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African Born Women Living with HIV in the United States: Unmet Needs and Opportunities for Intervention

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Abstract

African born (immigrant) women comprise a disproportionate number of Black women living with HIV in the United States. Though they are at risk for mental health disorders, including psychological distress and depression, little is known about their experience with these important predictors of quality of life, retention in care and adherence to antiretroviral therapy. In this qualitative study, we used constructivist grounded theory to explore the psychosocial and mental health challenges of African born women living with HIV in Boston and New York City. We conducted one-on-one semi-structured interviews with 45 women. Major themes contributing to psychological distress and depressive symptoms included (1) pre-immigration HIV related stigma; (2) persistent HIV related stigma post-immigration, (3) undocumented immigration status, (4) economic insecurity, and (5) intimate partner violence (IPV). Many participants described ongoing depressive symptoms or histories of depressive episodes. Yet, most had not been formally diagnosed or treated for depression. Prayer, consultation with faith leadership, and support groups were described most frequently as useful interventions. Future research should explore these thematic areas among a larger, more representative sample of African born women living with HIV to determine differences by country of origin across thematic areas. These data would be useful to inform development of innovative and culturally appropriate interventions.

INTRODUCTION

Non-US born women from Africa comprise a disproportionate number of Black women living with HIV in the US (Johnson et al., 2010; Hall et al., 2008). The diagnosis rate for non-US born Black women (from all countries) is twice as high as the rate for native-born Black women, and the diagnosis rate among African born women is more than 10 times higher than among women in the general population (Johnson et al., 2010; Hall et al., 2008; CDC, 2008). The number of newly diagnosed women who are African born is notably disproportionate within several jurisdictions (Massachusetts Department of Health, 2016; New York City Department of Health, 2017; Minnesota Department of Health, 2016; Kerani et al., 2008). In Massachusetts, 60% of Black women newly diagnosed with HIV were

immigrants, 46% from Africa (Massachusetts Department of Health, 2016). In 2016, 27% of all newly diagnosed individuals in New York City were non-US born women, and 14% were from Africa (New York City Department of Health, 2017).

Though reports describing clinical outcomes among African born women living with HIV have been published (Johnson et al., 2010; Page et al., 2009), little is known about their psychosocial and mental health concerns - important predictors of quality of life and retention in care (Kang et al., 2011; Lyketsos et al., 1993; Leserman et al., 2002). In the US, depression is more prevalent among HIV-infected compared to non-HIV-infected individuals (Ciesla et al., 2001), is higher among women than men (Rabkin et al., 1997; Ickovics et al., 2001), and is associated with decreased adherence to antiretroviral therapy (ART) (Lyketsos et al., 1993; Ndirangu et al., 2009). Data from Europe, where the proportion of individuals living with HIV who are immigrants from Africa is higher than in the US, suggest that mental health disorders are common among African women and are infrequently addressed (Ndirangu et al., 2009; Guionnet et al., 2014). African born women are at higher risk of depression due to the contextual characteristics of immigration (pre-migration trauma, acculturative and economic stress, and legal documentation challenges) (Wong et al., 2014; Montgomery et al., 2013). Black immigrants to the US also experience increased psychological distress due to newfound minority status, and consequent racism and discrimination (Ryan et al., 2006).

Individuals living with HIV, including African born women, are also at risk for mental health disorders due to HIV related stigma, the prevalence of which may be higher within immigrant communities compared to other racial and ethnic groups (Ojikutu et al., 2013). Lack of knowledge regarding HIV transmission risk and assumed promiscuity contribute to persistent stigma (De Jesus et al., 2007; Blanas et al., 2013). Internalized and anticipated stigma contribute to lack of HIV status disclosure, social isolation, and delays in initial linkage to care (Tsai et al., 2013; Weiser et al., 2003). African born women living with HIV may already experience delays in linkage to care due to challenges navigating an unfamiliar health care system, lack of legal documentation, and language discordance with providers. These delays likely contribute to higher rates of late diagnosis and later treatment initiation (Johnson et al., 2010; Page et al., 2009).

In order to understand the needs of this population and to inform the development of culturally appropriate interventions, this study explores the psychosocial and mental health challenges of African born women living with HIV in two cities in the US (Boston and New York City).

METHODOLOGY

Theoretical Framework

Constructivist grounded theory was selected as the philosophical framework for this study. Unlike classic grounded theory, constructivist grounded theory allows for a more interactive process between the researcher and participants to develop theory. Co-authors of this study include individuals who are African immigrants, second generation African immigrants and/or who have extensive experience working with African born individuals living with

HIV. Therefore, meaning and underlying theory were generated not just through observation, but were created through the interaction and interpretation of participant data by researchers who also have valuable experience in the phenomenon studied (Glaser et al., 1967; Crotty et al., 1998).

Participants

Africa born women living with HIV were purposefully sampled from two sites in Boston (a clinic and a community based organization) and one site in New York City (a community based organization). Sites were chosen because of the high concentration of African immigrants and the location of the investigators (Pew Research Center, 2007). Institutional Review Board (IRB) approved flyers were posted throughout all three recruitment sites and were disseminated by case managers. Potential participants were also approached by study coordinators. Maximum variation sampling was used to include participants from a variety of countries. All participants were aged 18 years and above and French or English speaking.

Data Collection

One-on-one semi structured interviews were conducted in English or French by four co-authors and a trained research assistant. Interviews were audio recorded. The average interview length was 1 hour and fifteen minutes. Interviews were downloaded onto an encrypted laptop and transcribed verbatim. Ongoing reviews were conducted by the PI to determine whether thematic saturation was reached. Interview domains are provided in Table 1. In addition, participants completed a short survey (e.g. age, country of origin, HIV risk). To confirm eligibility, each participants submitted documentation of HIV status as well as prescription of antiretroviral therapy (ART) and most recent viral load.

Ethics Approval

This study was approved by the Partners Healthcare Institutional Review Board. Written informed consent was obtained from participants.

Data Analysis

All interviews were transcribed and reviewed for consistency with the recordings. Inductive and deductive processes were used to identify common themes. Repetition across interviews and examples of psychosocial processes, behaviors, and cultural assumptions were noted (Jehn et al., 1996). Two investigators independently reviewed all transcripts to develop a list of common themes and a codebook was developed (Ryan et al., 2003; Miles et al., 1994). *NVivo* was used to examine the distribution of themes across subgroups (e.g. age, immigration status). Codes from the transcripts were assigned to relevant themes to facilitate interpretation. Where appropriate, verbatim quotes from the data were used to support the results.

RESULTS

Descriptive Characteristics

A total of 45 African born women participated in this study. Their mean age was 42.3 years (SD 9.2). Nineteen countries of origin were represented. More than 20% were undocumented. On average, participants had been living with HIV for 12.1 years (SD 6.3). Most (62%) were first diagnosed with HIV post-immigration. One-third (33%) were in serodiscordant relationships; 80% had disclosed their status to their partners. All participants had a regular source of HIV care. Most (93%) had been prescribed ART, and 76% had an undetectable viral load. (Table 2)

Summary of Qualitative Data

Across narratives, common themes included psychological distress, anxiety and depressive symptoms secondary to pre-migration HIV related stigma, persistent HIV related stigma post-migration, undocumented immigration status, economic insecurity, and/or intimate partner violence (IPV). Most had not been formally diagnosed or treated for depression. The faith community, health care providers and support groups comprised of other African women living with HIV were an important source of support. (See Table 3 for All Quotes)

Pre-Immigration Stigma—All participants who were diagnosed with HIV in their home countries immigrated to the US to improve their access to care and antiretroviral therapy. Many also faced HIV related stigma pre-immigration which led to rejection from family, censure from community members and loss of employment opportunities. In addition to HIV related concerns, displacement due to war, political conflict, and unforeseen environmental events were described as motivations for immigration. Participants described anxiety, post-traumatic stress and depressive symptoms stemming from all of these experiences. The following participant immigrated to the US hoping to escape HIV related stigma. She described fear and social isolation prior to immigration.

“I never told anybody...I never went back to teach (after my diagnosis). I didn't want the other teachers to know that I'm HIV positive, I didn't want the parents of the kids that I was teaching to stigmatize me...I never went anywhere...I was very afraid.”

-54 y.o. participant

Post Immigration Stigma—Participants who were diagnosed with HIV pre-immigration believed that there would be less HIV-related stigma in the US than in their native countries. Many described persistent stigma both within and outside of African immigrant communities. The 54 y.o. participant described above has not disclosed her HIV status to anyone except health care providers post immigration. The following participant has limited her social existence to church and has not disclosed her status to anyone (except for health care providers). As a result of her experiences, she noted anxiety and social isolation.

“Regardless of how people (in the US) say they have embraced this disease and stigma has decreased, they really do not. It takes someone who really has spiritual growth and maturity to accept you. Stigma is still a big problem (in the US).”

-39 y.o. participant

For some participants, fear of stigma led to avoidance of places that were HIV specific, such as HIV service organizations. Conversely, many participants relied upon HIV service organizations for support. Persistent stigma since arrival in the US also led to fear of HIV status disclosure for many. Some described negative experiences following disclosure to partners and loss of intimate relationships. For several women, disclosure to intimate partners who were reportedly seronegative led to housing insecurity. The following participant was in a serodiscordant, abusive relationship. After disclosing her status to her partner, she was forced to live in a homeless shelter. She was formally diagnosed with depression and treated with anti-depressants and counseling.

“I told the father of my children that my test was positive when I got here four years ago...he told his family who we stayed with...they told me to leave and locked me out of the house.”

-37 y.o., participant

According to participants, heightened stigma may exist within African immigrant communities. Many had overheard negative comments about PLWH made by other African immigrants, describing them as “dirty” or promiscuous. Immigrants from certain African countries were particularly stigmatized (e.g., “Those Ugandans, they are all sick. They all have AIDS”). Persistent HIV-related stigma was believed to be the result of low HIV knowledge, fear of transmission, and reluctance to accept the perceived added burden of a second stigmatizing circumstance (in addition to being an immigrant). The following participant described her perception regarding the root cause of stigma within African immigrant communities.

“Ignorance. People (African immigrants) still lack a lot of information about HIV. Once they know you’re positive, nobody would want to take you in because they still lack a lot of information about HIV...They seem to know much, but they know nothing.”

-54 y.o., documented

Undocumented Immigration Status—Undocumented participants described experiencing psychological distress due to their immigration status. Participants described feeling trapped (“in a cage”) with little ability to navigate through bureaucratic systems in the US. Fear of deportation led to delays in accessing care for some. In addition, undocumented immigration status made them feel dually stigmatized (along with HIV). For the following participant, these feelings contributed to her sense of vulnerability and hopelessness.

“I get depressed about the immigration status. Sometimes it just sicken(s) me. But I don’t know. To me, sometimes I feel like I’m hopeless. I’m like in a cage that I cannot come out. It’s like coming to America, yes, I said, Lord, you give me life. But in another way, I’m seeing my life is in a cage. I cannot do anything.”

-46 y.o. undocumented

Undocumented immigration status also inhibited participants' ability to gain employment. Participants described the need to send money home and to maintain families in the US. Some described working for employers and feeling exploited because they were not paid a fair wage. The following undocumented and unemployed participant described frequent depressive symptoms which she attributed to economic stress.

“It is not easy to stay in the United States because now I’m not working because I don’t have a working permit. I cannot do anything. It’s so difficult for me now...I cannot do what I want to do now because my immigration status is not great.”

- 43 y.o. undocumented

Several participants described entering into relationships for financial support or to obtain legal immigration status. One participant described engaging in sexual activity with a male partner because she desperately needed money. Following the sexual encounter, she was not compensated, and she described feeling depressed and remorseful.

“He told me if we slept together he will give me money. This was the first time someone ask me that. I believed that he would give it to me. When we finish making love, I thought he would give it (the money) to me. Up to when I left, nothing...I felt so bad”

-37 y.o. undocumented

Intimate Partner Violence—Intimate partner violence (IPV) in the form of physical, sexual, emotional and verbal abuse by male partners was described by several participants. For most participants, IPV began post disclosure of HIV status within serodiscordant relationships. Undocumented participants felt that there were limited resources available to them to address IPV. Other participants remained in abusive relationships because they feared having to disclose their status to a new partner. Across the narratives of IPV victims, depressive symptoms and anxiety were noted. However, several participants did seek out support and were eventually able to end their relationships. The following undocumented participant was in an abusive, serodiscordant relationship. With the help of a social worker, she was able to report the abuse.

“I decided to leave him for the first time, ended up in a shelter for maybe nine months and during the period I was in the shelter, I met this social worker who advised me to file against him. And so I did...it is a very sad and miserable time for me. But I’m glad I did.”

-43 y.o. undocumented

Addressing Mental Health Needs—Across narratives, participants described unmet mental health needs. Depressive symptoms resulting from isolation, fear of disclosure, uncertainty regarding immigration status, economic uncertainty and trauma were common, but not formally addressed. Suicidal ideation was mentioned in the narratives of two participants who sought medical attention and were hospitalized. However, for most participants, medication and other biomedical interventions were not the first choice to address their mental health needs. Other participants had not sought help due to fear of stigma (both HIV and mental health related stigma) and concerns regarding disclosure of

their status. Several participants relied upon support groups with other African born women living with HIV. Prayer, consultation with faith leadership, and counseling services were described most frequently.

“The first step is to talk to somebody. You feel better if you talk to somebody. Praying is good, too. It is very good to pray because if you know God is here to help you. Taking medication is the last way for me.”

-44 y.o., participant with depressive symptoms who relies upon the faith community for support

DISCUSSION

In this study, numerous psychosocial challenges were described by African born women living with HIV. For many, the confluence of these challenges – persistent HIV related stigma, uncertainty regarding immigration status, economic stress and IPV – resulted in mental health concerns ranging from psychological distress to depressive symptoms to suicidal ideation (in two participants). Though all participants at the time of this study were engaged, the mental health issues described may compromise quality of life and clinical outcomes.

A dominant theme within participant narratives was persistent HIV-related stigma post immigration (perceived and experienced). Previous studies have explored HIV related stigma among African immigrants and noted that stigma is a result of negative perceptions of HIV in Africa and the portrayal of HIV as an African disease (Koku et al., 2010). Other studies have identified anticipated stigma as a barrier to HIV testing and a contributor to late diagnosis in this population (Bova et al., 2016; De Jesus et al., 2015; Ojikutu et al., 2014). HIV related stigma may be more prevalent among non-U.S.-born versus US born individuals.³⁵ These perceptions within African immigrant communities could impact the clinical outcomes and mental health of individuals living with HIV (Okoro et al., 2017). Stigma is a well-established barrier to retention in care among US born individuals, as well as other immigrant groups, living with HIV (Dang et al., 2012; Rice et al., 2017; Maulsby et al., 2014). Though progress has been made, development of culturally appropriate interventions to address stigma within African immigrant communities is warranted.

Psychological distress regarding undocumented immigration status was also common among participants. Studies of undocumented immigrants have found that chronic stress due to fear of deportation promotes depression and anxiety (Garcini et al., 2016; Martinez et al., 2015). Among individuals living with HIV, fear of the ramifications of disclosure may dissuade undocumented individuals from accessing care. However, in the US, the Ryan White Care Act provides primary medical care and support services for people living with HIV who are uninsured or underinsured irrespective of immigration status (Congressional Research Service, 2015). Immigrants may not know where to access services. Of note, both of the community based organizations where this study was conducted offer linkage to care and treatment as well as counseling and support services for African immigrants living with HIV. Beyond health care needs, undocumented individuals have limited employment opportunities which was noted as a significant driver of depressive symptoms. African born

women living with HIV may be vulnerable to chronic stress and depression given the intersection of poverty, race, and discrimination in the US.

In this study, IPV was a common source of trauma among participants. High rates of IPV have been reported among women living with HIV (Morales-Aleman et al., Data also suggest that immigrant women are at risk for morbidity and mortality as a result of IPV (Stockman et al., 2015; Raj et al., 2003). Therefore, women with dual identities (living with HIV and immigrant status) are particularly vulnerable to abuse. Proactively assisting with disclosure, educating about decreasing transmission risk for serodiscordant partners (e.g. treatment as prevention and pre-exposure prophylaxis), and helping women navigate the legal system are important measures that must be undertaken. Research should also be conducted to develop culturally specific IPV prevention resources.

This study suggests that the psychological and mental health needs of African born women living with HIV are largely unmet. Though mental health disorders are significantly more common among people living with HIV, treatment is infrequently accessed (Asch et al., 2003; Bing et al., 2001). African born women living with HIV are at high risk of underdiagnosis of mental health disorders. Cross-cultural differences in the presentation of depressive symptoms may not be recognized, and as in this study, anti-depressants may not be desired (Karasz et al., 2005). Diagnosis and treatment may be further impeded by mental health stigma, limited availability of providers, lack of culturally competence, linguistic and financial obstacles. Additional study is needed to understand barriers and determine ways to overcome them. The faith community, an important source of support for the participants, should be engaged in research and intervention development.

Several limitations of this study should be noted. We recruited a convenience sample which limits the generalizability of our findings. The experiences of African born women living in Boston and New York City may not be similar to elsewhere in the US. The participants in this study were from many different countries of origin. While this strategy provided diverse narratives, more research is needed to determine differences by country across thematic areas. In addition, all participants reported that they were engaged care, and 93% were prescribed ART. Future research including women out of care might shed light on the unmet needs of this vulnerable population. Future research should also explore the perceptions of healthcare providers who serve African born women living with HIV. Findings will help with intervention development within the clinical setting.

In sum, African born women living with HIV face numerous psychosocial and mental health challenges. Future research should explore these challenges among a larger, more representative sample. These data would be useful to inform development of innovative and culturally appropriate interventions.

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Table 1.

Qualitative Semi-Structured Interview Guide*

Domains	Questions
Stigma	How have people here in the US reacted when you told them that you are HIV positive?
	Can you describe any experiences that you have had where you feel you have been stigmatized because you are HIV positive.
Immigration Status	Describe how you feel living with HIV has affected your life since moving to the US.
	How do you think your immigration status has impacted your experience living in the US with HIV?
Social Supports	Who (or where) do you go to for support?
	How well do you think that your need(s) for support have been met?
Intimate Partnerships	Describe your experiences with intimate relationships (boyfriends, husbands, etc).
	Describe any challenges that you have faced regarding disclosure of your HIV status to intimate partners.
Mental Health	What does depression mean to you?
	How does someone with depression feel/act?
	How do you think depression can be addressed?
	Describe your experiences with depression (if any).
Healthcare Experiences and Utilization	Tell me about your experiences (positive or negative) with the health care system.
	Describe any challenges that you have faced with health care.

* This script does not include question probes.

Table 2.

Characteristics of study participants

Total	45
Mean Age (SD)	42.3(9.2)
Country of Origin (N/%)	
Uganda	11(24.4)
Cote d'Ivoire	5(11.2)
Other	29(64.4)
Mean Duration in the US (SD)	10 (6.1)
Immigration Status (N/%)	
Undocumented	10(22.2)
Asylee	9(20.0)
Permanent Resident	12(26.7)
Other	14(31.1)
Primary Language (N/%)	
English	13(28.9)
French	12(26.7)
Swahili	4(8.9)
Other	16(35.6)
Marital Status¹ (N/%)	
Single ²	28(62.2)
Married or Living with a Partner	15(34.9)
Number of Children (Mean/SD)	2.8 (1.7)
Education³ (N/%)	
Associates degree, college degree or higher	17(37.8)
High school diploma/GED or less	27(60.0)
Unemployed (N/%)	20(44.4)
Household Income (N/%)	
<\$5,000	23(51.1)
Currently Sexually Active (N/%)	19(42.2)
Serodiscordant Relationship (N/%)	15(33.3)
Disclosed HIV Status to Sexual Partner⁴	12(80.0)
Mean Years Since Initial HIV Diagnosis (SD)	12.1(6.3)
Diagnosed in the US (N/%)	28 (62.2)
Contracted HIV through Heterosexual Sex	28(58.1)
Has a Healthcare Provider	45(100.0)
Prescribed ART	42(93.3)
Undetectable Viral Load	34(75.6)

¹. Missing responses from 2 participants

². Single status includes participants reporting widowed, divorced and separated status.

^{3.}Missing responses from 1 participant

^{4.}The number and percentage of participants among those who are in serodiscordant relationships and have disclosed their HIV status to their sexual partner(s).

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Table 3:

Themes and sub-themes with sample quotes from study participants

Themes	Sub Themes	Sample Quotes
Pre-Migration HIV related stigma	Perceived and experienced stigma	<p>"I never told anybody...I never went back to teach (after my diagnosis). I didn't want teachers to know that I'm HIV positive, I didn't want the parents to stigmatize me...I never went anywhere...I was very afraid."</p> <p>"Everyone was pointing fingers on me - my parents, my in-laws, they didn't support me at all, thinking that maybe I was the one who brought the virus into the relationship. I had to go to counseling."</p> <p>"In Africa, you cannot try and hide about this issue, there's no confidentiality, like here. People all over, they start talking about you. Many talked about me...so I had to leave."</p>
Post-Migration HIV related stigma	Within the US (General Population)	<p>"Regardless of how people (in the US) say they have embraced this disease and stigma has decreased, they really do not. It takes someone who really has spiritual growth and maturity to accept you. Stigma is still a big problem (in the US)."</p> <p>"It's like you're not a human being like anybody else. Because it's like you're something, like maybe you are coming from your own planet, that people when they see me, they freak out of you. And it's not a good feeling."</p>
	Within Families and Intimate Partnerships	<p>"My relatives here helped at first. They know. Later on they didn't want me around. They told me to leave and I lived in the basement of my church."</p> <p>"I told the father of my children that my test was positive when I got here four years ago...he told his family who we stayed with...they told me to leave and locked me out of the house."</p> <p>"That African guy I was dating and I disclosed to him my status. And after we broke up, he kind of told friends in the neighborhood and I had to move from the neighborhood."</p>
	Within African Immigrant Communities	<p>"Ignorance. People (African immigrants) still lack a lot of information about HIV. Once they know you're positive, nobody would want to take you in because they still lack a lot of information about HIV...They seem to know much, but they know nothing."</p> <p>"So the African community as an immigrant, they still have it, the stigma. Even if they have the information like you can get treated."</p> <p>"In the Ugandan immigrant community once you tell somebody, everybody knows...So I don't have any (non-HIV positive) friends. I only trust the people I know who are HIV positive. That's it."</p>
Undocumented Immigration Status	Feeling Trapped and Hopeless	<p>"I get depressed about the immigration status. Sometimes it just sicken(s) me. Sometimes I feel like I'm hopeless. I'm like in a cage that I cannot come out. It's like coming to America, yes, I said, Lord, you give me life. But in another way, I'm seeing my life is in a cage. I cannot do anything."</p> <p>"I'm thinking about my life. I'm confined in one place. I can't move. I can't do anything. That thing depressed me so much, so much, so much."</p> <p>I have suffered violence in this country but because I have documents, no documents, and I can't talk, I can't go out, I can't speak.</p>
	Economic Insecurity	<p>"Here, I have another second chance to live. But still, it's like I'm in a cage. I cannot do nothing. Because I need to go to work. I cannot work. It doesn't mean that I'm lazy. I'm not. But I don't have the thing that makes me go to work."</p> <p>"It is not easy to stay in the United States because now I'm not working because I don't have a working permit. I cannot do anything. It's so difficult for me now, and I know many things I can help, but I cannot do what I want to do now because my immigration status is not great now."</p>
	Transactional Relationships	<p>"He told me if we slept together he will give me money. This was the first time someone ask me that. I believed that he would give it to me. When we finish making love, I thought he would give it (the money) to me. Up to when I left, nothing...I felt so bad"</p> <p>"A lady I know told me about an opportunity, a way to fix it (my immigration status). She said if you go (with this man), you are not even going to bother about immigration issues. This guy had a lot of money and could help."</p>

Themes	Sub Themes	Sample Quotes
Intimate Partner Violence	Remaining in Relationship due to Stigma	<p>“You know, he started becoming abusive. Everything you can hear of. Verbal, physical, mental...even sexual...he forced sex on me three times. But I stayed for three more years...it’s hard to find someone when you are living like this (HIV positive) here.”</p> <p>“I was physically abused. Because of your status you think it’s okay for somebody to do that. I tolerated it for quite a while. I thought I couldn’t get out of that relationship because of my status. Because then, I would have no one. So it was okay for him to do what he wanted to do.”</p>
	Finding Support	<p>“I decided to leave him for the first time, ended up in a shelter for maybe nine months and during the period I was in the shelter, I met this social worker who advised me to file against him. And so I did...it is a very sad and miserable time for me. But I’m glad I did.”</p>
Addressing Mental Health Needs	Preference for Non-Biomedical Interventions	<p>“Taking medication is the last way for me.”</p> <p>“When I was diagnosed with HIV, my doctor talked to me, he said, “Are you depressed?” I said, “Yes, I’m depressed.” And he asked me if I wanted to take medication. I said, “I don’t. Not at all. I don’t see that it’s needed.”</p>
	Faith Community	<p>“Praying is good. It is very good to pray because if you know God is here to help you.”</p> <p>“My support system is just my church. Anything outside of that, I don’t do.”</p> <p>“I opened the door to talking to my pastor. He is kind of like a counselor. He deals with so many problems like a doctor.”</p>
	Support Groups	<p>“In the support group we treat each other the same. We feel for each other, and we are kind of there for each other.”</p> <p>“I can’t say I’ve been helped by so many organizations or so many institutions. I haven’t. The only institution that I can say has maybe been there for me is (an AIDS service organization), because they have support groups”</p> <p>“Just being able to come here for the support groups. Not even talk about stress, just talk about life, women issues, everything we talk about here. Just finding a moment or two in a day to kind of disconnect from stress.”</p> <p>“I met a lot of African women living with HIV. They supported me. They are my friends, they are my sisters.”</p>