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Sexual protective strategies and condom use in middle-age African American women: A qualitative study

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Abstract

The heterosexual transmission of HIV has affected middle-age African American women at alarming rates; yet there is a paucity of research and interventions focused on this population. This study used a qualitative approach to understand middle-age urban African American women's experiences with HIV-related sexual risk behaviors and to identify the sexual protective strategies they employed to reduce their risk for HIV infection. Ten African American women, ages 45 to 56, were recruited from low-income neighborhoods in New York City. Data were collected using in-depth interviews and analyzed using content analysis. Investigator triangulation and member checking were used to ensure rigor. Five salient themes emerged that highlighted the individual, gender/relationship power factors, and the sociocultural elements that influenced sexual protection or risk-taking behavior. Findings provide new insight into the complexities of HIV sexual risk behavior and can guide future HIV prevention interventions for middle-age, African American, urban women.

Keywords

African American; HIV; middle-aged; women; risk; sexual behavior

The heterosexual transmission of HIV has disproportionately affected African American women (Centers for Disease Control and Prevention [CDC], 2013) and, more specifically, middle-age women, in epidemic proportions. African American women ages 50 to 64 carry the heaviest burden of HIV diagnosis, as they comprised approximately 40% of newly diagnosed cases in 2010 (CDC, 2012). HIV research and health interventions have targeted African American female youth, but these may not translate to middle-age women (Cornelius, Moneyham, & LeGrand, 2008; Winningham et al., 2004). Middle-age and older African American women are more likely to engage in high-risk sexual practices and may

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Conflict of Interest Statement

The author reports no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

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have less experience with condom use than younger women (Jacobs, 2008; Jacobs & Kane, 2011; Lindau, Leitsch, Lundberg, & Jerome, 2006; Winningham et al., 2004). Women who are post-menopausal and not likely to become pregnant may view condom use as a form of contraception that is no longer relevant to them (Beaulaurier, Fortuna, Lind, & Emler, 2014; Cornelius et al., 2008). Moreover, older women who lack power in sexual relationships report less sexual self-efficacy and partner negotiation and are less likely to practice safe sex (Jacobs & Kane, 2011). Despite evidence that HIV disproportionately affects middle-age African American women, there is a dearth of research and intervention studies focused on this vulnerable population (Harris, Mallory, & Stampley, 2010). Understanding the determinants of sexual risk for middle-age African American women is the initial step needed to identify HIV risk practices and preventative measures for the target population.

This study was informed by the Theory of Planned Behavior (TPB; Ajzen, 1991) and the Theory of Gender and Power (TGP; Connell, 1987). The TPB posits that intentions are the primary determinants of behavior and the TGP asserts that gender-power imbalances in the intimate relationship may lead to sexual risk-taking behaviors. The variables of the TPB include behavioral, normative, and control beliefs, which have been associated with condom use among younger (Hutchinson et al., 2007) and middle-age/older African American women (Smith, 2013). The specific aims of this study were to: (a) identify strategies used by middle-age African American women to reduce risk for HIV and other sexually transmitted infections (STIs), (b) develop an in-depth understanding of those factors that contribute to condom use by middle-age African American women in heterosexual relationships, and (c) determine which theory-based constructs were most relevant to consider in this population (e.g., behavioral beliefs, normative beliefs, control beliefs, condom use self-efficacy, and/or gender/relationship power).

Methods

An exploratory qualitative descriptive approach (Grove, Burns, & Gray, 2013) was used to capture the broader phenomenon of risk and sexual protection in middle-age African American women. Qualitative descriptive research is exploratory in nature and aims to denote the meaning of participant stories with minimal interpretation from the researcher (Sandelowski, 2000). The method is particularly relevant when seeking to understand the sociocultural and contextual factors that place middle-age women at risk for HIV and other STIs.

Recruitment and Procedures

A purposive sample of middle-age African American women was recruited from low-income neighborhoods in New York City (NYC). The NYC vital statistic report was used to identify low-income neighborhoods in boroughs with the highest HIV seroprevalence rates (New York City Department of Health and Mental Hygiene, 2009). Women in the study were recruited and interviewed between January 2011 and February 2012. Inclusion criteria were: self-identified as a Black/African American woman between the ages of 45 and 75 at the time of enrollment; heterosexual; ability to read, write, and speak English; ability to provide informed consent; and sexually active within the previous 6 months. Participants

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were recruited from multiple sites where middle-age African American women typically congregated, including hair salons, supermarkets, and community centers. Advertisements were posted in the local newspaper and flyers were posted at recruitment sites. Contact persons at each of the recruitment sites were informed of the study and asked to refer individuals who might be interested. Because stigma is associated with HIV, advertisements and flyers did not include the word “HIV.” Instead, recruitment material invited African American women to participate in a confidential study about sex, health, and relationship issues in the African American community. Interested women were screened for eligibility and informed consent was obtained for persons who met the screening criteria. In qualitative research, the sample is generally small and there are no closely defined rules to determine the size of the sample. Instead, the sample size was consistent with the saturation of data and themes, which occurred in this study when no new information of significance was achieved for thematic development (Padgett, 2008).

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All of the interviews were conducted by the principal investigator (PI), who is the same gender and race as the interviewees. Each participant chose a location for the interview (e.g., library, office, participant’s home) and privacy was maintained. All participants were interviewed in one session. The study was considered exempt and received approval from the institutional review board at New York University. To further protect participant identity, written consent was waived and each interview transcript was identified only by a number code. Each interview was conducted in a 30- to 60-minute time period using semi-structured interview guides with open-ended questions and probes. Twenty-five dollar (USD) gift cards were given to express appreciation for participation.

Interview Guide and Data Analysis

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The interview guide was informed by the TPB and the TGP. Questions progressed from general (and least threatening) to more specific. Questions were designed to elicit attitudes toward sexual risk, perceptions of personal risk, gender power roles, sexual decision-making, and the use of sexual protective strategies in older African American women (see Table 1).

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The investigator concurrently collected, coded, and analyzed data. Data analysis involved the development of codes and the use of thematic analysis of categorized codes (Corbin & Strauss, 2008; Strauss & Corbin, 1990). Data transcription and translation were completed using the Atlas Ti 7.0. Interviews were audiotaped and transcribed verbatim. Transcripts were edited to remove any identifiers and data were analyzed using content analysis. Content analysis was the chosen strategy as noted in exploratory qualitative descriptive studies (Sandelowski, 2000) as well as coding, memo writing, and the constant comparative method (Corbin & Strauss, 2008; Padgett, 2008). Initially, the data were analyzed using open coding in which key concepts were identified and analytically interpreted. Then, axial coding was used whereby categories that were identified in the open coding process were compared to create an accurate account of personal stories. Finally, selective coding was used to organize the data in a coherent manner.

In order to ensure accurate representation of the data collected, the PI met with a small qualitative research peer review group of four people from New York University College of

Nursing; each reviewer independently developed selective codes addressing the study topic. Then the PI and peer reviewers met in two subsequent meetings and compared codes to achieve clarity and accuracy, and to explicate code relevance. The categories identified in the axial coding process were unified into core categories and themes and subthemes emerged (Corbin & Strauss, 2008). Comparative coding and content analysis were completed with a qualitative research consultant, in which there was 100% inter-coder agreement. To ensure that the rigors of qualitative research were maintained, investigator triangulation and an audit trail were maintained for replication and reproducibility. Further, member checking was done to verify the findings with three of the participants, who verbalized that the themes and subthemes accurately reflected their narratives.

Results

The sample consisted of 10 African American women ages 45–56, with a mean age of 50. A small number of women were interviewed because data saturation was met with the completion of eight interviews. The author interviewed two additional women to ensure that no new information or themes would emerge. All participants lived in low-income neighborhoods in NYC. All participants self-identified as heterosexual; 80% reported being in exclusive relationships. The remaining 20% of participants reported having both main and casual partners. Half reported never having been married but were living with a primary sexual partner, while 40% reported being divorced, and 10% reported being married. Although HIV status was not a criterion for participation in the study and the women were not asked about their status, eight women voluntarily reported their status: seven were HIV uninfected and one was HIV infected. The remaining two women did not offer information on their HIV status.

Five salient themes and 26 subthemes emerged from the interviews that encompassed behavioral, normative, and control beliefs that influenced sexual risk or protective behavior (see Figure 1.) The themes also highlighted gender/relationship power factors and sociocultural elements influencing sexual protective strategies or risk-taking behaviors. The five themes were: positive attitudes and beliefs about sexual protection/condom use, sexual risk behaviors and barriers to condom use, sociocultural factors influencing sexual risk behaviors, condom negotiation, and self-care.

Positive Attitudes and Beliefs About Sexual Protection/Condom Use

Approximately half of the participants had favorable attitudes and beliefs about sexual protection and/or condom use embodying the following subthemes: condoms provide protection against HIV and STIs, monogamy, partner infidelity, pregnancy risk, and perceived sexual risk.

Condoms provide protection against HIV and STIs—Almost all of the participants (90%) believed that condoms were the most effective measure to reduce HIV and STI risk. However, only half believed condoms were a requirement for sexual protection and reported they would refrain from sexual activity with a main partner if condoms were not used. One woman described her reason for the use of condoms at every sexual encounter with her intimate partner:

I made him use a condom because in this day and age HIV is nothing to play with, along with STDs [sexually transmitted diseases] ... HIV is something you definitely can't fight off, so before you put yourself in that predicament, just protect yourself. It's simple.

Monogamy—Eight women had positive beliefs about being in a relationship with only one partner and considered monogamy a form of sexual protection. Three women felt that condom use was not required once monogamy in the relationship was established. One participant described her sexual protective strategy:

What I do is I stay with one person. I don't go around and have sex with this one and that one and this one. I'm not into that. I have sex with one man and I know if I got something that you gave it to me.

Partner infidelity—Three women reported positive beliefs about consistent condom use in their relationships due to fear that their sexual partners may have been engaging in other sexual relationships. One woman described her fear of her partner being unfaithful and reported that condoms were used at every sexual encounter: "I don't trust him. I really don't trust him anymore. I mean after 14 years I just don't trust him." Similarly, another participant addressed the importance of being sexually protective:

Trust ... that's where probably the protection come in because ... you're not with them 24/7. Not that you think that person is doing something outside or whatever, but ... I have the fear in the back of my mind ... once they with me ... they will have to have a condom for protection.

Pregnancy risk—Few women were concerned about pregnancy because most were menopausal or postmenopausal. Three women reported concern about pregnancy as a motivator for condom use at each sexual encounter. Women under 50 reported that condoms had the dual effect of contraception and protection from STIs. One participant over the age of 50 reported that the only purpose for condoms in a monogamous relationship is to avoid pregnancy:

I'm fearful of becoming pregnant. I would continue to use condoms until that time comes when I can't get pregnant anymore and if I'm with the same partner that I'm with now ... then we can stop the condom use, but that would be only when I know that I cannot have any kids anymore. Everything stops with my menstrual cycle. As long as I'm having my monthly I can have a baby, and I'm not taking that chance.

Perceived sexual risk—Although all participants expressed knowledge and understanding of the risk inherent in sex, only six reported their consideration of risk at each sexual encounter. The remaining four felt their perceived level of risk was dependent on other variables, such as partner relationship factors, sociocultural factors, and gender-power dynamics. Those who reported considering risk described their major concern as any unprotected vaginal/oral/anal sex or having multiple sexual partnerships. One participant discussed how her beliefs regarding condom use were based on a past experience with contracting an STI:

I don't know how many years it was ago that I caught crabs and I tell you that scared me. So I've been protecting myself, I would say, since then and I wasn't even in active addiction then, but it, you know, the experience of it all just like drove me crazy ... My life experience caused me to protect myself.

This participant also admitted to having other compounding factors in her life including a history of drug addiction that increased her awareness of sexual risk and diseases. However, having a positive attitude toward condom use based on perceived risk did not necessarily translate into consistent condom use. One woman in the study perceived herself as being at increased risk for HIV but reported that she did not use condoms consistently in her present relationship. She reported, "he kind of put me at risk for certain different things ... going back and forth to this girl and you're not wearing no condom. That's putting me at risk."

Influence from peers, family, and God—Approximately half of the women reported that their peers, family, and God influenced them to have positive attitudes toward consistent condom use. Some women discussed their experiences observing friends die of HIV-related complications that influenced their decisions to use condoms consistently. One participant discussed her peers' influence on her decision to use condoms with her intimate partner:

They influence me to use a condom because listening to their stories will make you think twice ... if it happened to her ... that can happen to me ... So I have to really stay up on top of my game because I have to know that I'm dealing with people and people will fail you every time ... So you gotta' be safe. If I want to be careful with me and stay alive with me then I need to take these precautions and start using condoms.

Two participants identified God as a motivator force and reported their strong confidence in God to assist with condom use decision-making.

Sexual Risk Behaviors and Barriers to Condom Use

Sexual risk behaviors and barriers to condom use are represented by six subthemes: sexual risk, drug abuse/addiction, paid sex work, multiple sexual partnerships, trustworthiness, lack of perceived risk, and limited education/knowledge about HIV and STIs.

Sexual risk—Sexual risk was discussed within the context of any behavior that threatened a woman's sexual safety and increased her chances of HIV or STI transmission. All participants had their own interpretations of sexual risk, each relating it to HIV or STI transmission. Each woman discussed her experiences in current and past relationships and sexual encounters that placed her at risk for HIV and STIs. One HIV-infected participant, a 56-year-old woman, disclosed how she contracted HIV from unprotected sexual intercourse.

I was in a relationship and the guy gave it to me. I know he gave it to me because he was the only one I was with. He died. He didn't take care of himself ... I never did drugs ... I never been to jail so I had unprotected sex with somebody that was HIV positive.

A 46-year-old participant described her views on the inherent risk in any form of sexual contact:

Sexual risk is ... having sex and not having a condom basically ... casual sex. Me and you gonna' do something and you're not strapped ... you're not having no condom on. I always believe ... anything condoms ... Like nobody, you know, you say the condoms work, but you know a person could have a sore in they mouth and they go down on you ... You get it that way too. He can have a sore in his mouth. He may have the virus ... He going down on you to eat you ... Or a female, she may have a sore on her mouth and she giving a man a blow job; you still gonna' get it either way. You still at risk ... It's real scary ... You know they got herpes on the rise ... AIDS and the virus is the most ... this is the most common place here in Brooklyn ... I said, "Wow there's a lot of people infected here in Brooklyn with ... HIV and AIDS," you know.

Drug abuse/addiction—Seven of the 10 participants reported past (60%) or active (10%) drug abuse and/or alcohol addiction and that it made them more likely to engage in risky behavior. A 46-year-old participant admitted to an active addiction to crack/cocaine and described how her present addiction placed her at risk for STIs:

Yeah I would say ... I would be more at risk because I'm dealing with ... the undesirables ... I would be more at risk because of my... drug use ... I'm dealing with ... people who are more promiscuous, who are less careful as far as their sexual partner ... Yeah I think because of the class ... the kind of people you find in the drug world.

Most of the participants who acknowledged early drug addiction discussed the compound factors, such as multiple sexual partnerships or sex work that increased the risk for sexual diseases. A 50-year-old participant, who had stopped using drugs and alcohol 4 months before being interviewed, discussed how her addiction placed her at risk for STIs and jeopardized her safety:

... prostitution, sleeping with different men ... when I was hanging out in the streets I would, you know, get intoxicated and there were men present, women present ... getting high with different people, smoking behind different people, you can end up with herpes ... That was a risk.

Paid sex work—Only two participants were involved in paid sex work and these participants reported that it could be a barrier to condom use depending on condom availability, finances, and the need for illicit drugs. A participant described her experience with paid sex work:

I do little sexual favors for money at times, because of my financial situation ... 90% of the time but there has been a percent of the times that I haven't. I take the risks. Why? Because there was no condom available or the person just didn't want to and I needed the money. So desperation, I guess, that's a harsh word, but yeah.

Although the two participants discussed paid sex work as a barrier to condom use they were also aware of the risk for HIV and STIs when engaged in paid sex work.

Multiple sexual partnerships—Half of the participants made reference to perceiving their main partner as having multiple sexual partnerships or “cheating.” Two additional participants reported that they themselves had undisclosed casual partnerships. One participant discussed her behavior as risky and stated that she was not always consistent with condom use:

Yeah there’s a lot of risks because sometimes if the person ... if the man is promiscuous ... not only men, women are promiscuous ... And there have been occasions where I did not use protection, but thank God I didn’t catch anything.

Although participants acknowledged that their main partners might have other sexual partners, they did not consistently use condoms. Many felt that because they were having sex with only one man, there was no need for condom use. Many women echoed the sentiment that a “man is going to be a man” in reference to outside sexual relationships. One participant shared this sentiment about her main sexual partner: “You know a man is going to be a man at all time ... you could have been with your husband for a long period of time and not know that ... he’s HIV positive.”

Trustworthiness—A sense of trust in the intimate sexual relationship was noted as a barrier to condom use. Half of the participants discussed trustworthiness in their relationships, defined as having a sense of safety and comfort such that condoms seemed unnecessary. One participant stated:

I don’t know, I just thought I trusted the person, you know, even though we didn’t go to the doctor, I just trusted the person. I guess it was the smooth talk and you know... so OK, he’s alright ... knowing that I could have put my life in danger, but I did it anyway.

Lack of perceived risk—Half of the participants did not perceive an increased risk for HIV/STIs or did not use condoms consistently in their main or casual relationships. Two main factors appeared to influence perceptions of risk: a sense of perceived partner cleanliness and duration of the relationship. Perceived cleanliness referred to deciding not to use a condom based on the physical appearance or apparent personal hygiene of the sexual partner. One participant described her decision not to use a condom with a casual sexual partner based on her notion of cleanliness:

If the person was, what I felt, was relatively clean, you know things like that ... And of course I know that that has nothing to do with whether they’re infected, but that’s how ... influence me ... I wouldn’t deal with someone who I felt was really dirty or unclean.

Another participant discussed the notion of cleanliness and how it influenced her practice of not using a condom with her partner: “You know, I made sure, you know, that he’s ... clean ... they take showers, you know, their clothes is clean. They’re not dirty and, they’re not unsanitary.” In addition, women reported a lack of risk perception when they were in a long-term relationship as defined by some of the participants as being with a partner for more than 2 months. One participant described her long-term relationship in this way:

But let me see, I say maybe about 2, 2 months or more, you know. Maybe 2 or 3 months, you know, before I feel that I was able to know not to use one ... we've been together so long, so I know he's not messing around on the outside, you know.

Limited education/knowledge about HIV and STIs—All of the participants reported an awareness of HIV/STIs and knowledge of how they are transmitted. However, some participants indicated that they were not fully aware of the treatment options. Only four of the participants indicated that they had what they considered to be a high level of knowledge regarding HIV and STIs. The other six participants reported that they had not received formal education on HIV and STIs.

Sociocultural Factors Influencing Sexual Risk Behaviors

Seventy percent of women made reference to sociocultural factors that contributed to sexual risk behaviors in older African American women, and five subthemes were embedded: incarceration of Black men, “down low” behavior, opposition to condom use by Black men, and a shortage of men.

Incarceration of Black men—Thirty percent of the women deemed incarceration of Black men as a major sex risk. These women felt that a high number of incarcerated Black men may have engaged in unprotected sex while in prison, which could expose Black women to HIV and other STIs. One woman discussed her views on incarceration:

Because I believe like if a man's been incarcerated ... I believe that they submit to homosexual sexual activity. It's human nature. Whether they want to admit it or not, that's what I believe ... because of the amount of time that they've been incarcerated ... I'm thinking maybe ... if they did partake in homosexual activity, did they use condoms?

“Down low” behavior—Forty percent of the participants discussed “down low” behavior as a sexual risk factor for HIV and STIs. The term “down low” refers to men who identify themselves as heterosexual and are sexually active with women but are also engaging in undisclosed homosexual activity. One participant shared the sentiment of the other women by describing “down low” behavior as:

They might like men and women. He might not get what he need from a woman so he'll go be with a man, but he'll come home to you as if never nothing happened. Or, “I'm going to go play poker.” Yeah he's playing poker alright, poking each other ... I think my husband was a little fruity ... There's a lot of men out here ... They not going to tell you they on the down low.

Black men opposed to condom use—About 50% of the participants discussed their perceptions of Black men being opposed to condom use. These women described such behavior as a cultural norm in the African American community. One woman stated, “A lot of these men don't like to use protection and the excuse is, ‘oh it feels different.’ But yet again, if they're sick—meaning if they have an STD or something they're not going to tell

you.” Another participant expressed her view of Black men’s divergent attitudes toward condom use:

A man ain’t thinking about no condoms. You know you got some brothas that think about condoms because I can’t say all the brothas, but half of them don’t ... Especially not the guys that’s out there tricking. They having sex and don’t care and that’s why this thing is being spread.

A woman described the lack of condom use with some of her Black male casual partners as:

A lot of times I find that, oh yeah found a lot of men don’t ... That’s why I say it was a cultural thing. It was a cultural thing as far as I found that a lot of West Indian men do not want to use the condoms. They say, “Look at me. I’m clean.” And they believe that just because they look clean that, “oh I’m clean.” Yeah I think it was a cultural thing.

Shortage of men—About half of the women in this study referred to a shortage of men available to date older women in the African American community. The cause of this perceived shortage was attributed to homosexuality, marriage or exclusive relationship, or other social and contextual factors. Some of the women reported that sharing men was an option (multiple sexual relationships) but acknowledged the health risk in such behavior. One woman had this to say about the shortage:

And as you know most of Black men is gay ... that’s what my friends tell me, there’s a lot of them that’s nice looking and stuff like that and when they get to that process then they go to a bar or they go somewhere to socialize ... end up that it’s not what they think he is. You know what I’m saying, so I think a lot us, have issues ... where are the men? The real men?

Condom Negotiation

Condom negotiation emerged as a bi-dimensional theme in that women expressed both positive and negative views in regard to sexual protection. Seventy percent of the women reported positive sexual decision-making abilities and no difficulty negotiating condom use in intimate sexual relationships because of a sense of shared power and equal control in their relationships.

Sense of shared/equal power in the sexual intimate relationship—A sense of shared power in the sexual relationship appears to be derived from communication and mutual sexual decision-making. In this study mutual sexual decision-making was defined as having equal and shared power in deciding whether and how sexual activity would take place; the woman would be able to openly discuss and negotiate condom use and safe sex with her intimate partner. One participant stated,

Yeah we consult on a lot of stuff ... because it’s about us ... If he wants, you know, some kind of sexual activity and I may not be in agreement to it, we talk about it ... we come to some kind of mutual understanding about it, whether I’m gonna’ or whether I’m not.

For another participant, sexual decision-making meant negotiating condom use, stating,

... negotiating for condoms it means to me that ... he respects me for being careful, you know, knowing that he's out there ... messing with another woman so ... you know he's just ... you know he can't ... He really can't with me, you know, but it's me that you know that's still taking risks, you know, even though you do use a condom.

Positive sexual decision-making—Thirty percent of the women in this study viewed sexual decision-making in a positive manner when they had the ability to always decide on condom use. One participant reported her attitude toward negotiation as, “I ain’t gotta’ negotiate with him. You go and use it and that’s what you gonna’ do or there ain’t gonna’ be no sex. Ain’t no negotiating.” On the other hand, one participant discussed having mutual power in her sexual relationship but positive power in her sexual decision-making abilities as a paid sex worker: “You want this, you have to use a condom. The power of the woman. The power of the pussy.”

Limited sexual relationship power—Many women discussed barriers to condom negotiation in their past or present relationships. Some women (30%) indicated that they felt a sense of limited sexual decision-making power, which meant that they were not able to effectively communicate or decide on condom use in the intimate sexual relationship. One participant described communication as, “Once you feel comfortable with one partner you just going to just do what you do. You ... not talking about really no safe sex.” Another participant reported that even though she was aware that her partner engaged in multiple sexual partnerships, she could not communicate about condom use due to fear. She described her inability to communicate about safe sex as, “He was having outside relationships out there, which I found out ... He would kill me talking about condoms; I would be dead.”

Male dominance in the sexual relationship—Some of the women (30%) felt that their partners had complete sexual dominance or sexual decision-making abilities (condom use or no condom use) in intimate relationships. One participant described her partner power as:

Some men want to be powered in that sense that they is in charge. They take over or whatever. So for me it might not be to that point so I’ll just let him, that person, have that power, you know ... Let them in charge, have that power, if it give them that satisfaction to that extent. It’s OK with me.

Similarly, another woman reported, “Well, power ... I like to let him have the lead way with the power because he’s, he’s the man.”

Self-esteem issues—A small percentage of women (30%) indicated that low self-esteem caused feelings of insecurity and low self-worth based on various factors including physical, psychological, social, and/or relational dynamics. Women in the study who reported issues with self-esteem all agreed that low self-esteem limited the ability to negotiate for condom use with intimate partners. A participant addressed how self-esteem impacted her sexual

relationship by stating, “In the past I just felt like I was being used ... And they made me feel low.”

Intimate partner violence—Many of the women (60%) discussed past histories of intimate partner violence that affected their abilities to effectively negotiate for condom use. Intimate partner violence refers to a woman being involved in and abused by her intimate sexual partner. The abusive patterns included physical, emotional, and/or mental abuse. A participant indicated the effects of her experience with abuse as:

You know when he hit me or when he would kick me in my knee or stomp on my foot, I take the hit and I don't feel it no more and he would go away ... 7 years and I couldn't tell nobody. I couldn't even tell my sisters that my husband beat on me because then I'll feel weak and I'll feel less than a woman.

Another participant described her experience as emotional and physically painful:

We were together like 4 years and he actually shot at me with a gun on top of my steps. Put two bullet holes in my glass door. No lie. Put two bullet holes. What he did... I didn't want to be bothered no more. I couldn't take the abuse. I couldn't take the hitting.

Self-Care

The final theme focused on self-care behaviors. Many of the women in the study (50%) reported that self-care was the means by which they reduced sexual risk. In this study, self-care encompassed drug treatment and recovery, self-effective behavior, and HIV and STI screening. Most of the women (60%) who had a past substance addiction reported that they were either in recent drug treatment or had completed a treatment program and were in recovery or attended sober support groups. Some of the women reported that maintaining a sober lifestyle enhanced awareness of the need for safe sex to reduce the risk of HIV transmission.

Many of the participants were able to describe their self-effective abilities with condom use. Condom use self-efficacy is defined as the degree of confidence that African American women have in their abilities to obtain condoms and use condoms with their partner(s) for protection from HIV and STIs (Bradford & Beck, 1991). A woman in this study described her confidence in obtaining condoms as being equipped with condoms at all times by indicating:

Always carry them in your bag because the man ain't gonna' protect you ... He's not going to protect you. The man is not gonna' protect you. If you the woman--you laying down with him--always have a stash. I do. I have a whole lot of stash.”

Many of the women in this study (60%) discussed self-care in relation to HIV and STI screening. These participants made reference to the necessity of medically screening for HIV and/or STIs prior to having any sexual relations with a man.

Discussion and Implications

The principal aim of this qualitative study was to better understand those factors that contribute to sexual protective strategies and those that increase HIV sexual risk behavior for middle-age urban African American women. The findings established that these middle-age African American women were engaged in risk-taking sexual practices, increasing their vulnerability for HIV and STI transmission. The findings centered around five themes. Some of the findings were encouraging, particularly because the majority of the participants expressed positive attitudes and beliefs toward condom use and sexually protective behavior. Factors influencing sexual protection included an awareness that condoms protect against HIV and the recognition of the risk of HIV and STI transmission at every sexual encounter.

Thirty percent of the participants used condoms consistently due to fear of partner infidelity. The findings revealed a dichotomy in that partner infidelity was often associated with sexual behavior with other partners and some of the women in the study viewed their partners' unfaithfulness as a barrier to condom use. The perceived barriers were related to the conviction that a partner's infidelity was a given in any heterosexual relationship. For instance, a participant reported that even though she was aware that her partner was unfaithful, she shared the sentiment regarding partner infidelity that "a man is going to be a man," and underestimated her own risk for HIV acquisition by not using sexual protection. Other women had positive beliefs about condom use, as they perceived partner infidelity as a good reason to use protection in order to mitigate the risk for HIV and other STIs. Correspondingly, another study found that middle-age and older African American women who reported partner infidelity were more likely to perceive themselves as being at risk for HIV (Winningham et al., 2004). Therefore, if women reported more knowledge about HIV or reported that their partners had been unfaithful or might be unfaithful, they perceived themselves as being at a higher risk for HIV transmission.

Earlier literature found that African American women's knowledge of HIV risk did not guarantee engagement in safer sexual practices (Cornelius et al., 2008; Jacobs, 2008). The current study indicated a significant gap in knowledge and risk perception regarding HIV transmission and sexual protection. Some of the women engaged in risky sexual practices based on the potentially misguided notion of risk as they specified that their partners' physical appearance of cleanliness was indicative of good health and meant they could have unprotected sex without the risk of contracting diseases. Lack of perceived HIV risk/vulnerability has been associated with inconsistent condom use among older African American women (Corneille, Zyzniowski, & Belgrave, 2008; Theall, Elifson, Sterk, & Klein, 2003). However, no studies were found to either support or negate the concept of perceived susceptibility to HIV based on physical appearance (e.g., clean vs unclean). The lack of appropriate self-risk appraisal found in this study may thwart HIV efforts, especially if a woman's decision to not use a condom hinges on the physical appearance of her partner. Further studies are needed to explore the multifarious concepts of HIV risk perception in this vulnerable population.

Half of the women in this study did not use a condom at every sexual encounter. This was consistent with the limited available literature, which has asserted that inconsistent condom use has been associated with an increased risk of HIV transmission for middle-age and older African American women (Winningham et al., 2004). Some studies pointed out that middle-age African American women might be less experienced with condoms than their younger counterparts (Lindau et al., 2006; Winningham et al., 2004). However, in this study many of the women did not cite a lack of experience as a causative factor; instead, other factors, such as trust and a sense of security in a monogamous relationship, were put forward as reasons for inconsistent condom use. Monogamy was viewed positively and it was noted to be a form of sexual protection rendering condom use unnecessary. The duality of the concept of monogamy was also viewed as a barrier to HIV prevention efforts because condom use was perceived as pointless once a woman was in a committed relationship. This finding adds weight to previous literature on the factors associated with inconsistent condom use by older African American women, but not the dual nature of monogamy, as it may be a form of sexual protection and risk. If a woman believes she is in a monogamous relationship but her partner has other concurrent, undisclosed sexual partners, as was mentioned in this study, her risk of contracting HIV and other STIs is increased. Additional research is needed to determine if monogamy is a protective factor against HIV and STIs; it also remains to be determined how monogamy, long-term commitment/marriage, and partner risk status influence women's sexual decision-making and overall sexual health (Beaulaurier et al., 2014; Lindau et al., 2006).

As indicated in this study, trustworthiness was a barrier to condom use. Sormanti and Shibusawa (2007) conducted a study with middle-age women and, although the majority of the women reported having sex, only 12% reported ever using condoms. Inconsistent condom use may be explained by the findings of Corneille et al. (2008) that suggested a significant association between length of the relationship and middle-age African American women's use of condoms. Thus, the longer African American women were in a relationship, the less likely they were to use condoms. It is imperative that researchers and health providers examine how sexual protection and trust are defined within the context of the "monogamous" heterosexual relationship as this study found that reliance on this relationship status can present a major health risk.

A surprising finding in this study was that 70% of the participants had a past or present drug abuse/addiction. Drug addiction increased the risk for HIV/STIs and, in some cases, acted as a barrier to consistent condom use. In harmony with previous studies (involving adolescents and young adults) on the association between drug abuse/addiction and sexual risk behavior (Inungu, Mumford, Younis, & Langford, 2009; Roberts & Kennedy, 2006), the participants in this study reported that when they used illicit substances they were more likely to engage in risky sexual practices. However, drug abuse/addiction was an unexpected finding in this study because of the limited literature on drug abuse/addiction as a sexual risk factor for HIV/STIs in middle-age and older African American women. A single study by Neundorfer, Harris, Britton, and Lynch (2005) offered similar results regarding HIV risk, and drug and alcohol addiction. However, those authors focused on midlife and older HIV-infected women, and more than half of their study participants reported contracting HIV prior to age 45. With the aging of the population, the findings of this study have particular relevance for

nurses and other health care providers who seek to provide comprehensive HIV risk reduction services tailored to the needs of midlife African American women with an active or past substance addiction.

HIV/STI risk increases with multiple sexual partners. Half of the women in this study expressed a belief that their partners were involved in other sexual relationships. Twenty percent reported that they themselves had more than one sexual partner, but middle-age African American women are no more likely to have multiple sexual partners than women of other races (Moreno, El-Bassel, & Morrill, 2007; Sormanti, & Shibusawa, 2007). A woman's HIV risk is not only due to individual risk factors, it is equally dependent on her sexual partner's risk behavior (Ivy, Miles, Le, & Paz-Bailey, 2014). Many of the women in this study were considered to be at increased HIV risk because of their main partners' risky sexual behaviors. It is, therefore, critical to examine the impact of the dyadic/relational dynamics for middle-age African American women and their partners as a potential contributor to risky sexual encounters. This is a fundamental step toward developing age-appropriate programs needed to eliminate barriers to HIV/STI prevention.

Many of the participants reported self-care behaviors that influenced or led to sexual protective strategies in their intimate relationships. Those behaviors included being a part of a drug treatment and/or recovery program, maintaining a positive attitude toward condom use, and an insistence on screening for HIV and STIs prior to initiation of sexual activities. A woman's ability to protect herself in a sexual relationship requires confidence in her ability to refuse unprotected sex and/or to advocate for condom use in the relationship.

The women in this study also indicated that sociocultural factors influenced their sexual risk behaviors. Thirty percent reported that incarceration created an imbalance in the male-to-female ratio in the African American community, resulting in a shortage of men. Gender-ratio imbalance occurs when the number of eligible African American women exceeds the number of eligible African American men, due not only to the higher incarceration rates but also to various socioeconomic and education differences and the higher mortality rates of African American men (Adimora, Schoenbach, & Floris-Moore, 2009; Ivy et al., 2014). Low socio-economic status, living in impoverished communities, and gender/sex-ratio imbalance increases HIV vulnerability for African American women (Harris et al., 2010; Ivy et al., 2014). Fifty percent of the women in this study cited the shortage of men in the African American community as problematic. The cause of the shortage varied with the women reporting it: incarceration, homosexuality, and marital status were most frequently mentioned. When an African American woman loses her partner to incarceration she may lose her financial support and seek other partnerships, and may be more willing to accept men who participate in risk-taking sexual behaviors. The male shortage affects older women because their dating potential is diminished, which may reduce the power and ability to negotiate personal needs in the sexual relationship (Harris et al., 2010). Further, male shortages create an imbalance in the African American community and can lead to Black women sharing male partners or having concurrent sexual partnerships that contribute to HIV susceptibility (Harris et al., 2010; Ivy et al., 2014). Therefore, HIV prevention strategies should address male shortages in the African American community by targeting

public health and social policies geared at eliminating racial disparities including the disproportionate incarceration of Black men (Ivy et al., 2014).

Nearly half of the participants mentioned a perception of Black men being unwilling to use condoms, but there is scant literature on this topic.

Forty percent of the participants discussed “down low” behavior as a sexual risk for HIV and other STIs. Many of the women further described “down low” behavior and homosexuality as stigmatizing characteristics in the African American community. Studies have examined the role that African American males play in contributing to the HIV epidemic when those who identify as heterosexual but clandestinely engage in high-risk same sex behavior fail to disclose this behavior to their female sexual partners (Neundorfer et al., 2005; Winningham et al., 2004). A qualitative study was conducted with a convenience sample of 11 African American women who were infected by male partners who engaged in extramarital/relational sexual activities. The women expressed anger at their partners for having undisclosed sex with other men (Whyte, Whyte, Cormier, 2008). Similarly, the women in this study verbalized anger and frustration with regard to “down low” behavior. Nevertheless, some women continued to engage in unprotected sexual relations with their partners, despite being aware of their partners’ sexual relations with other men, women, or both.

Societal norms tend to stigmatize homosexuality, making it difficult for African American men to disclose a homosexual sexual orientation for fear of being ostracized in the community (O’Leary, Fisher, Purcell, Spikes, & Gomez, 2007). Additional research is necessary to explore stigma and nondisclosure of sexual behavior by African American men as an HIV prevention effort aimed at decreasing the occurrence of HIV risk for Black women (Smith & Larson, 2014).

Participants in this study referred to power in the intimate relationship as either a sense of shared/equal power or positive sexual decision-making. Most of the women perceived themselves as having more power than their partners and could communicate and negotiate for condom use effectively. This finding coincided with the concept from the TGP that suggested that the person with the most power in an intimate relationship had major control over sexual decision-making (e.g., consistent condom use; Connell, 1987; McNair, & Prather, 2004). A few women discussed barriers to the negotiation of condom use, including limited sexual decision-making ability, male dominance in the relationship, and intimate partner violence. Sormanti and Shibusawa (2008) asserted that midlife and older women who experienced interpersonal violence might be at increased risk for HIV infection because of traditional gender roles and cultural norms as well as stereotypical power imbalances inherent in the sexual relationship. Thus, gender power imbalance in the relationship can negatively affect a woman’s ability to advocate for her sexual health with regard to condom negotiation.

Although low self-esteem was mentioned as a factor that can influence sexual risk behavior, it can also be viewed as a power differential. Relationship factors such as gender power imbalance in intimate relationships may have an impact on women’s self-esteem, thereby

influencing HIV risk for middle-age and older women (Jacobs & Kane, 2011). Some of the women in this study cited a past history of intimate partner violence and low self-esteem and reported a sense of limited power in a relationship when violence was present. This was consistent with literature on the association of limited power with violence, as well as the finding that women who reported interpersonal violence were more likely to report having multiple sexual partners, inconsistent or no condom use, and a partner with known HIV risk factors (Sormanti, Wu, El-Bassel, 2004).

The health care needs of middle-age African American women are unique, and clinical approaches must be developed that take into consideration distinct behavioral, social, and cultural attributes that characterize risk. Nurses and other health care professionals are in a prime position to assess risk and teach appropriate risk appraisal (Smith, 2013). Although the women in this study were knowledgeable about HIV transmission and prevention, they often failed to accurately perceive their risks for HIV and continued to engage in risky sexual behaviors. HIV prevention programs/interventions that include education must be created to help middle-age African American women assess not only their own risk, but their partners' risks as well, because this may lead to greater sexual protection and the reduction of HIV in the target population. Further, African American women in low income, urban settings are often unaware of having HIV and the lack of awareness can be a major health risk (Ivy et al., 2014). Therefore, HIV testing should be offered as part of routine clinical practice, and the importance of partner testing should be emphasized prior to the initiation of sexual intimacy.

Limitations

Some notable limitations exist in this study. The sample size was small, which was appropriate for the qualitative method, but, as such, inferences and conclusions are not applicable to the entire population. The age range studied here placed strictures on recruitment possibilities for the study, although recruitment continued until data saturation was met. The recruitment goal was to interview women up to age 75, but no women older than 56 volunteered for the study. Because HIV is a sensitive and heavily stigmatized subject, it is quite likely that older women were not comfortable discussing their sexual behaviors with the PI. Further, all of the participants were recruited outside of any health care facility, a setting where older women may have been less reticent to participate and talk candidly about sexual activity. In addition, participants were recruited from low-income neighborhoods in NYC and were not necessarily representative of African American women in other settings. Finally, the PI did not engage the participants for a prolonged period of time.

Conclusions

The risk of heterosexually-acquired HIV for middle-age African American women is a complex health issue that requires a comprehensive interprofessional approach in order to be adequately addressed. The findings of this study have provided a clear indication that middle-age African American women engage in risky sexual practices, knowledge of which carries implications for nursing and other health care disciplines. Health care providers must

be prepared to engage and adequately address, through culturally relevant programs, research studies, health policies, and clinical interventions, all that is necessary to promote HIV sexual risk reduction strategies for middle-age African American women.

Middle-age urban African American women are in dyadic relationships and must communicate more effectively with their partners about the risk of disease transmission. It is important to include men in future HIV education and prevention efforts, efforts that need to incorporate an understanding of such gender-specific relationship factors as those found in this study. Skills-building interventions regarding communication, condom negotiation, and sexual decision-making should be addressed in research (Jacobs & Kane, 2011) and implemented in clinical settings. In addition, nurses and other health providers may establish patient-peer support groups that encourage middle-age women to share the importance of safe sex with their peers. It may also be advantageous for health care providers to utilize faith-based initiatives to create relevant HIV risk reduction interventions for the target population.

Despite limitations, this study adds new information to the literature and nursing knowledge base that can further illuminate the complexities of HIV sexual risk in this population and serve as a basis for future HIV risk reduction interventions. Further qualitative and quantitative studies are needed to fully comprehend the phenomenon of sexual risk in this vulnerable population.

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References

- Adimora AA, Schoenbach VJ, Floris-Moore MA. Ending the epidemic of heterosexual HIV transmission among African Americans. *American Journal of Preventative Medicine*. 2009; 37:468–471.10.1016/j.amepre.2009.06.020
- Ajzen I. The theory of planned behavior. *Organizational Behavioral and Human Decision Processes*. 1991; 50:179–211.
- Beaulaurier R, Fortuna K, Lind D, Emlet AC. Attitudes and stereotypes regarding older women and HIV risk. *Journal of Women and Aging*. 2014; 26:351–368.10.1080/08952841.2014.933648 [PubMed: 25133946]
- Bradford LJ, Beck KH. Development and validation of a condom self-efficacy scale for college students. *Journal of American College Health*. 1991; 39:219–225. [PubMed: 1783705]
- Centers for Disease Control and Prevention. Diagnoses of HIV infection among adults aged 50 years and older in the United States and dependent areas, 2007–2010. 2012. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_18_no_3.pdf
- Centers for Diseases for Disease Control and Prevention. HIV in the United States: At a glance. 2013. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_basics_factsheet.pdf

- Connell, R. Gender and power. Stanford, CA: Stanford University Press; 1987.
- Corbin, J.; Strauss, A. Basics of qualitative research. 3. Thousand Oaks, CA: Sage; 2008.
- Cornelius JB, Moneyham L, LeGrand S. Adaptation of an HIV curriculum for use with older African American women. *Journal of Association of Nurses in AIDS Care*. 2008; 19:16–27.10.1016/j.jana.2007.10.001
- Corneille MA, Zyzniewski LE, Belgrave FZ. Age and HIV risk and protective behavior among African American women. *Journal of Black Psychology*. 2008; 34:217–233.10.1177/0095798408314139
- Grove, SK.; Burns, N.; Gray, JR. The practice of nursing research: Appraisal, synthesis and generation of evidence. 7. St. Louis, MO: Elsevier Saunders; 2013.
- Harris G, Mallory C, Stampley C. A qualitative study of man-sharing and the implications for midlife African American women's risk for HIV infection. *Women & Health*. 2010; 50:670–687.10.1080/03630242.210.520253 [PubMed: 21104569]
- Hutchinson MK, Jemmott LS, Wood EB, Hewitt H, Kawha E, Waldron N, Bonaparte B. Culture-specific factors contributing to HIV risk among Jamaican adolescents. *Journal of the Association of Nurses in AIDS Care*. 2007; 18:35–47.10.1016/j.jana.2007.01.008 [PubMed: 17403495]
- Inungu J, Mumford V, Younis M, Langford S. HIV knowledge, attitudes, and practices among college students in the United States. *Journal of Health and Human Services Administration*. 2009; 32:259–277. [PubMed: 20099580]
- Ivy W, Miles I, Le B, Paz-Bailey G. Correlates of HIV infection among African American women from 20 cities in the United States. *AIDS and Behavior*. 2014; 18:S266–S275.10.1007/s10461-013-0614-x
- Jacobs RJ. Theory-based community practice for HIV prevention in midlife and older women. *Journal of Aging Health*. 2008; 16:403–421.10.1080/10705420802473717
- Jacobs JJ, Kane MN. Psychosocial predictors of self-esteem in a multi-ethnic sample of women over 50 at risk for HIV. *Journal of Women and Aging*. 2011; 23:23–39.10.1080/08952841.2011.540484 [PubMed: 21271442]
- Lindau DT, Leitsch SA, Lundberg KL, Jerome J. Older women's attitudes, behavior, and communication about sex and HIV: A community-based study. *Journal of Women's Health*. 2006; 15:747–753.10.1089/jwh.2006.15.747
- McNair LD, Prather CM. African American women and AIDS: Factors influencing risk and reaction to HIV disease. *Journal of Black Psychology*. 2004; 30:106–123.10.1177/0095798403261414
- Moreno CL, El-Bassel N, Morrill AC. Heterosexual women of color and HIV risk: Sexual risk factors for HIV among Latina and African American women. *Women & Health*. 2007; 45:1–15.10.1300/J013v45n03_01 [PubMed: 18032159]
- Neundorfer MM, Harris PB, Britton PJ, Lynch DA. HIV risk factors for midlife and older women. *The Gerontologist*. 2005; 45:617–625.10.1093/geront/45.5.617 [PubMed: 16199396]
- New York City Department of Health and Mental Hygiene. New York City HIV/AIDS semi-annual surveillance statistics. 2009. Retrieved from <http://www.nyc.gov/html/doh/html/ah/hivtables.shtml>
- O'Leary A, Fisher HH, Purcell DW, Spikes PS, Gomez CA. Correlates of risk patterns and race/ethnicity among HIV-positive men who have sex with men. *AIDS Behavior*. 2007; 11:707–715.10.1007/s10461-006-9205-4
- Padgett, DK. Qualitative methods in social work research. 2. Thousand Oaks, CA: Sage; 2008.
- Roberts ST, Kennedy BL. Why are young college women not using condoms? Their perceived risk, drug use, and developmental vulnerability may provide important clues to risk. *Archives of Psychiatric Nursing*. 2006; 20:32–40.10.1016/j.apnu.2005.08.008 [PubMed: 16442472]
- Sandelowski M. Whatever happened to qualitative description? *Research in Nursing and Health*. 2000; 23:334–340. [PubMed: 10940958]
- Smith, TK. New York University; 2013. Gender power and HIV-related sexual risk behavior in older African American women. (Doctoral dissertation).
- Smith TK, Larson E. HIV sexual risk behavior in older Black women: A systematic review. *Women's Health Issue*. 2014; 25:63–72.10.1016/j.whi.2014.09.002

- Sormanti M, Shibusawa T. Predictors of condom use and HIV testing among midlife and older women seeking medical services. *Journal of Aging Health*. 2007; 19:705–719.10.1177/0898264307301173 [PubMed: 17682082]
- Sormanti M, Shibusawa T. Intimate partner violence among midlife and older women: A descriptive analysis of women seeking medical services. *Health and Social Work*. 2008; 33:33–41. [PubMed: 18326448]
- Sormanti M, Wu E, El-Bassel N. Considering HIV risk and intimate partner violence among older women of color: A descriptive analysis. *Women and Health*. 2004; 39:45–63.10.1300/J013v39n01_03 [PubMed: 15002882]
- Strauss, A.; Corbin, J. *Basics of qualitative research: Grounded theory, procedures and techniques*. Newbury Park, CA: Sage; 1990.
- Theall KP, Elifson KW, Sterk CE, Klein H. Perceived susceptibility to HIV among women. *Research on Aging*. 2003; 25:405–432.10.1177/0164027503025004004
- Whyte J, Whyte MD, Cormier E. Down low sex, older African American women, and HIV infection. *Journal of the Association of Nurses in AIDS Care*. 2008; 19:423–431.10.1016/j.jana.2008.08.001 [PubMed: 19007720]
- Winningham A, Corwin S, Moore C, Richter D, Sargent R, Gore- Felton C. The changing age of HIV: Sexual risk among older African American women living in rural communities. *Preventive Medicine*. 2004; 39:809–814.10.1016/j.ypmed.2004.03.005 [PubMed: 15351550]

Key Considerations

- Middle-age African American women engage in risk-taking sexual practices that may heighten vulnerability for HIV and STI transmission. The contributory influences are multifactorial and may be attributed to individual, social, cultural, and contextual dynamics.
- Although the women in this study were knowledgeable about HIV transmission and prevention, they often failed to accurately perceive their risk for HIV and continued to engage in risky sexual behaviors. Nurses and health interventionists should teach middle-age women appropriate the HIV self-risk appraisal skills necessary to accurately identify a prospective partner's risk for HIV.
- Health care providers should establish faith-based interventions and patient-peer support groups that encourage middle-age African American women to share the importance of safe sexual practices with their peers.
- Middle-age urban African American women are in dyadic relationships with men and must communicate more effectively with their partners about the risk of disease transmission. African American men should be included in future HIV education and prevention efforts for women; such efforts need to incorporate an understanding of gender-specific relationship factors, intimate partner violence, stigma, and nondisclosure of risk-taking sexual practices.

Figure 1.
Themes and Subthemes

Table 1

Sample Items From Interview Guide

What do African American women your age do to protect themselves from HIV?
What does safe sex mean to you?
What are your beliefs about condom use?
Why do some women practice safer sexual behaviors and some don't?
Do women talk to their partners about safe sex?
Do you talk to your partner about safe sex or condom use?
Do you need to consult with your partner about sexual decisions?
Did you use condoms at your last sexual encounter and what influenced your decision to use or not use condoms?
Who decides when you have sex or use condoms?