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Human ImmunoDeficiency Virus: Examining Critical Issues Associated With the Incidence in the South East Region of the United States

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Human Immunodeficiency Virus: Examining Critical Issues Associated With the Incidence in the South East Region of the United States

A Master Thesis

Submitted to the Faculty

of

American Public University System

by

Christopher L. Chandler

In Partial Fulfillment of the Requirements for the Degree of Master of Public Health

August 2015

American Public University

Charles Town, WV
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DEDICATION

I dedicate this thesis to my mother, sister, family, and close friends. Without their seamless support and relentless encouragement the completion of thesis work would not have been possible.
ACKNOWLEDGEMENTS

I would like to thank the faculty member for their support, encouragement, and willingness to provide their wisdom and knowledge throughout this process. I found the public health curriculum to be rigorous and stimulating. Overall, the program has provided me with all the tools to succeed in the field of public health.
ABSTRACT OF THE THESIS

Human Immunodeficiency Virus: Examining Critical Issues Associated With the Incidence in the South East Region of the United States

by

Christopher L. Chandler

American Public University System May 17, 2015

Charles Town, West Virginia

Dr. Carol Hoban, Thesis Professor

The study shall review the critical issues that relate to the Human Immunodeficiency Virus in the South East Region of the United States. More precisely these regions incorporate the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. More intently, the study shall scrutinize the aspects of access care and effective treatment plans, financial and housing assistance that is available and applicable, and prevention through awareness and education. Most importantly, the study shall scrutinize the existent programs and their effectiveness. The methodologies that will be applicable in the data collection process incorporate Literature review, focus groups, and observation. The HIV programs in the Southeast region of the United States operate in line with authoritative objectives, but they face challenges in eliminating and minimizing the HIV virus in the area. An all-inclusive framework is essential, and this will nurture new and robust HIV programs in
Southeast region of the US while enhancing the existent initiatives of the current HIV programs in the region.
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CHAPTER 1: INTRODUCTION

In the United States locale, over 1 million people are living with the Human Immunodeficiency Virus (HIV) (Kaplan, 2014). HIV is a serious infection, and anyone who contracts it must undergo treatment. If this lacks, the virus develops into Acquired Immunodeficiency Syndrome (AIDS) and one eventually dies. The object of the study is to review the critical aspects of HIV in regards to the Southeast Region of the United States. The states within the scope of the study encompass Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.

According to the CDC, the Americans diagnosed with HIV between the ages of 40 and 49 were approximately 37% of the population infected by HIV (Boehme et al., 2012). In addition, the African Americans accounted for about 48% of the infected population, and males accounted for approximately 72% of those infected. Moreover, approximately 21% of the Americans infected with HIV are not aware of their condition. In addition, majority of those who are aware have no access to adequate HIV care (Doshi et al., 2013). To review the features of HIV in the Southeast region, it is imperative to analyze the aspects of access care and effective treatment plans. In addition, it is crucial to review the aspects of financing, housing, prevention procedures, and the influence of the existent programs in these particular states. In the United States, the individuals living with HIV implement the use of antiretroviral treatment (ART), and this enables them to achieve a suppressed viral load. More precisely, they achieve a lower level of the virus.
The National HIV/AIDS Strategy deals with the reduction of new HIV infections, improving health outcomes among HIV positive individuals, and reducing the disparities that correlates with the virus (Morrell, 2010). The main program attributed to HIV reduction in the United States came into being upon the inception of an order by the head of state in 2013. The provisions of the executive order direct respective Federal entities to improve outcomes in line with the principles of the HIV care continuum with the aim of enhancing viral suppression among the Americans living with HIV. The HIV continuum incorporates HIV diagnosis, timely and reliable medical attention, and antiretroviral treatment (Duffus et al., 2009). The U.S. Centers for Disease and Control Prevention (CDC) states that, the first cases of HIV became evident over three decades ago in the US region. Since this period, over 1.5 million people have become victims of this virus, and over 500,000 people succumbed to it. Currently, over 1 million people are struggling with the virus. The National HIV/AIDS Strategy has come a long way in curbing the detrimental effects of the virus in the United States (Hoberg et al., 2013). Nevertheless, the Southern region of the United States exhibits the highest mortality rates and HIV infections in the country. The primary target of the NHAS is to eliminate the menace caused by the HIV virus in the Southern region of the United States.

The Southern part of the United States incorporates about 37% of the entire American population. However, over it accounts for over half of the cases that relate to HIV infections in the country (Kim et al., 2014). More intently, the rate of new infections
in the Southeast region is the highest. The rankings indicate that the Southeastern states of Florida, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee have the highest rates of infections (Table 1). In addition, HIV patients undergo the AIDS diagnosis when the ailment meets specific diagnostic criteria in line with the CDC standards (Merlin et al., 2014). The criterion incorporates their CD4 count and the presence of particular conditions attributed to AIDS. The Southeast region accounted for over 40% of new AIDS diagnosis in 2010, and the region has one of the highest AIDS diagnosis rates in the US.

The study shall review the critical issues that relate to HIV in each of the states in the Southeast region. The analysis of HIV is of utmost importance in all countries. Moreover, it is imperative for all governments, institutions, and scholars to conduct an in-depth research on the matters that concern HIV (O’Leary, 2010). Hence, it is crucial to formulate a research question in order to conduct an adequate study in relation to the critical analysis of HIV in the Southeast Region. Are the existent programs attributed to HIV adequately addressing the aspects of access care, treatment plans, finances, housing, prevention, and education in the Southeast region of the United States? It is crucial to conduct a thorough research in regards to the situation in the Southeast region of the United States. The healthcare system is the backbone of a nation, and there ought to be an improvement of the existing HIV related programs to achieve a stable and sustainable future for the Southeast region of the United States.
CHAPTER 2: LITERATURE REVIEW

The primary object of this section is to scrutinize the findings of various researchers that concern the influence of HIV programs in the Southeast region of the United States. More precisely, the analysis shall focus on three core areas in line with the given research question. The core areas include access care and effective treatment plans, financial and housing assistance, and prevention through awareness and education.

2.1. Access Care and Effective Treatment Plans

2.1.1. Access to Care

The National HIV/AIDS Strategy aims to coordinate the plans that relate to it with the plans of the Affordable Care Act (Norton et al., 2014). The ACA Act provides access to insurance services to individuals living with HIV in the Southeast region of the US. More intently, the provisions of the Act provide a platform for enhancements in the areas of access to health care and effective treatment plans (Penman et al., 2014). The provisions of the act articulate that the entities attributed to the Federal Government, State government, and the local, tribal, and community partners should ensure that all citizens have access to quality care. In addition, the healthcare personnel should always coordinate with all this entities to provide the people living with HIV/AIDS with the most appropriate treatment plans and access to care at all times.
A body named AIDS United came into being and formulated a multi-sponsored initiative that relates to public-private partnership access to care (A2C). The primary aim of this initiative is to increase the access to care and promote effective HIV healthcare. In addition, the initiative supports frameworks for Americans infected with HIV in the Southeast region (Pollini, Blanco, Crump & Zuniga, 2011). The program sought for Americans living below the poverty line. In addition, these individuals were aware of their HIV status but they were not receiving any HIV care or support services. The A2C initiative aimed to reach the remote areas of the Southeast region and several mandates guided the operations of the program. The mandates encompassed the systematic identification of personal barriers HIV positive individuals encountered in the process of accessing HIV care. Secondly, the A2C initiative endeavored to eliminate any barriers that relate to accessing HIV care by supporting various developments and intervention plans in the Southeast region (Poindexter, 2010). In addition, the A2C initiative embraced innovative approaches to promote access to HIV care and consistency in the provision of care at all times. However, the initiative encountered some challenges. The original intention of the program was to reach the remote populations by applying outreach strategies, but the appropriate resources were deficient in most cases.

The A2C program was a multi-site initiative, and the selection of sites had to incorporate the review by an external committee. The committee encompasses professionals in the fields of public health, program evaluation, and strategic
philanthropy, and HIV/AIDS (Sprague & Simon, 2014). Moreover, the selection criteria applicable to this committee incorporated the burden of need, geographical region, viability of the program design, and the objectivity of the proposed evaluation procedures. In addition, in line with the aspects of the individual community and local expectations, the target of the A2C initiative was to nurture diverse program models (Underhill, Dumont & Operario, 2014). In the process, the employed strategies, models, and the structures of the program of each site varied according to the site’s specific needs relating to the HIV care systems. Moreover, the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia had to formulate their program designs. The designs have to be in line with the strategies that highlight preliminary levels of evidence (Villegas et al., 2013). More precisely, several features were applicable in the HIV programs in relation to access to health care in these Southern states. The features incorporated the use of community health workers, peer/patient navigation, and motivational interviewing and care coordination (Table 2).

The funded projects within the A2C initiative nurtured organizational links that coordinate to minimize the barriers to HIV care. In addition, the links provide innovative solutions to persistent challenges relating to access of HIV care (Boehme et al., 2012). Furthermore, the organizational networks transformed the manner in which systems operate in the Southeast region of the United States. The A2C initiative focused on enhancing systematic change in the Southeast region of the US to promote sustainability
in the matters that concern the access to HIV care. More intently, the scope of the A2C initiative is in line with the three goals articulated in the NHAS strategy (Doshi et al., 2013). The three objectives incorporate reducing the number of Americans infected with HIV, increasing access to HIV care and improve the health outcomes for Americans living with HIV. The third goal is to minimize the health disparities that relate with HIV. The primary target of the A2C framework is to ensure that the second goal that concerns access to care and treatment plans is successful.

In line with the policy framework articulated in the NHAS, the A2C initiative works with Americans living with HIV in the Southeast region along the continuum of care. The initiative enhances the linkages to care by strengthening the links between HIV cares for Americans who are newly diagnosed with HIV in the Southeast region (Duffus et al., 2009). Moreover, the A2C initiative ensures that HIV positive Americans living in the Southeast region who have never had access to HIV care receive the appropriate care at the right time. Thirdly, the initiative reaches out to HIV positive Americans who dropped out of care in the Southeast region.

2.1.1.1. An Analysis of Access to Care in Alabama

Analyzing the situation in Alabama with respect to care various themes come into play. The first theme apparent in this state is the prevalence of delayed care (Kim et al., 2014). Americans living with HIV in Alabama had challenges linking with HIV care following diagnosis and most of the residents in the state lacked information about
starting antiretroviral treatment (ART). The second theme relates to the structure of social services and a framework in Alabama to link, re-engage, and support Americans living with HIV in the state. The AIDS Service Organizations in Alabama played a linking role to the clinics in the state. More precisely, they responded directly to the needs of Americans living with HIV in regards to accessing HIV care (Kim et al., 2014). Thirdly, the social workers in the clinics and AIDS service organizations play a crucial role in linking, re-engaging and retaining Americans living with HIV in care. The fourth theme relates to the enabling of spaces in Alabama. Hence, this enables the Americans living with HIV in this state will learn about available resources, programs, and HIV support (Kim et al., 2014). More intently, the incorporation of HIV-related studies in the educational curriculum of the schools in Alabama was lacking. In addition, Alabama had minimal health campaigns to sensitize people about HIV in some of its regions. It is imperative to increase sensitization campaigns in Alabama given the rising numbers of HIV infections in the Southeast region of the United States.

2.1.2. Effective Treatment Plans

Horberg et al. (2013) argued that it is imperative to review the issues that pertain to the available treatments for patients living with HIV in the Southeast region of the United States. More importantly, with some areas being poverty stricken it is crucial to ensure that effective treatment plans are accessible to Americans living with HIV. The public insurance programs principally Medicare and Medicaid meet an enormous
percentage of the cost of HIV/AIDS in the Southeast Region of the USA (Kaplan, 2014). The two programs avail health insurance facilities for more than 50% of the individuals who are living with HIV and receiving HIV care at the same time. The vitality of the Medicaid program as a source of funding for low-income Americans living with HIV will become sufficiently evident upon the full implementation of the Affordable Care Act in the Southeast region of the USA. Important to note, most of the states in the Southeast region rejected the Medicaid expansion despite the increasing rates of HIV infections in these particular areas. Out of the 9 states, it is only Kentucky that appreciates the notion of expanding Medicaid (Kim et al., 2014). Tennessee is still considering the possibility of expanding the Medicaid program. The states of Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, and Virginia rejected Medicaid expansion.

However, in the states accepting Medicaid expansion there is an existent disability requirement. Upon the full implementation of Obama care, there will be an extended coverage to nondisabled low-income Americans living with HIV in the Southeast region (Merlin et al., 2014). When it comes to ensuring low-income Americans living with HIV Medicaid plays a crucial role. More specifically, Medicaid can avail an adequate source of data that pertains to the types and costs of treatments delivered to some of the most vulnerable individuals with HIV. The data that relates to insurance claims comes in handy in monitoring HIV treatment without substantial additional investments because this data is available in the form of electronic records (Norton et al., 2014). The claims
data that relates to the Southeast Region of the USA will provide a comprehensive account of the treatment plans received from diverse providers across multiple platforms. The various platforms include outpatient, inpatient, laboratory, and pharmacy. In addition, the claims data incorporates the procedural codes that outline the treatment plans provided and their accompanying costs.

According to Morrell (2010), data that relates to insurance claims can provide information about the treatment plans of many Americans living with HIV in the Southeast region. However, another concern arises, the design of the claims data focuses on the billing function. Hence, they are deficient in the clinical detail that is vital in reviewing the treatment plans in the Southeast region of the USA. For instance, the claims data that relates to a laboratory test will only indicate if the conduction of the test was successful or not. It will not focus on the outcome of the laboratory test, and this outcome is crucial in examining the treatment plans of individuals living with HIV (O’Leary, 2010). In order for the review of the data that relates to treatment programs to be successful, it is prudent to scrutinize the diagnosis information that is available on insurance claims.

2.1.2.1. An Analysis of Treatment Plans in Florida

Sprague and Simon (2014) argued that, the primary target of adopting managed care plans is to enhance access to HIV care services while containing the costs involved. In Florida Medicaid, enrollment rates grew at an alarming rate of approximately 3 times
as fast as the population growth in the period between 1990 and 2010. The state’s Medicaid expenditures increased significantly in the same period. The Medicaid program that is available in Florida is the fifth in regards to Medicaid expenditure and is in the top 5 in matters of Medicaid enrollment (Sprague & Simon, 2014). In the past, Florida endeavored to minimize the costs that relate to Medicaid and the state introduced the Medicaid Managed Care (MMC). Two programs that relate to effective treatment plans operated under the MMC initiative. The programs are Health Maintenance Organizations and Provider Service Networks (Sprague & Simon, 2014). The HMO program incorporates the financing and delivery of comprehensive health care services and supplies for HIV patients into one entity. The PSN program is a consortium established and operated by health care providers in Florida or a conglomeration of affiliated health care providers in the state.

Medicaid pays health care providers directly so that they can avail the appropriate treatment plans to Americans Living with HIV. However, the Provider Service Networks program applies different managed care techniques to regulate the utilization and the cost of treatment plans available to HIV patients in Florida (Kaplan, 2014). The Agency for Healthcare Administration (AHCA) manages the entire Medicaid program in Florida, and it contracts the health maintenance organizations on a prescribed fixed monthly rate. The HIV patients in Florida have been accessing treatment plans at these rates since 1984. To expand Medicaid Florida
Introduced the Medicaid Provider Access System (MediPass), which is a primary care case management program available in the entire state. The MediPass programs enable medical practitioners to avail care coordination services and disease management services for patients living with HIV and are part of this program’s enrollment (Penman et al., 2014). Presently, more than 15 managed care program options in Medicaid are available to Americans living with HIV in Florida. Moreover, more than two-thirds of the residents in Florida are part of at least one managed care treatment program. Despite all these programs, the rates of HIV in Florida are still high with Florida having the highest HIV diagnosis rate as of 2010 (Table 1). Researchers believe that the factors that lead to the increase of HIV in Florida attribute to the state’s resistance to expanding Medicaid in line with the Affordable Care Act.

2.2. Financial and Housing Assistance

According to O’Leary (2010), the matters that pertain to housing have been a persistent problem for Americans living with HIV in the Southeast region of the USA. One of the most prevalent programs that relate to housing for HIV patients is the Housing Opportunities for Persons with AIDS. The management of this program falls under the US Department of Housing and Urban Development. The program caters for the housing needs of HIV patients through its formula frameworks (Pollini, Blanco, Crump & Zuniga, 2011). The allocation of financial resources occurs in line with a statutory formula that ensures eligible states and cities in the Southeast region get the appropriate funding that
can cater for their housing needs. The statutory formula is dependent on the cumulative AIDS cases in the Southeast region and respective area incidences (Sprague & Simon, 2014). The Centers for Disease Control and Prevention avail this data. The organizations that fund housing programs in the Southeast region incorporate secular entities, government entities, and faith-based entities.

Poindexter (2010) argues that, the faith-based entities in the Southeast of the United States play a vital role in availing housing facilities to Americans living with HIV in the region. Moreover, according to the National Congregations Study, more than 80% of many congregations engage in serving emergency needs. The needs include food, clothing, and shelter for HIV patients in the Southeast region of the United States. The religious entities, the community development fraternity, and the denominational non-profit entities also play a crucial role in addressing the housing needs. Moreover, these needs relate to patients living with HIV in the Southeast region of the US (Underhill, Dumont & Operario, 2014). The entities implement housing development programs that target the low-income Americans who are HIV positive.

The faith-based entities play a crucial role in availing housing services to the Americans living with HIV. In addition, they act as valuable partners in matters of advocating and addressing the needs of HIV-infected Americans in the Southeast region. The relationship between the housing challenges of Americans living with HIV and the adverse health and social outcomes is worth studying (Villegas et al., 2013). In cases whereby HIV-infected
individuals experience housing challenges, they undergo many troubles coping with their condition. More intently, the housing challenges make the HIV-infected individuals have difficulties in attaining higher suppression levels in regards to the HIV virus (Boehme et al., 2012). Due to the high depression, that housing challenges come with, an individual infected with HIV cannot withstand such high levels of stress, and they end up succumbing to death much earlier than anticipated.

According to Kaplan (2014), approximately a third of Americans living with HIV in the Southeast region are homeless, and many individuals who have HIV in this region face an imminent threat of being homeless. In addition, an enormous percentage of persons living with HIV in the Southeast region are unable to access the programs that relate to providing housing facilities. It is important to note that the housing programs help in ensuring the presence of secure, stable, and adequate housing facilities for individuals living with HIV. Moreover, the housing programs in the Southeast region also ensure that Americans living with HIV retain their houses if they have any (Doshi et al., 2013). More intently, the situations of homelessness and unreliable housing facilities correlate with a variety of health related effects on Americans living with HIV in the Southeast region.

There is a significant positive relationship between enhanced housing facilities for Americans living with HIV and better adherence to medication. More precisely, if an individual is infected with HIV and this particular person has access to adequate housing then the prescribed medication is more effective (Duffus et al., 2009). However, if an
individual lacks proper housing facilities, it is likely that this particular person will not respond positively to any medication administered to them.

According to Morrell (2010), adequate housing facilities are the primary determinants when it comes to matters that relate to enhanced utilization of health and social services, better health condition, and reduced HIV risk behaviors. More intently, if a person living with HIV lacks housing the HIV continuum principle cannot be successful in any way whatsoever. The elimination and minimization of the occurrence of the HIV infections among Americans in the Southeast is largely dependent on the available housing facilities (Horberg et al., 2013). Studies indicate that the periods attributed to homelessness among HIV positive individuals in the Southeast relate to increased rates of emergency department utilization and hospitalization. Any homeless American living with HIV in the Southeast is likely to visit the hospital more often than another person who lives in a stable home with a similar condition.

Kim et al. (2014) argued that, Americans living with HIV in the Southeast with inadequate housing facilities receive inappropriate health care services. Hence, the increased homelessness in the Southeast region is a critical factor that ever increases the rates of HIV infection in the states in this region. In most cases, the Americans living with HIV and with unstable houses do not manage to see the physician at the recommended intervals. Moreover, they experience detrimental clinical outcomes than those with stable homes (Merlin et al., 2014). The homeless, the unstably housed, or the
HIV-infected Americans in the Southeast who have housing needs are likely to lack a continuous medical care. Another concern is the response to antiretroviral treatment. In situations whereby there is a prolonged period of lacking adequate housing the individual exhibits poorer adherence to antiretroviral therapy. Lack of adequate housing facilities causes Americans living with HIV in the Southeast to respond poorly to antiretroviral therapy (Morrell, 2010). Antiretroviral therapy is the only lifeline for any individual who is already HIV positive. Moreover, if a person does not conform to the entire criterion set for antiretroviral therapy, then the results will be devastating. Antiretroviral therapy lengthens the lifespans of people living with HIV in the Southeast of the US, and if the treatment is not successful then that is very worrying.

According to O’Leary (2010), risk behaviors such as prostitution, drug abuse, and crime that relate to Americans living with HIV in the Southeast are prone to be higher among the homeless. The homeless individuals will undergo through periods of extreme depression and this makes them vulnerable to these risk behaviors. Prostitution is a menace in the Southeast region because the homeless HIV-infected individuals will accept any amount of money in return for sexual favors (Norton et al., 2014). A homeless person encounters many difficulties even if he/she is completely healthy and free of HIV. It is more disastrous for a person to be homeless and HIV-positive at the same time. Moreover, a homeless person living with HIV is most likely to engage himself/herself in activities of prostitution, crime, or drug abuse. Prostitution increases the rates of HIV
infection in the Southeast region of the United States. More intently, the main catalyst of a rise in prostitution is the lack of adequate housing facilities (Penman et al., 2014). In addition, engaging in drug abuse leads to contracting other chronic diseases like cancer. For instance, an HIV-positive individual who is addicted to alcohol may in the end also contract liver cancer on top of the existing HIV. Hence, this turns out to be chronic HIV, and the increase in mortality rates becomes evident. Housing is crucial and many factors depend on it, adequate housing is directly proportional to decreased HIV infection rates.

According to Poindexter (2010), Americans living with HIV in the Southeast region encounter high levels of discrimination when searching for adequate housing facilities. Hence, this also acts as a digressing factor to the well-being of these individuals. HIV-infected individuals in this region have trouble in accessing safe, decent, and affordable housing facilities and this is the case in both public and private housing programs. The stigma associated with HIV patients makes their access to adequate housing facilities become like a fantasy (Sprague & Simon, 2014). Thus, this contributes to the alarming rate of increasing HIV infections in the Southeast region. Discrimination attributable to HIV makes it extremely difficult for an individual who is HIV positive to access decent housing. In addition, some of the Americans living with HIV in the Southeast have an experience with drug abuse and the criminal justice system. It is next to impossible for individuals like this to rent or purchase a decent house especially if their condition becomes public knowledge (Underhill, Dumont & Operario,
2014). Hence, because of these high levels of discrimination in obtaining proper housing, the rates of HIV keep on increasing in the Southeast region. The existing programs attributed to Americans living with HIV in the Southeast are trying, but the discrimination issues still pose a significant challenge.

Analyzing the financial assistance, various programs aim to encourage Americans living with HIV to rejoin the existent workforce. Moreover, a majority of Americans living with HIV endeavor to rejoin the workforce so that they can make a livelihood (Villegas et al., 2013). However, discrimination still comes into play. The levels of discrimination in the workplace are extremely high. In any recruitment process, a medical test is mandatory and a job offer goes out the window the instant an employer discovers that a candidate is HIV-positive. Hence, Americans living with HIV in the Southeast region end up lacking enough housing options. It is hard to get employment with HIV and this makes HIV-positive individuals to end up being homeless or lacking adequate shelter and financial facilities.

The provision of housing facilities for Americans living with HIV in the Southeast is not an easy task, and the project is challenging and costly. Nevertheless, housing programs for Americans living with HIV are of utmost importance. HIV-infected Americans who manage to benefit from the available housing programs exhibit an improved physical and mental health and an increased capability to access and implement the appropriate treatment plans (Boehme et al., 2012). In addition, the HIV-infected
individuals manage to benefit from various social networks because their stress levels drastically lower. Moreover, the housing programs enable the Americans living with HIV in the Southeast region to obtain emotional support from other people with a similar condition in the region. The provision of housing services for low-income Americans infected with HIV minimizes the expenditures of the health care systems (Doshi et al., 2013). Hence, the healthcare systems are able to spare more resources for the attainment of the features of the three-continuum principle. Stable housing will enable Americans living with HIV in the Southeast to retain their employment and they will be able to adhere to the recommended treatment plans and medication regimens (Duffus et al., 2009). Stable housing for Americans living with HIV in the Southeast enables them to plan and implement long-term objectives that will ensure they increase their lifespans.

2.2.1. An Analysis of Housing Assistance in Tennessee

The main program that deals with housing issues in the state of Tennessee is the Housing Opportunities for persons with AIDS (HOPWA). The program came into being after obtaining authorization from the National Affordable Housing Act (Kim et al., 2014). The main object of the program in Tennessee is to provide resources and incentives that facilitate the obtaining of stable housing facilities for people living with HIV. The primary target of HOPWA in Tennessee is to provide housing assistance and facilities that assist the residents of the state to attain housing stability. Hence, in the process of availing a stable home for HIV-infected individuals the HIV-related programs
become more efficient. The program ensures that all people living with HIV in Tennessee access the appropriate treatment plans and they attain an increased lifespan (Horberg et al., 2013). The management of the funds that support the HOPWA programs under the docket of US Department of Housing and Urban Development (HUD). The US Congress administers the funds to HUD in every fiscal year. The awarding of the HOPWA funds occurs in line with a prescribed formula to all the eligible states, and Tennessee is an eligible state.

The Tennessee Housing Development Agency is the main body that deals with providing housing facilities for HIV-infected individuals in the state (Kaplan, 2014). At the inception of the HOPWA program in Tennessee, only Memphis and Nashville were the eligible areas that would benefit from the program. That posed a major challenge because many Americans living with HIV in the state could not access the advantages of the program. It was crucial to ensure that all HIV-infected individuals benefit from the HOPWA program. The state amended the geographical breakdowns that pertain to HOPWA program so that all the seven counties not eligible for the HOPWA program would also access housing facilities (Merlin et al., 2014). However, later on most of the counties were able to benefit as Eligible Metropolitan Statistical locales and various project sponsors dealt with the operations of these programs.

The Tennessee Department of health coordinates with various non-profit organizations to ensure that the Americans living with HIV are able to access adequate
housing facilities at all times. The Tennessee HOPWA program operates in line with the requirements of the US Department of Housing and Urban Development (Morrell, 2010). There are three main components of the HOPWA program in Tennessee. The first component relates to the aspects of mortgage, short-term rental facilities, and utility payment programs. The objective of this component is to certify that all the individuals living with HIV are able to access great mortgage plans and utility services that relate to stable housing facilities (Norton et al., 2014). The second component deals with the aspects of indirect costs and the program ensures that the prevalent costs of housing services are favorable to all the people living with HIV in the state of Tennessee. The third component links to the availing of supportive services such as case management, drug, and alcohol treatment services, counseling, and nutrition advice (O’Leary, 2010). There are several programs in Tennessee that deal with providing housing programs for Americans living with HIV. The programs include the New Hope Programs that is run by Frontier Mental Health, the Chattanooga CARES program, the Nashville CARES program, and so forth.

2.3. Prevention through Awareness and Education

According to Morrell (2010), the Centers for Disease control and prevention have the Heightened National Response program to address the HIV crisis in the Southeast region of the United States. Some researchers are of the opinion that the African American and Hispanic communities are the most affected by the HIV infection. The
situation is like that because of the rising poverty levels in these two communities. In addition, the aspects of crime and drug abuse also contribute to the increased cases of HIV infection in these two respective communities (Penman et al., 2014). The CDC programs in the Southeast region of the US endeavor to prevent HIV at any cost whatsoever. In addition, the CDC engages various partners in the prevention of HIV to ensure that the rates of HIV in the Southeast reduce drastically. Another program incorporated by the CDC is Act against AIDS. The program refocuses all the attention on the domestic HIV crisis in the United States (Pollini, Blanco, Crump & Zuniga, 2011). More specifically, this program aims to minimize the evident HIV menace that is prevalent in the Southeast region of the country. The CDC preventive programs in the Southeast region have come a long way in providing preventive services for HIV. However, it is still apparent that the rates of HIV infections in the Southeast are still high and it is imperative to act promptly.

The overall program that deals with the prevention of HIV in Southeast is the National HIV/AIDS Strategy. The inception of the program was in line with the three HIV continuums (Kim et al., 2014). The three continuums are reduction of HIV incidences, reduction of HIV-related health disparities and enhancement of access to care. The prevention of HIV in the Southeast is entirely dependent on these three continuums, and if the implementation of the NHAS strategy is successful then the rates of HIV infection in the Southeast will drastically reduce. In addition, the CDC launches
programs that aim to increase community-level understanding of HIV as a sexually transmitted disease (Poindexter, 2010). The CDC initiates numerous educational programs in the Southeast region to ensure that all individuals are aware of the various means of preventing the spread of HIV through responsible sexual behaviors. The programs initiated in the Southeast improve public health interventions, and this comes a long way in the prevention HIV spread in the region.

According to Sprague and Simon (2014), the public health intervention that is present in Southeast region aims to reduce the onset sex. Moreover, it reduces the numbers of sex partners and enhances the systems that promote safer sex behaviors. More intently, several programs in the Southeast always reiterate the importance of consistent and correct condom use at all times. The spread of HIV through irresponsible sexual behaviors is an enormous challenge in the Southeast region. Moreover, this factor contributes to the alarming rates of HIV infections in this region (Underhill, Dumont & Operario, 2014). Sexual transmission of HIV incorporates heterosexual and male-to-male transmission. In the Southeast locale of the United States, the incidences of this sexual transmission cases have been dominant. In addition, the incidences of rape in the male prisons also contribute significantly to the alarming rates of HIV in the Southeast. Sexual transmission of HIV accounts for about 90% of all the newly reported cases in the Southeast region (Villegas et al., 2013). Hence, if the prevention and educational
programs are to be successful in the Southeast region they have to combat the menace of sexual transmission of HIV at all times.

O ‘Leary (2010) argued that, injection drug use is another problem in the Southeast region, and its effect has become significant in the recent past. In some areas in the Southeast, the rates of drug abuse are significantly high. Moreover, in most cases, individuals end up injecting themselves by using the same syringe, and this contributes significantly to the increased rates of HIV in the Southeast region (Penman et al., 2014). The CDC launches many campaigns to educate the citizens about the dangers of injection drug use. However, CDC has not been entirely successful in achieving this purpose. The high levels of poverty among some communities in the Southeast contribute to the increased cases of drug abuse. In addition, many Americans living with HIV in the Southeast undergo extremely high levels of depression. Thus, this makes them forget the dangers of injection drug use in many scenarios (Pollini, Blanco, Crump & Zuniga, 2011).

Various programs in the Southeast have come into being, and the aims of these programs are several. The CDC being at the center of taking precautionary measures has set out various targets that aim to abrogate the spread of HIV in the Southeast (Poindexter, 2010). The first target is to ensure that Americans living with HIV grasp the concepts of the factors that make them spread the HIV infection. The factors include high levels of poverty, decreased access to preventive and required health care, and
discrimination. In addition, among some communities, there exists disrupted social networks and this causes higher levels of incarceration (Sprague & Simon, 2014). Many Americans living with HIV face the above challenges on a daily basis. Putting these challenges into consideration, an infected person might act misguided and opt to spread the HIV infection to other people. The CDC endeavors to educate such kind of people on the various ways of alleviating stress and in the process preventing the spread of HIV infection in the Southeast.

The second target of the CDC is to expand HIV testing and access to medical care (Underhill, Dumont & Operario, 2014). HIV testing for people living with HIV is of utmost importance because it is a beginning step towards acceptance and attaining a viable solution. It is crucial for individuals living with HIV in the Southeast to comprehend their health status. Comprehending one’s health status enables the execution of prevention actions at all times. If an individual accepts his/her condition and decides to engage in the appropriate medical care, then the prevention of the spread of HIV has a chance of success (Villegas et al., 2013). The CDC invests substantial resources in programs that aim to test individuals for HIV in the Southeast region of the US. Thirdly, the CDC initiates new interventions and it scales up the availability of effective interventions in the Southeast region. The initiation of new HIV prevention programs in the Southeast is extremely vital. The Center for Disease Control sponsors many community-based organizations in the Southeast region (Boehme et al., 2012). The
Community-based organizations in the Southeast region reach out to many people living with HIV in this region. The CBOs provide counseling services, access to appropriate care, housing, and employment opportunities to persons infected by HIV (Doshi et al., 2013). Hence, this comes in handy in the HIV prevention initiative in the Southeast. In addition, the CDC facilitates the activities of existing community-based organizations and faith-based organizations in the Southeast. It does this by offering more funding and availing a professional workforce that can engage in the activities of the community-based organizations.

Finally, the CDC mobilizes the Americans living with HIV in the Southeast region to combat the menace that faces them (Duffis et al., 2009). A person in a similar situation to an infected individual has a better chance of making a difference as opposed to an individual in a different situation. More precisely, the Americans living with HIV in the Southeast have a better chance of encouraging better outcomes within themselves when they encourage each other. It is crucial to mobilize the people living with HIV. They can spread the word that relates to the three continuum principles, and this will be in line with the NHAS (Horberg et al., 2013).

According to Kaplan (2014), it is crucial to review the pregnancy in relation to HIV prevention. Many women may face an imminent risk of contracting HIV during pregnancy and postpartum. Reviewing the risk of women contracting HIV during this period is crucial because it allows for the formulation of optimal prevention programs.
Most importantly, the prevention of mother-to-child HIV transmission has to be successful in all scenarios to minimize the rates of HIV infections in the Southeast of the USA (Kim et al., 2014). Antenatal HIV testing is mandatory to discern HIV-infected women who require engaging in antiretroviral therapy. Prompt isolation of the HIV before giving birth prevents mother-to-child HIV transmission and it enhances the levels of maternal health. In some cases, women may test negative for HIV in the antenatal period. Thus, this makes these particular women feel extremely confident about their safety and that of their unborn children (Merlin et al., 2014). Nevertheless, a woman might contract HIV during the pregnancy or postpartum period and this condition may remain undetected if repeat tests are not evident. Various programs in the Southeast region of the US recommend repeat tests during the third trimester or at delivery in a serene environment. In most cases, the aspects of repeat testing are not successful and this causes an increase in the rates of HIV infection in the Southeast region.

Morrell (2010) argued that, the lack of retesting procedures during the pregnancy and postpartum periods indicates a missed opportunity to identify women who have recently contracted the HIV infection. Moreover, such women pose a high risk of increasing mother-to-child transmission because they possess high viral loads during incident infection. The HIV prevention programs in the Southeast of the USA initiate antiretroviral therapy programs. The programs aim to prevent Mother to child HIV transmission by all possible means among HIV-infected mothers that did not manage to
access antenatal care and lacked HIV testing during pregnancy (Norton et al., 2014). The incidences of HIV infection during pregnancy and the postpartum period are high in the Southeast. Moreover, there are increased incidences of HIV infections among women in the pregnancy and postpartum periods as compared to non-pregnant women.

The HIV preventive programs in the Southeast offer several solutions for preventing HIV transmission from the mother to the child. The first solution is offering repeated HIV testing to women in high prevalence settings such as the Southeast region of the USA (O’Leary, 2010). Hence, this enables the detection of incident HIV infections and the diagnosis of women in the postpartum period that did not receive antenatal care. The approach acts as an endowment because it enables the early detection of maternal HIV infections. In addition, women are able to access the appropriate HIV care treatment in a prompt manner (Penman et al., 2014). Programs in the Southeast of the USA encourage maternal antiretroviral therapy during pregnancy as the best option in scenarios of high maternal viral loads during incident infection. Secondly, the HIV preventive programs in the Southeast promote the wider distribution of more sensitive HIV tests. The tests incorporate the fourth-generation rapid test, and this enhances early detection of incident HIV infections (Pollini, Blanco, Crump & Zuniga, 2011). The fourth-generation tests have the capability to detect HIV antibodies and HIV p24 antigen, and this minimizes the rates of HIV infection among the women who contracted HIV early and are incorrectly categorized as being HIV negative. Finally, the HIV preventive
programs in the Southeast advocate for continued counseling on the need for condoms to prevent HIV transmission during the pregnancy and postpartum periods.

2.3.1. An Analysis of Prevention through Awareness and Education in Georgia

Many programs that aim to advocate continuous prevention in Georgia among populations at risk of contracting HIV infection have been operating for a long time. The objective of the existent programs in Georgia is to raise awareness, increase knowledge and change behavior of key populations in the state including both HIV positive and HIV negative individuals (Poindexter, 2010). In the year 2000, the initiation of HIV preventive programs that aim to educate female sex workers were common in Georgia. Moreover, in the year 2004, many programs came into existence to educate men who have sex with fellow men on the appropriate HIV prevention procedures (Sprague & Simon, 2014). The Georgia HIV preventive programs have had a massive impact in the state, but the rates of HIV infection are still extremely high. The HIV preventive programs in Georgia implement various intervention packages. The first step taken by HIV prevention program is conducting individual counseling (Underhill, Dumont & Operario, 2014). Individual counseling comes a long way in preventing the spread of HIV infections in Georgia. It is crucial to ensure that all the individuals living with HIV in Georgia have peace of mind, and this minimizes the rates of HIV infections.

The second initiative taken by HIV preventive in Georgia is reaching out to places of aggregation. To realize optimal HIV preventive systems, it is imperative to
reach out to a vast portion of people infected with HIV (Villegas et al., 2013). For instance, in the state of Georgia it would be prudent to reach out to areas whereby female sex workers are prone to exist. Hence, this will ensure minimal levels of prostitution and it will enhance the systems that cater for responsible sexual behavior. Thus, this will act as a significant step towards achieving an optimal HIV prevention system. Thirdly, the HIV preventive programs in Georgia provide for the features of HIV counseling and testing. Apart from conducting individual counseling, it is important to conduct a general HIV counseling of the affected areas in Georgia. Hence, this enables newly HIV-infected individuals to adapt to their new condition and take precautionary measures (Boehme et al., 2012). Moreover, HIV-infected individuals in Georgia become aware of antiretroviral treatment and the best HIV care practices.

The Georgia HIV preventive programs engage in peer education and provision of condoms to the individuals infected with HIV in the state (Kaplan, 2014). Responsible sexual behavior is of much significance in the matters that concern HIV preventive programs. Moreover, the principal manifesto of all HIV prevention programs in Georgia should be nurturing responsible sexual behaviors. The rates of HIV transmission attributable to irresponsible sexual behaviors account for a higher percentage of HIV infections (O’Leary, 2010). Hence, it is vital to certify that the people infected with HIV in Georgia grasp the concept of appropriate sexual behaviors. Provision of condoms is of utmost vitality, many people infected with HIV in Georgia are below the poverty line. An
initiative aimed at providing condoms to such individuals comes a long way in preventing the spread of HIV in Georgia (Sprague & Simon, 2014). In addition, peer education groups also help in realizing the authoritative objectives of the HIV preventive programs in Georgia.
CHAPTER 3: THEORETICAL FRAMEWORK/APPROACH

To abrogate the spread of HIV in the Southeast region of the United States, it is mandatory to implement an all-inclusive framework of the concerned stakeholders (Norton et al., 2014). The Federal government, the State governments, the community-based organizations, and the religious based organizations should all work as a unit to achieve a unified purpose. The Federal and State governments should ensure that issues such as stigma and discrimination become extinct in the Southeast region of the country. The stigma associated with individuals infected with HIV is extremely high in the Southeast, and this increases the rates of HIV infections in the region.

It is crucial to accept the persons living with HIV as part of the community and endeavor to encourage them at all times so that they might also act as an endowment in the society. The motive of this section is to review gaps in the available literature that relates to the impact of HIV programs in the Southeast of the USA. More intently, the section shall scrutinize how this dissection shall assist in filling these gaps, and it shall justify the theories and models applicable to the study. Moreover, this section of shall outline several hypotheses that relate to HIV programs in Southeastern Region of the US. The study shall review several theories that relate to HIV programs in the Southeast region of the USA. The theories encompass the Protection Motivation Theory (PMT), the Four-Phase Model (FPM) (Boeheme et al., 2012). Furthermore, the approaches also
include the Disclosure Decision Making Model (DDMM), and the Disclosure Process Model (DPM) (Doshi et al., 2013).

In the past, the review of the effectiveness of HIV programs in the Southeast region of the United States has been evident. Many researchers have made significant contributions in regards to evaluating the effectiveness of HIV programs in the Southeast region of the country. However, many researchers tend to ignore the weight that the matters of stigma and discrimination carry in the effectiveness of HIV programs in the Southeast region of the United States (Duffus et al., 2009). In addition, there is a notion that HIV is more prevalent in the African American and the Hispanic community that resides in the Southeast of the USA. Some researchers believe that this is so because of the increased levels of poverty among these communities. In addition, they believe that the rates of HIV are high in the African-American and Hispanic communities because of the existence of inappropriate social networks among these communities. Even if this is the case, it is imperative to refrain from discriminating these two communities (Horberg et al., 2013).

It is mandatory to approach the HIV issue in a prudent way in the Southeast region of the USA. The present HIV programs have to ensure that individuals from all races are on board with their respective initiatives (Kaplan, 2014). Some programs openly discriminate the African-American and the Hispanics, and this is a digressing factor. The success of the HIV programs in the USA is entirely dependent on the inclusiveness of all
races. If a particular group discerns any gesture that seems to be discriminatory, then this specific group might opt to engage in misguided activities. Such activities include unprotected sex and drug injection uses (Kim et al., 2014). Hence, it is mandatory to ensure that no race or group feels discriminated in any way whatsoever. Such procedures will guarantee the success of the HIV programs in the Southeast region of the USA in all instances.

Many researchers in the past gave a cold shoulder to the discrimination issues that encounter the African American and Hispanic communities in the Southeast region of the United States (Merlin et al., 2014). The rates of HIV infections in these two communities are extremely high, but the existent programs have to be professional about this and refrain from discriminatory gestures at all times. The HIV programs in the Southeast region try their level best, but the HIV menace in this area is still evident. One of the aspects that inhibit the efficiency of HIV programs in the Southeast is the high level of discrimination and stigma towards some communities residing in the region.

3.1. Protection Motivation Theory

According to Morrell (2010), the Protection Motivation Theory is a social cognitive theory that relates to behavioral change. Moreover, it exhibits relevant social, cultural, cognitive, and psychological variables related to behavior and changes in one’s behavior. The PMT theory reviews the coupling of the environmental and social factors combined to pose a potential threat to the people living with HIV in the Southeast region
of the United States. In addition, the theory scrutinizes the aspects of a maladaptive response (Norton et al., 2014). Maladaptive response relates to a situation whereby the individuals infected with HIV in the Southeast region of the USA encounter difficulties in adapting to their current situation. The successes of the HIV programs in the Southeast of the USA are dependent on the adaptation capabilities of individuals infected with HIV in the region. More precisely, if the HIV-infected individuals in the Southeast accept their condition and adapt to it, then the HIV programs will be extremely effective in the region.

O’Leary (2010) argued that, the factors that influence the adaptation levels of HIV-infected individuals in the Southeast incorporate a balance between rewards accompanying their behaviors. More specifically, individuals infected with HIV in the Southeast will only adapt to their condition if the HIV programs ensure that a positive outcome becomes evident in the lives of these infected individuals. After these individuals access the various HIV programs in the Southeast, they should transform positively, and this will make them accept and adapt to their HIV status. Analyzing the aspect of rewards, there are two types of rewards, and these are the intrinsic rewards and the extrinsic rewards (Penman et al., 2014). The intrinsic rewards deal with the influences of individual factors. More precisely, intrinsic rewards examine the positive outcomes that a particular person will realize if he/she manages to access a particular HIV program in the Southeast. The extrinsic rewards analyze the impact of perceived societal, peer, and
parental factors. After an HIV-infected individual manages to access an HIV program the individual’s parents, peers, and the society should accept this person fully. Extrinsic rewards examine the levels of acceptance after an individual accesses an HIV program (Pollini, Blanco, Crump & Zuniga, 2011). Acceptance is crucial, and if the society does not coexist with HIV-positive individuals, it will be extremely difficult for these individuals to adapt to their condition.

Poindexter (2010) argued that, another significant factor is the perceived severity, and HIV-infected individuals in the Southeast have to embrace the available HIV programs in the region. If the individuals infected with HIV in the region obtain an adverse impression about the program, they might opt to ignore the programs and this will be catastrophic. The HIV programs in the Southeast of the United States should have a good reputation among individuals living with HIV (Sprague & Simon, 2014). The HIV positive individuals should never have a negative perception of the existent HIV programs in the Southeast. Instead of them having a perceived severity, they should have a perceived enthusiasm about the existent HIV programs in the Southeast region of the USA. The aspect of personal vulnerability also comes into play. An individual living with HIV in the Southeast region of the USA should not feel vulnerable in any way whatsoever when accessing the HIV programs (Underhill, Dumont & Operation, 2014). The HIV programs should be receptive to the infected persons and they should not make these individuals feel inferior in any way. Many HIV-infected individuals ignore the
available programs because they fear that engaging in the HIV programs would incorporate discrimination against them.

According to Villegas et al. (2013), the Protective Motivation Theory emphasizes the aspects of adaptability to a particular condition. Adaptability is of utmost importance to the people living with HIV in the Southeast region of the USA. More precisely, adaptability depends on several aspects such as the response efficacy, self-efficacy, and the response costs. The response efficacy relates to the perceived likelihood of an action reducing a threat (Boehme et al., 2012). An HIV-infected individual must not have any doubts regarding the effectiveness of the HIV programs in the Southeast region of the USA. Hence, these individuals should be confident that engaging in the available programs would reduce the HIV threat that is facing them. Once these individuals obtain confidence in the available programs in the Southeast, their adaptability levels will drastically increase. Self-efficacy refers to the ability of an individual to adapt to a particular situation (Doshi et al., 2013). The available HIV programs in the Southeast should enhance the abilities of the HIV-infected individuals to adapt to their HIV status.

Duffus et al. (2009) argued that, there are various viable initiatives available to HIV-related programs. Hence, these actions improve the infected individual’s self-efficacy levels. The actions include counseling, engaging the community-based organizations, and engaging in peer support activities. Finally, the Protective Motivation Theory examines the response costs, and this refers to the barriers and inconveniences of
accessing the HIV-related programs in the Southeast. The individuals living with HIV in the Southeast should be able to discern that the HIV programs available in the locale will act as an endowment to them (Horberg et al., 2013). If this happens, they will not worry about the barriers and inconveniences involved in accessing the HIV programs. Hence, they will be more than enthusiastic to engage in the available HIV programs in the Southeast region of the United States.

3.2. The Four-Phase Model

According to Kaplan (2014), the four-phase model relates to a framework that aims to understand the feelings and concerns of any patients who are suffering from a terminal illness. In addition, the theory scrutinizes the series of stages through which the patients with terminal diseases may have to endure. More intently, the four-phase model reviews the perspectives of dying people and their families. The four-phase model serves as a guide of disclosing one's HIV status to a loved one (Kim et al., 2014). Disclosure of one’s HIV status to their loved ones is a milestone that many people in the Southeast locale of the US have to deal with. The effectiveness of HIV programs in the Southeast will also depend on the aspects of disclosing one’s status to their loved ones. When an infected person gains the courage to reveal his/her status to a loved, then the HIV programs have a chance of success. Moreover, the individuals who are close to the infected patients play a massive role in offering support and encouragement (Merlin et al., 2014). The support and encouragement provided enables the HIV-infected patients to
embrace HIV-related programs. Hence, in the process the rates of HIV infection drastically reduce.

According to Morrell (2010), disclosure is of utmost vitality, and it is imperative for an infected person to be open about his/her HIV status. Being open will enable the infected person to obtain the help that he/she needs. The Four-Phase Model describes the disclosure process as a continuum that incorporates four phases. The four phases include the secrecy phase, the exploratory phase, the readiness phase, and the disclosure phase (Table 3). However, not all individuals experience disclosure problems, but in most cases, the sequence depicted in Table 3 carries the day. In the secrecy phase, the infected individual maintains the utmost levels of secrecy and confidentiality (Norton et al., 2014). The secrecy phase is one of the hardest periods that an infected individual has to endure. Moral support is of utmost importance, and if a person infected with HIV keeps things inside the situation might become detrimental to the HIV patient. More intently, in the secrecy phase the HIV programs will not be very effective. The professionals in the respective HIV programs in the Southeast of the US will not be able to obtain the support of the infected individual’s loved ones in the secrecy phase (O’ Leary, 2010). The effectiveness of the HIV programs becomes limited in the secrecy phase because there is a lack of support from the loved ones of the HIV patient.

Penman et al. (2014) argued that, in the exploratory phase, the infected individuals begin to associate with people in similar conditions. The exploratory phase is
vital because an infected person will obtain encouragement from people facing similar situations. Thus, this is crucial because of the responsiveness of the patient to the available HIV programs in the Southeast will be positive. In addition, the professionals in the various HIV programs have an easier time. That is the case because the infected individual has a platform to talk about the experience he/she is going through (Pollini, Blanco, Crump & Zuniga, 2011). Moral support is important to the work done by HIV programs in the Southeast of the US. More precisely, if the infected individuals lack moral support from people in similar situations, then the HIV programs might not be effective.

According to Sprague and Simon (2014), in the readiness phase, an individual infected with HIV begins to prepare himself/herself psychologically before disclosing the HIV status to a loved one. The effectiveness of HIV programs in the Southeast region of the United States depend on the aspects articulated in the Four-Phase Model (Poindexter, 2010). In many instances, the concerned stakeholders do not pay attention to the issues set out in the FPM model. In all scenarios, the responsiveness of the individuals living with HIV in the Southeast will depend on the dimensions set out in the FPM model. Moreover, if a person is not ready to disclose his/her status to a loved one, then this person is likely not to benefit adequately from the HIV programs in the Southeast region of the US.
Finally, in the disclosure phase, HIV-infected people gain the courage to reveal their status to their loved ones (Underhill, Dumont & Operario, 2014). Hence, in this stage the effectiveness of the HIV programs in the Southeast becomes extremely high. Disclosure is vital, and it is necessary for HIV-infected individuals to be frank so that they can access the assistance required promptly. It is imperative to ensure that the HIV patients in the Southeast of the US have a longer and healthier life. Presently advanced therapies are available for HIV patients in the Southeast region (Villegas et al., 2013). Moreover, many HIV programs in the Southeast have become aware that HIV is not only a fatal disease but also a chronic one. The HIV programs in the Southeast of the US have to incorporate the features of the Four-Phase Model when formulating their authoritative objectives. Disclosure of one’s HIV status to a loved one is not easy, and it entirely affects the effectiveness of the HIV programs operating in the Southeast of the US.

3.3. Disclosure Decision Making Model

Boehme et al. (2012) argued that, it is imperative to understand the decision-making process that relates to disclosure of one’s HIV status. Disclosure is necessary because an HIV-positive individual will not be able to benefit from any program in the Southeast if he/she dies not disclose the HIV status. More precisely, the success of any HIV program is entirely dependent on if the infected individuals will disclose their status or not (Doshi et al., 2013). It is crucial to know when, why, and how HIV-infected individuals will disclose their status. The HIV programs in the Southeast have to be
aware of these aspects so that they can plan adequately for any initiative aimed at reducing HIV infections. The Disclosure Decision Making Model incorporates the aspects of several HIV-related theories. The HIV-related theories include social influence theory, disease progression theory, and the consequence theory (Table 4).

According to Duffus et al. (2009), the decision-making models with different perspectives incorporate various factors as the antecedents to disclosure or non-disclosure. More specifically, different individuals undergo variant process before they decide to disclose their HIV status to anyone. In addition, a particular background setting enables HIV patients to disclose their status to their loved ones or to professionals. Disclosure is crucial to the success of HIV programs in the Southeast of the United States, and many HIV models and theories focus on the features of the disclosure (Horberg et al., 2013). Important to note, is that several factors influence disclosure in different relationships. More intently, the aspects of a disclosure are of extreme vitality in a sexual relationship. An HIV-infected individual should be courageous enough to be honest with his/her spouse or a sexual partner. In the Southeast locale of the US, the rates of HIV infection attribute to sexual transmission in most cases. Hence, it is imperative for the HIV programs in the area to emphasize the importance of disclosure especially between two people in a sexual relationship (Kaplan, 2014).

Kim et al. (2014) argued that, the Disclosure Decision Making Model also focuses on the influence of stigma on disclosure. Stigma in the Southeast region of the United
States is a menace that the existent HIV programs in the area have had to deal with. In addition, if an infected individual discerns the features of stigma in any environment, then this particular person will think twice before opening to anyone. Moreover, the model focuses on the individual cognitive or motivational factors that influence the levels of disclosure among infected patients (Merlin et al., 2014). More specifically, most HIV patients in the Southeast of the US experience problems with ego system motivations. Hence, they protect and inflate a desired self-image about themselves. In addition, the aspects of ego hinder the HIV-infected patients in the Southeast from accessing the HIV care and support required (Morrell, 2010). It is imperative for the HIV patients to accept help, and this will be a major progress on the part of the HIV programs in the Southeast region of the United States.

According to O’Leary (2010), the model also focuses on the ecosystem motivations of disclosure. It is crucial to embrace an environment that makes HIV-infected individuals to be comfortable with the process of disclosure. In addition, the ecosystem motivations incorporate contributing to the affairs of infected individuals or supporting them in any way whatsoever. Moral support is a critical component to disclosure, and if a person lacks the moral support then the effects become detrimental (Penman et al., 2014). The Disclosure Decision Making Model also reviews the expectations of infected individuals concerning disclosure. The decision-making process that pertains to disclosure has to relate to the infected individual’s expectations and
projections of benefits or risks of full disclosure. Before the HIV-infected individuals decide to disclose their status, they have to analyze the benefits or the risks that come with the disclosure (Pollini, Blanco, Crump & Zuniga, 2011). If the benefits outweigh the risks, then they will open up about their condition. However, if the risks outweigh the benefits, it will be extremely difficult for the infected individuals to disclose their status.

Underhill, Dumont and Operario (2014) argued that. The HIV-infected individuals in the Southeast make the ultimate decision on whether to disclose or conceal their status based on anticipated outcomes. The first benefit that relates to disclosure is the relief from stress that originates from maintaining secrecy. Secondly, disclosure enables the HIV-infected individuals to stop worrying about their loved ones discovering the truth from another source (Poindexter, 2010). In addition, disclosure facilitates the support from loved ones, and in the process, the existent HIV programs become successful. However, disclosures also come with risks. The risks encompass rejection from loved ones and discovery of other family secrets such as drug use (Sprague & Simon, 2014). In addition, one’s loved ones might decide to disclose their HIV status to third party individuals and this leads to discrimination and stigma. Disclosure also depends on individual and environmental variables such as demographic aspects, family relationships and the values of the community (Villegas et al., 2013). In addition, some HIV-infected individuals might opt to refrain from disclosing their status to protect their loved ones. Disclosure of one’s HIV status might affect the lives of their loved ones in a
negative way, and many HIV positive individuals may opt to keep it inside. The successes of the HIV programs in the Southeast of the USA depend on the factors of disclosure (Boehme et al., 2012). It is prudent for the HIV programs in the region to nurture a framework that enhances the levels of disclosures among infected individuals.

3.4. The Disclosure Process Model

According to Doshi et al. (2013), the model reviews the feature of a disclosure among the HIV-infected individuals living in a stigmatized environment. As shown in Table 5, the Disclosure Process Model incorporates three interrelated stages, and this includes decision-making, the disclosure event, and outcomes. The decision-making stage will influence the disclosure event in several aspects (Duffus et al., 2009). The aspects include content of the disclosure and the reaction of the targets. An HIV-infected individual will make a decision on the contents that need disclosures. For instance, an individual might be HIV-positive, and at the same time a drug addict. However, the individual might only disclose his/her HIV status and conceal the fact that he/she is a drug addict (Horberg et al., 2013). Hence, the decision-making stage influences the disclosure event in all circumstances. The disclosure event will affect the outcome of disclosure in three mediating ways, and these ways include alleviation of inhibition, social support, and changes in social information. More precisely, once an HIV-infected individual disclose their status the first thing that happens is that the patient stops being embarrassed about their prevalent condition (Kaplan, 2014). Secondly, the HIV-infected
individuals obtain social support immediately they decide to come clean with their condition. Thirdly, social information that is vital to the HIV programs in the Southeast of the US becomes available (Kim et al., 2014). Moreover, the HIV programs can formulate their authoritative objectives based on this social information obtained because of a disclosure event.

Merlin et al. (2014) argued that, the changes in social information relate to a situation whereby the HIV-infected individuals are aware that their status is out in the open. In addition, their loved ones and the existent HIV programs also obtain valuable information and act upon it accordingly. As shown in figure 8, the outcomes of a disclosure event might also influence future disclosure decision-making procedures via a feedback loop. The projections of benefits and risks always come into play in all aspects of a disclosure (Morrell, 2010). More intently, the impact of HIV programs in the Southeast of the United States depends on disclosures, and the disclosures depend on projected benefits and risks by HIV-infected individuals. The Disclosure Process Model also scrutinizes the aspects of unplanned and indirect disclosure events. When individuals discover that they are HIV-positive, they undergo tremendous pressure. In some cases, they have to give in and disclose their status to their loved ones (Norton et al. 2014). Unplanned disclosure refers to a situation whereby infected individuals expose the truth about their HIV status unknowingly. Indirect disclosure relates to a scenario, whereby infected individuals knowingly reveal the truth about their HIV status but in a concealed
manner (O’Leary, 2010). More precisely, in cases of indirect disclosure, the infected individuals beat around the bush and they avoid getting directly to the point at hand.

According to Penman (2014), the outcomes of disclosure are of much importance to the HIV programs running in the Southeast region of the United States. The Disclosure Process Model analyzes the consequences of exposure at three distinct levels. As shown in figure 8, the levels encompass the individual level, the dyadic level, and the social level. In the individual level, the HIV-infected individuals might experience psychological distress. The distress originates from the reactions of their loved ones upon becoming aware of their HIV status (Pollini, Blanco, Crump & Zuniga, 2011). In addition, the HIV-infected individuals might begin to adhere to clinical visits and appropriate antiretroviral treatment procedures at all times. In the end, at the individual level, the health of the infected individuals improves in massive ways. In the dyadic level, the HIV-infected individuals become aware of the sexual risk they pose to other individuals, especially those with whom they have an intimate relationship (Poindexter, 2010). Hence, they take preventive measures such as embracing protective sex to ensure that their loved ones do not contract the HIV infection at any point whatsoever. More intently, in the dyadic level the concern of the infected individuals is the wellbeing of their loved ones in all scenarios. In the social level, the infected individuals become aware of their status. Thus, they take the initiative to go for testing and encourage other
infected persons who are experiencing challenges with disclosure (Sprague & Simon, 2014).

3.5. Statement of Hypotheses to be Tested

According to Kim et al. (2014), the Disclosure Process Model reviews the potential effects of disclosure in the Southeast region of the United States. The effects include increased educational programs that relate to HIV and a reduction in HIV-related stigma in the Southeast region. In addition, disclosures enable the social discussions of HIV and the enhancement of HIV-risk reduction behaviors such as HIV counseling and testing activities (Underhill, Dumont & Operation, 2014). The testing of several hypotheses can occur to establish if disclosure affects the mechanism of psychosocial or clinical outcomes. By extension, the testing of the hypotheses examines if the aspects of an exposure affect the effectiveness of HIV programs in the Southeast region of the United States. The hypothesis that needs to undergo testing includes:

1. The existent programs attributed to HIV in the Southeast of the US operate effectively, and they provide adequate access to care and treatment plans.

2. The HIV programs in the Southeast of the United States avail adequate services in regards to finances, housing, and prevention and education programs.

3. HIV programs face challenges in the Southeast of the USA, and the alleviation of these challenges depends on the aspects of a disclosure.

4. Disclosure can eliminate the psychological stress that relates to embarrassment.
5. The psychological stress of embarrassment associates with the outcomes of disclosure such as treatment adherence.

6. Social support mediates the association between disclosure and its outcomes.

7. Disclosure might facilitate improvement of certain outcomes.
CHAPTER 4: RESEARCH DESIGN/METHODOLOGY

The testing of the articulated hypothesis will focus on the states in the Southeast region of the United States. More precisely, this section shall analyze the impact of HIV programs in the Southeast on the aspects of care, treatment plans, housing, finance, and housing. In addition, this section aims to scrutinize the aspects of the disclosure and their effect on HIV programs in the Southeast region of the USA. The data applicable in this section will originate from various methods of data collection. The applicable methods of data collection will include a literature review, focus groups, survey, and observation (Villegas et al., 2013). More intently, the section shall scrutinize the effect of HIV programs in the Southeast region of the United States. The dependent variable is the impact of HIV programs in the Southeast region of the United States. The independent variables relate to the aspects of access care and treatment plans, financial and housing initiatives, and disclosure (Boehme et al., 2012). In addition, the features of preventive procedures also fall under independent variables. The independent variables will influence the dependent variable, which is the effectiveness of HIV programs in the Southeast region of the USA.

4.1. HIV Disclosure among African American Women in the Southeast of USA

The study reviewed the relationship between HIV disclosure, social support, and depression among 340 participants residing in the Southeast of the USA. The aspects of social support that were under examination included perceived availability of programs,
sources of available programs and satisfaction of available programs (Kaplan, 2014). In addition, the relation of these aspects with depression and disclosure were also under consideration in the study.

4.1.1. Method

The method applicable incorporated the conduction of a secondary data analysis that originated from the Rural Women Health Project (Merlin et al., 2014). The aim of the dissection was to review the effectiveness of different methods of delivery of a peer-counseling program such as face-to-face, or via telephone. The peer-counseling program attributes to decreasing depression and increasing disease management among the women living with HIV in the Southeast region of the United States (Kim et al., 2014). In addition, the program also aims to improve the quality of lives of women living with HIV in the Southeast region of the United States.

The study focused on 340 African-American women who resided in the rural areas of South Carolina, North Carolina, and Alabama. The aspects of stratified sampling were apparent in this study, and subsets of the resident population with similar characteristics were applicable in the research (O’ Leary, 2010). The criteria that were relevant to participation in the study incorporated various aspects. The first aspect was that any resident who will participate in the study must have been residing in the rural areas or towns that have a population of less than 50000. Secondly, the participants in the study must have been above 18 years of age. Thirdly, the participants HIV status must
have been positive. In addition, participants had to be English-speaking individuals (Norton et al., 2014). Fifthly, the participants had to prove that they are mentally fit, and medical records were applicable in verifying this aspect. Moreover, the participants must have not engaged in any prior counseling initiative in the past. More intently, the candidates had to attain a score of 16 or more based on the scale that relates to the Center for Epidemiologic Studies of Depression.

The independent variables relating to the study associated with a nine-item scale that had a 3-point Likert based response format (Kim et al., 2014). Hence, this mechanism was applicable in measuring the aspects of HIV disclosure, which also functioned as the independent variable. The participants responded to various questions, and they had to indicate how many people were aware of their HIV status (Morrell, 2010). More precisely, nine groups of people were involved in the research, and the participants had to indicate which groups of these people were aware of their status. The groups included sex partners, parents, children, brothers, and sisters. Moreover, other groups included relatives, close and casual friends, employers and supervisors, and healthcare providers. Responses to all items summed up to obtain a disclosure score of between 9 and 27. Higher scores indicated a greater disclosure, and the reported reliability for the scale applicable was .78.

The measurement of perceived availability of social support occurred based on the Medical Outcomes Study Social Support Survey (Penman et al., 2014). A five-point
response format that was ranging from 1 to 5 was applicable, in this case. Perceptions of different types of programs valuable to the women were under assessment (Kim et al., 2014). The types of support programs under consideration included emotional, informational, tangible, and sufficient social interactions. The measurement of available support and satisfaction with support occurred based on a social support questionnaire. The first part of the respective items analyzed the available support with a score of 1 being low and a score of 6 being high. The second part of the respective items analyzed the levels of satisfaction by using six-point response formats such as “very satisfied,” “very dissatisfied,” and so forth.

The dependent variable in this study was depression, and depression relates to the effectiveness of HIV programs in the Southeast of the US (Boehme et al., 2012). The higher the levels of depression among HIV-infected individuals in the Southeast, the less the effectiveness of HIV programs in the area. The less the depression levels of HIV-infected individuals in the area, the more the effectiveness the HIV programs in the area. A 20-item CES-D scale was applicable in the measurement of the depression levels among the women living with HIV in the Southeast (Doshi et al., 2013). The participants rated their respective levels of depression in line with a 4-point response format ranging from “rarely/none of the time,” to “most/all of the time.”
4.2. Age Differences in HIV Risk Behaviors among Residents Who Use Drugs in Kentucky

The purpose of the study was to examine HIV risk behaviors in Kentucky. More specifically, the research focused on drug use and sexual practices among the individuals living with HIV in Kentucky (Duffus et al., 2009). The study sample was 1038 (N=1038), and a majority of the participants were male (72%). Moreover, 81% of the participants originated from the African American community.

4.2.1. Method

The Prevention and Education on AIDS in Kentucky (PEAK) project recruited the participants of the study (Horberg et al., 2013). The participants came from Lexington and Louisville. The aspects of traditional sampling were not a viable option for the study, and peer groups from Lexington and Louisville were applicable. The participants received a description of the research activities. Moreover, urine samples were relevant in determining the drug use and eligibility of the participants in the study. Majority of the respondents were single males who have never been in marriage. In addition, most of the participants possessed qualifications beyond the high school level and were on employment (Duffus et al., 2009). However, most of the participants viewed themselves as being homeless. The average age of the participants was 36 years, and over 67% of the participants were crack users. About 33% of the participants injected drugs, and less than 10% of them engaged in activities of injection drug use. More than half of the
respondents articulated that they had been in drug treatment before. The study focused on
three locations in Kentucky, and this included the rural Kentucky, Louisville, and
Lexington (Horberg et al., 2013). In these three locations, significant variances in
demographic characteristics and drug injection use were evident. Participants in the study
were between 30 and 49 years. The selected sample incorporated two groups, and these
were “the younger mature drug users” and “the older mature drug users.”

The eligible participants in the study had to be above 18 years, and they had to be
current injectors or crack users. Moreover, they must have not engaged in any drug user
treatment in the 30 days prior to entering the research activity (Kaplan, 2014). More
intently, it was mandatory for the participants to be free from the criminal justice system.
In addition, participation in the research was voluntary and the utmost levels of
confidentiality were vital in the study. The participants in the study underwent HIV tests
to establish if they are HIV positive or negative. Samples of blood were applicable in
testing the HIV infection status of the participants (Kim et al., 2014). The critical
components of study incorporated demographics, drug use, injection drug use, sexual
activity, sexual exchange practices, and drug user treatment.

Various aspects were under consideration in the study, and the first aspect was
whether participants have ever undergone an injection by someone else. Secondly, the
study aimed to establish the drug use patterns of the participants in the preceding 30 days
before the research activity. Thirdly, the establishment of the number of sex acts in the
preceding 30 days before the study was evident. Furthermore, the study aimed to establish the number of times that the participants engaged in unprotected sex in the 30 days preceding the study (Merlin et al., 2014). Finally, the study aimed to ascertain the number of times that the participants engaged in sexual activities for financial gain.

4.3. HIV Screening in North Carolina

A model for incorporating rapid HIV screening into community health centers was applicable. Moreover, the model acted as a guide for a program testing activity in a small town in rural North Carolina. Anonymous surveys were appropriate in the study, and the study incorporated 138 participants (Norton et al., 2014). Seventy-two percent of the participants (100) participants accepted the HIV test. Moreover, 61 % of those who underwent the test were female and about 90 % were of African-American origin.

4.3.1. Method

Out of the 138 participants, 100 accepted to undergo the HIV antibody testing at the private care clinic. Various medical practitioners attributed to different HIV programs in North Carolina conducted the HIV tests (Morrell, 2010). In addition, all the 138 participants completed the anonymous surveys. The surveys aimed to ascertain the socio-demographic variables that had an influence on HIV testing. The study occurred in the Henderson area in the state of North Carolina. The study focused on this geographic scope because in the past, no other HIV programs initialized HIV screening activities.
The Henderson area was unique because the population under focus exhibited a constellation of social features that influence health behavior (Norton et al., 2014). The social factors include religion, racial minorities, poverty, low literacy levels, stigma, and homophobia.

After the conduction of an HIV test, the medical practitioners had to enter various details in an electronic medical database (O’Leary, 2010). They had to indicate if the test was acceptable to a participant, and the results of the test. In the event that a participant endorsed the test, a medical practitioner had to fill in various details in the electronic medical records. The details that had to be present in the electronic database included a test ID, test result, test date, developing time, and so forth (Penman et al., 2014). The names of the participants were not part of the study so that the utmost levels of confidentiality would be successful in the research. The aim of the study was to ensure that all patients filled in some survey forms anonymously. The anonymity would ensure that the patients who did not undergo the test become as discrete as possible when disclosing their reasons for refusing the HIV rapid test (Sprague & Simon, 2014). As shown in figure 13, the survey enabled the collection of valuable information concerning the HIV rapid testing. The study had to involve individuals above the age of 18 years. For the minors, consent would have been paramount and this would pose a barrier to the study.
CHAPTER 5: FINDINGS/RESULTS/DISCUSSION

5.1. Results of HIV Disclosure among African American Women in the Southeast of USA

As depicted in figure 11, the average age of the participants was 41.52 years, and 80% of the participants were single. In addition, about 43% of the women in the study were single women. Most of the women were unemployed women who receive some form of public assistance from the programs in the Southeast (Merlin et al., 2014). In addition, the annual income of the women was below the $10000 mark. More than 50% of the women had undergone a depression diagnosis. Moreover, only a half of the women suffering from depression were receiving treatments such as medication or counseling. The average depression score was 27.82, and this was an indication that there were high levels of depressive symptoms among the participants. A CES-D score of 16 or above correlates to a clinical diagnosis of depression and higher levels of the scale attribute to depressive symptoms (Merlin et al., 2014). Approximately 53% of the participants reported higher levels of depression than the group mean.

The results depict high levels of perceived availability of support (mean \[M\] = 66.1, standard deviation \[SD\] = 19.2), sources of support (\(M = 5\), \(SD = 1.8\)), and satisfaction with support (\(M = 29.6\), \(SD = 9.5\)). A higher percentage of the participants had disclosed their HIV status to some or all of the family members. Moreover, some disclosed their status to friends, and/or colleagues and the average score was of 15.6 (SD
Only 19 women (5.6%) had not disclosed their status to anyone (Merlin et al., 2014). The highest rate of disclosure was to health care providers (96.75%) followed by sex partners (84.36%) and parents (67.85%). Forty percent of the participants had not disclosed their HIV status to any of their children.

5.1.1. Discussion

Social support variables were significantly associated with depression. In addition, higher social support whether perceived or actual, and enhanced satisfaction with the support can alleviate the effects of psychological stress that relates to HIV infections (Villegas et al., 2013). The findings also reveal that disclosure of one’s status helps in alleviating the levels of depression that HIV patient’s experience. Lower levels of depression facilitate the activities of the HIV programs in the Southeast region of the United States. Moreover, it is necessary for the HIV programs in the area to embrace the utmost levels of social support, and this will guarantee the effectiveness of the HIV programs at all times.

5.2. Results of Age Differences in HIV Risk Behaviors among Residents Who Use Drugs in Kentucky

As depicted in figure 13, a comparison of HIV risk behaviors between two age groups occurred. There were notable differences between the two age groups in the proportion of those that had engaged in the use of drugs before. In addition, 49% of the
older participants had ever injected drugs, and 32% of the younger participants had injected drugs. As depicted in figure 13, 28% of the older individuals engaged in crack and injection drug use. However, 24% of the younger individuals had engaged in crack and injection drug use (Hoberg et al., 2013). More intently, 31% of the older mature individuals exchanged money for sex while the corresponding figure for the younger individuals was 24%. In most scenarios, the participants from the younger group engaged in riskier sexual behaviors than the older groups.

5.2.1. Discussion
The effectiveness of HIV programs in the Southeast region of the United States is dependent on the prevalent behaviors among the resident people (Underhill, Dumont & Operation, 2014). The lack of adequate access to care and treatment plans makes individuals engage in HIV risk behaviors and in the end, the individuals might end up contracting HIV. In addition, the low levels of poverty among such persons may cause some of them to engage in injection drug use. It is imperative for the HIV programs in Kentucky to coordinate with various housing and financial institutions. Such coordination activities will ensure that the individuals living in Kentucky possess a stable home (Poindexter, 2010). Hence, the incidences of engaging in drug abuse in the streets because of depression will drastically reduce.

The results also depict that HIV-related programs are not effective among the old population in Kentucky. In addition, the more elderly population in Kentucky is not
sensitive in the matters that concern HIV risk behaviors. Behaviors such as drug abuse and exchanging sex for money are catastrophic. Thus, it is imperative for the HIV programs in the Southeast to ensure that the older population becomes more informed (Pollini, Blanco, Crump & Zuniga, 2011). HIV-related programs should target both sexual and drug use behaviors of the HIV-infected individuals in Kentucky. Moreover, the modification of HIV-related programs is crucial, and this will ensure that the programs focus on HIV risk behavior patterns in Kentucky.

5.3. Results of HIV Screening in North Carolina

As depicted in figure 14, among the individuals who refused to undergo testing 35 out of 38 submitted their reasons for making such a decision. As shown in figure 14, 28.6% of the respondents believed that they are not at risk (Morrell, 2010). Of the respondents, 25.7% already knew their status, and 22.9% had recently undergone testing for HIV. Among the respondents, 14.3% did not want to respond because of personal reasons, and 5.7% of the respondents did not have the time. In addition, 2.8% of the respondents had worries about their privacy.
5.3.1. Discussion

The HIV testing rates improve in a variety of healthcare settings when a universal approach to the matters of screening becomes evident (Norton et al., 2014). The test conducted in North Carolina had an acceptance rate of 67%. It is imperative for HIV-related programs in North Carolina to ensure that the creation of awareness among the residents of North Carolina is successful. It is an enormous challenge to HIV programs when individuals refrain from engaging in an HIV test (Penman et al., 2014). The lack of effective educational programs in North Carolina acts as an inhibiting factor in the progress of the HIV programs in the region.

5.4. Discussion of the Results as they relate to the Thesis Statement and Hypotheses

The health care system of any nation is its backbone, and the HIV-related programs in a particular country ought to be effective. According to the results, many HIV programs attributed to the matters of disclosure, HIV risk behaviors, and HIV screening are satisfactory to some point. However, it is important to note that the existence of challenges is still evident (Morrell, 2010). For instance in North Carolina, 38 out of 138 participants refused to engage in rapid HIV testing. Hence, this is an indication that at least some form of HIV program is present in North Carolina. However, the program still faces immense challenges while conducting its fieldwork among patients living with HIV in North Carolina (Norton et al., 2014). In Kentucky, the menace of drug abuse, injection drug use, and exchange of sexual favors for money is still apparent.
Nevertheless, the HIV programs are functioning, but the challenges overwhelm these HIV programs occasionally (O’ Leary, 2010). The hypothesis examines the aspects of access care, treatment plans, finances and housing, prevention programs, educational programs, and disclosure. More intently, the hypothesis statements attempt to compare the mentioned aspects with the effectiveness of HIV programs in the Southeast locale of the US.

The results relate to the hypothesis in several ways. For instance, the rapid HIV testing exercise in North Carolina is an aspect of access to care and treatment plans (Kim et al., 2014). The response of the participants indicates the effectiveness of the HIV programs in the area. More intently, 72% of the participants embraced the HIV testing. Hence, they highlighted adherence to proper health practices (Sprague & Simon, 2014). The aspects of a disclosure in the Southeast of the USA also highlight the effectiveness of HIV programs in the region. It became apparent that an exposure is critical to the effectiveness of HIV programs in the Southeast of the USA. The HIV risk behaviors in Kentucky relate to several aspects of the hypothesis, and these elements include housing, finances, access to care and treatment plans, and educational programs. All these issues come into play in matters of drug use, injection drug use, and exchanging sexual favors for money (Villegas et al., 2013). There ought to be an integration of the efforts of the HIV programs, the State and Federal governments, and the concerned stakeholders in the Southeast of the USA.
5.5. Future Implications of the Research

1. Further research is mandatory to establish the mediation and causality between disclosure, social support, and depression in relation to HIV programs in the Southeast of the USA.

2. More practices that associate with the best practices for HIV screening ought to be present in the rural primary care settings in the Southeast region of the US.

3. Research directed towards the novel strategies for increasing testing rates among men who have sex with other men is paramount in the Southeast region of the USA.

4. Future research needs to focus on age-appropriate HIV-related programs so that the dynamics of all age groups are inclusive in the HIV programs operating in the Southeast of the US.

5. Novel strategies for the integration of all the efforts of all the concerned stakeholders are worth studying in the future.

In conclusion, the proposed future studies will act as a leeway in eradicating HIV infections in the Southeast region of the USA. Such studies will guarantee the robustness and the reliability of the HIV programs in the area. Hence, the programs will be fruitful in the Southeast of the USA, and more specifically, they will serve as an endowment to humanity.
References

Boehme, A. K., Moneyham, L., McLeod, J., Walcott, M. W., Wright, L., Seal, P., & ...


doi:10.1521/aeap.2014.26.2.95


<table>
<thead>
<tr>
<th>State</th>
<th>HIV Diagnosis Rate 2010</th>
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<tbody>
<tr>
<td>Florida</td>
<td>33.0</td>
</tr>
<tr>
<td>Georgia</td>
<td>32.9</td>
</tr>
<tr>
<td>New York</td>
<td>29.5</td>
</tr>
<tr>
<td>Louisiana</td>
<td>28.8</td>
</tr>
<tr>
<td>New Jersey</td>
<td>22.8</td>
</tr>
<tr>
<td>Mississippi</td>
<td>21.3</td>
</tr>
<tr>
<td>South Carolina</td>
<td>19.9</td>
</tr>
<tr>
<td>North Carolina</td>
<td>19.7</td>
</tr>
<tr>
<td>Texas</td>
<td>18.4</td>
</tr>
<tr>
<td>Tennessee</td>
<td>17.2</td>
</tr>
<tr>
<td><strong>U.S. Diagnosis Rate</strong></td>
<td><strong>17.4</strong></td>
</tr>
</tbody>
</table>

**Table 1. Top Ten States By HIV Diagnosis Rate per 100,000**

**Appendix**

**Source:** CDC HIV Surveillance Data, 2010.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Brief Description</th>
</tr>
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<tbody>
<tr>
<td>Peer/Patient Navigation</td>
<td>The target of the strategy was to reduce disparities in HIV care for low-income women in the largely African American and Latino community. The peer/patient navigation systems proved to increase the women’s engagement in care and medication adherence.</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>They refer to professionals who work in coordination with the medical and care community. Research has shown that they are a cost-effective strategy to increase health care utilization and improving health outcomes. However, research that is more rigorous is required for the impact of CHWs in HIV/AIDS care.</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>The White House Office on National AIDS Policy suggests a medical home to provide integrated, patient-centered medical care, case management, and treatment. Research additionally supports ancillary services such as case management, transportation, and drug treatment, to improve retention in HIV Care.</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>Motivational interviewing was originally targeted for addictions treatment and is a technique now used to empower individuals to manage a variety of health issues, including HIV/AIDS.</td>
</tr>
</tbody>
</table>

Source: AIDS Education and Prevention
Table 3: The Four-Phase Model

<table>
<thead>
<tr>
<th>Phases</th>
<th>1. HIV Positive Individuals</th>
<th>2. Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secrecy phase</td>
<td>• Feel shock, loneliness, isolation.</td>
<td>• Respect and meet individuals’ need for confidentiality</td>
</tr>
<tr>
<td></td>
<td>• Identify trusted adults to disclose their HIV Status.</td>
<td>• Create a trusting and safe environment for individuals to discuss their decisions</td>
</tr>
<tr>
<td></td>
<td>• Professionals may be the only people with whom they can share feelings.</td>
<td></td>
</tr>
<tr>
<td>Exploratory Phase</td>
<td>• Search parent support groups to explore feelings about disclosure to children</td>
<td>• Recognize that it is the infected who make final decision of disclosing to their loved ones (when and how)</td>
</tr>
<tr>
<td></td>
<td>• Consider talking with children about clinic visits and treatment or offering some explanations about their health conditions</td>
<td>• Honestly express their opinions to provide different perspectives</td>
</tr>
<tr>
<td>Readiness Phase</td>
<td>• Move closer to disclosing the diagnosis to their loved ones</td>
<td>• Collaborate with parents in planning disclosure</td>
</tr>
<tr>
<td></td>
<td>• Begin to plan disclosure and discuss strategies of disclosure with professionals, trusted adults and support groups</td>
<td>• Mutual respect for knowledge and skills of both infected individuals and professionals</td>
</tr>
<tr>
<td>Disclosure Phase</td>
<td>• Disclose their HIV status to their loved ones following a specific plan and with or without presence of</td>
<td></td>
</tr>
<tr>
<td>professionals</td>
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Table 4: Selected Theoretical Perspectives of HIV Disclosure

<table>
<thead>
<tr>
<th>Theory</th>
<th>Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social influence theory</td>
<td>HIV disclosure is influenced by a number of contextual factors that HIV-positive persons are living with (e.g., social norms, cultural values and beliefs, and experiences of discrimination).</td>
</tr>
<tr>
<td>Disease progression theory</td>
<td>HIV-positive persons will disclose their HIV status when HIV progresses to AIDS and it becomes difficult for them to conceal the symptoms.</td>
</tr>
<tr>
<td>Consequence theory</td>
<td>There is a linkage between disclosure decision and analysis of anticipated outcomes. Disclosure occurs when the benefits of doing so (obtaining social and emotional support) outweigh the costs (being stigmatized by others).</td>
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Key Components

<table>
<thead>
<tr>
<th>Descriptions</th>
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<tr>
<td>Decision-making</td>
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</tbody>
</table>

Decision-making of HIV disclosure is influenced by antecedent goals, including approach goals such as pursuing positive outcomes (e.g., stronger relationship, educating others) and avoidance goals such as preventing negative outcomes (e.g., social rejection, relationship conflict)
Table 5: Key Components of the Disclosure Process Model
<table>
<thead>
<tr>
<th>Decision-Making</th>
<th>Decision-making of HIV disclosure is influenced by antecedent goals, including approach goals such as pursuing positive outcomes (e.g., stronger relationship, educating others) and avoidance goals such as preventing negative outcomes (e.g., social rejection, relationship conflict)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosure event</td>
<td>The disclosure event is characterized by content of disclosure (e.g., depth, breadth, duration) and reaction of the target</td>
</tr>
<tr>
<td>Outcomes of disclosure</td>
<td>Individual outcomes: psychological (e.g., distress, self-esteem), behavioral (e.g., antiretroviral treatment adherence), and clinical outcomes (e.g., CD4 counts) on disclosers Dyadic outcomes: well-being of disclosure targets (e.g., psychological and physical well-being of the infected individual’s loved ones who were informed about their HIV-positive serostatus), the well-being of both the discloser and disclosure target (e.g., safer sexual behaviors with sexual partners), and their relationship with each other (e.g., interpersonal liking, intimacy, and trust) Social outcomes: impacts of disclosure event on social and cultural context (e.g., creating awareness of HIV, reducing HIV-related stigma)</td>
</tr>
</tbody>
</table>
Pathway to Care in Alabama: Continuous HIV Care with Integration of Social Enablers and Support for High Risk Southern PLHIV

Background Conditions to Enable HIV Care (Enabling Environment)
- Physical stability (food, housing, transport)
- Psychological well-being and support
- Rehabilitation services
- Spiritual stability (church, community)
- Economic stability (employment, disability, insurance, ADAP, Ryan White programs)
- HIV information
- Stigma managed

Continuous HIV care
- Social enablers re-engage and maintain care
- Routine consistent HIV care (retention)
- Social enablers maintain care
- Entry into care: Medical HIV care/ART initiation
- Social enablers link PLHIV to care
- Testing for HIV: Linkage to care
- Social actors enable care (nurse, doctor, health counselor, social worker) - “Social enablers”

Lapse / Drop Out of Care

Not in HIV Care
Not in Medical Care

Figure 1: Source: http://www.equityhealthj.com/content/13/1/28
Figure 2: Analysis of HIV in Georgia

Figure 3: Analysis of HIV in Florida
Figure 4: Analysis of HIV in Alabama

Figure 5: Analysis of HIV in Tennessee
Figure 6: Protective Motivation Theory
Figure 7: The Disclosure Decision Making Model
Figure 8: The Disclosure Process Model
Figure 9: Illustrating HIV/AIDS in the Southeast region of the United States.
Figure 10: Analysis of HIV in the Southeast of the United States
<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (M = 41.52, SD = 9.47, Range = 21-67)^a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30 years</td>
<td>43</td>
<td>12.65</td>
</tr>
<tr>
<td>31-45 years</td>
<td>186</td>
<td>54.71</td>
</tr>
<tr>
<td>&gt; 45 years</td>
<td>109</td>
<td>32.06</td>
</tr>
<tr>
<td>State</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>43</td>
<td>12.65</td>
</tr>
<tr>
<td>North Carolina</td>
<td>22</td>
<td>6.47</td>
</tr>
<tr>
<td>South Carolina</td>
<td>275</td>
<td>80.88</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single^b</td>
<td>271</td>
<td>79.71</td>
</tr>
<tr>
<td>Non-single</td>
<td>69</td>
<td>20.29</td>
</tr>
<tr>
<td>Living with children under 18 years^c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>195</td>
<td>57.52</td>
</tr>
<tr>
<td>Yes</td>
<td>144</td>
<td>42.48</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>231</td>
<td>67.95</td>
</tr>
<tr>
<td>College/more</td>
<td>109</td>
<td>32.05</td>
</tr>
<tr>
<td>Full-time/Part-time employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>269</td>
<td>79.12</td>
</tr>
<tr>
<td>Yes</td>
<td>71</td>
<td>20.88</td>
</tr>
<tr>
<td>Annual household income^d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$5,000</td>
<td>141</td>
<td>41.47</td>
</tr>
<tr>
<td>$5,000-9,999</td>
<td>104</td>
<td>30.59</td>
</tr>
<tr>
<td>≥$10,000</td>
<td>93</td>
<td>27.35</td>
</tr>
<tr>
<td>Public assistance/welfare^g</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>105</td>
<td>30.88</td>
</tr>
<tr>
<td>Yes</td>
<td>234</td>
<td>68.82</td>
</tr>
<tr>
<td>HIV duration (M = 7.28, SD = 5.4, Range = 0-23)^i</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 5 years</td>
<td>156</td>
<td>46.71</td>
</tr>
<tr>
<td>6-10 years</td>
<td>78</td>
<td>23.35</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>100</td>
<td>29.94</td>
</tr>
<tr>
<td>Depression diagnosis^h</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>132</td>
<td>38.82</td>
</tr>
<tr>
<td>Yes</td>
<td>196</td>
<td>57.18</td>
</tr>
<tr>
<td>Current depression treatment^d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>95</td>
<td>48.47</td>
</tr>
<tr>
<td>Yes</td>
<td>100</td>
<td>51.02</td>
</tr>
</tbody>
</table>

Note. M = mean and SD = standard deviation. *n varies owing to missing responses. ^ This category includes those never married, separated, divorced or widowed. This category includes those married or living with a partner. ^d n = 196 because it is applicable only for those who had the depression diagnosis.

Figure 11: Sociodemographic Characteristics of Rural African American Women With HIV-disease Participating in the Study (N = 340)
<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV disclosure—total</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV disclosure to children</td>
<td>.61</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived availability of support</td>
<td>.21</td>
<td>.18</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sources of available support</td>
<td>.22</td>
<td>.13</td>
<td>.53</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with available support</td>
<td>.14</td>
<td>.15</td>
<td>.44</td>
<td>.61</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>-.11</td>
<td>-.12</td>
<td>-.26</td>
<td>-.11</td>
<td>.16</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Note. All results are statistically significant at $\alpha \leq .05$. Other items in disclosure scale were significantly associated with one or more social support variables but not with depression and therefore, are not included in this table.

**Figure 12: Pearson’s Correlations among the Study Variables**
<table>
<thead>
<tr>
<th>Reason for Declining an Offer of HIV Testing</th>
<th>Respondents Citing Each Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I do not think I am at risk&quot;</td>
<td>10 (28.6)</td>
</tr>
<tr>
<td>&quot;I already know my status&quot;</td>
<td>9 (25.7)</td>
</tr>
<tr>
<td>&quot;I was recently tested for HIV&quot;</td>
<td>8 (22.9)</td>
</tr>
<tr>
<td>&quot;I do not want to be tested for personal reasons&quot;</td>
<td>5 (14.3)</td>
</tr>
<tr>
<td>&quot;I did not have time for an HIV test today&quot;</td>
<td>2 (5.7)</td>
</tr>
<tr>
<td>&quot;I am worried about my privacy&quot;</td>
<td>1 (2.8)</td>
</tr>
</tbody>
</table>

Figure 13: Reasons Cited by Respondents for declining to take the test.