior… anal sex, oral sex, all kinds of things that would not land them pregnant, but, uh, certainly

doesn't protect them from disease. So that's something that I'm really concerned about. DENISE

We're in a generation of children…they don't even really know what connotes sex. We're so big in the church, teaching them about not getting to a place of penetration, that we forgot oral sex. And we forgot to teach about anal sex. So a lot of our girls think that if we don't do vaginal sex, then that means that we're still virgins, because we have to remain pure. LILLIAN

On the other side of the age spectrum, Goddess, a former Associate Pastor, addressed the lack of protection from the vantage point of older adults. She spoke about what she observed doing prevention work at her former church where there were large numbers of retired and older congregants:

[In another state] …in that age group, it [contracting HIV] started happening more. And, I don't want to make this an aside, but you know the theory was that you have the one lone, rooster in the henhouse there [laughter]. And so that was how a lot of it was passed along. A lot of older women, in terms of that culture, not using condoms and dental jams [sic].

Gender. Sexual related risks that were germane to gender were also discussed. Many of the participants made direct references to the growing number of African American women who are now infected with HIV. Lillian said, "We primarily know that that's where the majority of the women are getting it, from their men, not from same sex. I'm not saying it can't happen, but primarily women are getting it from their men..." To this point, there were other participants who offered what they perceived as factors or situations that contribute to women's engagement in unprotected sex. For example, the issues of self-esteem, self-worth, and the desire for intimacy were addressed by a few (3) of the participants. Justice suggested that the lack of self-esteem might impact a women's self-efficacy to demand protection:

I think with women in particular, it can also come down to a self-esteem issue , and feeling like you don't have the right to exert a certain level of control over your body so that when you are going to have sex with someone insisting that they wear a condom.

Lillian illustrated how the desire to "feel worthy" can lead women to tolerate risk as captured in her comment, "I didn't always practice, because you know I loved him, or…I know he's a whore and the condom slipped off. But so I can feel worthy for just a second, I won't trip

this time." Zoey explained, based on her observations and conversations with female friends, that women's desire for intimacy may cause them to quickly "transition to the bedroom."

> One… they want, need that level of intimacy. Two, I think they [her female friends] understand that if I'm not giving it to them, someone else is, and they [the men] will move on. I think that's something else that's going on. … a lack of self-love…not loving yourself to say, "you know, I'm not going to put myself at risk like this. You know, I just need to wait until I know that," I mean, you don't really ever know-know, but at least know that this guy is trying to be just with me, and that takes time.

Some participants identified the practice of multiple, concurrent sexual partners as a sexual risk behavior that is characteristic of both women and men. Stemming from the conversation about women's desire for intimacy, Zoey further explained that some of the women in her network knowingly participate in concurrent relationships even with married men:

> TMA: When you mentioned that people are having sex with multiple partners, do you think that--are we speaking in terms of just having multiple partners while they're still dating or are you speaking in terms of infidelity?

> ZOEY: (LAUGHTER) Both….I'll put it like this. I think it was some of my girlfriends, we were just talking about the guys that we may be dating…sometimes there maybe two or three that we're just sort of like, we see or we call, or whatever. But there's always like that one we *really* like. Well what happens it seems in the conversation is, as I'm listening, they probably having sex with all of them but they like one over the other. And there have been situations where [my female friends] know that this guy is married and he's seeing you. So if he's seeing you, in my mind, this is what I'm thinking, 'he might be seeing other women. I mean, he's not being faithful to his wife; he's not being faithful to you. Of course, he can't be faithful to you because he's married. He's not your man.'

Similarly, Son suggests that in the African American community there is a cultural persona of what it means 'to be a man' that encourages men to engage in risky sexual behaviors. This is illustrated in his statement, "Because of this false sense of 'you're not a man' unless you're having sex with so many women."*Same Sex Practices.* There were several participants (5) who associated same sex behaviors as a major contributor to the spread of HIV. For example, Son mentioned, "homosexuality [and] lesbianism" and Jaybird talked about "alternative lifestyles" as issues that contribute to HIV in the African American community. Although Denise, Jake, and Zoey stressed the importance of people seeing HIV beyond homosexuality, Justice, who shared

similar sentiments throughout her interview, yet when speaking in terms of contributing factors, could not ignore the current statistics:

> I'm not saying that HIV/AIDS is a gay disease or anything like that, but you know...just reading from statistics the other day, and statistics still show that the primary way people are getting it is from men who have sex with men.

Another growing trend mentioned by half of the participants was the undisclosed same sex practices of men who have sex with men and women as indicated by Denise, "there are a lot of brothers who are bisexual or who just enjoy same sex...but they're not communicating that to their female partners." Goddess, who referred to this practice as the "down low" had this to add:

> Well, one of the things that just came out just recently over the last few years has been the down low brothers... they [women] think that they're dealing with a man who is into women, but they're finding out that he's perhaps tipping in, you know, slipping out or what have you.

Zoey spoke with great passion about this issue throughout the interview and believes that she has been approached by two men on the "down low". In the following quote, Zoey reflected on a scene from a movie that she had just viewed prior to our interview, *"For Colored Girls",* and vehemently expressed her attitudes about how this behavior endangers women:

> Knowing that you are in this relationship, and it's something that you're not going to let go,[and] not at least have protected sex with this man? And, you know it's coming to your wife… That is to me a deep level of hatred, to intentionally or not to be intentional about infecting someone that you call your wife or your friend... And you know they can die from this… I just could not understand it.

Relational Factors. Relational factors speak of practices and situations that may increase the vulnerability of intimate partners contracting HIV. The perceived relational factors described in this category further explained the connection between behavioral factors previously described and the vulnerabilities for HIV in the intimate context. The relational factors are classified into the following properties as (a) Lack of sexual communication, (b) All guards down, (c) The blind eye, and (d) Blindsided.

Lack of sexual communication. The overwhelming majority of the participants (8) valued communication in general, yet sexual communication in particular, as important to the

development and maintenance of healthy relationships. Despite what they perceived as important, many implied that this does not occur as suggested by Justice, "people aren't having open discussions and being open with each other." Zoey echoed this in her comment: "people are not going to tell anybody about their sexual history, for the most part. Most people are not having that conversation." To this point, Jake said:

> And usually, the dialogue doesn't happen until the back end, until someone contracts an STD or gets pregnant or you know something happens or whatever, and then it's all of a sudden, now we're talking about it and now it's an important issue. JAKE

Some participants also suggested that partners may be intentionally dishonest or withhold information out of fear of the repercussions of telling the truth. Two participants honed in on the lack of honest communication in the following ways:

> …about the communication piece is, a person not being honest about who the other people that they're …having intimate relationships with. So whether it is deceptive, whether it's out of fear, - 'if I'm really, really honest, this person is not going to want to deal with me, so I'll just tell them what they want to hear.' Could be a lot of different motives behind it. But I think that's definitely near the top of the list, someone giving the impression that we're just monogamous with one another and yet I'm sleeping with all these other people---maybe protected, maybe not. JAKE

> I feel that when we're not able to…whether it be because of societal pressures and stigmas…people are not able to be authentic, live authentic lives and be honest and open about who they are, then it puts other people in positions where they're not able to make informed decisions, because people have to live lies. ZOEY

There were others who felt that partners are not forthcoming with their sexual history, in part because of their fear of rejection. This was conveyed in the following illustrations:

> I think that in intimate relationships, that becomes a real issue, because everybody is not always honest in their relationship. And when you ask a person their body count or how many partners they've had, folks don't always tell the truth… and maybe it's because some people are afraid of what people think or just embarrassed…CHRIS

> People hide things from their partners that they should be telling…Maybe it's a guy or woman that's been incarcerated some kind of way and caught it (NIMH Multisite HIV/STD Prevention Trial for African American Couples Group)while they were incarcerated and just don't feel like sharing that because they feel that its counterproductive with them re-acclimating into society. And so if it's a man,

he's caught this virus and it's transmitted because he couldn't own up to it, so to speak. And that's a trust issue. He doesn't trust her enough to stick with him. And, maybe she wouldn't and maybe she has every right not too but just the fear…so I guess that's another component, just the fear of rejection. The fear to even have a conversation and definitely to admit it. JACK

All guards down. Most of the participants (6) indicated that intimate partners are vulnerable to contracting HIV due to a false sense of security. This signifies that intimate partners, particularly those who perceive that they are in a monogamous relationship, tend to let their guards down. This is reflected in the excerpts shared by Denise and Jake:

It's the comfort level. I think HIV is a virus that can be dormant in the body for a long time. And so I think people assume because they are monogamous, that they don't have to be safe. But, I think that's a mistake. I think that makes intimate partners vulnerable to that assumption. DENISE

I would say comfort level with the partner that you're with, because there is a situation where you can start off like using protection, for instance, and then you grow to a level of like -----'okay, I've been with this person for a couple of months, or whatever.' Different people, it may be a couple of weeks for some people, I don't know. So it's like 'okay, well, now I feel like its okay now' or 'they look like everything is okay'... so I think reaching a certain comfort level allows people to put their guard down. JAKE

Blind eye. Some of the participants (4) described instances where a partner may choose to ignore or avoid confrontation about issues or concerns that they suspect are going on for the sake of maintaining the relationship, or the idea of turning a blind eye. Chris had this to say: "I think our values of the 'other' can often times cloud our judgment... I think that because we often value people so much, that we look past certain risk factors that could possibly... really boil down to a life-threatening situation."

Lillian shared similar sentiments suggesting that some people in intimate relationships, despite what they suspect or know to be true, may try to convince them that their partner actually values them enough to not place them in harm's way:

My husband or my wife might be out there doing it. I might know that they're cheating, but they love me, because they stay with me, so they wouldn't do anything to hurt me...we must be meant to be together…They won't hurt me like that. I mean, maybe if they're sleeping with somebody else, they'll use protection.

Blindsided. All of the participants referred to unfaithfulness as a major vulnerability to intimate relationships. Unfaithfulness was typically discussed from the standpoint of married partners, but also in relationships that assume monogamy. While the *Blind Eye* alluded to instances where one or both people in a relationship suspected their partners' behaviors, *Blindsided* referred to instances where the partner is both unsuspecting and uninformed of any indiscretions. For example, Goddess, a former Associate Pastor who has been married for 38 years and has counseled couples within the church concerning issues of infidelity stated, "One of the biggest vulnerabilities is infidelity… Because most of the time, in a marriage, by that time, particularly a long marriage, you don't deal with condoms and they don't think they need to deal with condoms."

Denise also provided an illustration of blindsided in recount of an example about a friend who married for the first time in her forties and later found out she contracted HIV from her husband:

> I have a very dear friend in North Carolina…I always tell her story because it's so powerful to me. She's a heterosexual woman that only had three male partners in her whole life. She's probably in her 50's now. She married her husband and was so excited, trying to get pregnant and have a baby, because she was a little older when they got married. And he was positive, knew he was positive--Never shared that; never practiced safe sex. People around him knew he was positive. So she went into this thinking that she's going to have happily ever after. They got married, probably two years into their marriage, she started getting very ill, and could not figure it out. The doctors couldn't figure it out. She was a nurse and had every kind of test. And then sort of jokingly said, well, just give me an HIV test. Because…you know, this is not getting better. And it came back positive. And she came home and told her husband that she had taken the test. Within a week, he moved out and disappeared before she even got the results back.

Sociocultural Factor*s.* In addition to behavioral factors and relational factors, the *sociocultural* category explained factors that were perceived to perpetuate the spread of HIV. Sociocultural factors pointed to the cultural attitudes and social dynamics that foster the proliferation of HIV in the African American community. Issues such as lack of resources in the rural area, lack of education, limited access to health care, and incarceration were amongst some

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of the contributing factors mentioned by many of the participants. However, the foremost socio-cultural factors discussed are (a) "Superman effect," (b) "We just don't talk, and (c) Stigma.

"Superman effect." There were some participants who attributed risk taking to feelings of invincibility. Jake described invincibility as the "superman effect" suggesting that people's behaviors are influenced by their beliefs:

> [Its] what I would call the Superman effect…humans have… this unique sort of capacity to be able to reflect on something that can be considered, objective in a sense. So they can look at statistics and say, "okay, yeah, those statistics ring loudly, but that's not me, that's not going to affect me." So I can continue with whatever my activities are, sexually or physically, whether that's unprotected sex, whatever it is, and still think that it will always be the other person and it won't be me, that I'm immune to it for some strange reason.

Son also equated risk taking to invincibility; however, he argued that it's not that information is unavailable. Rather, he said:

> The [Bible] tells us that my people are destroyed for lack of knowledge; not that knowledge wasn't available, but they rejected it. And so we reject a lot of things… 'that can't happen to me, that's not me.' You know, transmitted diseases can lay dormant for a while and then all of a sudden... here it is,and you didn't know anything about it, weren't educated about it and not checking on it... it could become detrimental to your existence.

"We just don't talk". All of the participants addressed how this notion of 'silence' about sex and sexuality posed a major hindrance in constructively combating the AIDS epidemic in the African American community. Lillian passionately stated the following:

> What do I know about HIV and AIDS? I know that HIV and AIDS is a silent epidemic, still in my community, because if it were something that we talked about and didn't look at as a stigma, we probably would still be living in greater proportions. But because we are a people who do not talk, culturally, we just don't talk. In our homes, we just don't talk. And so when we get to church, we just don't talk.

Others such as Zoey, Son, and Justice expressed concerns with what they perceived to be negative connotations about sex that are diffused in the African American community. Justice's comment is typical of the other views:

> I think too, people are reluctant to really talk about sexuality, and I think that's more of a societal and cultural issue where we think of sex as being bad and

nasty. So we don't talk about it. But people are having sex, and we need to talk about it.

Stigmatizing views. Almost all of the participants mentioned stigma in some context. In most instances, stigma was centered on negative or erroneous views about HIV that are maintained in the community. For example, both Jake and Denise discussed HIV in comparison to other terminal diseases such as cancer. Jake described what he perceived to be the general attitude of people toward HIV:

> …something like cancer, people feel like well, 'I've been designated to have cancer. It's out of my control'… 'I didn't choose this life myself.' I think people feel less inclined to have a positive outlook towards HIV and AIDS because they feel that it is a decision that you brought upon yourself…your practices and your decisions sexually brought this upon you, so don't expect me to have sympathy for you…

Another stigmatizing view was the perception that HIV is a gay or homosexual disease. For example, Jaybird reflected on how people in rural areas tend to concede to such beliefs, "that it's a homosexual disease. That's probably the biggest myth." Zoey had this to say:

> Because HIV is in the minds of many people is connected with...it's the gay disease. So, because people are not educated and they don't understand…it's bigger than that. It really is. This is a public health issue. It's not a gay issue…

Others argued that the stigmatizing views about HIV have far-reaching implications. Denise explained, "Somehow we've got to remove the stigma because it's killing people, really, because people, even when they know, don't talk about it." Justice shared similar sentiments in this example:

> One of the biggest reasons that it continues is because of the stigma that's attached to it. And I think that makes people be reluctant to get tested, and I think it makes people reluctant to disclose their status, because you can be ostracized and I think that's one of the primary reasons that it continues to spread.

Overarching Theme 2: Testing as Prevention

Overarching Theme 2, **Testing as Prevention**, explores participants' attitudes about the role of HIV testing in prevention. Two thematic categories emerged: (1) *By Any Means* conveys their attitudes toward promoting HIV testing; and (2) *The Gateway* specifically reflects their

attitudes about the role HIV testing has in prevention. Both include three and four sub-categories, respectively.

By Any Means Necessary

All of the participants agreed that HIV testing is essential and repeatedly expressed the importance of people knowing their status, as typified in the statement by Jaybird, "You need to know your status. That's the main thing…" Seminarians' attitudes about the importance of promoting HIV testing were depicted in the theme, By Any Means Necessary. Participants understood HIV testing as a mechanism to detect HIV, and therefore were in support of promoting HIV testing. To this point, several participants (6) discussed specific ways to encourage HIV testing which are comprised of the following categories: (a) Free access, (b) Routine testing, and (c) Encourage your circle.

Free access. The notion of 'free access' was to demonstrate the importance of making testing available to all people regardless of their circumstances. Denise, for instance, was particularly sensitive to the needs of disenfranchised populations as reflected in her statement: "I think just offering testing to populations that don't always have access -- poor and young -- and people without insurance." Likewise, Goddess had this to say: "If there is no insurance and all those other kinds of things, if there is no way to pay… folk ain't gon' do it."

Both Goddess and Denise believed that it is important to reduce the barriers often associated with HIV testing. As an example, Denise described how she found that 'taking' testing to the community via a mobile testing unit was one approach that she found to be effective to reach the disenfranchised:

> I would like to just be able to do more of that [mobile testing], like show up in a community, give them some hot dogs or something --whatever and be able to test them because they don't have insurance. They don't go to the doctor on a regular, they're not getting their physical---but here was something that was free and available and they didn't have to get on the bus, or have money to do it.

Routine testing. While community outreach was one approach, three participants advocated for making HIV testing a routine practice. For example, Jake suggested that sexually active people might consider testing regularly such that it becomes part of their lifestyle:

> …If a person was able to make it [HIV testing]… regimental in a sense…where you have something said when, or it depends on how sexually active you are, to what degree, with whom, you know, "I go every three months on this day,"… or something like that. Where it just becomes a part of your routine…a part of your lifestyle choices that you're making.

Both Justice and Lillian were in favor of making testing a routine practice in health care settings. Justices suggested routine testing in a health care setting as a means to de-stigmatize HIV testing:

> I think a lot of it is making it available, taking away the stigma... like every time you go to the doctor, having the doctor ask you, 'do you want to get tested?' Because I think that some people don't even think about it when they go into the doctor. And I think if people were really more aware of what the rates were, they might realize they are at a higher risk than they thought they were.

Lillian, on the other hand, felt offended by the need to request a test and argued that HIV testing should be a mandatory part of health care services:

> I don't think that this is something I should have to ask my doctor to do. I resent the fact that I got to go to the doctor's office and ask you for a test. Why aren't you checking it like you check my lipids? Why aren't you checking it like you check my sugar? Or glucose levels, you know? Knowing this is a pandemic--- you check my lump in my breast before you give me an HIV test. You've searched me for syphilis and gonorrhea and Chlamydia before you give me an HIV test. And so where I'm standing is how is it a choice? Why isn't it not a mandatory?

Encourage your circle. Because of her awareness that many people may not seek testing on their own, whether free or routine, Denise briefly mulled over whether testing should be mandatory. She eventually decided that others should encourage those within their sphere of influence to get tested:

> I struggle because freedom is important to me… The right to choose is important to me. But there are days when I say just make it mandatory… I don't think I really believe that because I think that we could go down a slippery slope if we start demanding that people do stuff like that. … I think that people who are aware and take personal responsibility for their circle of people… their family,

their circle of friends, the people that they have close relationships with… you need to be tested, let me go with you.

The Gateway

In thinking further about HIV testing the term, "gateway," used by Son, described the essence of how seminarians perceived the role of HIV testing in the arsenal of HIV prevention. The sub-categories for this theme include: (a) Wake up call for most, (b) Knowledge is power, (c) Teachable moments and (d) Beating the odds.

Wake up call for most. All of the participants, except for Jake and Jaybird, expressed a link between HIV testing and prevention. The vast majority indicated that people are more likely to change their behaviors after learning their HIV status; therefore, HIV testing was perceived as a risk reduction strategy. Goddess had this to say:

> I think it plays a large role in that, first of all, hopefully the answer is going to be, the person will find out, 'oh, no, I'm fine.' But it's going to make me start thinking about it in terms of their behavior. I want to keep on being fine. So, I'm not going to be just so caught up in the moment, 'okay, let's get with this and we'll worry about it later.' No, not if I've just gone through that process, and had to wait to hear...

In his transparent recount about his own testing experience, Chris expressed a similar perspective about how learning his status caused a "light" to come on for him:

> I think that for me personally, I know when I got tested… I was like ok, I know that I've always done everything across the board right. I know that I've been alright, but it was just that, 'what if?' It's always that 'what if' and I think when you get that 'whoo' [sigh of relief], I think that a light clicks on in your mind, 'I really need to be aware of this because spiritually this may have been my wake up call. You need to really chill out.' I think it brings an awareness… I think it reinforces principle in the life of a Christian, I believe.

In contrast, Jake offered a different perspective. He acknowledges, "It's always been historically linked to prevention and so it's like they kind of go hand in hand, like being tested is to prevention, prevention is to testing." However, Jake adds, "I'm getting hung up on the preventing word. I don't think that it helps with prevention… as a standalone..." In fact, he expressed what he perceived as the irony of HIV testing:

I've discussed with people before, it's like, after people go and get tested and then you find out… that you're negative and you go out and actually have more sex. Because you're kind of, like 'whoo, I dodged that bullet or whatever, so I'm cool.' So that's like the irony that is behind it.

Jake was not the only person to indicate that some people may not change their behaviors. Denise also mentioned this too; however in her assessment, she perceives it as the exception rather than the norm:

I think that testing in terms of prevention…I think what I see is that when people get a negative result, because they didn't know, in hearing "I'm not," really increases their safe behavior. You know, it's not always the case, because sometimes people are like, "see, I know that I ain't got nothing or whatever." But for the most part, I think that people are able to sort of exhale, because they were so scared before the results, that now they're like okay, God gave me another chance, or whatever their belief is, I'm going to do this right, now.

Knowledge is power. A few participants (3) alluded to HIV testing as a mechanism for increased education and awareness about the epidemic. Son, particularly, described the HIV testing experience as a "gateway for information," as illustrated in the following statement:

For the testing part, when you come in for testing, through that testing, you explain to them, why we are doing this. And then what will happen is, it should stir up your curiosity to learn more about it. So through the testing, it's sort of like a gateway. A gateway of information whereby I'm gon get tested because I've been doing this and I need to make sure. So it opens up a door now through the testing that this individual can be informed.

While Jake did not view HIV testing as prevention, he did find it a useful approach for raising awareness, particularly from the standpoint of making people aware of the severity of the issue in different communities:

…Awareness is key...being able to gather statistical information, being able to have numbers. I think numbers can be helpful when they're used properly and appropriately...and also from a funding perspective, of course, if you can justify that this is affecting this X group of people, by this percentage over and above another group or something like that, then of course you're able to open up more federal dollars towards it, and get support of the work that you're doing.

Teachable moments. In addition to increased awareness, there were two participants, Son and Zoey, who perceived the testing experience as an opportunity for people to educate and

encourage their partners, friends, and family, thus creating teachable moments. The following example from Son illustrates this concept:

> Once this individual is informed, all of those that he's dealing with, he's going to or she is going to inform them, 'You need to go get yourself checked out.' Once that occurs, it's sort of like you get a ball rolling. It may be in secret, but nevertheless, you're getting yourself checked out. So I look at it as a gateway. It opens up a gate for that information to come in and when you get good information, you know people, they start telling other people about it. SON

> What role does HIV testing play-well, it's essential, in that I would want to think that if a person knows her status, then they're going to act more responsibly---about you know their partners, their sexual behavior, that they will even seek out counseling to deal with this new information. And even share and teach ...their family and friends,' look this is what happened to me, I don't want this to happen to you. Don't do this, don't do that.' ZOEY

Beating the odds. There were also a few participants (3), who acknowledged the medical advancements, particularly in regards to medications, which are currently available to help prolong and improve the quality of life for people living with HIV. Denise mentioned, "I know that...people are living a lot longer now that there are a lot of effective medications." Likewise, Chris shared similar sentiments: "People need to know their status, because I think the medical enhancements…we (Alder et al.) just become so advanced in how we use medicine …I've heard that people can live a normal life…"

Like many others, Jack agreed that testing may reduce the spread of HIV. In addition, he went on to suggest that access to medications and support is a benefit linked to HIV testing:

> So the whole getting yourself tested, I think it would cut down some of the spread and allow some people to live healthier lives. I think it's better to know because then you can get on some medication, you can get the support groups working and find out how you can beat it and live with it as best as possible.

Promoting HIV Testing at the Church Level

Although the participants personally supported and endorsed HIV testing, when asked on their Participant Profile whether their place of worship sponsored, offered, or referred members of the congregation or community for HIV testing, no more than four participants responded "Yes" (see Figure 1). More specifically, Justice was the only participant who responded in the

affirmative for all three questions. Jake was the only additional participant who also reported that his church has sponsored an HIV testing initiative. And, for HIV testing referrals, Denise and Lillian were the only others who indicated that their place of worship made referrals for HIV testing.

Promoting HIV Testing at the Church Level

Does your church...

Refer congregants/community to local agencies for HIV testing?	3
Offer onsite HIV testing to congregants/community/?	1
Ever sponsor HIV testing initiatives?	2
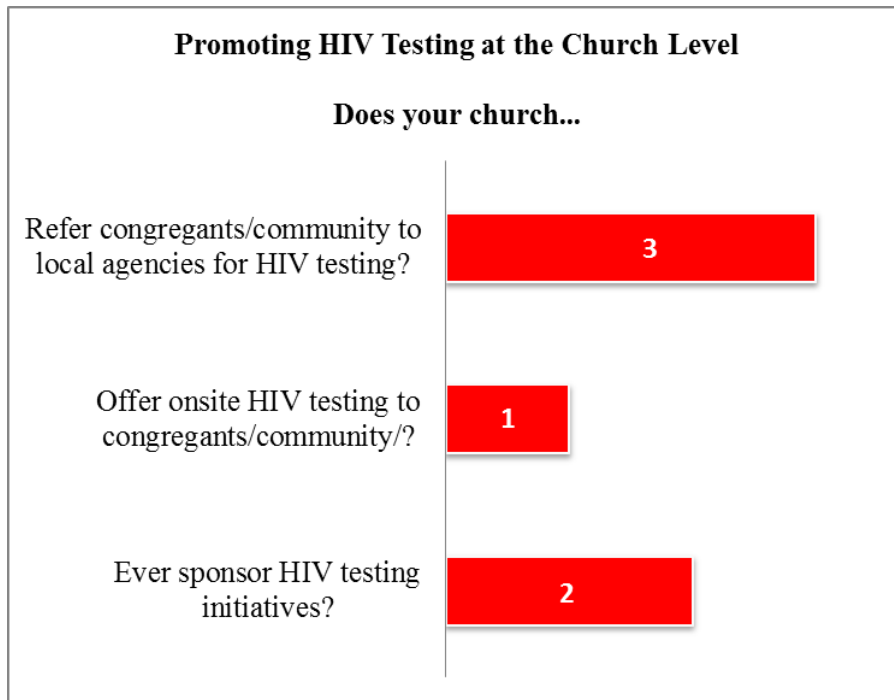
Figure 1 – Promoting HIV Testing at the Church Level

Overarching Theme 3: Meaning of MHT

Overarching Theme 3, **Meaning of Mutual HIV Testing,** examined the seminarians understanding about MHT. There were three thematic categories within this theme: (1) *It Takes Two* speaks to how they defined MHT and contained four sub-categories; (2) *A Symbolic Gesture* looked at the symbolism of MHT and is comprised of three sub-categories; and (3) *"Double Edged Sword"* delved into the benefits and barriers surrounding MHT with partners. Both benefits and barriers, the two sub-categories also included several properties.

It Takes Two

Once the participants' views about HIV and HIV testing were established, the attention shifted to their understanding and views about mutual HIV testing (MHT). By virtue of the

meaning of mutual, all of the participants determined that MHT suggested that there are two people involved. However, there was a great deal of variability in terms of 'who' the two individuals should be. Hence, this theme referred to how the participants interpreted the phrase 'mutual HIV testing.' Three variation, or sub-categories, along these lines emerged based on the participants' perceptions: (a) Testing between intimate partners, (b) A Tester/Testee relationship and (c) Testing between two people. An alternate interpretation, (d) An Internal Agreement also emerged as the fourth sub-category.

Testing between intimate partners. For the majority of the participants (6), their initial response suggested they viewed MHT as testing between intimate or sexually active partners as exemplified in Justice's comment "its two people who have decided they want to be sexually partnered going together to get their test."

Like the others, Goddess, who has been married for 38 years, immediately thought about couples being tested as well. She used the example of couples who plan to marry to illustrate her understanding; a practice that she was surprised to learn is no longer in existence:

GODDESS: I've not heard that term before. I heard it for the first time from you. So we know that that happens when people go for their marriage license now, uh, but-

TMA: Which one?

GODDESS: The mutual-you know, they're both tested mutually, because they're applying for a marriage license. And from what I understand, that's not in all states.

TMA: It's not required anymore in Georgia, it's not required in most states.

GODDESS: And it was in [Southern state] you know...so when they went for it...they would do a test for both of them during that time ...Really? Get out of here.

The tester/testee relationship. There were three participants, Son, Chris, and Jaybird, whose initial interpretation suggested an agreement between the tester and testee (person being tested). Among the comments cited were those by Son and Jaybird:

Mutual---meaning that you are in agreement to get it done. I have an understanding that I need what you're doing for me. And I will go through the process, because I know you want to help me. SON

That everybody's okay with it. All parties are okay. The person who is being tested and the person who is testing. There's a mutual understanding, there is an agreement. I want to be tested--- and I have some responsibility in it and for those who are testing me, you have some responsibility. JAYBIRD

It is important to note that with additional probing, that these participants expanded their interpretation to include, two partners being tested together.

Testing between two people. Denise, distinctly, considered MHT in a broader context; not necessarily limited to "sexually intimate" partners:

Two people getting tested together...To me, it doesn't have to be intimate partners. It is just two, intimate relationship, but not necessarily sexually intimate. That's what it brings up for me. Somebody that you're close to, but not necessarily, that's your partner.

Also, Zoey, whose initial thoughts aligned with 'testing between intimate partners,' extended her thoughts to include a similar view, particularly from the perspective of women:

Well, you know what-I don't necessarily think…I think that two friends could go together. I mean, I know two dudes ain't going to do it, but women could say, "girl, let's go. You know, we'll support each other. You know we need to know. We know we're out here fucking around, we need to go see"... And you know that kind, having that kind of support could be good.

An internal agreement. Lillian, who disclosed during the interview that she did not know her HIV status, offered a unique perspective about MHT. On the one hand, she shared similar views expressed by the majority, but then, as if she considered her own situation, Lillian offered this alternative outlook:

Naturally what comes to mind is-ooh, this is crazy, but I naturally think mutual HIV testing is my partner and I agreeing to have the test---or it might be, God…maybe, it's within me, that it has agreed with me-that because I'm interested in my own health, I need to know my status.

A Symbolic Gesture

Perceptions about the symbolism of MHT in the context of intimate relationships were captured in the following sub-categories: (a) Care for self and partner (b) A healthy start, and (c) Call to action.

Care for self and partner. Most of the participants (6) felt that MHT foremost symbolized that they care about their own health as well as the health of their partner. Two participants expressed this notion of 'care for self and partner' in the following ways:

> It symbolizes that I want to live and I'm willing to do it so I can live. I don't know if that makes sense, but it just does for me, it says like more than me going...for the gynecological visit, to the primary care to check on the mucous in my lungs, or something like that---it says to me that I care, and I care about me. And I even care about the partner where just in case, the condom does come off, that I care enough to let him know, or that he cares enough to let me know…that we are in this together. LILLIAN

> That symbolizes that these two people care about themselves and one another…I mean, love themselves and one another---and that they are ready to deal with reality of what may be the outcome of this… and they are trying to be responsible. ZOEY

A healthy start. There were several participants (6) who described MHT as a symbol of commitment. Justice, for example, stated: "To me it symbolizes a commitment to your relationship and to your health and that it's a mutual decision." Likewise, Son had this say: "Honesty, commitment, togetherness, fidelity, we're in it for the long haul." There were others who suggested that MHT symbolized an establishment of trust in the relationship as reflected in the comment by Jaybird: "What does it symbolize?...That's a good way to start a relationship, with mutual testing. I think that's a good first step in building trust and that it gives some confidence in the intimacy part."

Call to action. Jake suggested that MHT also represented something that extends beyond the action of the two people involved; but something that evokes a call to action as captured in the following comment:

> It's back to that sort of, self-community paradigm. I think that, it also serves as something symbolic-I mean, it's like what we're doing here, is not just for us but it's representative of something that our entire community should be doing, should be participating in.

"A Double-edge sword"

While the previous themes looked at the interpretation of MHT and its symbolism in the context of intimate relationships, this theme examined MHT in terms of the perceived

implications. There are two sub-categories associated with this theme: (a) Perceived Benefits and (b) Perceived Barriers, which include several properties, respectively.

Perceived benefits. Perceived benefits refers to the implied advantages or favorable outcomes associated with MHT. The sub-properties are (a) Informed decision, (b) Instant support, (c) Establishes standards, and (d) Early detection & education.

Informed decisions. Most of the participants (6) perceived the ability to make informed decisions as an advantage to MHT. Among the comments cited were those by Justice, who said this: "I think it's that you both know and you're not relying on someone's word." Chris also commented, "the benefits to it is that…one person is HIV positive and the other person is HIV negative, it brings that awareness already to the forefront." Likewise, Denise discussed the importance of knowing each other status from the vantage point of being informed about how to take care of each other as captured in the following comment:

> … I trust you, I love you, all of that. But, I still want to see the test. Not because it matters to me either way in terms of whether or not we're going to be together, but it matters to me in terms of how we take care of each other.

Instant support. A few participants (3) described having one's partner available to support each other as a benefit of MHT. Jack, for instance, had this to say:

> It's no pressure on one person, the pressure is equal. And there is some security in that because what if one or both come back positive? Then right from the start, at least you have one person that you can hold hands with through the journey, either way it go.

Another participant, Denise, was very transparent about her current MHT practices with her long-term partner. Despite her partner's initial resistance, she recounted increased intimacy, feelings of gratitude, and support:

> Yeah, I think it's right to do it together, because once my partner and I started doing it together-the first time we did it together-it was very emotional. I mean, both of us had a negative test, but -we both still cried- because she was like, I'm really sorry. We should have just did this. And, you know, her tears were really about, this makes me feel even closer to you…my tears were more about gratitude and happy that regardless of the results, that she was there to be supportive to me. Because, it reminded me that it could have been the other way. It didn't have to be a negative test. I hadn't always been safe. And so I think it

helps to do it together because I think it can bring you closer together. And I think …if you hear any news that you're not expecting or don't want to hear--- that's the person you want to be there as your rock… and you can be there for each other. So, yeah, I think it was definitely beneficial.

Establishes standards. Two participants, Son and Zoey, suggested that MHT was beneficial because it communicates the expectations and standards for the relationship. The following examples capture this view:

So it would have to be something that would be adopted by the individual saying these are my standards, before we become active, you got to get checked out… and I'm going to go and do it with you, too. So that would bring some mutuality in it…but before you get with me, this is the requirement. SON

I think that for a woman or a man to ask their partner in being tested that's saying something about how I feel about myself and how I feel about you and what I'm expecting in this relationship. And hopefully it means that I'm anticipating that... we're going to hold one another together and that you're not just going to be out here fucking around, putting me in jeopardy, putting us in jeopardy. ZOEY

Early detection and education. Son was the only participant who directly identified early detection and education as a potential benefit of MHT:

… if it has occurred, you know, early detection…informative to the couples. If they don't have it, it's some information that they can share with their friends. So, from that a lot can come out of them going in themselves, like early detection, you could stop it before it become full blown…

Perceived barriers. In contrast to perceived benefits, perceived barriers refers to the potentially unfavorable consequences of MHT. The properties associated with this sub-category are (a) "What's really going on?," (b) The fear factor, (c) Forced re-examination of relationships, (d) Private made public, and (e) Implied elimination of condoms.

"What's really going on?" Several participants (5) indicated that some partners might perceive MHT as a sign of distrust and question the motive behind the request. Zoey, for instance, said, "…if you had a history where you've been sexually engaged and involved, and all of a sudden you're talking to me about HIV, so, what's really going on here?" Likewise, Denise, who

regularly practices MHT, spoke expressively about the challenge that she experienced with her partner:

> I think for her, it meant, there was a level of distrust - like what are you really saying? Like is there something behind this--other than just, you know, it's the right thing to do? Are you having some questions about fidelity? Are you having some questions about, my past that you think I didn't tell? So I think for her, it was like, do you really trust me? And for a while, she was sort of defiant about it, because she was like, you know you've got to just trust me.

The fear factor. Others (5) addressed fear as a potential barrier to MHT. For example, there were concerns that MHT may raise questions about sexual history, which could result in rejection. Goddess and Lillian had this to say:

> … [It's] the fear or the perception of promiscuity. Because, again, it's okay if the dude has some experience and got a few notches on the back, but you know, he's ready to call her a garden tool if she needs the test, because now, 'how many people you been with?' that kind of thing. So I think that's a barrier. GODDESS

> I'm exposed. I might be rejected. You could have told me and you didn't. I'm embarrassed. Because it forces me to look at something, even if I love my partner, it forces me to look at a mistake versus something that was clear to me. LILLIAN

Jaybird, on the other hand, spoke about fear from the position of a person being afraid because they know their history and may suspect that they are positive: "Because they probably been with a bunch of partners and probably don't want to know…a sense of fear that they might have it."

Forced re-examination of relationship. While there were some participants who perceived the ability to make an informed decision as a benefit, particularly in the case of serodiscordant results, there were others (4) who suggested a forced re-examination of the relationship as a barrier to MHT. Two participants conveyed this view when they said:

> But, there could be a down side too, because if you go with this particular person and then you find out you have it and they don't, I mean, how does that now change the dynamic of your relationship? And your life…?JAKE

> …A really good relationship that could possibly have really strong implications but because of one person is positive and one is negative, it causes a lot of issues… because you saw the hope of the relationship but all of a

sudden…somebody can't deal with the other being that [HIV positive]…I think that's when it could be hard for some people. CHRIS

Another subsequent barrier related to 're-examine the relationship' is the possibility of partners' making erroneous assumptions. In Son's example, he presumed that a positive test result would imply that the other partner has not been "truthful" in the relationship:

> And so it could be a double edge sword, it could be beneficial on one hand, and it could be detrimental on the other hand, if you are the guilty party and you ain't being truthful in that relationship. So it could bust that relationship, be it just, intimacy without responsibility or married couples, it will reveal you're not being committed in that relationship. So it could just destroy a family, it could destroy a relationship.

Private made public. Four participants alluded to this idea of private made public. Most of the participants (Justice, Goddess, and Zoey) framed it from the standpoint of a person's sexual indiscretions, in terms of sexual history as well as unfaithfulness, being exposed as suggested in the following examples:

> Like if a person is concerned that they may have something or whether they've been doing something and they might be afraid to go with someone else and not have that private moment for themselves. JUSTICE

> Well, if someone is not being faithful in that relationship, or if they have a past that they have wanted to hide, they may be afraid to go with their partner. Because some things may be disclosed. Their indiscretions may be brought forth …ZOEY

In contrast, Jake viewed this from the position of a violation of privacy:

> … Something like that being very personal to people. So it's, though it's something that you should know if you are participating with me sexually, it's also something that it's like, well, that's a medical health related thing. I don't know if I want my business out there like that. Whether I don't have it or whether I do have it.

Implied elimination of condoms. A few participants (3) directly addressed the elimination of condoms as a norm for relationships, especially after an HIV test. Yet, they also recognized how it can be a drawback to MHT. Justice illustrated this point using her friend's relationship as example:

> One of my friends said she didn't want to do it with the guy she was dating at the time because she wasn't ready to be in a committed relationship with him. So she

felt like doing that [getting tested together] would push them in a commitment that she wasn't ready for. She didn't want to stop using condoms. She was happy with the way the relationship was.

For Chris, his initial belief was that if both partners received a negative result, especially in the case of marriage, that they are free to eliminate condoms. However, as the discussion continued, he had this to say:

> …If we both negative, then it's a free for all…we can do whatever…let's just go. We ain't got to use condoms, we both clean…[until] somebody cheats or maybe contracts something and we remember our initial test was negative, but all of a sudden, what happened? And then you found out somebody's been unfaithful and you just open up a whole new box of matches and some stuff gon' burn.

Jack openly shared how this has been the typical pattern for him as well. However, his belief about 'dormant viruses' prompted a different perspective:

> …At that point, you kind of let your guard down. You say, as long as you not messing with nobody else, and I'm not messing with nobody else then that means, we don't have to use protection. But what about the fact that sometimes these viruses lay dormant in your body. That's my thing. Like, so I don't know if it's the healthiest thing, but I know it happens. In some of my relationships, I've acted as such. But I'm not so sure that the healthiest thing.

Overarching Theme 4: Normalizing MHT

Overarching Theme 4, **Normalizing MHT** explored the seminarians' attitudes about with whom MHT should be normalized and how to go about doing so. There are two thematic categories associated with this theme. Specifically, the first thematic category, ***It's Complicated,*** identified the complexities of normalizing MHT in different relationship contexts. The second, ***Making MHT the Norm,*** revealed strategies that could assist in the normalization of MHT with intimate partners.

It's Complicated

Once participants framed MHT, they were asked their views about whether MHT should be considered with intimate partners in different relationship contexts such as dating, cohabiting, engaged and married. The sub-categories that subsume this theme are (a) the Nature of the relationship, (b) Exception to the rules, and (c) "Falls on women".

Nature of the relationship. Several participants (5) indicated that the length and type of relationship were important considerations. For instance, there were some who suggested that MHT was most appropriate at the onset of an intimate relationship as typified by Goddess: "Every time there is a new relationship where there is sexuality involved, then those people should be involved in mutual." Along this line, others suggested that MHT would be more acceptable within relationships of shorter duration versus long-term relationships. Chris best illustrates this idea in this exemplar:

> If I'm in a relationship with you for a month and we decide we're going to be intimate, it's probably not going to be very hard for me to say let's get tested first. But if we been together for about you know, 10 or 15 years, 'oh you don't trust me now after all these years…and now you want me to…' I think it becomes a lot more complicated. And I think it could have negative implications that a relationship may not want to face…if it's a good relationship. But if the person knows that their partner has been an infidel and they know that something is going on, then I think it's a legitimate reason to ask that they get tested…especially if you catch them cheating. That's when it becomes a legitimate reason. But I think it complicates things…very much so...

Unsurprisingly, there were several participants (4) who expressed ambivalence about MHT in the context of marriage. Goddess, for example, initially expressed agreement with MHT in all relationships. However, in mid-thought, she was reminded about her current situation which shifted her response:

> Yes. They should get tested even in the, because the biggest question I'm asking, as I'm answering that, I think of myself as a woman who's been married 38 years, husband in [another state]. And we see each other on weekends---when I'm here. So, what that says to the other person, "honey, let's go and get mutual HIV tests." Well, the first question would be, why would you want to do that?

Exception to the rules. In contrast, despite the perceived barriers associated with MHT, there were several (4) participants who believed that MHT should occur regardless of the relationship type. Following are two examples to illustrate this point:

> I think everybody needs to be tested. I don't necessarily think that everybody needs to be tested as often as me. But I think everyone needs to be tested in the context of any kind of intimate relationship...just because the way the virus works and because of what we do know about it and what we don't know about it. So that's the primary reason I think that everybody needs to be tested. DENISEI think all of them...because if you cohabiting with someone, you going

to have intercourse; all of these relationships, they going to do that. And if you dating someone that you know been active, for your own benefit you're going to want to get that tested, especially in the times in which we're living in… they want to make sure because you don't know how many partners he had or vice versa. And then if those partners are getting married, then those [other partners] are who coming in there, you know what I'm saying, so all of those [relationship types]...need to have it. SON

"Falls on women." A few of the participants (3) perceived gender as an important factor in the initiation of MHT. Goddess, for example, reflected again on her own situation when she stated, "Whoever were to suggest that [MHT], it would cause the other person to begin to 'hmmm.'" (LAUGHTER). Yet, she and two others implied that women would be more likely to raise this issue. Two participants conveyed this view when they said:

> The first thing that pops up is like, "you been messing around on me?" You know what I'm saying. "We've been together, and you ain't never said anything." And that probably would be from the male side. From the female perspective, it's like… a health issue. 'Cause normally, females are into health. They want to get stuff checked out... they have no problem going to the doctor... But men are so reserved, "you invading my privacy," and all of that kind of stuff. But when you start explaining why you want it to get it done…"this is about a health issue. It ain't about you messing around...But it's something that we need to do because, I don't know if it lays dormant…" SON

> I think that, I hate to say this... because it seems like the responsibility always falls on women. But because it's affecting us, we have to do what we have to do. I think women need to encourage their partners. Bring it up, talk about it, and if they're not willing to, that should be some red, not flags, flares! ZOEY

Despite the varied views regarding MHT in different relationship contexts, the majority of the participants supported the normalization of MHT, making it a standard practice for partners in intimate relationships. Goddess typified the rationale for this in the following example:

> I think that'd be great though…because we just identified earlier that that was one of the greatest risks for couples...that's where they're most vulnerable, is one person is HIV positive and passes it on, unbeknownst to the other.

Though Jake thought normalizing MHT "would be good in theory," Zoey conveyed an understanding about the concept of making MHT a normative behavior in the following exemplar:

> When you say normalize, I think it becomes a part of our tacit culture. Sort of like, it's just something that we do, without really even thinking too deeply about

it. It's like, this is sort of the thing to do… we're sort of inundated with it that it's just commonplace, that to not do it is like, "you mean you haven't done that?"

Making MHT the Norm

Participants were asked several probing questions in an effort to explore strategies to normalize MHT within the context of intimate relationships. Although they mentioned a number of considerations, two overarching sub-categories emerged: (a) Healthy community, healthy church and (b) Beyond the church. Each is comprised of several properties.

Healthy community, healthy church. While all of the participants agreed that the Black church and its leadership are influential, there were differences of opinion in regards to the degree of influence. For example, half of the participants expressed that the influence of the Black church has diminished. Jack described it this way:

"At one point in time, the Black church carried an influence…you just couldn't name it because it was just that powerful. Today, I think we are looking at a Black church that has influence but not to the same degree."

Yet, there were others (4) who viewed the Black church's influence as critical to shaping attitudes and norms. For example, Zoey described it this way: "Churches, preachers have an enormous influence...And so what they say, I mean, has... exponential power and influence. So, what they're not talking about is just as important as what they are talking about." Similarly, Jake honed in on how the church's influence can be both productive and counterproductive:

In the U.S. context, and I think certainly, like here below the Bible Belt, churches have a lot of influence in shaping norms. And, also breaking down the myths and misunderstandings, misconceptions that churches wrestling with same gender loving relationships and how that plays into 'well, yeah, all the gay people are the ones with HIV and AIDS.' That sort of mentality can in a lot of ways be more detrimental or could completely undermine the work of actual professionals in the field that are trying to combat that or say, 'No, look at the numbers, it's not that.' 'Yeah, I know it's not that, but you know, my pastor said it was this.' So, I definitely think, depending on where you are somewhere like the institution of the church can be influential.

Contrary to the mixed views of the participants concerning the Black church's influence and role in shaping norms, everyone felt it was important for the Black church and clergy to have some level of involvement in promoting MHT. Several perceived the overriding benefit of the

Black church's involvement as endorsing the importance of a healthy community, which subsequently leads to healthy churches. Jake described it in this way: "It's a healthier society. Healthier congregation. An informed congregation, which may be just as powerful as a healthy congregation." Likewise, two other participants had this to say:

> The benefit's that people will live long and healthy lives. That's the benefit. Because, every soul makes up the black church, no one excluded. So for them to live long healthy lives and productive lives, I think that's the benefit. JAYBIRD

> You're trying to grow a church, but the community has to be informed also. And so they will come to say, this place really helped me, not only spiritually, but it helped with my health, it helped to become more aware of what is going on in our community, our surroundings…SON

From the vantage point of this 'benefit,' all of the participants identified strategies and roles that the Black church and clergy could play, respectively, to promote and normalize MHT within the context of intimate partners. The properties include (a) Facilitate the conversation, (b) Pulpit as a platform, (c) Intimate influence, (d) A 'holistic' approach, and (e) Collaboration.

Facilitate the conversation. The overwhelming majority (9) indicated that in order for churches to begin to promote MHT, they need to facilitate and create a healthy dialogue around the issues pertaining to HIV, to include conversations about sex. Chris, for instance, hand this to say:

> Realistically, our churches do not talk about this. I do. I think is necessary, because if we can, if we can actually fool ourselves into thinking that these children, and our teenagers, and people in our church…not even teenagers…but folks in the church period…are not having sex, then we are in for a rude awakening in our lifetime and I think if we continue to ignore the issue, then it's only going to get worse.

There were several others who agreed that healthy discussions about HIV/AIDS were necessary in order to remove the stigma associated with the epidemic. For example, Justice stated: "HIV/AIDS needs to be something that we talk about it, and not just in terms of homosexuality, but just in terms of human sexuality." Likewise, Denise shared similar sentiments in the following exemplar:

Yeah, they got to talk about it (NIMH Multisite HIV/STD Prevention Trial for African American Couples Group) out of the context of homosexuality and out of the context of sin-it's got to get real about what people are really doing…because it's hard to talk about mutual testing, for example, if you're not talking about relationships in general in a positive way. And HIV, the only time a lot of churches bring it up is in some negative context. So, I think we just have to do a better job removing the stigmas about the disease and a better job of not attaching it to a certain population. It comes up in the conversation with down low brothers you know...we just got to stop that, because then it doesn't get talked about with loving couples. DENISE

"Pulpit as a platform." Many of the participants said it is imperative to get the pastor and

church leadership to endorse MHT, as in a top-down approach. Among the comments cited were

those by Jake, who said: "I think when it becomes important for the leadership, then it becomes

important for the congregation." Also, Lillian indicated: "A pastor that condones and affirms

what being a brother and sister's keeper is; that no need is taboo…the congregation who knows

where the pastor stands, can be the voice that condones and affirms what should be done."

From this top-down perspective, half of the participants gave suggestions about ways in

which clergy could use the "pulpit as a platform." One way was to address important social issues

that affect their congregants. Denise, who initially used the term, as well as Son, illustrates this

view:

I really think it would help if pastors would say something about it in the pulpit...I just think that religious leaders, particularly black religious leaders, have lots of power. Sometimes that's good, sometimes it's not. But the way that we can use it for good is to use the pulpit as a platform for social issues, things that are happening in people's lives every day…Yeah, I just would love to see in just a regular old Baptist church, Methodist, whatever it is, where there is two, three, 500, 1000 people sitting there on Sunday, for a pastor to say, 'this is important.' DENISE

Especially like these mega churches...those are the nucleuses right now that can funnel that information into our communities. We have to use those forums that God has set up, to bring in information, not only personal, but for the community: healthier relationships, marriage, to promote abstinence. And so the church could be a big launching pad, so to speak, for getting that information out [about promoting MHT]. Especially those churches pumping in 20, 30,000 people a weekend. SON

Jack, for instance, specifically expressed the importance of clergy using the pulpit to

educate and integrate HIV education and prevention messages into their sermons:

[I want to hear] the reality of our situation as black people in terms of how at risk we are for HIV. That's the sort of thing. If I'm listening to a good message…and some kind of way that type of information is relevant to the message … I'm more likely to receive that more than seeing it on a commercial, hearing about it, seeing a flyer, anything like that. Even probably more so than word of mouth, because I think those of us who attend black churches and churches probably in general, there is a certain amount of authority that goes along with the preached word that commercials can't manufacture, that common word of mouth can't manufacture. It means more when it's there from the pulpit.

Intimate influence. The majority (6) believed that clergy could effectively promote

MHT in a more intimate fashion, particularly during the role of counseling. To this point,

Goddess stated: "…Because clergy is involved in pastoral care, people do care about our

opinions. Yeah, you can't tell people what to do, but they listen. It's like EF Hutton talks, same

thing with clergy." Other participants (5) recommended premarital and marital counseling as a

viable approach to advance MHT in these settings:

> If I had that setting [premarital counseling], people I had to counsel, I have more leverage as a pastor. 'Okay, these are my requirements, you're going to meet six times…and I need you to do HIV/AIDS testing.' I can just say it; no need to ask it. I can't make them do it. But these are my requirements. You want me to marry you? These are my requirements. JAYBIRD

> I think it should be part of marriage counseling. I know our church, you have eight sessions of counseling as a couple before we'll do a union. I know a lot of churches, do couples counseling before they will marry a couple. And we even marry people who don't go to our church, but they still have to commit to that eight weeks or eight sessions...But I think it should be a part of that, 'you're going to marry this person; you're going to say I want to spend the rest of my life with them. Then you know, let's talk about this, too'….So that's one way too, clergy can be involved. DENISE

Justice saw premarital counseling as outlet to not only promote MHT, but also to reframe

the conversation. She explained it this way:

> Well, I think that one thing, when you get to the marriage stage is that, when you're going through your premarital counseling that whoever… the pastors who are doing the counseling need to be open. Just like they talk about finances and things, they need to add testing as a part of the conversation. And I think that a lot of it has to do with stigma and fear. So having the church address that stigma and address that fear, and continue to embrace people. Because first, our stance, 'is okay we have a couple and they both got tested and one is positive and one isn't.' Then, the default position is okay, "well, I can't be with you because you're positive." Maybe a part of that discussion can be, what do you do if your

partner is positive, how you can still be in a relationship with this person and protect yourself from infection.

"A holistic approach". Besides the pulpit and using their influence in the context of counseling, the vast majority of participants (7) recommended that MHT be integrated into the various ministries offered within the church as another strategy to promote and normalize MHT. Jake framed this as a "holistic approach." He described it in this way:

> Holistic approach being that, the church and God should be concerned with the well-being of an individual from a 360-degree perspective. Concerned with their health, concerned with their lifestyle choices, concerned with their...not from an invasive way, but more of this is integrated into how we do ministry as a church. So we have health and wellness ministries; we have ministries that encourage you to get involved politically and getting invested economically in some way in the community. Concerned with the state of your family, your children, every single thing that touches your life, the church should have... ministerially [sic] have an approach to addressing that and being able to be a support system for that.

Along those lines, the majority of the participants (7) believed that different ministries offered within the church as well as lay mentors from within the congregation, could help to engage the conversation and encourage MHT, especially amongst existing relationships. For example, Goddess spoke as a married woman: "While I think [MHT] should happen, I think that in the whole sphere of it being a part of a program that a church or a ministry is doing, would make it easier." Following are some ways these participants expressed this idea of lay mentors within the context of holistic, auxiliary ministries:

> Churches that have ministries for couples, that's a great way that they can incorporate couples talking about it. If it's somebody else's idea, and if it's not the wife's idea, and usually it's the woman who's initiating these types of things. So if it's not the wife's idea, but the pastor saying it or the facilitator saying it, the nurse or the doctor saying it, it really, softens it. ZOEY

> …Even a congregant that was trained, or a married congregant, a married couple that was trained in HIV/AIDS and if they sold it, I think it might fare better than a pastor selling it. That's just me personally because sometimes members do better by hearing from their own. Some things...not all things, some things are sold better from the congregants, rather than the pastor. JAYBIRD

Lillian saw an opportunity for the congregation to be educated about MHT using an each one, teach one model within the various auxiliary ministries. She stated, "It's the hierarchy that speaks to a specific group that influences many groups." She went on to describe the following:

> Maybe it's just a quiet thing in the marriage and couples ministry...in the marriage ministry you're talking about all the things that make your relationship whole. Well, this is a part of the voice that makes your relationships whole. So what you do is manage that seminar at that point for that group, then that group becomes ambassadors to the singles. And then the singles be ambassadors for the young adults, who eventually are about to get booed up with each other anyway so face it. And then the young adults, who are not far in age, go and talk to youth…

Collaboration. Most of the participants (6) suggested that clergy could collaborate with other ministries, such as churches, or organizations to address MHT. Denise gave the following example of how churches could come together on this issue:

> I think we've just got to work together, because you know our people are dying. That's just the bottom line. [If] the health ministry or singles' ministry or whatever, would hook up with mine and we would get over whatever differences there are…Just for the sake of people and community, we could pool money resources, we could pool knowledge resources, all kinds of things to have a greater impact, a more far reaching impact…there would be all kinds of things that we could [if we] put our heads together. And we wouldn't have to do it in a particular church, but something like a sponsored community-wide testing for couples... DENISE

Jaybird addressed this notion of collaborating from a different angle. While he agreed that MHT was most appropriate for clergy to promote with engaged couples, he expressed some ambivalence about the role of clergy when intimate partners fell outside of that context:

> I don't know if we play a role in the mutual testing of people who are not married...Because it's such a thin line...in church, it's a thin line...I don't know if the church would be able to...I don't know if it's my business as a pastor, to be that precise that, I'm going to do couples who are in a relationship. I think I would be more apt to do everybody get tested, rather than be more specific.

Alternatively, he made the following concession, "Listening helps, listening to non-profits that are already, doing what you don't want to do and supporting them...partner with non-profits that are already got their hands in the process."

Beyond the church. Many of the participants discussed the importance of engaging other sectors, beyond the church,. as a necessity to make MHT a normative behavior. Jack, in particular, offered the following as a rationale to consider other alternative

> The church is not the social institution that it used to be in terms of its authority and its importance---it's relevance in people's lives. And so since our situation is different in terms of people's attitudes toward the church---that's going to directly affect our system of ministry. Because we see the old tactics just won't work anymore for the society that we're dealing with. A lot of people that we're ministering to maybe didn't grow up in church. Their grandparents did. And their grandparents made their parents go to church, but their parents didn't make them go to church. And so it's less of that connection, it's less of that well; God says you should do that. And people's response is, "okay, so why should that be important?"

The properties associated with this sub-category are (a) Power of media, (b) Request or Require, and (c) Campus life.

Power of media. Most of the participants (6) indicated that norms are largely shaped by the influence of the media. One of the participants described it this way:

> I say, media…And by media, I mean, what we take in on TV, what we read, what we're exposed to-billboards, how things are advertised for us…Our responsibility as individuals is to accept or reject what we receive. But a lot of times, I don't think we're aware by how much were being impacted by the things we see on TV. JACK

This perception was shared by others who repeatedly suggested the use of various mediums to help partners begin to broach the topic of MHT. To this point, Jake said: "… even just looking for opportunities… if the couple is watching TV or something, they're sitting on the couch and then something comes in and then they use that as sort of a springboard to start the dialogue." Similarly, Zoey said, "any media where people can you know, it takes it off of them, and we can sort of talk about this, but people go home and they think and they reflect, I really believe that."

Several other participants advocated for the use of social marketing campaigns to help normalize MHT:

> ... Some type of campaign that they see, even in the pamphlets, now. Because you know the whole publicity about RAPP-IT UP…Well, people are not afraid now to ask that their man to put on a condom or what have you. Well, I think the

same thing, if there was more talk about mutual testing, people won't be afraid, if you're in a relationship -- let's do the mutual testing. Let's have it out there on the black radio stations. Let's have it out there…then it doesn't come or cause an alarm of suspicion. GODDESS

But we would just have to put out there. It would have to be something that we hear more, 'let's get tested together.' 'The power of support, from day one.' I think anybody in ministry would champion the idea of having a support system, in anything you do, especially in something as scary as getting tested in the world we live in. JACK

Require or Request? For two of the participants, Jaybird and Chris, the word "normalization" initially triggered the perception of a requirement rather than seeing it as a social norm. On this point, Jaybird commented: "No, I don't think it should be. People have freedom of choice." Similarly, Chris said:

I think it will be good. I don't have any arguments about that. But I am always privy to peoples' choice in their own lives. I think freedom of choice is a gift to humanity and we choose to do things and that realistically, nobody ever really wants to be forced to do anything...So I guess in a sense, I may be against normalizing it. Whereas I see the necessity of it, I definitely see the need for it, but I also respect a human's right to choose whether they want it or not.

A similar divergence ensued around the notion of MHT being a prerequisite before marriage, otherwise viewed as a government intervention. This issue was raised by most (6) of the participants. Goddess and Jack thought MHT was a requirement before marriage and were surprised to learn that it was not. On the other hand, Son and Justice were aware that blood test are no longer required before marriage. Nevertheless, all of these participants, which included Chris, who initially argued for "freedom of choice," believed that it should be required before marriage. Two participants conveyed this view when they said:

That's interesting. I wonder why it's not and I think it should be. You're entering into marriage and you're probably, if it's a heterosexual marriage, then you'll probably want to have children. And if neither one of you are in the know, you could pass this detrimental virus onto a child. So at that point, not for the adults in marriage, but for seeds that they'll probably produce…I think it should be a mandatory, at least once. And then continuous, maybe a yearly thing that you would do. JACK

…Even if it was like the old blood testing before you get married…I think that would be a good first step in that direction making it a prerequisite to get your marriage license. I know that there is some sort of privacy issues around

that…not first amendment, but I'm sure there is some constitutional issues around that…but I think that would be a good first step in normalizing it. JUSTICE

In contrast to the view of making MHT a normative behavior through a state policy, Jaybird offered a contrasting opinion. While he agreed that MHT should take place before marriage, he firmly maintained his position regarding the "freedom of choice." Rather than making it a government policy, he argued that clergy could make it a church policy. His point is conveyed in the following comment:

> I think it can be normalized if you're just giving a personal option. Now you making me do it to get a marriage license, then that's a problem. I ain't with that. I can normalize where if I'm marrying somebody, that I would suggest that. As a pastor, I can say, "everybody I'm going to marry, I'm going to suggest, I want you all to think about getting mutual testing."

Campus life. Some of the participants (4) alluded to the risk taking amongst youth and young adults as a rationale to consider schools as a viable venue to normalize MHT. Justice, for example, stated: "I think the university environment is a good place, 'cause that's where people are coupling up like crazy." Likewise, Jack had this to say: "Well, I was thinking in terms of colleges and universities. But it would be nice to get it in some high schools too, just to be real; it would be nice to get it into some high schools as well."

In the following example, Chris shared a unique perspective for why schools are best suited to help normalize MHT:

> I would say churches, but realistically folk just not attending churches like they used to... And that's a reality. So whereas the church is one venue I don't think it can be the primary venue anymore… I think…especially colleges and universities are huge. School system, I think is a huge venue. CHRIS

Overarching Theme 5: Tensions of MHT

Overarching Theme 5, **Tensions of MHT,** uncovered many of the conflicts that may hinder the promotion of MHT in the Black church. Two thematic categories emerged: (1) *Crossroads*, which alludes to the challenging decisions that clergy must make and (2) *Roadblocks* represents obstacles that may prohibit action.

There were a number of perceived tensions identified when asked about promoting MHT within the context of intimate relationships in the Black church. Two thematic categories emerged to further illuminate these issues: (a) Crossroads and (b) Roadblocks, with each consisting of several properties.

Crossroads

In speaking about the tensions, crossroads referred to the crucial choices and decisions that clergy are likely to be faced with when promoting MHT. Although there were numerous tensions identified, the majority of the data revealed the following three sub-categories: (a) Ideal vs. Reality, (b) "Practice What I Preach?", and (c) "Just an either/or people."

Ideal versus reality. The majority (8) of the participants perceived that the Black church and its leadership do not adequately deal with the reality of what is going on in the church, particularly in the context of sex. Chris, for instance, described the "ideal" perception of people in the church in this way: "We supposed to be Christian folk. We don't suppose to be doing nothing. We're supposed to be every Sunday coming to church, 'Holy, holy, holy, Oh Lord Almighty.' That's supposed to be us. That's our MO…that's our identity." Similarly, Zoey stated:

> I'm not sure how many churches know about mutual testing, first of all. And, I'm not sure even if they knew about it…how many churches would be open to have someone come in and say, "We're doing HIV testing." "Why are we testing our folk? We're good Christian folk… We ain't having sex, number one…so who is supposed to go be tested? Married people ain't going to go because 'we've been married.' Single people aren't going to go because we ain't fucking… ZOEY

As suggested by the previous excerpts, the reality is often masked by perceptions of what should be rather than what is, thereby causing a tension. This point is further addressed in the following examples from Justice and Jack:

> I think the church needs to just be more open about things that happen in real life. Just the same way we talk about people who fall down and backslide in different ways, it happens sexually as well…And the reality that they are all human and people are making mistakes, and yielding to temptation. JUSTICE

> So our stance is that sex is only right in the confines of marriage, great that's our stance, but we got people sexually active. That means we need to go ahead and talk about it as a reality. Since we're having sex, let's be referring people to

different resources to get tested. Let's be talking to our young ladies about birth control; let's be talking to our young men about healthy practices; and not just young people …I be surprised like in dating situations the questions that I get from women who are older than me. JACK

"Practice what I preach?." Some participants (4) discussed the tension associated with telling their congregants to do something that they may or may not be willing to practice themselves. Following are some the ways these participants expressed this tension:

I never ask my congregation to do anything that I wouldn't do or that I'm not currently practicing…I think we have to just do more of that as a model. Like the pastor and his wife should do it and they should say we did it and then this is why you should do it. I think part of it [the tension] is that 'practice what I preach.' So if I'm going to be promoting this, I better be doing it and I don't know that clergy people are even having those conversations in their own relationships. DENISE
Yeah, yeah [MHT]…that's a way to reduce HIV and AIDS. I think that's a way to reduce it, but if for me, if I was married, I wouldn't. I would think I would have a little trust with my wife and we wouldn't even have to go there. That's just me personally...that ain't everybody… that ain't how the world works. A lot of people are cheating, or on the down low. JAYBIRD

"Just an either/or people." In addition to acknowledging the realities of sex in the church and practicing what they preach, there were several (5) participants who suggested that clergy are often challenged with the decision of where to focus their attention in ministry. Such decisions were perceived as a tension regarding MHT. Participants conveyed this in the excerpts:

I think a big tension...a lot of clergy will just decide, this ain't my battle, I'm not going down this hill. I'm more concerned about blah-blah, whatever it is. Because we're just an either/or people. Like if this is my issue, this can't be my issue, as if they're not all connected. DENISE

So here's the other thing, every ministry is going to have what their passionate about. So if that ministry is not passionate about HIV/AIDS and they see their passion, social justice or maybe homelessness, or whatever, they might do something cursory about this, but their energies and everything is going to go in that other direction. GODDESS

Yeah, it's that, it's not important enough, so to speak, there are more other pressing things that we have to worry about. We have to be concerned about your soul, before we can be concerned about your body, which is very Augustinian at its core-- really valuing the soul above the body and the flesh. So that whole philosophy, of course, is ingrained in the psyche of American civil religion. There is a disconnect between the body and the soul and so the clergy, this is not my belief, but this is sort of like the thought, is that clergy is concerned about soul. Individuals are concerned about the body, that's not the role of the clergy. JAKE

Roadblocks

Similar to 'crossroads,' the category 'roadblocks' signified references that were perceived as obstacles or backlash that may hinder whether clergy would broach or promote MHT in the Black church. The sub-categories are (a) Politics of ministry, (b) Reputation on the line, (c) Perception matters, (d) Don't want to offend and (e) Worry about pushback.

Politics of ministry. The overwhelming majority (9) of the participants provided illustrations of 'politics' that clergy have to take into consideration before moving on an issue. Two of these participants described the denominational politics in this way:

> People who have to seek ordination…they have to stick within the confines of the theology of their conferences and denominations. So that is huge, even if your theology is different, you're by and large going to teach and preach whatever they say you're supposed to teach and preach, because that is your bread and butter. Okay, so if you have a lot of that going on, unless they are really bold and courageous, and have the wherewithal to say, "You know what, I'm really going to do what I know or feel or think to be right versus support the status quo here." ZOEY

> The tension would be, if I'm a person that is a pastor of a church, but I'm also part of a larger denominational body that has a strong hierarchical structure, my district superintendent or my bishop may not want me to take up this issue. So now what? Now I'm kind of torn because I have my personal convictions about this needing to be something that's important for my congregation. But my bishop feels like no, there are other things that you could be focused on. That's one of the reasons why I don't like denominations because I don't…if I feel pulled by God to take the congregation in a particular direction, I don't want a human being to tell me that that's not the appropriate course of action. JAKE

Reputation on the line. There were other participants (5) who also expressed issues that centered on motives and reputations being questioned. To this point, Lillian said: "The tension…tension is promoting HIV period. Promoting HIV prevention period. Mutual testing, individual testing, their own testing." Goddess and Zoey spoke about it this way:

> We live in such a climate now where people look at clergy with suspicion; assuming that you are sleeping with someone in the congregation or...you're living a life less than what you should be. So you don't want to give any hint of any impropriety on your part. GODDESS

> Many won't because they know that my buy in to this, or my involvement with this, is making a statement about who I am as a minister, or what I believe as a minister, what we stand for, and what we accept and embrace. ZOEY

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Perceptions matter. There were a number of instances where participants suggested that the attitudes of the congregation could hinder a clergy's course of action regarding the topic of MHT. For example, a few (3) participants suggested that conversations about MHT could be perceived as endorsement of sex outside of marriage. To this point, Justice stated: "It can be seen as being encouraging premarital sex which we're not supposed to do." Likewise, Goddess said: "There are people that still feel by having this conversation; you're going to promote promiscuity. It's very difficult to reconcile with that." This tension is illustrated further in the following example:

> The whole subject of HIV and AIDS is a risky conversation. It's risky in the sense that people could construe it--it depends on, what people think that you're really saying, what they think you're promoting and how they believe. Sometimes people think, talking about testing, talking about birth control and any those kinds of things, that you're promoting promiscuous sex. So, like how is my congregation going to even read me talking about this? DENISE

Don't want to offend. Other participants (5) gave examples of how MHT could "offend" the congregation. Son, for instance, stated: "...You stick with preaching the word of God... spiritually, you don't have no dealings with what I'm dealing (Beckwith et al.) in my relationships…" Jack and Chris expounded on this notion of "offense" in the following ways:

> Some clergy might not want to talk, they don't want to offend people because they know, that whole process of getting tested can be so scary that if I start talking about this, I don't want to run people away. So sometimes as clergy, you want to elicit certain responses and so that might taper or hinder some of the things you say cause you don't want to stir it up too much. JACK

> The problem is we don't have enough leaders who are willing to assume authority in their position, to speak out. I guess it's because of fear, we might make folks uncomfortable and the folks who pay the money, may not be paying the money no more because we made them feel uncomfortable...and we're afraid of stepping on people's toes…CHRIS

Worried about pushback. Related to the "offense" that the congregation may feel about the issue of MHT, there were also concerns raised about getting "push back" from the congregation. Some of the ways participants described "push back" were as follows:

> Old mindsets. You got a group in the church that just, they just-you know, it is what it is, they older, they love the Lord, but it's just some things they just--see

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because it (NIMH Multisite HIV/STD Prevention Trial for African American Couples Group) really wasn't in their time… so they're not willing to compromise with some things like HIV/AIDS testing or opening your door for HIV/AIDS testing. They don't comprehend that. JAYBIRD

So I think there could be some tension around sort of stepping up. You know clergy people are always worried about push back. There is always a range of people in the congregation--people with political beliefs, people from different socioeconomic status-there is always a range of people. And so, they're always worried about like, 'who's going to agree with this? Who's going to automatically be on board? Who's going to be easily convinced and who's just going to give me hell outright. And so is it a battle I even want to fight? DENISE

But I think the majority of times that we become victimized by our own calling. That we give in to the pressures and one would be the money. If I'm a pastor, upstanding, and I got my family, I'm making 40 or 50 thousand dollars a year and now all of a sudden I'm doing HIV/AIDS testing, and I know the people don't go along with that, I won't do it. Or even a sermon, God done gave me a word to speak about HIV/AIDS. God done gave me that word, I know, but I don't preach it. JAYBIRD

Overarching Theme 6: Ways to Facilitate MHT

Overarching Theme 6, **Ways to Facilitate MHT,** identified the seminarians' perceptions toward their own preparation, needs, and interests in conducting MHT with intimate partners. This theme includes three categories: (1) *Life/Course* reflected on the experiences on which they have drawn on to address HIV; (2) *It Takes More* comprised discussions with participants regarding their perspectives on what they need to feel prepared to promote MHT with intimate partners; and (3) *I Think I Can* encompassed participants' perceptions of their personal roles in facilitating MHT reveals strategies they could use to assist in the normalization of MHT with intimate partners.

To determine what participants felt was necessary to facilitate MHT with intimate partners, several questions were asked to get a sense of their personal readiness to address HIV, their perceived needs to facilitate MHT, and ways in which they could begin to promote MHT in the context of intimate relationships. The sub-categories are as follows: (a) Life/Course, (b) It Takes More, and (c) I Think I Can.

Life/Courses

Life/Courses refers to the experiences that participants perceived as important to draw from in order to address HIV in general as well as MHT. From this vantage point, the majority (8) of the participants shared examples of how life and practical experiences were their primary source of preparation. Participants conveyed this in the following ways:

> I think particularly now as a divorced, single woman, I think I stand in the shoes of a large percentage of the church population because there are a lot of single black women in church, and definitely a lot of women...coming from my own experiences being in relationships, making decisions about whether they should be sexual or not, and making choices about safety…JUSTICE

> ...I would say life experiences…being able to connect with somebody through life experiences. Like not just talking numbers, but let's talk real life situations that either happened to me or to someone else or to you...and use that as a teaching moment. JAKE

Besides life experiences, all of the participants referenced their coursework as another central source of their preparation. For some participants, their contextual field experience seemed to offer the most direct exposure to addressing issues concerning HIV as suggested in the following exemplars:

> I think the only coursework that would be helpful was in the context of my Contextual I experience, particularly dealing with the homeless population, dealing with mental illness, and also dealing with the issue a lot of people who are HIV positive …end up being homeless because of resources and so that has been some exposure that I have coursework wise. JUSTICE

> I would even say that… doing some contextual education work at Metro Transitional Center, a women's prison. They had a teacher, an instructor who would come and talk to women about sexual health. She shared a lot of information…it was mind boggling. And, actually she's someone I want to go and speak with again, to just get more information, learn from her. ZOEY

Although the participants described a host of electives that had some direct and peripheral relationship to HIV, Pastoral Care/Counseling and Ethics were the most frequently mentioned courses that they felt contributed towards their understanding about addressing HIV. For example, in regards to Pastoral Care, Chris said this: "…in my pastoral care class the professor he did a significant amount of work on HIV and AIDS and he added that as a big

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dimension of his class… More like a pastoral care with individuals with HIV/AIDS." Likewise, Jack had this to say about Ethics: "…I'm taking now pastoral ethics…we deal with the ethical component of negligent pastoral care. So that's the, 'not talking about things,' how that's really unethical…we also talk about sexual ethics."

There were a few (3) participants who argued that due to the limited number of required courses for all Master of Divinity students, such as Pastoral Care/Counseling, that many seminarians matriculate through seminary with little to no exposure or preparation to address issues regarding sex, sexuality or HIV. For instance, when Son was asked whether his institution provided courses pertaining to HIV, public health, or social justice, he indicated, "No, I don't know, I can't say for certain because I'm in the grad program." The following exemplar illustrates this point:

> I would say they are as prepared as they try to be. The school doesn't do a lot per se to equip us with the necessary tools to talk about some of these things. If you take the right classes, if you go to the right meetings, if you get a part of the right organizations, then you'll know. But if you don't, then you could really come into [seminary] and graduate from [seminary] never dealing with some of the realities of the way our society and our church deals with sexuality here currently in 2010. JACK

To expound further, while not directed at all seminarians, Jake expressed concerns about some of his collegial peers that have negative attitudes about HIV and sexuality:

> So individuals…are leaving [seminary] and going to pastor churches. So now what does that mean for discussions around HIV and AIDS when you're entering into a space with this already, this sort of negative thrust towards populations and groups that have been deemed the contributors of HIV and AIDS to our larger society? You know, how does that now shape the way that you interact or counsel, or give pastoral care and stuff like that?

It Takes More

As the participants reflected on their personal experiences and the lack of required coursework for themselves and their seminary counterparts, they were able to identify several additional needs. The following sub-categories were considered important in order to move

beyond addressing HIV to being able to facilitate MHT with intimate partners: (a) Engage the new generation, (b) Formal coursework, (c) Continued education, and (d) External partnerships.

Engage the new generation. There were two participants, Jack and Jaybird, who specifically suggested that the new generation of church leaders play a pivotal role in the normalization and promotion of MHT. Jack, for instance, stated: "…It would also be helpful for this new generation of young church leaders that's coming up to commit to making it an aspect of our ministry." Likewise, Jaybird had this say:

> ...[MHT] that would really have to be put in the minds of seminarians--yeah …I think it would work... I don't know what setting or what class it can be under, but if you can normalize it in that way—that this is something that we can teach that'll be part of a curriculum or part of a class--that mutual testing is done in premarital counseling... Something that seminaries could use, I think that's the better play. I think you'd be wasting a lot of your time trying to get every old pastor to do that. I think you'd be better off with upcoming powerful preachers that have a different mindset, living in a different context to get them in to that.

Formal coursework. Related to this point of engaging the "new generation," there were several (4) participants who suggested that seminaries provide and require coursework that explicitly prepares seminarians to deal with the complexities of HIV in the context of intimate relationships. Following are two exemplars that conveyed this point:

> Understanding what mutual HIV testing is-- I think that would be a huge piece to it. I would honestly wish seminary would offer some kind of course on how to address this with congregations. Just HIV/AIDS period and all the subtopics that come underneath the broad scope of HIV and AIDS. I think that would help out a lot, especially for the church context; those who are going into pastoral ministry. Even more so, those who are going into campus ministry because they probably see it or have to deal with the issue more, I guess more vividly and more candidly to a certain degree. CHRIS

> …what would help me? Probably just some course work that you might get generally about…and this is probably part of pastoral care, which I haven't taken, something about marital counseling or premarital counseling, those sorts of things…because if its routine and it's a part of what everybody does, it doesn't have to be specifically geared to, if your test comes out positive then what?...Its just a routine thing that you raise and when deciding to go into that sort of relationship. So I think maybe something on couples counseling would be helpful for that. JUSTICE

Continued education. Besides training seminarians through formal coursework, a few participants felt that clergy, including seminarians, should participate in continued education

through specialized trainings with their peers to stay abreast of the most current information.

Denise and Goddess said it this way:

> I would like to see some kind of gathering that was just for clergy. Where not only,... sort of lecturing to them about the stats and everything --although some of that's needed as well, more where they had to do some hands-on type of stuff. Like where the testing was available to them, as couples. Where like it was a training that involved them doing it. And then where they could be just with other clergy and get real about what they're scared of and where their stuff is around HIV. You know, if it has to do with, you only think HIV comes from anal sex between men and that pisses you off, or whatever--just be able to just say that and not have to have shame around it…DENISE

> We definitely need a presentation with current information. Because...it's also preferable for someone that's teaching that or has that passion with it, to bring the newest, the up-to-date information. So I think that would be beneficial, just all of those other gaps that I told you that I didn't know about, in terms of how often [to test]? All those other kinds of things that we should know about before you advocate something like that and say that, 'well, you should do this.' So it [presentation of current information] needs to be beyond a onetime kind of thing. GODDESS

External partnerships. While formal coursework and continued education were seen as important, there were others (4) who expressed the necessity of establishing external partnerships. On the one hand, external partnerships were viewed as a resource to clergy to help them become better informed, which in turn can be integrated into their ministry. Jake said it this way:

> A great pastor recognizes that they're not able to be an expert on everything...I am expected as a pastor to be the leading theological voice for this particular congregation. Outside of that, I have to be realistic to say I'm not going to be an expert in everything else. So let me figure out how to do this, let me worry about this theology piece. And then let the health professionals worry about what they worry about. But let's figure out a way to sort of meet in the middle and say, now, how can I start to work on developing sermons that addresses this, now that I have this knowledge and this sort of resource from a person that I can tap into about this. JAKE

On the other hand, external partnerships were suggested as a way to mitigate the perceived tensions previously discussed. Participants framed this perspective as follows:

> If you get ten churches to hook up with a non-profit with HIV/AIDS, you've done such a great service already. Because like you say [the negative perception issues]…the church don't really want that, they don't want to be a part of that. So why not support the non-profits, through volunteers, or donations, and allow them to come in and educate your people? I think that's more ideal than the actual church doing it themselves, that's just me personally. JAYBIRD

> I guess the only thing that I would say is that I think that churches need not to feel like they are alone, if they decide to do this. That it's always good and can be

helpful, of course, to them, to partner with people who have already done a lot of research and have all of the knowledge, whether it be, public health agencies, non-profits or whatever, to partner with them. Use them as a resource. And even if you don't want to do the work, support them financially, or both…their involvement [the church] says something. That the community says the church cares; this is important. And the parishioners see that this is important. The church… affirms the importance of this work, by virtue of their involvement. ZOEY

I Think I Can

In addition to preparation and needs, participants also discussed what they felt they could do personally to promote MHT. Based on their perceived preparation and understanding about MHT, many participants described ways that they could begin to facilitate discussions about MHT with intimate partners. For example, there were a few (Son, Denise, and Jaybird) who mentioned they could integrate MHT into their future premarital counseling, as captured by Son: "…you know what, I'm going to incorporate that in my counseling from now on. You know, you need to have an AIDS test…you've been active; you need to put that out there." Two others (Jake and Denise) spoke about sharing with their friends. To this point, Denise stated:

> Probably our friends, for example, probably don't know that we go and get tested. So I think maybe one thing could be just, talking about it, or you know like making those suggestions. Like I've never even heard the term, mutual testing until you just said it, like even though I was doing it, I didn't have a language for it. So, maybe it's another education piece, so that, you know, planting the seed---like planting the thought.

Other participants (Jack and Chris) spoke about sharing from the pulpit. This is best illustrated in the exemplar from Jack who said:

> I teach bible study every Wednesday, and usually whatever that's been going on with me, that's how I intro it. And so this Wednesday, they'll probably get some of this, you know what I mean. And so, that's one, really quick way that I can …and also being proactive about starting an HIV testing campaign. And the only thing I would do, like I said I heard of the GYT - get yourself talking, get yourself tested. And so I would probably look for some posters, something like that. See if I can get them hung up. And put my name on it too and hopefully that will get some conversations off to the side. Some people might not be comfortable talking about it in an open space, like bible study, but get some people one on one talking about it.

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Chapter Summary

This chapter presented a detailed description of the findings regarding African American seminarians' attitudes, perceptions and knowledge about HIV and mutual HIV testing within intimate relationships. In summary, the results clearly indicate that the seminarians in this study are knowledgeable about factors contributing to the spread of HIV in the African American community and fully support HIV testing. They also believed that there is merit to MHT, and described various strategies to promote, normalize and facilitate MHT to include the Black church as well as strategies beyond the church. They were cognizant of the challenges that MHT presents for couples and clergy as well. Nevertheless, they outlined several approaches to help them facilitate MHT within intimate relationships. A more detailed summary and discussion about the findings are presented in the next chapter.

CHAPTER 5

SUMMARY, DISCUSSION AND RECOMMENDATIONS

The purpose of this exploratory qualitative research study was to explore African American seminarians' attitudes, perceptions and knowledge about HIV and mutual HIV testing within intimate relationships. The study addressed six research questions:

1. What knowledge do African American seminarians have about HIV/AIDS?

2. What attitudes do African American seminarians hold about HIV testing as a form of prevention?

3. What meaning do African American seminarians ascribe to mutual HIV testing?

4. What attitudes and perceptions do African American seminarians have about normalizing mutual HIV testing with intimate partners?

5. What are the perceived tensions within the Black church associated with promoting mutual HIV testing with Intimate partners?

6. What are the perceived needs of African American seminarians to facilitate mutual HIV testing with intimate partners?

Using purposeful sampling techniques - criterion, snowball, and emergent - 10 African American seminarians in pursuit of their Masters of Divinity from three seminaries in Georgia were recruited for the study. Three methods - semi-structured interviews, a Participant Profile and an HIV Knowledge Scale - were used to explore their views of mutual HIV testing within the context of intimate relationships. Participants were given a one-time $20 gift card as a token of appreciation for their time and participation in the study. Symbolic Interactionism was the theoretical perspective that guided the design and analysis of this study. To analyze the data, constant comparative, thematic analysis as well as descriptive statistics was used. The previous chapter presented a descriptive analysis of the findings. This chapter includes an interpretive

discussion of the key findings and the implications drawn from this study. The chapter concludes with recommendations and the limitations and strengths of this research.

Summary of Findings

There were seven major findings to this study. **First,** while the participants had a moderate knowledge about HIV risk and prevention they possessed a good understanding about the factors that contribute to the spread of HIV in the African American community and the challenge that HIV poses to intimate relationships. **Second,** the majority of the participants perceived HIV testing as beneficial and an important part of HIV prevention. **Third**, most of the participants defined mutual HIV testing (MHT) as two intimate partners who agree to get tested for HIV together. Overall, the participants felt that MHT was a positive action with many benefits. They were equally cognizant of the barriers associated with MHT as well. **Fourth,** in general, the participants agreed that MHT should occur within the context of intimate relationships; however the context of the relationship was considered critical. **Fifth**, to promote and normalize MHT, the participants identified a number of strategies to include the use of the Black church, media, policy, and schools. **Sixth**, the participants identified several Crossroads and Roadblocks that may impede the Black church from becoming actively involved in promoting MHT. **Lastly,** the seminarians noted the need for more formal training, continued education, and external partnerships to aid them in promoting and normalizing MHT.

Summary and Discussion

Based on the overarching findings, a detailed summary of the related findings and its interpretations is presented and discussed in relation to the existing literature. The interpretations drawn from this study include the following:

1. There is more to HIV than individual risk behaviors;

2. Understanding the importance of HIV testing is critical to prevention;

3. MHT challenges norms;

4. A comprehensive approach will work best to promote and normalize MHT;

5. The facilitation of MHT depends on building capacity and partnerships.

There Is More to HIV than Individual Risky Behavior

An exploration of the seminarians' factual knowledge and perceived understanding were considered central to situate the phenomena under study. As indicated in the participant summaries, the seminarians' sources of knowledge and understanding about HIV/AIDS were largely informed by their personal experiences: interactions with family and peers; and the culture and media. This information is important for it demonstrates what has influenced and shaped their attitudes and perceptions.

From a factual standpoint, the seminarians in this study yielded moderate scores on the HIV Knowledge Scale (range 15-23). In general, the majority of the participants had a good understanding regarding the basic facts about HIV, transmission/risks, and a fair understanding about myths[11]. The main areas where the participants were uninformed include perinatal transmission and prevention of HIV; the use of bleach to clean needles for IDU; and uncertainty about whether a vaccine is available to prevent HIV. Research conducted by Lindley et al. (2010) with African American faith leaders, parishioners, and care team members yielded similar findings for the same items. The uncertainty about existing vaccines has also been documented in other studies with African Americans as well (Isbell, 2009). Despite their moderate scores on the HIV Knowledge scale, from a perceptual standpoint the seminarians were able to vividly articulate the complexity of HIV in the African American community. The rich, descriptive excerpts conveyed their understanding of the various situations that heighten the risk of acquiring or transmitting HIV and were discussed in terms of three thematic categories– behavioral, relational, and sociocultural.

Historically faith or religious leaders have oversimplified HIV transmission to the consequence of individuals engaging in risky or immoral behaviors (Shelp & Sunderland, 1992).

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[11] A discussion regarding HIV testing has been reserved for the next topical section

In fact, early in the epidemic, the literature has shown where many Black faith leaders have shied away from addressing HIV because of its association with certain behaviors such as drug use, sex outside of marriage and homosexuality (Fullilove & Fullilove III, 1999; McMickle, 2008; Thomas, Quinn, & Billingsley, 1994). These attitudes have led some to perceive the faith community as part of the problem, particularly in the African American community.

In contrast, seminarians in this study, new generation ministry leaders, were keenly aware of the myriad of contextual factors that are associated with the startling rates of HIV transmission in the African American community. Although they identified unprotected sex as the primary contributor of HIV for African Americans in general and intimate partners specifically, they also understood that individual behaviors are only one part of the ongoing spread of HIV. For example, to attribute the spread of HIV to individual behaviors alone diminishes the impact of sociocultural factors such as stigma, invulnerability, and silence around sex (Fullilove & Fullilove III, 1999; McMickle, 2008). Furthermore, while race in and of itself is not a risk, research has shown that the disproportionate rates of HIV amongst African Americans are further exacerbated by racial disparities in poverty, unemployment, incarceration, access to equitable health care, and educational systems (Adimora & Schoenbach, 2002; Sampson, 1995).

The seminarians' perceptual understanding about the issues that increase the vulnerability of contracting HIV for couples further revealed their sensitivity to the notion that HIV is more than simply the result of individual risk. The findings pertaining to relational factors centered on the lack of honest communication, assumed monogamy, and partners who are either unsuspecting of their partner's indiscretions, or those who suspect but hope otherwise. As illustrated in Figure 2, the first sphere represents individual behaviors identified by the participants that heighten the risk of individuals contracting HIV whereas the second sphere describes the sociocultural factors mentioned that perpetuate the ongoing spread of HIV. When overlapped, the relational context is implicated by the confluence of individual behaviors and sociocultural factors. As indicated by the arrow, these factors distinguish the relational vulnerabilities identified by the participants. In

other words, when viewed from a relational perspective, the behaviors and circumstances of one partner in a relationship places the other partner at risk. This suggests that HIV transmission is not solely the result of an individual's personal behaviors.
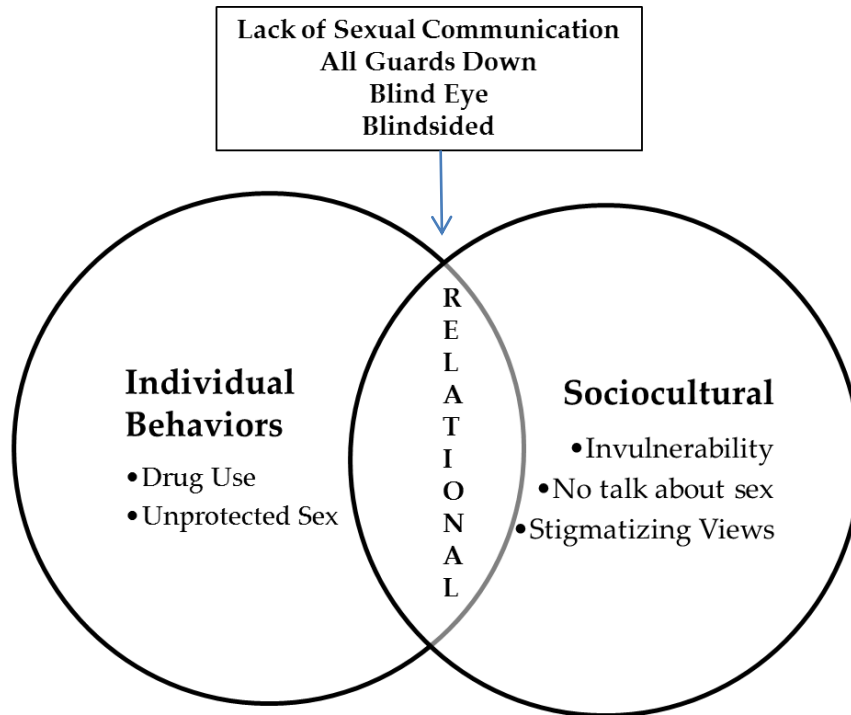
Figure 2 - Factors that Contribute to HIV in the Relational Context

To put this in context, several studies have shown where partners conceal their sexual history whether out of fear of being stigmatized or judged (Lichtenstein, 2000) or to maintain their relationship (Lucchetti, 1999). Other studies have addressed how stigma and social pressures to conform to what is culturally acceptable has led people to live double lives as they secretly engage in undisclosed same-sex practices that in turn endangers their partners (Montgomery et al., 2003). Research conducted with low income African American women found that some would prefer to engage in unprotected sex as a way to maintain the belief that their relationship is monogamous because to think or do otherwise, would damage their self-esteem (Sobo, 1993). Also, in her book, *Man Sharing: Dilemma or choice: A radical new way of relating to the men in your lives* Chapman (1986) discussed how the shortage of available men may lead some women to engage in concurrent sexual relationships, even with married men, to have their desires met.

Subsequently, these choices have been shown to place all parties, including the unsuspecting spouse or partner who assumes that she or he is in a monogamous relationship at risk (Crowell & Emmers-Sommer, 2001).

A conclusion that can be drawn from these findings is that the seminarians' in the study have an appreciation for the complexity of HIV. While this is not to suggest that they dismiss individuals from accepting responsibility for their behaviors, it does indicate that they were able to delve deeper to consider the situations and even the rationale behind such actions. This is an indication of their willingness to interpret what is going on in the culture. Therefore, it is important to see beyond individual risk behaviors when considering the factors associated with HIV transmission. In fact, being sensitized to the contextual factors that are associated with the spread of HIV is necessary to appropriately combat the epidemic amongst individuals and couples, alike. Notwithstanding, these findings also suggest that while the majority of participants are quite perceptive about the contributing factors associated with the acquisition and transmission of HIV, particularly from the sexual standpoint, they were less knowledgeable about facts and prevention regarding other risk areas.

Understanding the Importance of HIV Testing Is Critical To Prevention

Making testing accessible. The seminarians placed a high value on people knowing their HIV status and felt that every effort should be made to promote HIV testing and make it accessible. As indicated in the summaries, all of the participants were impacted by HIV in some way which influenced their attitudes and understanding about the significance of HIV testing. Their perceptions about the acquisition and transmission of HIV clearly indicated that partners may not be aware that they have been exposed to HIV. Therefore, finding ways to increase HIV testing while also alleviate the barriers of testing was considered critical. In particular, strategies such as community outreach to the disenfranchised, routine testing in medical settings, and encouraging one's network to get tested were suggested to mitigate issues pertaining to access and stigma. Although the CDC's recommendations regarding HIV testing were not specifically

explored, some of the participants alluded to them in different ways. For example, Lillian and Justice strongly supported the inclusion of routine testing during medical exams. Although this strategy aligns with current recommendations for all persons 13-64 to be screened for HIV in health-care settings as proposed by the CDC (Beckwith et al., 2005; Branson et al., 2006), it was discussed as a practice that should be adopted rather than one that is currently in place. This suggests that some of the participants may not be aware of the current HIV testing recommendations and guidelines.

On the other hand, Denise and Goddess expressed concerns about people who have limited access to health care or do not get annual physical exams. This finding has been supported in the literature. According to KFF (2010) most testing takes place in private physicians' office, hospitals, and within HMOs. This suggests that if people are without insurance, despite the attempt to reduce the stigma or to normalize individual HIV testing by way of a universal approach, there are still many who may not benefit from this recommendation.

Another related concern in regards to the issue of access came up in terms of the number of churches represented in the sample that have sponsored, offered, or referred people in their congregation and community for HIV testing. In the previous chapter, Figure 1 revealed that of the nine participants who responded to these questions, only four participants responded 'yes; to at least one question; and only one reported yes to all. Several important findings emerged from this data. First, with the exception of Denise, all of the churches that respond yes to any of the questions had congregations ≥1000. Second, all of the churches were located in either an urban or suburban area. Perhaps an explanation for these findings is that HIV testing in not a priority for the leadership of their respective churches. However, another plausible explanation is limited resources. Previous research has found that churches with small congregations or located in rural areas are often least likely to engage in HIV prevention outreach initiatives due to limited resources (Eke et al., 2010; J. Smith, Simmons, & Mayer, 2005). A conclusion that can be drawn is that the size and location of the church has potential implications on the type of HIV prevention

services, particularly HIV testing, offered or available to congregants. This is particularly important for rural communities where access and availability of services are limited.

Benefits of HIV testing. The seminarians were cognizant of the benefits of HIV testing. Their descriptions including risk reduction, education, access to medical services and linkage to care and support aptly defined benefits identified in the literature (Branson et al., 2006; Myers, Worthington, Haubrich, Ryder, & Calzavara, 2003). The vast majority perceived a connection between people who learn their HIV status and a reduction in risk behaviors. However, there was one who argued that testing did not change behavior. Both perspectives have been addressed in the literature. For example, the research states that when people test positive for HIV, that they are more likely to reduce their risk behaviors to prevent the spread of HIV thus making it an important secondary prevention strategy (Fenton, 2007; KFF, 2010; Weinhardt et al., 1999). On the other hand, the research indicates that a negative HIV test does not necessarily result in changed behaviors and therefore is not effective as a primary prevention strategy (Weinhardt et al., 1999). Be that as it may, the CDC recognizes and promotes HIV testing as a critical component of HIV prevention and imperative for early detection (CDC, 2009b; Fenton, 2007; Shouse et al., 2009). Furthermore, from a relational perspective, HIV testing is crucial before engaging in sex with or without a condom (Hageman et al., 2009). A conclusion drawn from this finding is that while HIV testing is not a primary prevention strategy such as abstinence and condoms, the benefit expressed by the seminarians and echoed in the literature demonstrates the significance of HIV testing in prevention.

Need to demystify HIV testing. While the seminarians' attitudes and perceptions about the significance of HIV testing and the benefits are important, there were aspects regarding their factual knowledge about HIV testing that was surprising. On the HIV Knowledge Scale, there were one myth and four items that were directly related to HIV testing (see Figure 3) .

Correct Responses to HIV Testing Related Items

6	10	10	10	3
A negative HIV test indicates the absence of the virus if it is performed after at least six months with no exposure to risk.* (Item 7)	If one-partner tests negative for HIV after having unprotected intercourse, the untested partner's HIV status is deemed to be negative.* (Item 15)	People who have unprotected oral, anal, or vaginal sex should get tested for HIV regularly. (Item 23)	People who share needles should get tested for HIV regularly. (Item 24)	It can take 10 or more years for someone with HIV to test positive. (Item 8)

Figure 3: Correct Responses to HIV Testing Related Items

As illustrated in Figure 3, the vast majority of participants correctly responded to items regarding the importance of regular HIV testing in the case of unprotected sex and sharing needles. They also understood that "testing by proxy," an item added to the scale, is not a suitable alternative for intimate partners to determine their HIV status (Morrill & Noland, 2006). However, their responses to two particular items raise some concern. Several participants responded incorrectly or were unaware of the following statement, "A negative HIV test indicates the absence of the virus if it is performed after at least six months with no exposure to risk." This suggests that some of the seminarians are uninformed of the recommended window period commonly used to determine a negative HIV status.

A related, yet more disturbing concern is the belief by most in the myth, "It can take 10 or more years for someone with HIV to test positive." This misperception, a finding that also emerged in Lindley et al (2010) study, is often confused with the fact that HIV can be

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asymptomatic for 10 years or more before the virus manifest into AIDS (Avert.org, 2006; Shouse et al., 2009). Similarly, three participants – Denise, Son, and Jack - occasionally made reference to viruses lying dormant during their interview as a justification for HIV testing. It is conceivable that a person may have been exposed to HIV (since their last HIV test) and now the virus is asymptomatic and therefore encouraged to be tested because of this possibility. However, it is inaccurate to believe that a person may have contracted HIV, yet the disease is undetectable (i.e. dormant) for 10 years before it shows up, regardless of the frequency of screening (Avert.org, 2006; Vernon, Mulia, Downing, Knight, & Riess, 2001). The findings associated with these misperceptions suggest that the seminarians' endorsement for regular HIV testing may be fueled by erroneous beliefs about the window period and accuracy of HIV testing. Unfortunately, these misperceptions create unnecessary anxiety, perpetuate confusion, and undermine the accuracy of the HIV testing process.

A conclusion that can be drawn is that while the seminarians were passionate about HIV testing and understood the benefits of HIV testing, it was evident that there were several gaps in their knowledge about key facts and recommendations pertaining to HIV testing. Some could argue that having passion or zeal without knowledge could lead to the proliferation of erroneous information and therefore points to the need to demystify HIV testing

MHT Challenges Norms

Understanding MHT. The seminarians' knowledge and views about HIV and HIV testing set the backdrop for their attitudes and perceptions about mutual HIV testing. The participants discussed in detail the meaning they ascribed to the concept of MHT. The majority of the seminarians described MHT as a gesture that involves two intimate partners agreeing to test together. This interpretation is consistent with other studies where this concept of MHT has been encouraged or studied within intimate relationships (Exner et al., 2002; Hammer et al., 1996).

There were numerous symbolic meanings attributed to MHT. Whereas HIV testing was symbolized as a "gateway" to prevention for individuals, MHT was perceived as a symbolic act

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that demonstrates the attributes of a caring and healthy intimate relationship that is manifested in care for self and other, commitment, and trust (Hammer et al., 1996). Like the findings from a couple-based HIV prevention intervention conducted with African American couples (Nabila El-Bassel et al., 2001), the idea of "call to action" as suggested by Jake symbolized a tacit normalcy that the community-at-large should engage in to keep themselves, their relationship, and the community safe.

The symbolisms of MHT expressed by the seminarians closely align with the existing literature aimed at couples The research has shown that couple-based approaches to HIV prevention are designed to strengthen and build upon the protective aspects of intimate relationships (i.e. trust, open communication, commitment; N. El-Bassel et al., 2010; Nabila El-Bassel et al., 2001; Karney et al., 2010). For example, in speaking about the benefits of MHT, there were three viewpoints expressed by the seminarians. First, they perceived MHT as a way to establish the standard for a relationship, especially prior to the onset of a sexual relationship. The assumption inherent in this view is that if they both receive a negative serostatus at the start of the relationship, there is an expectation that they will commit to keep each other safe and healthy going forward (Karney et al., 2010). Second, there seemed to be an awareness of the possibility of a serodiscordant outcome thus making early detection important. To this point, they perceived being able to learn each other's status together rather than relying on the other person to disclose their status enable partners to make informed choices. Third, there was the perception that partners could become each other's support system, regardless of the outcome.

These views regarding MHT were perceived as advantageous for intimate relationships and in some instances, mirror findings in the existing literature. For example, the results from Marelich and Clark (2004) regarding falsely disclosed HIV status between sexual partners supports their position to not rely on someone else's word. Project EBAN, a risk reduction intervention that specifically targeted serodiscordant couples, demonstrated the significance of partner' making informed choices and also emphasized the importance of partners working

together to ensure that the non-infected partner did not seroconvert (NIMH Multisite HIV/STD Prevention Trial for African American Couples Group, 2008), which is consistent with the finding in regards couples working together to keep their relationship health. However it is important to note that there are contrasting views concerning the perception of partner support and HIV testing. While Project EBAN provides a positive example where partner support was central to the outcomes of the intervention, research has shown that there is an increased probability of domestic violence against women when they learn their status or when their partner is notified of their HIV status (North & Rothenberg, 1993).

Though all of the participants perceived MHT as a positive gesture, they were also cognizant of the dual implications of MHT. For instance, the metaphor, "double-edged sword" symbolized their attentiveness to the barriers that intimate partners may encounter as a result of MHT. Many of their illustrations regarding the barriers were framed from the perspective of a partner and how they interpret the gesture of MHT. For instance, some felt that MHT implied a sign of distrust in the relationship; others felt that MHT could mistakenly be interpreted as an implicit agreement to eliminate condoms; however, the most salient was fear. Whether it was concerns about being judged about their sexual history, anxiety about testing positive, the possibility of a relationship being terminated, or afraid that indiscretions might become exposed, fear was obvious across several of the barriers described. Past studies have found similar barriers to MHT such as fears of insulting their partner or the relationship coming to an end (Hammer et al., 1996).

A conclusion that can be drawn from these findings is that the seminarians' awareness of the benefits and barriers implies that they realize that MHT in many respects is a value-laden gesture. In other words, each partner within an intimate relationship may have a different interpretation of the motivation behind the gesture which may have implications on what is perceived as beneficial or costly to their relationship. Being conscious of this reality is important when working with couples.

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Complex but necessary. Despite the complexities that MHT presents to intimate relationships, majority of the seminarians agreed that MHT should be normalized; however, context played a significant role in their overall perceptions. As discussed in an earlier section, the seminarians were descriptive in their articulation of the different factors that increase the vulnerability of HIV in intimate relationships. Yet when asked about the normalization of MHT, the duration of the relationship and the type of relationship were considered key factors. The vast majority agreed that MHT should be normalized within intimate relationship defined as new or of short duration. Premarital couples, those who plan to marry, were also considered an appropriate relationship context to normalize MHT. However, there were two schools of thought regarding MHT in the context of long-term relationship or marriage.
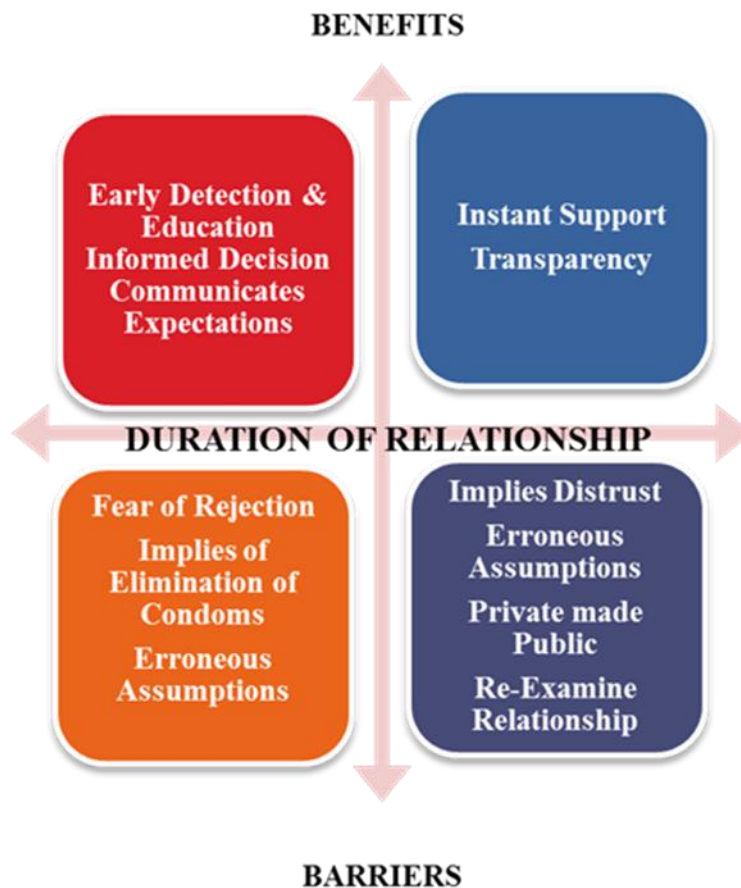

Figure 4 – Benefits and Barriers of MHT in Context

As depicted in Figure 4, the benefits and barriers identified in the previous chapter have been organized according to the seminarians' preconceived notions about MHT and duration of relationships. The upper-left quadrant suggests that the seminarians expect relationships of a shorter duration to experience greater benefits if MHT is practiced compared to relationships of longer duration. Despite the general consensus by most of the participants that deception and unfaithfulness are factors that place intimate relationships at risk, MHT was viewed as more complicated to normalize within relationships of a longer duration. Nearly half of the seminarians were concerned about the perception of violating social norms and expectations for relationships. For instance, although both, relationships of short and long duration, are subject to barriers (see bottom left and right quadrants of Figure 4), the participants perceived greater ramifications for couples in long-term relationships. This in turn, evoked uncertainty about promoting and normalizing MHT in the context of long-term relationships, especially marriage.

From a relational standpoint, this sentiment expressed in these findings align with the literature which suggests that to integrate HIV prevention into existing relationships, especially in marriage, threatens the trust and commitment of the relationship (Emmers-Sommer & Allen, 2005; S. M. Noar et al., 2004). Nevertheless, it is problematic to use the duration of a relationship as the standard primarily because there is no definitive measure to determine the manner by which intimate partners define a short versus long-term relationship. For example, research has shown that some youth and young adults consider their relationship exclusive in as few as three weeks (S. M. Noar et al., 2004). Furthermore, it is common for premarital couples to date or cohabit for a number of years prior to marriage which further contradicts the duration or type of relationship as the standard.

In contrast, a small minority of participants who were married or in a long-term relationship spurred an alternate perspective. Although they acknowledged the challenges it presents, they argued that MHT should be conducted with couples in all relationship contexts; marriage was no exception. Their position was influenced by previous interactions. For example,

some of the seminarians had dealt with or were aware of couples who had engaged in extradyadic encounters; others have ministered to individuals who contracted HIV within the context of an intimate relationship. The views presented from this perspective are consistent with past studies that have found the length of a relationship, especially amongst cohabiting partners, may actually heighten the risk of having a secondary sexual partner or infidelity (Forste & Tanfer, 1996; Treas & Giesen, 2000). Moreover, the extramarital sex that occurs in approximately 15% of women and 25% of men implies that infidelity has become a part of the social fabric of American culture (E. S. Allen et al., 2005; Christopher & Sprecher, 2000) .

A conclusion that can be drawn from the mixed perspectives is that MHT challenges existing norms for relationships and illuminates the flaws of reason. Furthermore, as suggested by the literature, the need for MHT across all relationship contexts may be more salient than previously assumed.

Power Differentials. Gender was also perceived to be an important indicator to increase the likelihood of MHT occurring in intimate relationships. Several participants indicated that women are more likely to raise this issue with their partner than would men. Although women are often socialized to be the caretaker in relationships, there are several concerns inherent in this belief. In 2008, the American Community Survey revealed a gender imbalance between African American males (46.3%) and females (53.7%) $\geq$ 18 years old, which translates into over two million more African American women than men (US Census Bureau, 2008). There is a preponderance of literature that has addressed the negative effects of the low sex ratio of men to women in the African American community (see Adimora & Schoenbach, 2002; McNair & Prather, 2004). The research has indicated that the gender imbalance diminishes African American women's relationship power which in turn impacts her ability to negotiate safe sex strategies (Corneille, Zyzniewski, & Belgrave, 2008; McNair & Prather, 2004), including HIV testing. In addition, the theory of gender and power indicates that the social and cultural norms

place men in the position of power, especially in sexual relations (Wingood & DiClemente, 2000).

The existing literature and findings from this study illuminates an implicit double standard in our culture where women are expected to have the responsibility, yet not the power. As a result, when women attempt to take the responsibility, they are often critiqued or silenced. Furthermore, research has shown that women are less likely to raise concerns that could be misconstrued as a confrontational or detrimental to the relationship (Corneille et al., 2008; Sobo, 1993; Wingood & DiClemente, 2000). A conclusion that can be drawn is that seminarians in this study appear to lack an understanding about relationship dynamics that challenge African American relationships. In particular, the findings suggest that the participants attitudes about gender may endorse the gender power differentials that in actuality exacerbate the risk of HIV in African American women.

A Comprehensive Approach Will Work Best to Promote and Normalize MHT

The seminarians discussed a variety of strategies to promote and normalize MHT in a comprehensive manner. The factors considered were (a) the role of church and clergy, (b) tensions; and (c) alternative approaches to advance MHT. The discussion that follows is organized accordingly.

The role of church and clergy. Although the church was considered an instrumental venue to promote MHT, surprisingly, discussions on how to engage the Black church generated diverse views. For example, the Black church has historically been viewed as a pillar in the African American community. Yet some participants indicated that they sensed a diminishing shift of influence particularly amongst the younger generation who no longer find relevance in the church. In contrast, for many African Americans churchgoers, there was agreement that clergy play a significant role in church life and the lives of its members. Furthermore, the participants indicated that congregants generally hold their pastor in high esteem and place value on what he or she considers as important. This suggest that while the Black church as an institution may have

experienced a shift in terms of relevance, the clergy as an individual is still perceived as both influential and powerful.

In spite of their mixed views regarding influence, the participants agreed that the Black church serves an important role in shaping cultural and social norms in the African American community. Thus, five strategies were identified that reflected the seminarians' perceptions about the important role of clergy and the church in promoting MHT: (a) facilitate the conversation, (b) use of pulpit, (c) intimate influence, (d) a holistic approach, and (e) collaboration. A closer examination of the strategies described in the previous chapter revealed a typology as shown in Figure 5 that exhibits the different levels for clergy to become engaged in promoting MHT within the church context. In the typology, each level of engagement is inclusive of the previous level.

CHAMPION

Pulpit as Platform

Intimate Influence

Facilitate the Conversation

INTEGRATION

Holistic Approach

PARTICIPATION

Collaboration

STATUS QUO

Promote HIV Testing in general
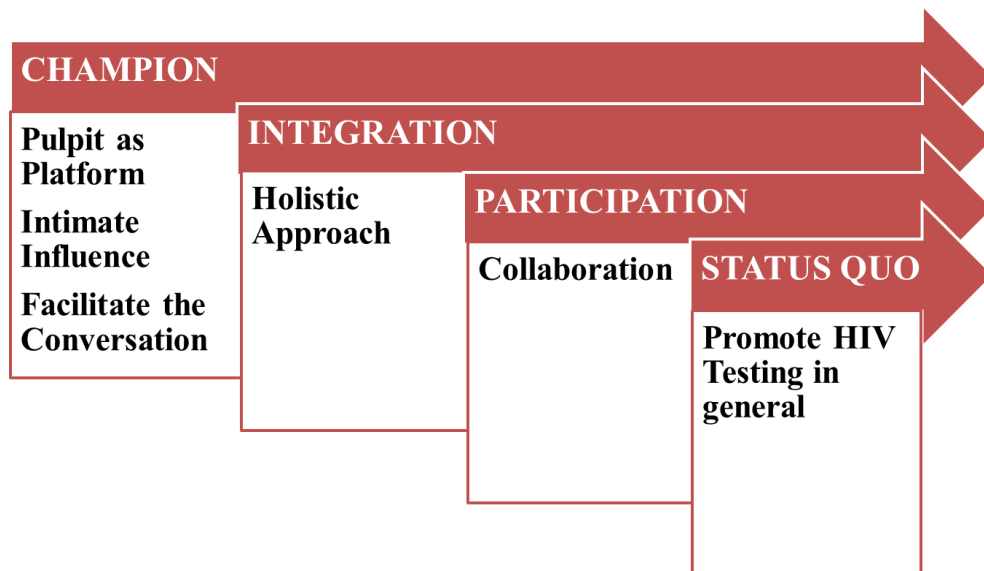
Figure 5 – Typology of Clergy & Church Engagement in Promoting MHT

The least inclusive level is **Status Quo** which refers to clergy who are more likely to support or encourage HIV testing for the general population rather than focusing on intimate partners. As implied by Jaybird, to promote HIV testing for everyone is more compatible with the churches stance regarding health promotion (D. W. Watson et al., 2003). Conversely, to promote

MHT with unmarried intimate partners was perceived as contradictory to messages that encourage abstinence until marriage. Although MHT has not been widely studied, this finding is similar to those reported in other studies regarding condom use. For example, studies conducted with Black clergy have shown where they recognize the need to promote HIV prevention amongst their congregants, yet they seek to do so in a manner that still aligns with their religious beliefs (Berkley-Patton et al., 2010; McNeal & Perkins, 2007).

The second level is **Participation** which alludes to situations where clergy recognizes the merit in promoting MHT, yet seeks to partner or collaborate with another church or organization to assist in promoting the efforts. Whether due to limited resources such as human or financial or limited interest in taking the lead in the effort, collaboration was perceived as a strategic way for clergy to participate in the promotion of MHT. The example provided is when churches collectively share their resources and come together to host a community-wide couples HIV testing initiative.

Next is **Integration** which suggests that MHT is promoted in a holistic manner. More specifically, this means that in addition to the aforementioned levels, information regarding the importance and benefits of MHT should also be integrated into the various ministries offered within the church setting (i.e. marriage ministry, couples ministry, singles, etc.). At the core of this level is peer influence. Instead of the pastor taking the lead, he or she lends their commitment to MHT by ensuring that laypersons are equipped to influence their peers or their juniors to practice MHT. An example provided is when married couples are trained to promote and normalize MHT with other married couples. This strategy is congruent with other studies that have examined the efficacy of peer networks (Branson et al., 2006; Latkin & Knowlton, 2005; Lightfoot et al., 2001).

Moreover, the literature suggests that African Americans often perceive health messages conveyed by their peers as reliable (Stroman, 2005). For example, in a church-based study, Lightfoot and colleagues (2001) trained volunteers from within the congregation to diffuse

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messages to other church members to seek an HIV test. In light of the data, this particular finding as well as the existing literature pertaining to the use of peers is significant. Several exemplars suggested that married and long-term existing relationships may benefit from having an external source, whether a program or message delivered by someone other than a partner in the relationship, that can serve as an intermediary to mitigate the conversation.

The most inclusive level of engagement is **Champion** which implies that the clergy is engaged in all the other activities, in addition to taking the lead role to promote MHT. For example, consistent with the literature was the suggestion to use the pulpit (Francis & Liverpool, 2009; Khosrovani et al., 2008; Weatherford & Weatherford, 1999). Participants recommended that clergy use their power and influence in the community and within their congregation to educate about the facts and myths concerning HIV as well as advocate about the significance of MHT. Additionally, through the use of televised sermons and social media, participants also recognized that for many clergy their reach and influence often times extended well beyond their church and community, therefore making the pulpit a prime platform to reach the masses. Although there were some concerns expressed about the potential misuse of power, participants generally felt that influence and power were vital to facilitate healthy conversations about HIV/AIDS as well as promote MHT within the church. To further punctuate this point one participant, Denise, asserted that the impact of the pulpit would be greater if a clergy and their spouse would be willing to model the behavior. In fact, there have been instances where clergy members have tested in their pulpit to help normalize HIV testing with members in the church and community (Isbell, 2009). In like fashion, this research suggests that faith leaders can use their power and influence to normalize MHT as well as demonstrate the importance of keeping their union/relationship healthy by doing this publically with their spouse.

Another strategy included at the **Champion** level was premarital counseling. Throughout the study, the seminarians expressed the significance of MHT for couples preparing for marriage. Hence, premarital counseling was strongly endorsed as an applicable venue for clergy to

encourage MHT as a normative behavior before marriage. Some argued in favor of clergy making MHT a prerequisite for marrying a couple within their respective churches. The existing literature lends support to this finding indicating that premarital counselors should encourage couples to seek an HIV testing before marriage (T. Aholou et al., 2011; Slater & Aholou, 2009).

The tensions. As evidenced by the variety of approaches, there was a consensus that the clergy and the Black church are strategically positioned to promote and normalize MHT. Nevertheless, participants were cognizant of the dynamics that influence choices and actions. As such, various crossroads and roadblocks, otherwise known as tensions were identified. The tensions are summarized as (a) issues pertaining to the realities regarding sex; (b) perception and reputation; and (c) offense and pushback.

The foremost tension centered on the 'silence' related to sex and sexuality. The seminarians argued that the church does not adequately discuss or deal with the reality of what is going on in the culture and in the church, particularly in regards to sexual activity and sexual orientation. For example, when the seminarians were asked on the Participant Profile the percentage of congregants at their respective churches who would say "they are" sexually active, of the nine participants who responded six estimated that 80% or greater of the congregation would say that they were sexually active while the other three participants reported 40% or less. Although marital status and age range are unknown, an inference can be made that unmarried women make up a sizeable share of this estimate, a finding that mirrors the overall Black church constituency in the US (Sahgal & Smith, 2009).

Their perception of the Black church's unwillingness to constructively address sex raised concerns for some of the seminarians, particularly given that women are disproportionately infected with HIV/AIDS through heterosexual transmission (Hatcher, Burley, & Lee-Ouga, 2008). Research has shown that topics regarding sexuality in the church are often insufficiently addressed (Francis, Lam, Cance, & Hogan, 2009) or deemed as taboo such as homosexuality (Moore, 2007).

Unfortunately, the denial of certain behaviors such as sex outside of marriage or alternative lifestyles does not change the reality that it does exist. Case in point, the participant summaries revealed the seminarians' stance on HIV prevention. Half of the participants were foremost proponents of abstinence, while the others were in support of risk reduction strategies such as the use of condoms or needle exchange. As evidenced by the findings, the participants were clearly aware of the cultural norm to engage in sex outside of marriage. While this awareness did not necessarily sway the position of those who advocate for abstinence, everyone in the sample acknowledged the importance of condoms for sexually active individuals. Paterson (n.d.) further illustrates this point as she underscores the tensions between the ideal social norms and reality:

> Abstaining from sex before marriage and being faithful to spouses afterwards is what most cultures officially expect. In practice, this is often a fiction and most people know it. Thus, the chastity and abstinence scenario becomes a kind of parallel reality: intended for public consumption, backed by social and religious sanctions, and designed to conceal the real facts. This is bad news for public health planning, which depends on addressing what is *really* going on, not what people wish were true. It is also bad news for the church, which cannot be successful in combating transmission of HIV until it engages with the moral contradictions implicit in this reality gap (p. 3).

For the Black church and its clergy to ignore or deny the realities of sex and sexuality sends a message to their congregation about what is important. This issue continues to be a major criticism of the church in general and the Black church in particular regarding the ongoing spread of HIV in the African American community (Fullilove & Fullilove III, 1999; Sommerville, 2008; Weatherford & Weatherford, 1999).

Secondly, MHT brings about issues regarding perception and reputation. The seminarians indicated that people may perceive support for MHT as an implicit endorsement or acceptance of sex outside of marriage. Likewise, participants suggested that any type of HIV prevention outside of 'abstinence until marriage' and 'fidelity in marriage' could be viewed as controversial (Francis et al., 2009; McKoy & Petersen, 2006). From the seminarians' viewpoint, the politics of both

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issues – perceived endorsement and controversial approaches – could jeopardize a clergyperson's reputation in their local church and potentially at the denominational level as well.

Lastly, is the tension whereby clergy are faced with the risk of potentially offending the congregants or receiving pushback as a result of raising the topic. For instance, to promote MHT in premarital counseling is more likely to be viewed as a socially acceptable conversation for clergy to hold with couples preparing for marriage. However, to promote MHT with non-marital, existing or married couples may be perceived as offensive to the congregants, which in turn leads to push back from the members. As described by the seminarians, the implications of offense and pushback can ripple into other areas of ministry (i.e. finance). These findings suggest that while a clergyperson may personally perceive MHT as an important topic to promote within the church or community, the social and cultural norms and expectations of the Black church poses a barrier. A conclusion that can be drawn is how the clergy's choices and actions are perceived by others, including the Black church as an institution and its members will likely influence the level of engagement or priority clergy will give to promoting MHT.

Alternative approaches to promote MHT. As a result of the various tensions that may impede the church or clergy from taking a more active role, the previous chapter described several other avenues to advance MHT. Particularly, they suggested several strategies that can be offered in conjunction with church-based approaches or as a means to circumvent the tensions associated with the church such as media, policy, and schools.

It has been documented that media plays a significant role in influencing behavior and shaping social norms (Flora, Maibach, & Maccoby, 1989; S. Noar, 2007). It was evident that the seminarians were conscious of this fact as well. As a point of reference, participants mentioned campaigns that have been used to normalize the use of condoms (e.g. BET's Rapp It Up). In like fashion, they felt that mass media could be used to normalize MHT (Flora et al., 1989; S. Noar, 2007). Also, as in the strategy of peer influence, seminarians suggested that commercials or

movies could potentially be an effective way to hear or see MHT promoted from an external source that could then segue into a conversation between the partners.

The use of policy was also considered a mechanism to promote and normalize MHT with couples before marriage. More specifically, a strategy that emerged in most of the interviews was the policy for mandatory blood tests before marriage. Several seminarians argued in support of reinstating a mandatory blood test for couples, with MHT as an addition to the requirement, in order to obtain their marriage license. For some, it came as a surprise that MHT was not already mandatory; others perceived the idea of making it a requirement as a violation of one's freedom of choice. To his point, Jaybird was particularly sensitive to "freedom of choice." He argued for making MHT a church policy which would still give couples the choice to be married elsewhere if they opted to not undergo MHT. Ironically, approximately two decades ago this issue was a major topic of debate in legislation. Then, in the late eighties, the prevalence of heterosexual transmission of HIV was rare and the cost associated with mandatory premarital testing was viewed as wasteful spending (Turnock & Kelly, 1989). As a result, low risk sub-groups such as committed couples did not warrant the need to undergo mandatory premarital HIV testing (Turnock & Kelly, 1989). However, as indicated in chapter one, the epidemic has shifted significantly. Furthermore, the seminarians' understanding about the relational risk factors suggests that it may be worth revisiting.

The last sector and strategy was to engage the educational system such as college campuses and high schools. Past studies have found high rates of unprotected sex among youth and college students (Duncan et al., 2001) and issues regarding deception amongst college-aged students (Lucchetti, 1999; Marelich & Clark, 2004). Therefore, promoting MHT on school campuses was perceived as an important strategy for the youth and young adult population (Francis et al., 2009).

Overall, the different strategies to include church-based and those in other sectors serve as a reminder that there are no silver bullets. While the Black church may be influential in certain

demographics within the African American community, it may not be as relevant to others. Therefore, the seminarians recommendations encourages a comprehensive approach to promote MHT which includes the church to the extent that they are willing or able; while at the same time engage other sectors literature (Khosrovani et al., 2008).

MHT Depends On Building Capacity and Partnerships

To facilitate MHT with intimate partners, the seminarians identified the need to engage the new generation faith leaders, formal training, continued education, and external partnerships. Many of the seminarians understood that by and large, the idea of promoting MHT requires a different way of thinking about HIV prevention. The point was made that it would be difficult to persuade older faith leaders who were trained in a different era and hold distinct worldviews about the norms of church culture and social norms regarding sex, sexuality, and HIV prevention. Hence, for MHT to become a normalized and integrated part of ministry going forward, some of the participants made the argument that it must begin with new generation faith leaders in seminary, who can make this part of their future and ongoing ministry focus (Gould-Champ, 2008).

With seminarians being viewed as central to advancing MHT, formal training and continuing education was considered paramount. For example, most of the participants referred to their personal, life experiences as the basis of their preparation. Some seminarians felt they were primed to address MHT as a result of coursework in pastoral counseling, sexual ethics, or courses that prepared them to offer care and compassion to people living with HIV/AIDS (PLWHA). Although there were numerous electives mentioned, there was clearly a gap in terms of **required** courses pertaining to human sexuality or HIV prevention for all Master of Divinity. Hence, they expressed the need for additional formal training and coursework to address topics pertaining to sex and sexuality.

While premarital counseling was the most commonly recommended venue to promote and normalize MHT, with the exception of one seminarian, the participants had not taken any

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formal courses in this area of study. Instead, it seemed for some, to be a module integrated into a pastoral counseling course thus giving them a peripheral exposure to issues concerning marriage and family at best. The lack of required coursework in the areas of human sexuality, HIV/AIDS, and premarital counseling are congruent with other studies that have examined seminarians' preparation to tackle many of these issues (Conklin, 2001; Edelheit, 1994; Noll, n.d.; Ott, 2009) .

In addition to formal training at the seminary level, participants also recognized the need for continued education (i.e. post-seminary). This idea was suggested to stay abreast of the epidemic in terms of trends and advancements. Furthermore, partnerships with other people, professionals and organization that have the expertise and skills to support faith leaders in their efforts to address HIV and promote MHT within intimate relationships were perceived as significant.

Finally, while predicting the seminarians' likelihood of promoting MHT was not a direct aim of this study, in spite of the perceived tensions, several participants proposed ways they could begin to promote MHT with intimate couples. There were two existing clergy who indicated that they would begin to integrate topics related to MHT when working with couples for marriage or civil unions. Others suggested that they would begin by engaging their peers in conversations about MHT. Also, one participant expressed that he would start by including the topic in his upcoming sermon. These findings suggests that contrary to the various tensions described in chapter 4 and discussed in the previous section, that the new generation faith leaders in this study appeared to recognize the relevance and importance of addressing MHT and expressed a willingness to do so with their peers and congregants.

Implications and Recommendations

This exploratory, qualitative study has obtained findings with significant implications for seminaries and seminarians in general, as well as practitioners who work with couples, and policy that impacts couples.

Implications and Recommendations for Seminary

There are numerous curricula implications that this research presents. Given the times in which we live, it seems unimaginable that seminarians, the future faith leaders of churches, can matriculate through seminary without being **required** to take courses that specifically address sexuality or HIV. Yet, based on the seminaries represented in this study, the findings suggest that this is possible. During the first decade of the epidemic, Edelheit (1994) reasoned that clergy ordained before the onset of AIDS in the early 80s were not trained to combat the HIV/AIDS epidemic. This offers an explanation for older generation clergy in regards to their lack of knowledge and understanding about the complexity of HIV. Sadly, now in the third decade of the epidemic there are still seminary institutions that do not require students to take courses in sexuality or HIV/AIDS.

It is recommended that our modern day faith leaders are prepared to address the social issues that impact our society. While offering a range of course electives that may address these topics is important, the fact remains that when doing ministry, a faith leader may not have the luxury to 'elect' the issues that their congregants face. Thus, it is incumbent upon seminaries to intentionally integrate course regarding HIV/AIDS and sexuality in the program of study for Master of Divinity and Master of Ministry regardless of concentration. For example, a course that addresses sexuality must transcend from conversations simply about homosexuality to a broader discussion that addresses sexual health and human sexuality. This is recommended to adequately equip them to respond to the changing needs and trends in the culture regarding sexuality.

As for courses regarding HIV, it is recommended to include literature that helps to sensitize faith leaders about the complexities of HIV/AIDS especially amongst populations that have been disproportionately impacted by the epidemic. Although, courses that prepare seminarians on how to demonstrate compassion and care to people living with HIV is critical when addressing HIV/AIDS; however, in order to be part of the solution to eradicate the epidemic, it is imperative that seminarians are equipped with knowledge about HIV to ensure that

they are able to communicate information accurately. This also applies to being informed about the various prevention strategies, to include harm reduction approaches. As evidenced by the participants in this study, having an understanding about HIV and HIV testing does not always translate into facts. This is particularly important because well-intentioned people can mistakenly spread erroneous information.

Based on the findings from this study, issues regarding sex outside of marriage, whether before marriage or infidelity, are real concerns for the clergy. For this reason, it is imperative that seminaries prepare the existing and emerging faith leaders to address these concerns directly rather than to ignore them. Seminaries are therefore encouraged to increase seminarians' skills on how to communicate the facts about HIV or introduce MHT to their congregants as well as those with whom they counsel. In doing so, there needs to be an acknowledgement that the people, with whom they will serve, whether in their congregation or their community, come from different walks of life. This suggests the need to be aware and sensitive to prevention messages and approaches that are inclusive of all people, regardless of their age, gender, sexual orientation or relationship status. Mutual HIV testing is one approach that encompasses this criterion.

Another implication for curricula is in the areas of premarital counseling and relationship education. To counsel and offer guidance to couples as they prepare to make a life transition into marriage is a major undertaking (Slater & Aholou, 2009). As previously mentioned, premarital counseling was considered an important venue to promote and normalize MHT. Research has shown that clergy are the primary provider of premarital counseling (Stahmann, 2000), yet the participants still report a lack of preparation in this important area of study. Therefore, seminaries are urged to require all seminary students who intend to serve in a pastoral capacity to take a minimum of one course that is specifically devoted to introduce and educate future faith leaders about the vast issues that premarital and marital couples may encounter. Additionally, as suggested by the literature, premarital counselors should be prepared to address sexual health and introduce HIV testing with couples (Slater & Aholou, 2009).

Seminarians would also benefit from a course or coursework that specifically address relationship education from a gender and cultural perspective to prepare them to respond to power differentials in relationships. This recommendation stems from participants lack of understanding about gender dynamics in intimate relationships. The assumption is as faith leaders are trained in premarital counseling and have a better understanding about the nuances of relationships, rather than relying on anecdotal information, they may become a 'champion' for MHT when working with couples. Furthermore, if faith leaders grasp the symbolism and benefits of MHT as described by the participants, they may see themselves as an intermediary that helps women to navigate this issue in their relationships, while also promote healthy relationships for all couples.

Finally, college campuses were identified as a vital venue to promote MHT with college students. Also, though military did not come up in the data, McMickle (2008) raised an important consideration regarding the sexual risks that military personnel engage in while deployed. This suggests that campus ministries and military chaplains could be important channels to promote and normalize MHT. Hence, this underscores the need to equip church-based and non-church based religious functionaries in these important areas.

Implications and Recommendations for Practice

In moving the discussion towards mutual HIV testing, it is important to note that MHT is not about individual choice, nor individual behavior. Rather MHT is about couple choice and couple processes. Therefore, the findings illuminate specific implications for all practitioners who work with couples such as marriage and family therapist, social workers, and professional counselors. First, the current study indicated that there are particular areas clergy are uncomfortable addressing; therefore, relying on the support of external partnerships. For example, Weaver and colleagues (1997) strongly suggested that both clergy and MFT could benefit from each other's expertise. When this is placed in the context of the current study, a faith leader may seek to collaborate with an external partner to aid them in communicating about MHT to their congregants. This implies a need for buy-in from mental health professionals as well. Moreover,

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it also suggests the need for mental health professionals to understand the underlying concerns regarding HIV risk in intimate relationships while also endorse the benefits and strengths of MHT. Also, while there was no mention of violence, participants did discuss potential resistance to MHT because of the perceived implication of distrust of infidelity. Therefore, it is imperative that practitioners, including faith and mental health professionals, be prepared to address or make referrals as needed regarding conflict resolution, negotiation skills, and if necessary, intimate partner violence.

Second, Lieser, Tambling, Bischof, and Murry (2007) found in their review of six evidenced-based premarital and relationship education programs that sex is inconsistently addressed. Just as participants indicated that clergy must first engage in honest communication about sex before they can really begin to promote MHT, the same is true for practitioners outside of the church. There is literature to support clergy looking to the resources of marriage and family scholars when preparing couples for marriage (Barlow, 1999). Bearing this in mind, if clergy are seeking MFT and other mental health professionals (i.e. clinical social workers) for continuing education, external partnerships or resources to support their work in ministry, then it is imperative that the literature from these professions address the pressing issues that exist in today's culture.

Implications and Recommendations for Public Health Policy

The findings also highlight some areas for policy considerations. First, the HIV surveillance data currently only captures the following demographic information: gender, race/ethnic city, age range, and geographical location. It does not capture, marital or relationship status. Due to the lack of data regarding the marital/relationship status of individuals infected with HIV, it is difficult to definitively state the number of people who contract HIV in the context of a relationship. Including this information in the epidemiological data could help to inform interventions that are aimed at HIV prevention for couples. Also, this information has

implications for healthy marriage initiatives and other programs that promote healthy relationships.

Second, rather than focusing on MHT from a pathological view, it is imperative to frame MHT from a positive perspective which entails illuminating the advantages. Historically, HIV testing has focused primarily on at-risk and high-risk populations, yet the research has shown that intimate partners rarely view themselves in this light. The recently revised recommendation to test all people ages 13 through 65 in medical settings is a universal approach to increase individual testing. Universal approaches are designed to make population-level change. Likewise, in order for MHT to become a normative behavior the emphasis can solely focus on couples who display dysfunctional or unhealthy attributes. Instead, MHT requires the promotion and adoption of a universal approach that targets all couples, regardless of risk level.

To create a culture where MHT is be viewed as a socially acceptable, normative behavior will definitely take time. Individuals alone cannot produce this type of change. As evidenced by the tensions, the church may have limitations that impede their ability or willingness to promote MHT. As suggested by the seminarians, for MHT to become a normative behavior there are other sectors that need to be involved including media, government policy, and schools.

An additional opportunity to promote and normalize MHT suggested by this research is in the area of policy. In 2003, Georgia eliminated the required medical exam and blood testing requirement before marriage. Although HIV testing was not a requirement in most states, the elimination of required medical examinations suggests that not all couples seeking marriage will be motivated to go to the doctor or get a medical examination prior to marriage. For this reason, the suggestion to reinstate mandatory blood testing with the addition of MHT was offered. One approach to promote and normalize MHT is to incentive it with couples before marriage. Just as couples now, since 2004, are eligible to receive a discount on their marriage license if they go through six of hours of premarital counseling, the state could offer an additional discount for

couples who voluntarily seek MHT. This in turn may be perceived as a positive benefit to MHT for couples preparing for marriage instead of a punitive punishment for this sub-population.

Last, this research also points to the need for more education accessible to lay people about the new routine, opt-out testing recommendations in medical settings as well as the testing window.

<h3 style="text-align:center">Recommendations for Future Research</h3>

There are several ways whereby this research should be extended. First, although the goal of this study was not necessarily to determine or predict seminarians' behaviors concerning the promotion of MHT, when asked what role they can play to promote MHT, many of the participants were forthcoming with suggestions. Therefore, a study that specifically examines faith leaders' willingness to promote, or diffuse MHT, using the Diffusion of Innovation Theory (Rogers, 2003), would shed light in terms of the feasibility of using the faith community to advance MHT. As in the case of Lightfoot et al (2001) who trained members of the congregation to encourage other members to seek an HIV testing, a similar approach could be conducted using couples as ambassadors or mentors to influence other couples to seek MHT.

Second, is to replicate the current study with a larger sample that includes Caucasian seminarians as well to compare and contrast the findings across race/ethnicity. The rationale in broadening the inclusion criterion is because many African Americans worship at churches where Caucasians may have a significant role in church leadership. This research can be further expanded by viewing the data through the lens of critical race theory. According to Ford & Airhihenbuwa (2010) critical race theory was initiated out of a concern for social justice and seeks to illuminate the racial components that confound a particular phenomenon. Although the data in this study focused on the individual behaviors and sociocultural factors as contributors of HIV, critical race theory would argue that racial disparities which are entrenched in the underlying forces of sociohistorical and sociopolitical factors further complicate HIV for African American individuals and couples. To replicate with Caucasian seminarians would reveal the

extent to which they understand the complexity of the AIDS epidemic in our culture, to include the relational vulnerabilities. A study of this nature could also compare and contrast their perspectives regarding the role of the church in general, rather than solely on the Black church.

Third, using the data from this study and any subsequent replicated study to develop a quantitative survey and research design to measure intimates partners' attitudes about MHT based on the perceived benefits, barriers, and relationship contexts. Likewise, given that mental health professionals are potential stakeholders warrants an exploration of their knowledge and perceptions pertaining to this topic as well.

Fourth, due to the influence of media in shaping social norms and its utility in health promotion efforts, a social marketing campaign that promotes MHT should be developed. This can be accomplished using a Community-Based Participatory Research (CBPR) approach that engages members of the faith community in partnership with an interdisciplinary team (i.e. social/family science, public health, and health communication) to develop culturally-relevant and culturally-competent social marketing/mass media campaign materials.

Fifth, gender was an important issue in this research. In our culture, gender role socialization not only promotes a double standard, but also a mixed message. On the one hand, women are generally socialized to be sexually passive when it comes to sexual behavior while sexual permissiveness is acceptable for men. On the other hand, men generally have the power in sexual relationships, yet women are expected to take the lead in sexual health. Future research should further explore these concepts of sexual scripts and gender socializations with the faith community, with a specific focus on gender differences to determine the degree that they endorse these conflicting cultural norms.

Last, is to test the efficacy of the different strategies (i.e. pastor, peers, premarital counseling, or media) to promote MHT.

Limitations of the Study

There are a number of limitations that need to be acknowledged. First, although there were three seminaries represented in the sample, a number of participants in the study attended the same seminary. This may suggest that their views are indicative of the culture of their institution. It has been stated the Black church is not a monolithic entity. Likewise, black clergy are not a homogeneous group either. As evidenced by their participant profiles and the overall findings, what they deem as salient and instrumental for ministry may differ for others. Second, although there was an established inclusion criterion to participate in the study, a self-selected sample always presents the possibility for bias. For instance, the views represented in this sample may be exceptional compared to other black seminarians. Hence, the results may not be generalizable. Last, additional demographic data (i.e. marital status, gender, age range) would have been helpful to further explicate the perceived estimations of sexually active congregants.

Conclusions

This study is best concluded by highlighting the strengths of this novel research. Despite the limitations, the findings from this study are unique in the following ways. First, it addresses a topic, HIV testing within the context of intimate relationship; an area that has received very little focus in the US. Furthermore, it adds to conversation the importance of addressing HIV prevention from a relational perspective.

Second, there is a paucity of empirical research that specifically targets African American seminarians. This study gave voice to our current and future faith leaders on a sensitive topic regarding HIV prevention for couples. While the sample was small, their diverse backgrounds, experiences and ideologies added to the richness of the findings.

Third, the attitudes and perceptions expressed by the seminarians in regards to promoting and normalizing MHT demonstrated an ability to offer a balanced and objective view. For example, though they recognized the importance and need for MHT, they also were cognizant of

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the challenges that it poses for couples and clergy, alike. Yet, they were still able to consider various approaches to promote this strategy within the context of intimate relationships.

Fourth, it is groundbreaking in that it presented an opportunity for a diverse group of African American seminarians to be involved in identifying solutions to promote MHT rather than projecting answers onto them. In fact, it was evident that the research provoked them to not only consider the role of the church or clergy, but to consider personal ways to begin to advance this strategy.

Last, while MHT is by no means a panacea to prevent the spread of HIV within the context of intimate relationships, it is considered a strategy that seeks to neutralize the process of intimate partners' knowing each other's HIV status by promoting shared responsibility between both partners. To this point, the findings present a clarion call for seminaries, mental health, public health and policy to respond to the signs of the time. This can be accomplished by building capacity, devoting resources, and promoting strategies, namely MHT, that addresses HIV prevention from the perspective of intimate relationships.

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qr_name=ACS_2008_3YR_G00_S0201TPR&-ds_name=ACS_2008_3YR_G00_&-redoLog=false&-_caller=geoselect&-geo_id=01000US&-format=&-_lang=en

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Email/Recruitment Letter

Greetings!

My name is Tiffiany Aholou, a doctoral candidate in the Department of Child & Family Development at The University of Georgia. I would like to invite you to participate in a research study that I am conducting entitled "**An Exploration of Black American Seminarians' Knowledge, Attitudes, and Perceptions about HIV Prevention within Intimate Relationships**." More specifically, the purpose of this study is to gain an understanding of the views Black/African American seminarians' have regarding HIV and ways to reduce infection within intimate relationships. My hope is that this research will contribute to the dialogue about HIV prevention for intimate partners from the perspective of Black/African American seminarians. In addition, the findings may inform intervention strategies and programs aimed at faith leaders as well as contribute to future seminary curricula. For your participation in the study, you will receive a small token of appreciation in the form of a $20 gift card for your time and contribution.

In order to be a participant in this study you must:

- **Identify as Black/African American**
- **Attend seminary in Georgia**
- **Be a 2nd or 3rd graduate student pursuing a degree in Divinity or Pastoral Counseling**
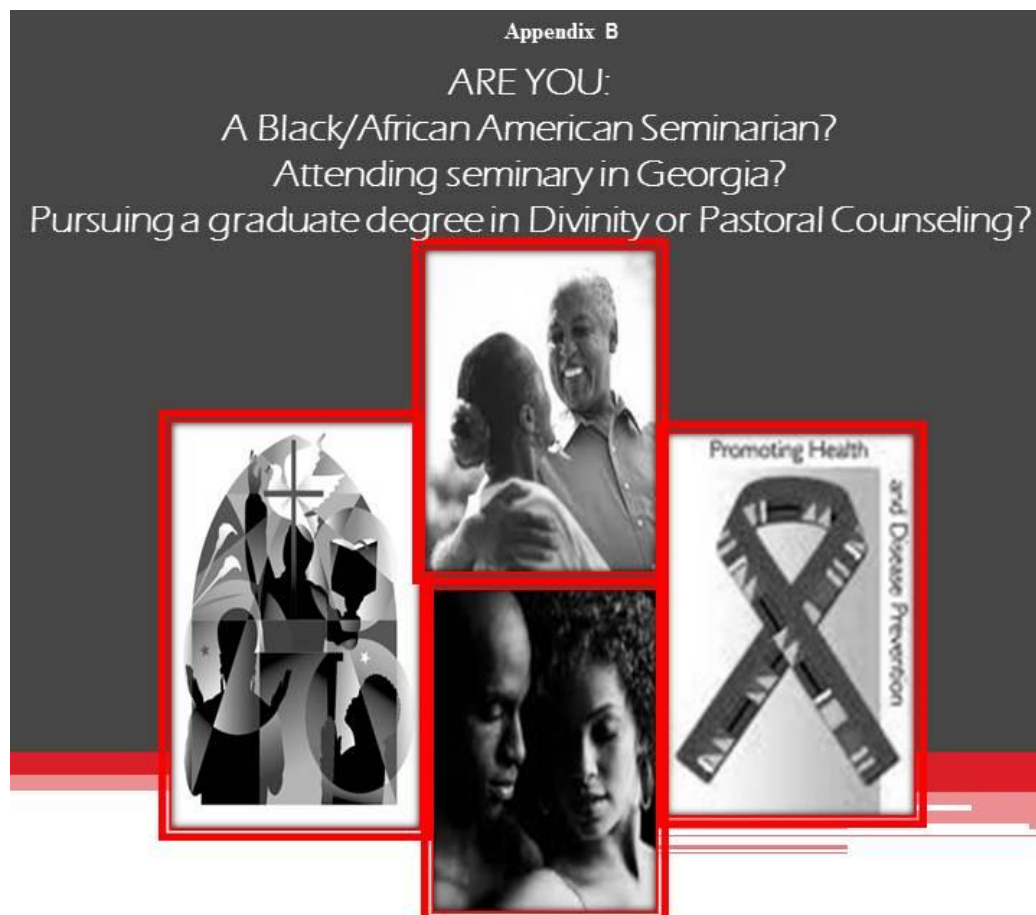
To learn more about how you (or someone you know) can participate in this study, please contact me, Tiffiany Aholou, at 865-224-6568 or via email at tmaholou@gmail.com.

Thanks in advance,

Tiffiany M. Aholou,

Tiffiany M. Aholou

Eligibility Screening Script[12]

Thank you for calling to find out more about my research study. My name is Tiffany Aholou, and I am a doctoral researcher at the University of Georgia. The purpose of this study is to gain an understanding of the views Black/African American seminarians' have regarding HIV and ways to reduce infection within intimate relationships.

As part of the study, I will be asking people to complete a Participant Profile questionnaire, a paper-and-pencil questionnaire about HIV and participate in an interview to discuss strategies to reduce the spread of HIV within intimate relationships. Do you think you might be interested in participating in that study?

[If No]: Thank you very much for calling.

[If Yes]: Great! Before I can enroll you in the study, I need to determine if you are eligible. With your permission, I would now like to ask you a few questions about your current academic studies. Answering these questions is voluntary, therefore if at any point you want to discontinue, you are free to do so. Also, please understand that all information that I receive from you by phone, including your name and any other identifying information, will be kept strictly confidential and secured in the recruitment database under lock and key. The purpose of these questions is only to determine whether you are eligible to participate in the study. Do I have your permission to ask you these questions?

[If No]: Thank you very much for calling.
[If Yes]:

First Name or initials only: _____

What is your race/ethnicity?:   _____

What is your gender?[13]**:**   □ **Male**
                          □ **Female**
                          (only ask if it is indeterminate by phone)
Which seminary do you attend?:   _____

What degree are you pursuing?:   _____

---

[12] Adapted from http://www.irb.pitt.edu/IRBMailings/screeningscript.doc

[13] Gender is not an eligibility criteria; however the goal is to have an even distribution in terms of gender.

What year is this for you in your program?   _____

What are your aspirations upon completing your program?:   _____

How did hear about the study   _____

[If ineligible]: I would like to thank you again for your interest in participating in the study. Unfortunately, as this time, you are not eligible to participate in the study. However, if you know of other seminarians who may be interested, please forward the email invitation and ask them to contact me for more information. Your information will be

[If eligible]: Congratulations! It appears that you are eligible to participate. With your permission, I would like to enroll you in the study! To do so, let me collect just a little more information:

First Name: _____

Last Name: _____

Date of Birth: _____

Unique ID (8-digit DOB/Gender/   _____

First & Last Initial):

Preferred Email Address: _____

Date & Time for Face-to-Face Interview   _____

Thank you for sharing this information. I will see you on _____ (Day),

_____ (Date) at _____ (Time) at the _____

(Location). Please indicate your preferred gift card:

☐Barnes & Nobles
☐Target
☐Wal-Mart
☐Ruby Tuesday

APPENDIX D

Participant Profile Questionnaire

Participant Profile Questionnaire

1. Participant selected pseudonym   _____

2. What is your age?   _____

3. What is your marital status?   _____

4. What is your highest level of education?   _____

5. Where are you originally from?   _____

6. How long have you lived in Georgia?   _____

7. What seminary do you attend?   _____

8. Which degree are you seeking?   □ Master of _____
     □ PhD of _____

9. What year is this for you in your program?   □2nd year
     □3rd year

10. Where do you attend church (participant-selected pseudonym)?   _____

11. How long have you been attending your current church?   _____
     □Rural □Urban □Suburb

12. What is the denomination of your church?   _____

13. Do you currently hold a position in your church? If yes, what is the position?   □Yes _____
     □No

14. Do you hold a position at any other church? If so, in what capacity?   □Yes _____
     □Rural □Urban □Suburb
     □No

15. What is the approximate size of the congregation at the church you attend?   □<100   □100-250   □250-500   □1000 – 2000   □ >2000

16. In your estimation, what are the demographics of your church (in percentages)

17.

Race/ethnicity	Caucasian_____ African American _____ Hispanic/Latino _____ Other Race _____
Gender	Males_____ Females_____
Married/unmarried	Married _____ Unmarried _____

18. In your estimation, what percentage of the congregants would say "they are" sexually active?   _____%

19. Does your church:
   - Ever sponsor HIV testing initiatives?   □Yes   □No
   - Offer onsite HIV testing to congregants/community/?
   - Refer congregants/community to local agencies for HIV   □Yes   □No
     testing?   □Yes   □No

APPENDIX E

Semi-Structured Interview Protocol

Opening Questions

1. Participant selected pseudonym
2. What is your age?
3. What is your relationship/marital status?
4. What is your highest level of education?
5. Where are you originally from?
6. How long have you lived in Georgia?
7. What seminary do you attend?
8. Tell me what prompted you to go into seminary.
9. What are your intentions beyond seminary/after completing your program?

What knowledge do Black/African American seminarians have about HIV/AIDS?

10. Let's shift gears now and talk about the AIDS epidemic. Tell me what you know about HIV/AIDS in the African American community.
11. What do you think are the main issues that contribute to the transmission of HIV in the African American community?
12. What would you say are some of the reasons (risks) that contribute to the spread of HIV in intimate relationship?
13. In what ways have the AIDS epidemic impacted you?

What attitudes do Black/African American seminarians hold about HIV testing as a form of prevention?

14. What's your position about HIV prevention?
15. It's been said that about 20% of the population are unaware of their HIV status. Tell me your thoughts about promoting HIV testing.
16. What role do you think HIV testing plays in preventing HIV?

What meaning do Black/African American seminarians ascribe to mutual HIV testing?

17. When you hear the phrase "mutual HIV testing," what comes to mind?
18. What does mutual HIV testing symbolize to you?
19. What do you see as the benefits to mutual HIV testing? Barriers?
20. What has informed your views about mutual HIV testing?

What attitudes and perceptions do Black/African American seminarians have about normalizing mutual HIV testing with intimate partnerships?

21. There have been some who believe that people in intimate relationships (i.e. dating, engaged, cohabitating, and marriage) should be tested for HIV and others that disagree. What is your opinion?
22. What might hinder couples from seeking mutual HIV testing?
23. Tell me your thoughts about normalizing [mutual] HIV testing (making a standard practice) for people in intimate relationships, regardless of the length of their relationship.
24. What strategies would you suggest to help normalize [mutual] HIV testing for people in intimate relationships?
25. What venues are most suitable to promote and normalize HIV testing?
26. What strategies would you suggest to help normalize [mutual] HIV testing for people in intimate relationships?

What are the perceived tensions associated with HIV testing in the relational context in the Black Church?

26. What role do you think the Black Church can play to normalize [mutual] HIV testing among people in intimate relationships?
27. What do you see as the benefits to promoting [mutual] HIV testing within intimate relationships in the Black Church? What about the barriers?
28. What role do clergy play in normalizing mutual HIV testing?
29. What tensions do you think clergy might experience promoting mutual HIV testing?
30. What might hinder clergy from broaching this topic?

What are the perceived needs of African American seminarians to facilitate HIV testing in the relational context?

31. What skills, knowledge, or preparation do you have and/or received to address [mutual] HIV testing in intimate relationships?
32. What, if any, course work has prepared you to address HIV/AIDS within intimate relationships?
33. What additional/preparation would help you to effectively facilitate this issue with intimate partners?

HIV/AIDS Knowledge Scale[14]

1. Birth control pills protect against HIV.	True False Don't Know
2. There is no cure for HIV/AIDS at present.	True False Don't Know
3. HIV is often asymptomatic for 10 years or longer.	
4. A person can be infected with HIV and not have AIDS.	True False Don't Know
5. Most people who have HIV look sick.	True False Don't Know
6. If having sex, the best way for someone to reduce his or her risk of getting HIV is to use a condom every time.	True False Don't Know
7. A negative HIV test indicates the absence of the virus if it is performed after at least six months with no exposure to risk[15]	
8. It can take 10 or more years for someone with HIV to test positive.	True False Don't Know
9. People can get HIV by sharing needles or syringes (to inject drugs) with someone who has HIV.	True False Don't Know
10. There is a vaccine available that protects a person from getting HIV.	True False Don't Know
11. In order to prevent getting HIV, people who inject drugs should never reuse or share needles.	True False Don't Know
12. ~~It is possible, but unlikely, to get HIV from an HIV test.[16]~~	~~True False Don't Know~~
13. Bleach can be used to clean dirty needles for injecting drugs to reduce the risk of getting HIV.	True False Don't Know
14. If a person has an STD, such as gonorrhea, herpes, or syphilis, s/he is more likely to get HIV.	True False Don't Know
15. If one partner tests negative for HIV after having unprotected intercourse, the untested partner's HIV status is deemed to be negative.[2]	
16. HIV can be transmitted through casual contact, such as shaking hands, hugging, or sharing a drink with someone who has HIV.	True False Don't Know
17. If a man pulls out before orgasm, condoms don't need to be used to protect against HIV.	True False Don't Know
18. There is medicine available to prevent a pregnant woman infected with HIV from passing it to her baby.	True False Don't Know

[14] Lindley, Coleman, Gaddist, & White (2010) Informing Faith-based HIV/AIDS Interventions: HIV-Related Knowledge and Stigmatizing Attitudes at Project F.A.I.T.H Churches in South Carolina**.**

[15] Morrill, A. C., & Noland, C. (2006). Interpersonal issues surrounding HIV counseling and testing, and the phenomenon of "testing by proxy". *Journal of Health Communication, 11*(2), 183-198.

[16] Item omitted due to poor wording

19. Any person with HIV can pass it on to someone else through oral, vaginal, or anal sex.	True False Don't Know
20. Someone can get HIV by having unprotected oral sex with an infected partner.	True False Don't Know
21. If a mother has HIV, the baby can get it by drinking breast milk.	True False Don't Know
22. Unprotected intercourse is safe only after both partners have established the absence of HIV, and only as long as both partners remain 100% monogamous	
23. People who have unprotected oral, anal, or vaginal sex should get tested for HIV regularly.	True False Don't Know
24. People who share needles should get tested for HIV regularly.	True False Don't Know

Kuder-Richarson alpha 0.756
Response choices – True, False, Don't Know - All correct responses are scored a 1 and incorrect responses including Don't Know scored 0.
Range of Scores – 0-24 – with higher score, more knowledge

Informed Consent Form

I, _____, agree to participate in a research study titled **"An Exploration of Black American Seminarians' Knowledge, Attitudes and Perceptions about HIV Prevention within Intimate Relationships."** Tiffany M. Cummings Aholou, a doctoral candidate from the Department of Child and Family Development at the University of Georgia under the direction of Dr. Jerry E. Gale, Department of Child and Family Development, University of Georgia, is conducting the study. I understand that my participation is voluntary. I can refuse to participate or stop taking part without giving any reason, and without penalty or loss of benefits. I can ask to have all of the information about me returned to me, removed from the research records, or destroyed.

I understand that the purpose of this study is to gain an understanding of the views Black/African American seminarians' have regarding HIV and ways to reduce infection among intimate relationships. The researcher is also hopeful that this research will contribute to the dialogue about HIV prevention for intimate partners from the perspective of Black/African American seminarians. In addition, the findings may inform future seminary curricula, intervention strategies and programs aimed at faith leaders.

If I volunteer to take part in this study, I understand that:
- I will complete two questionnaires that will take approximately 20 minutes to complete.
- I will also participate in a 90-minute individual interview session at a mutually identified location.
- The researcher will ask me open-ended questions regarding my knowledge about HIV/AIDS as well as my opinions and attitudes about HIV prevention within intimate relationships.
- The interview will be transcribed to capture and maintain an accurate record of the discussion.
- I may be asked by the researcher to suggest other participants who may be willing to participate in the study.
- I may be asked by the researcher to participate in follow-up interviews to either ask additional questions or seek clarity.

I understand that this research poses minimal risk, however if I experience any discomfort or concern about my participation, I may contact the researcher at any time during or after the completion of the study to request my withdrawal. For my participation in the study, I will receive a small token of appreciation in the form of a $20 gift card.

My interviews will be audio recorded and pseudonyms will be used in an effort to keep my identity confidential. The audio recordings will be transcribed and analyzed, then destroyed thereafter to eliminate the possibility of my information being identified. All other data collected will be locked in a secure file cabinet and will be only accessible to the researches. All data

collected will be retained up to five (5) years. No individually identifying information about me will be shared with others without my written permission. If I have any questions regarding the research or my participation, I can contact the researcher, Tiffany M. Cummings Aholou at (865) 224-6568 or tiffiany@uga.edu, who will answer my questions, now or during the course of the project. I may also contact the researcher's advisor, Dr. Jerry E. Gale, at (706) 542-8435.

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

_____   _____
Signature of Participant   Date

_____   _____
Tiffiany M. Cummings Aholou (Co-Investigator)   Date
(865)224-6568
tiffiany@uga.edu / tmaholou@gmail.com

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, University of Georgia Institutional Review Board, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411;Telephone (706) 542-3199; E-Mail Address IRB@uga.edu

Category Designation Chart

THEME	THEMATIC CATEGORY	SUB-CATEGORY	PROPERTY	SUB-PROPERTY
KNOWLEDGE ABOUT HIV (1A)	Factual Knowledge (4A)	Basic HIV Facts (4A) HIV Testing (4A) Medical (4A) Myths (4A) Risk Reduction (4A) Transmission Risk (4A)		
	Perceptual Knowledge (3A)	Behavioral (1A)	Drug use (2C) Unprotected Sex (2C)	Age (2C) Gender (2C) Concurrent (4C) Same Sex Practices (2C)
		Sociocultural (4C)	"Superman effect" (2C) "We just don't talk" (2C) Stigma (4C)	
		Relational (1A)	Lack of sexual communication (4C) All guards down (2C) The blind eye (3C) Blindsided (3C)	

1 – Theme/Category derived by the research questions/interviews questions 2 – Theme/Category derived by the participants/invivo 3 – Theme/Category derived by the investigator 4 – Theme/Category derived from the existing literature/theories	A – A priori – Before the data are actually collected B – Posteriori – After the data have been collected C – Iterative – Created at some point in the analysis

THEME	THEMATIC CATEGORY	SUB-CATEGORY	PROPERTY	SUB-PROPERTY
TESTING AS PREVENTION (1A)	Any Means (3C)	Easy access (2C) Routine testing (2C) Encourage your circle (2C)		
	The Gateway (2C)	*Wake up call (2C)* *Knowledge is power (3C)* *Teachable moments (3C)* Beating the odds (3C)		
MEANING OF MUTUAL HIV TESTING (1A)	It Takes Two (2C)	*Testing between intimate partners (2C)* *The tester/testee relationship (2C)* *Testing between two people (2C)* *An internal agreement (3C)*		
	Symbolic Gesture (3C)	*Care for self and other (2C)* *A healthy start (2C)* *Call to action (3C)*		
	"Double-Edged Sword" (2C)	Perceived Benefits (1C)	*Informed decision (3C)* *Instant support (2C)* *Establishes standards (2C)* *Early detection and education (2C)*	
		Perceived Barriers (1C)	*"What's really going on? (2C)* *The fear factor (3C)* *Forced re-examination of relationship (2C)* *Private made public (2C)* Implied elimination of condoms (2C)	

THEME	THEMATIC CATEGORY	SUB-CATEGORY	PROPERTY	SUB-PROPERTY
NORMALIZING MHT (1A)	It's Complicated (2C)	*Nature of relationship (3C)* *Exceptions to the rules (3C)* *"Falls on the woman" (2C)*		
	Making MHT the Norm (3C)	*Healthy community, healthy church (2C)*	*Facilitate the conversation (2C)* *"Pulpit as a platform" (2C)* *Intimate influence (3C)* *A "holistic" approach (2C)* Collaboration (2C)	
		Beyond the church (2C)	*Power of media (3C)* *Required or require? (3C)* *Campus life (3C)*	
TENSIONS OF MHT IN THE BLACK CHURCH (1A)	Crossroads (3C)	*Ideal versus reality (2C)* *"Practice what I preach? (2C)"* *"Either/or people" (2C)*		
	Roadblocks **(3C)**	*Politics of ministry (3C)* *Reputation on the line (2C)* *Perception matters (3C)* *"Don't want to offend" (2C)* *"Worried about push back" (2C)*		

THEME	THEMATIC CATEGORY	SUB-CATEGORY	PROPERTY	SUB-PROPERTY
WAYS TO FACILITATE MHT **(1A)**	Life/Courses **(3C)**			
	It Takes More (3C)	*Engage the new generation (2C)* *Formalized coursework (4A)* *Continued education (4C)* *External partnerships (C2)*		
	I Think I Can (3C)			

APPENDIX I

Spradley's Universal Semantic Examples

Title	Form of Relationship	Examples
Strict Inclusion	X is a kind of Y	• Informed choice **is a kind of** benefit of MHT • Engaging the church **is a kind of** strategy to promote MHT.
Spatial	X is a part of Y	• Education **is a part of** HIV testing
Cause-Effect	X is a cause of Y	• Unprotected sex **is a cause** of HIV transmission
Rationale	X is a reason for doing Y	• Knowing one's HIV status **is a reason for doing** an HIV test. • Care for self and partner **is a reason for doing** MHT.
Location for action	X is a place for doing Y	• Premarital counseling is a place for doing [promoting] MHT.
Function	X is used for Y	• The media **is used for** normalizing MHT.
Means-End	X is a way to do Y	• Engaging seminarians **is a way to do** [promote] MHT.
Sequence	X is a step (stage) in Y	• Having honest conversations about sex/prevention **is a stage in** promoting MHT.
Attribution	X is an attribute (characteristic) of Y	• Two people testing **together is an attribute** of MHT.

HIV Knowledge Scale – Participant x Item Chart

Item		Chris	Jack	Jake	Lillian	Justice	Jaybird	Zoey	Denise	Son	Goddess	Item Frequency
1)	Birth control pills protect against HIV. - F	1	1	1	1	1	1	0	1	1	1	9
2)	There is no cure for HIV/AIDS at present. - T	1	1	0	1	1	1	0	1	1	1	8
3)	HIV is often asymptomatic for 10 years or longer. - T	1	0	1	1	1	1	1	1	1	1	9
4)	A person can be infected with HIV and not have AIDS. - T	1	1	1	1	1	1	0	1	1	1	9
5)	Most people who have HIV look sick. - F	1	1	1	1	1	1	1	1	1	1	10
6)	If having sex, the best way for someone to reduce his or her risk of getting HIV is to use a condom every time. - T	1	1	1	1	1	0	1	1	1	1	9

Item		Chris	Jack	Jake	Lillian	Justice	Jaybird	Zoey	Denise	Son	Goddess	Item Frequency
7)	A negative HIV test indicates the absence of the virus if it is performed after at least six months with no exposure to risk. - T	1	0	0	1	1	1	0	1	1	0	6
8)	It can take 10 or more years for someone with HIV to test positive. - F	1	0	0	0	1	1	0	0	0	0	3
9)	People can get HIV by sharing needles or syringes with someone who has HIV. - T	1	1	1	1	1	1	1	1	1	1	10
10)	There is a vaccine available that protects a person from getting HIV. - F		0	1	0	1	1	1	1	0	0	1	6
11)	In order to prevent getting HIV, people who inject drugs should never reuse or share needles.- T		1	1	1	1	1	1	1	1	1	1	10
13)	Bleach can be used to clean dirty needles for injecting drugs to reduce the risk of getting HIV. - T		0	0	0	0	1	1	0	1	0	1	4

Item	Chris	Jack	Jake	Lillian	Justice	Jaybird	Zoey	Denise	Son	Goddess	Item Frequency
14) If a person has an STD, such as gonorrhea, herpes, or syphilis, s/he is more likely to get HIV. - T	1	1	1	1	1	1	1	1	0	0	8
15) If one partner tests negative for HIV after having unprotected intercourse, the untested partner's HIV status is deemed to be negative. - F	1	1	1	1	1	1	1	1	1	1	10
16) HIV can be transmitted through casual contact, such as shaking hands, hugging, or sharing a drink with someone who has HIV. - F	1	1	1	1	1	1	1	1	1	1	10
17) If a man pulls out before orgasm, condoms don't need to be used to protect against HIV. - F	1	1	1	1	1	1	1	1	1	1	10
18) There is medicine available to prevent a pregnant woman infected with HIV from passing it to her baby. - T	0	1	0	0	1	0	0	1	0	0	3
19) Any person with HIV can pass it on to someone else through oral, vaginal, or anal sex. - T	1	1	1	1	1	1	1	1	1	1	10
20) Someone can get HIV by having unprotected oral sex with an infected partner. - T	1	1	0	1	1	1	1	1	1	1	9

Item	Chris	Jack	Jake	Lillian	Justice	Jaybird	Zoey	Denise	Son	Goddess	Item Frequency
21) If a mother has HIV, the baby can get it by drinking breast milk. - T	1	1	0	0	1	0	1	0	1	1	6
22) Unprotected intercourse is safe only after both partners have established the absence of HIV, and only as long as both partners remain 100% monogamous. - T	1	1	1	0	1	1	1	1	1	1	9
23) People who have unprotected oral, anal, or vaginal sex should get tested for HIV regularly. - T	1	1	1	1	1	1	1	1	1	1	9
24) People who share needles should get tested for HIV regularly. - T	1	1	1	1	1	1	1	1	1	1	10
	20	19	15	18	23	20	16	20	18	19	
	20/23	19/23	15/23	18/23	23/23	20/23	16/23	20/23	18/23	19/23	
	87%	83%	65%	78%	100%	87%	70%	87%	78%	83%	