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Knowledge, Awareness and Behavior: HIV/AIDS and Disasters

Eloise Dunlap*

Director, National Development and Research Institutes, New York, USA

***Corresponding author**: Eloise Dunlap, Director, National Development and Research Institutes, Institute for Special Population Research, 71 West 23rd Street, 4th floor, New York, United States, Tel: 6466427358; Fax: 9174380894; E-mail: dunlap@ndri.org

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Abstract

African Americans are the most affected by HIV/AIDS. Both males and females continue to be disproportionately affected by HIV/AIDS. They are often drug users or participate in street/drug subculture. Recent weather disasters have required identification of knowledge, beliefs, conduct norms and behavior patterns that are HIV/AIDS risk factors for disaster survivors. This paper examines patterns of behavior and common practices related to HIV among disaster survivors.

Study background: Data for this paper come from a three year renewal project which focused upon the processes by which illicit drug markets were reformulated after disasters and practices of risk behaviors for HIV/AIDS. Hurricanes Katrina, Gustav and Ike presented the opportunity to examine the impact of disasters upon risky behavior among illicit drug users and sellers.

Methods: From 2010-2013 ethnographic study was conducted in New Orleans, Louisiana, Houston and Galveston, Texas. Staff completed in-depth interviews with 132 focal respondents of drug users and sellers. There were 57 focus groups with 243 focus group participants; 350 drug using/selling respondents completed a survey protocol (CAPI), organized around their experiences during the hurricanes.

Results: In both cities respondents displayed knowledge about HIV, modes of transmission and knew that HIV infection can lead to AIDS. Knowledge about time between exposure and infection was mostly imprecise. Most respondents reported they had been tested for HIV multiple times. A large number of participants reported learning about HIV in school, older respondents (mid-40s to 60) reported their knowledge came from television or the streets. Participants expressed fatalistic attitudes toward HIV, believing the virus was fatal even with medication.

Conclusion: With the increase of disasters, more attention needs to be placed upon programs focused on drug consumers. Schools, clinics, public information sources, i.e., TV and radio can make understanding HIV/AIDS a priority through taking into consideration specific populations and making sure literature and other forms of information is adjusted to their understanding.

Keywords HIV/AIDS; Disasters; Illicit drug markets; Behavior patterns; Street/drug subculture; Socialization; Drug use

Introduction

African Americans are most affected by HIV/AIDS. The rate of new HIV infection in African Americans is 8 times that of whites [1]. They accounted for 44% of new HIV infections among adults and adolescents in 2010, although they represent 12% of the United States population. In 2010 men accounted for 70% of the estimated 20,900 new HIV infections among all adult and adolescent African Americans. African American women accounted for 29% of the estimated new HIV infections among all adult and adolescent African Americans [2]. One in sixteen black men is expected to be diagnosed with HIV at some point in his lifetime as well as one in 30 black women [3]. Both African American females and males continue to be disproportionately affected by HIV/AIDS [1]. They are often drug users or participate in street/drug subculture [4].

In recent years, numerous weather disasters (hurricanes, tornadoes, tsunamis, earthquakes, etc.) have become a part of our daily lives. Such disasters (i.e., Katrina, Ike, Gustav) have required the identification of knowledge, beliefs, conduct norms and behavior patterns that are HIV/AIDS risk factors for disaster survivors (drug users/sellers). This paper explores patterns of behavior, knowledge and common practices related to HIV among Hurricanes Ike and Gustav persons in New Orleans, Louisiana, Houston and Galveston Texas.

Socialization theory

This paper looks at the different agents of socialization in order to examine HIV/AIDS. Socialization is the process by which children and adults learn from others. It is how we learn to fit into the world in which we live. The two main agents of socialization can be seen as Primary and Secondary. Primary agents include family and friends. The most important primary agent of socialization, family, plays an important role in shaping the life and behavior of an individual within the society. Primary agents focus upon how we are brought up in our family, learning the society's general norms, values, and our roles within the structure. The secondary agents of socialization are those institutions or places that help an individual find his place within the society. These include religious institutions, schools, work places, etc.

The secondary agent of socialization helps the person to learn social skills that helps him/her to integrate within the society. In addition, the media and other social factors also play a role as agents of socialization. The process of socialization can be defined as a process in which a person transitions toward becoming a member of a social group [5,6]. Merton saw the process of socialization as a smooth and gradual conformity to and internalization of social values and expectation [7].

According to Merton, certain kinds of behaviors are not accepted or incorporated into the social norm. Such behaviors are seen as deviant. For him, a social normative system along with legislation, help to establish what is considered "deviant." There are many different views on what is seen as "normal" and what is consider as "deviant." For Merton, cultures and even subcultures have their own contextual boundaries of what they consider "normal" and "deviant." It is important to understand that deviance occurs when an individual does not conform to the expectations of other's or the cultural normative system that they live in [7]. Drug sellers and users in this research are considered as deviant and as such the information they acquire from social institutions will have a subculture essence to it. This will be seen in the findings from this research.

The theoretical framework of this paper also includes the philosophical tenets of social learning theory [8] phenomenology [9,10]; symbolic interactionism [11]. The unifying theme running through these perspectives is the importance of understanding the meanings of human behavior and the socio-cultural context in which interactions and the specific arrangements occur. Understanding any social phenomenon requires unravelling the dynamic definitions and the interactional patterns of the social actors. In the social learning paradigm, a continuous reciprocal interaction occurs among personal factors, the immediate environment (e.g. family members and household activities), and the neighbourhood. Individuals primarily learn by observation and talking so that people acquire large, integrated patterns of behavior without having to form them gradually by tedious trial and error. Some complex behaviors can be produced only through the aid of modelling [12].

The theoretical orientation which guided this research approach required a particular methodology. One which allows people (as subjects) to be understood through their own eyes, their own words, and living patterns. The way subjects interpret their world is emphasized. What the subjects believed they are doing and how they described it in their own terms is emphasized, rather than the way outsiders may interpret what they are doing [13].

Methods

Research activities were primarily ethnographic in its approach. Over the three year period, it emphasized completing in-depth interviews with 140 carefully selected drug users and sellers (Focal Respondents), and conducting 50 Focus Groups with 250 participants. These activities also included careful observations of illegal drug markets and writing of descriptive field notes by well-trained ethnographers. In addition, 350 drug using/selling respondents completed a survey (CASI), organized around their experiences during and following Hurricanes Gustav and Ike. All major data collection protocols were carefully developed (conceptually and as working documents) for interviewing selected persons.

During field work and focus group recruitment, ethnographers selected persons who were knowledgeable and articulate about the illicit drug market(s) of primary interest (crack, heroin, etc.) at each site. These persons were invited for personal interviews and given their full Informed Consent. Project staff recruited Focal Respondents and completed in-depth interviews and follow-up interviews every six months. The purpose of these qualitative interviews was to obtain information about an individual's background/behavior patterns and conduct norms related to HIV/AIDS and drug use/sales prior to the hurricane, during the hurricane and at new sites where they were placed. Focus group respondents were seen only once at the Focus Group session, respondents completing in-depth interviews were seen over time and often served as "contact persons" to introduce the ethnographer into the drug using/selling community [13,14].

For purposes of subject recruitment and data collection, staff focused upon persons who clearly participated in and had knowledge about specific drug markets. The ethnographers developed a network of associations within each of the sites, so that they could identify potential subjects who were primarily heroin users/injectors, or primarily crack sellers, or primarily marijuana users. For every participant invited to a focus group, the ethnographer had informally screened two to three other persons who were eliminated as not involved, relatively unknowledgeable, or not sufficiently forthcoming to be eligible for participation in a specific focus group. The focus groups were organized to elicit information about four different illicit markets: a) Heroin market, b) Crack market, c) Marijuana market, and d) Other market(s) the latter included cocaine powder, ecstasy, and methamphetamine, prescription drug misuse, and any other drugs that had come into the market as well as behavior patterns and conduct norms related to HIV/AIDS.

Ethical clearance for this research: research integrity, intellectual honesty, accuracy and fairness were shaped by the Belmont Report to ensure respect for research respondents. Informed Consent established confidentiality, potential risks, protection against risks, benefits of the research, safeguards to address potential risks and a Certificate of Confidentiality. The research project was approved by the Institutional Review Board at National Development and Research Institutes, Inc.

Findings

Few literatures focus specifically on disasters and impact of the disaster on HIV. Looking at persons living with HIV/AIDS following Hurricane Katrina, Robinson et al. found that large scale disasters have an impact on persons with HIV/AIDS [15]. This paper focuses upon the social aspect of HIV: perceptions, beliefs, knowledge, socialization agents and behavior patterns among drug users who had experienced Hurricanes Gustav and Ike are analyzed.

Parents are the primary socialization agents. They guide and teach the child until he/she becomes of age to attend school. In the school phase of the child's life, he/she learn to interact with others outside their immediate environment. Teachers play a vital role in the individual's socialization process. Other agents such as television, movies, friends and neighborhood must also be considered. Socialization agents are significant when examining the behavior of drug consumers during crisis situation. Perceptions, behavior patterns and conduct norms stemming from socialization processes must to be understood when considering issues pertaining to HIV/AIDS.

Age learned about HIV/AIDS

This first section covers the age that respondents learned about HIV/AIDS. Age group 16-18 (35%) had the largest number of

respondents who reported they first learned of HIV/AIDS. The next age group was 13–15 with 30%. Only 7% of respondents reported having learned about HIV under the age of 12 (ages 9-12). Respondents in the age group 41–60, had the smallest percentage of those reporting first learned about HIV/AIDS, 1.3%. Nine percent of respondents fell in age group 21-30 who reported first learned about HIV/AIDS. United States Statistics reported in 2009 the age group 20-24 accounted for the highest rate of new HIV diagnoses [2]. This research shows that 9% of respondents in that age group were first learning about HIV and perhaps had not adjusted their behavior patterns to what they were learning. This brings in the issue of how they learned about HIV/AIDS.

How learned about HIV/AIDS ?

This section looks at the various ways in which information about HIV/AIDS were acquired through the various social institutions and socialization processes.

Famous persons: Respondents learned of HIV in many ways, one was through famous persons having acquired it. Cinch (African American, M, 67) replied: "AIDS just came when Magic Johnson came up with that shit over night, he made everybody aware, that's when everybody focused on it." This was reported by a number of respondents: No Good (African American, F, 35) reported "when Easy-E died, I'm saying, that's when I learned." Further, Candy Girl (African American, F, 26) reported: "When I got older, maybe in my twenties I think it was Magic Johnson, no Rock Hudson had it. That was when they first talked about it." Although the 9% of respondents who first learned about HIV fell in the 21-30 age groups, data from this study shows respondents at different ages learned about HIV through information on famous persons.

Family: How respondents learned about HIV/AIDS includes both Primary and Secondary agents of socialization. The family, as the most important agent in shaping beliefs, behaviors and first source of information, is seen in a dual fashion in transferring or not transferring information about HIV/AIDS to its members.

In this study, school/teachers constituted 42% of HIV/AIDS information source, the next highest percentage of how respondents learned information about HIV/AIDS was from family members; 22% of respondents reported learning from various family members. Top Model (African American, F, 34) reported she had learned about HIV at the age of 13 from the death of her uncle: "I had an uncle that died from AIDS. He told me he caught his from shooting up drugs with dirty needles, he was shooting up heroin." Family is the main socialization institution [12,15]. Although 22% reported that they learned through a family member, 37% reported that their parents did not talk to them about sex and therefore learned about HIV through other sources. Hot Cheeks: (African American, F, 40) "My parents never really talk about sex we just didn't talk about it." Ice (African American, F, 35) related: "My mom never elaborated on AIDS and stuff." Others like Denny (African American, F, 50) reported her parents told her: "When I was about seventeen, just try not to do unprotected sex. When you be burning they'd tell you 'ooh girl you sick go to the doctor' that's about it." A substantial number of respondents reported their parents did not introduce them to information on STDs or HIV/AIDS. A number of respondents reported they had learned from independent persons, had taught themselves, or had learned from other sources. In many cases respondents drew heavily from street drug subculture beliefs and conduct norms.

Street drug/subculture: Street/drug subculture can be the driving force behind particular patterns of behavior [16]. Cohen in his theory of subculture call attention to factors and circumstances that produce a problem come from people's frame of reference and the situations they confront [17]. Where people are located in the world in which they live includes a setting within which they must operate. In these excerpts we see the habits, perceptions, knowledge and behavior patterns of street drug subculture. This is the subculture from which drug users and sellers are socialized, from which they experience the world and from which they view the world. Learning through experience is a pattern of street/drug subculture.

The following respondents learned about HIV through their experiences of STD. Lady Pine (African American, F, 28) for example, talked about acquiring a disease before learning about HIV: "Well, I had learned about it on my own when I was messing with somebody, they gave me some STD and I had passed it and I had to go get checked, I was fifteen, and then that's when they had to talk to me about all the STDs and HIV." Learning through street knowledge can be seen through chatter among youths about unprotected sex and getting "burned." For example Sunshine (African American, F, 39) in her remarks related there were a number of youths both male and female who had acquired STD resulting in their learning about HIV. Sunshine related: "The only thing I knew was that you hear people gossiping about this person and that person had got burnt and I didn't even know what that meant. But I knew somebody slept with somebody unprotected and got some type of disease but I really didn't know what it was. Later on I found out that it had to do with having unprotected sex and maybe one of the other partners was having multiple partners and wasn't using protection and got an infection. You just hear it from little girls gossiping and talking. No one actually sat me down and enlightened me what it was."

Further, Renee (African American, female, age 45) had a child before she became aware of HIV. Renee reported: "I learned after I had my first child 'because my husband had given me an STD. And when I went back for my check up, I think it was like a month or two later I had, what was it? Gonorrhoea or something, the clinic, the doctor, just told me about different STD's, gave me a brochure to read about different ones and stuff. And I really learned about it when I got in the field of working, dealing with HIV and stuff like that." Lastly, Cowboy (African American, male, age 55) explained: "Well, at an early age, I was aware of it because I got caught up with gonorrhoea, somewhere along the way; I come up with gonorrhoea at an early age. I was taught to use protection with everyone you know. I called myself trying to use with this one and that one, whatever. And that's what happened. Well, I really I taught myself, understanding what was going on, growing up." Learning about HIV through experience of STDs was a common pattern in street/drug culture.

These next excerpts highlights further the role of street/drug subculture in learning of HIV and other STDs. Tex (African American, male, age 56) emphasizes the neighbourhood and friends as he related: "I didn't learn about HIV and sexually transmitted disease until I got out of school. I was taught that if you got a sexually transmitted disease it hurt, it was painful, and that you could also give it to your partner. I learned everything from the guys in the neighbourhood mostly." The social environment, location, neighbourhood and friends are considered as significant socialization agents. The contexts in which people are educated, acquire cultural values, and learn appropriate ways to interact with others are important to understand. Cultural values are displayed through personal experience which draws heavily

upon the social environment in which the individual has the experience. Here the street/drug subculture is shown as an important socialization agent.

School: School and teachers were mentioned by 42% of respondents as being their source for learning about HIV/AIDS. School is the secondary agent of socialization and source of information. In this research it was the main way in which respondents learned about diseases, sexual behaviors, and HIV/AIDS. Individuals learned about HIV/AIDS and STDs both in High school and in Middle School. Tree was unsure of whether he learned about STD and HIV in high school or middle school but remember learning in school. Tree (African American, M, 23): "I don't know how old I was but I remember it when I was in school and all that. I mean we talking about the HIV evolve from AIDS you know-like make sure you use protection." Here is shown that teachers play a vital role in providing information about HIV/AIDS. Learning both in Middle School and High School reinforced information as well as injecting new information into the learning process of diseases acquisition as a result of sexual behavior.

Pamphlets, television and clinics: Respondents reported having learned about HIV/AIDS from sources such as literature acquired through various institutions. Peaches (African American, female, age 45) replied: the pamphlet from the welfare office." Hot Cheeks and Roy are examples of learning about HIV from clinics. Hot Cheeks (African American, female, age 40) learned about HIV at the health clinic: "If you have unprotected sex you can catch AIDS, gonorrhoea, syphilis, Chlamydia, and all that shit. Herpes, Hepatitis A, B and C." Roy (African American, male, age 47) reported he "learned about different types of diseases that you can catch. I went to a class on this too at the clinics where they send you." For television and commercials, Green (African American, male, age 38) reported: "It was on TV and I saw it on TV and I was like "Lord! I thought it was gay disease at first. But once I found out it wasn't, it made me more paranoid. And the reason why I say paranoid is because I know I was dealing with a lot of females but I went to thinking that they got dudes that mess with other dudes that mess with females and that really spooked me. So I was really paranoid behind HIV and AIDS–and still is." Green revealed the cycle that can take place when having random sex without condom use with multiple partners.

When adding the learning of HIV through commercials, television, newspapers, words and phrases in pamphlets given in clinics, doctors' office and other social institution, we got 18.4%, a substantial source of learning.

Jackie not only displayed television as a source of information but also Prison. Jackie (African American, female, age 59) revealed: "I just know by intercourse, that's all I know. It tell it on TV, films and stuff like that when I was locked up–that's how I know. When I was locked up, they start showing us films." Through Jackie another agent of socialization is revealed, the institution of Prisons. Respondents reported that they learned about HIV in prison. Such females are generally involved in street/drug subculture [18]. Risky sex and drug use behaviors are primary factors before and during incarceration [19].

How the information was presented to the person, words and phrases used were very important to the understanding of what was taught. Pacifica (African American female, age 29) related: "The information that was given to me wasn't really broke down that I'll get. If I was to do it I'll put more information in and break it down for kids so they'll understand it." This may be indicated in the understanding of what was learned about HIV/AIDS.

What was learned ?

This section looks at what was learned and how this occurred. When respondents were asked what they knew about HIV/AIDS 93% responded that they knew that it was passed through sexual intercourse; 27% spoke of needles; 25% mentioned blood transfusion; and 24% mentioned bodily fluids. Mentioned less frequently were those who talked about tattoos, animal sex, anal sex, and the passing from mother to child. Through excerpts respondents displayed what was taught through the various ways in which they learned about HIV/AIDS. Also the modes of transformation of information are displayed in their various forms and what was retained by the respondent. Findings indicated respondents retained a key point of information that was taught to them whether at home, school, television, reading literature or neighbourhood/friends. Sexual intercourse was a major theme that respondents brought up about HIV/AIDS and what they had learned through the different ways in which they had been taught.

What learned in school ?

Extra (African American, male, age 20) reported in school he learned "Basically to use protection if we was to do it and to wait and how important it was to not sleep around with just anybody." Tree (African American, male, age 23) also related the sexual intercourse aspect as what learned, as he replied, "I mean we talking about the HIV evolve from AIDS you know-like make sure you use protection." Smokey (African American, male, age 34) also learned from school: "you have unprotected sex you can have a sexually transmitted disease-chlamydia, gonorrhoea, syphilis or you're supposed-the HIV thing and the best, use a latex condom if you have sex." John Henry (African American, male, age 35) learned in the seventh grade "Don't have sex." The theme of sexual intercourse and condom use as well as avoidance of sex was a major theme.

In addition, other reports of what was taught in school were sometimes rare information as shown by Lips (African American, male, age 28): "They said if you got a cut on yourself you need to go get that checked out. Mr. Jim, he uses to work at the school too. He was a teacher."

How interpret what learned ?

In these next excerpts, respondents display how they interpret what they have learned. Tanya (African American female, age 30) reported: "That's real, it's not a game, it's really spreading around. It's sexually transmitted disease. And something about your blood low-something about your teeth filled, or something-I really don't know too much about it-basically. But what I do know about it is, I know how you get it, how you prevent from getting it and if you was to mess with somebody that you heard that had it you would have to go every 3 to 6 months to get checked out-it's like up to like 5 years or something for it to show in your system." This time element was seen a few times among respondents, another example of it is seen through Cinch (African American male, age 67): "Ain't anything nice. Say it gets you in 10 years; I think they say 10 year before it take effect. So if I get it right now, at my age, I'll be dead before I get it."

An important finding was the retention of the amount of time that a person progress from HIV to AIDS. This was mentioned by a number of respondents. As seen information retained was it takes approximately five to ten years for someone with HIV to develop AIDS. This knowledge was mixed in with other ideas that indicated what was taught had been reformulated into what was seen by the

persona as most important. For Cinch he rationalized that he would be dead before it affected him.

A number of respondents relayed the idea that important change needed to be taken into consideration when teaching about HIV; especially when giving out information in pamphlets and booklets but also in classrooms. Missey (African American female, age 39) reported: " I would have it more people friendly, I hate to stereotype, but in the predominately low income areas, say the projects, I would produce a booklet to whereas you're talking in their everyday terms; slang. 'Cause some words that's used in the pamphlets, a lot of the teen-agers is high school drop outs and they don't understand those words." The level of education as well as the age of the person should be taken into consideration when preparing information sources that is to be read. Most likely individuals with learning impairments will not reveal they do not understand what was taught or did not know what the words used meant. Thus there is the issue of teaching in the language that can be understood by the group in which HIV information is given.

HIV/AIDS: Perceived, risk, testing

A number of respondents reported HIV was not an issue during the early years of their lives. Black Goose (African American, male, age 55) reported: "AIDS didn't come about until, I don't know, it hadn't been here but probably 20 years, 25 years, we didn't know anything about AIDS when I was growing up." The following are the various ways in which respondents reported that HIV/AIDS was not an issue and that they did not know about it while growing up:

Butterscotch (African American, female, age 41): "They weren't too popular with HIV. They ain't known too much about that. I was an adult when I learned about HIV. I learned HIV when I was in my early 20's on TV."

Hank (African American, male, age 59): "Well AIDS, I didn't know nothing about AIDS until it first came out. I think that was around in 1980, 1981. I remember when it first came about, my wife was a RN and she told me about AIDS. They had a patient that came in at East Holloway."

Rock (African American, male, age 60): "Nah, we didn't learn about that until after, that didn't come out until, I was out of school. That come out in the '80s, I guess, early '80s. I finished school at sixteen, it weren't any HIV then."

Blade (African American, male, age 47): "No, it wasn't AIDS. AIDS wasn't in the picture at that time. It was mostly sexual transmitted diseases. The worst thing I knew about it was, herpes, and syphilis. AIDS wasn't in the picture at that time. It probably was a virus out, but we didn't know about it."

Respondents in the age group 41-60 had the lowest percentage (1.3%) of age learned about HIV/AIDS. The information they acquired and how they understood HIV was somewhat different from the younger respondents. Such individuals' information came from the early years of the introduction of knowledge about HIV/AIDS in society. Seeing how different age groups learned about HIV reveals beginning knowledge of the disease and the early learning process. A few respondents pointed to 1980s as when they first heard of HIV. HIV virus emerged in the United States in the 1980s and was originally linked to gay, bisexual, and other men who had sex with men [20]. Some respondents based their information on earlier information sources. The following excerpts are examples of this learning:

Joy (African American, female, age 36) "At first, you know, everybody was saying that if you had AIDS you was a punk or you was gay, you know, stuff like that." And Ruth (African American, female, age 62) "I guess I was probably about 35 or 40 when I first started to pay attention to HIV/AIDS. A lot of people were dying from AIDS, mostly homosexuals. I learned from newspapers, magazines, hearsay." Today it is known that anyone can acquire the disease regardless of sex, ethnicity or sexual orientation. Generally, in this study, it was older persons and people who acquired their information from neighbourhood/street/friend that related the gay aspect of HIV/AIDS. This earlier information has been discarded and proven incorrect however the ideas are still alive in a few respondents' understanding of HIV/AIDS.

Perceived: Where people are located in the world in which they live includes a setting within which they must operate. In this setting they acquire their habits, expectations, perceptions and desires. This is the subculture from which respondents from this study were socialized and from which they viewed the world. As such, "hard" problems, such as HIV/AIDS, may leave people with feelings of fear, anxiety or hopelessness. Such feelings along with the inadequacy of the solutions are the result of the frame of reference through which solutions are contemplated. What people see and how they feel about what they see, their points of view as much as the situation in which they encounter determine responsiveness. In this section we examine how HIV/AIDS is perceived, the expectations of the people and what they see as the outcome of it.

The most frequent response when talking about HIV/AIDS demonstrated that it was seen as a killer disease. It was seen as a death sentence, it is incurable and you will die from it, even if you receive medication. Rated R (African American male, age 33) set the tone for what others relay. He related: "that's the ugliest word I've ever seen in my life." The following excerpts show that a number of people saw it as a killer and a hopeless disease:

Sammy (African American male, age 22): "I know AIDS could kill you and HIV is just the beginning of the process." Pacific (African American female, age 29): "Really I just know it's like a disease, I don't want to catch it. It's like a death disease." Ronnie (African American male, age 27): "I know you can die from it and there's no cure for it. I learned that you can die from it basically and there's no cure or anything for it and the medicine for it cost a lot of money and I don't have it".

As indicated, a sense of despair, doom and hopelessness is seen through respondents. The hopelessness is further inferred by Ronnie who brings the economic aspect of HIV/AIDS into the picture through looking at the cost of medication. He sees treatment as too expensive for him to afford. Throughout responses from respondents the hopelessness, despair and a sense of sure death was seen.

Risk: One by-product of the way in which respondents perceived HIV was whether they saw themselves at risk or not. When asked whether they saw themselves at risk of catching HIV, 72% responded no and 20% responded yes. Only a couple of people replied that they did not know. When asked whether they were concerned about catching HIV 57% responded yes and 42% responded no. Some respondents replied that they did not know because they were not with their partner all the time. Many responses indicated perceptions of doom and despair when looking at HIV; what could happen to them if they caught it, uncertainty of prevention, and the high cost of medicine. Although most respondents mentioned using condoms,

their behavior patterns due to drug use many times left them vulnerable. For example, some respondents were not sure whether their partners were faithful to them. There were others similar to Renee (African American female, age 45): "No I'm not because I trust my partner I don't think he's fooling around and if he does, or if he is fooling around I don't think he'll fool around with no one that maybe at risk of HIV; like a sex worker." Here she sees her only threat as coming from a sex worker through her partner. She simply sees sex workers as those who are passing HIV not others who are not sex workers but who have multiple partners.

Testing: When looking at testing for HIV/AIDS, we found that 49% of respondents answered yes they had been tested however 51% of respondents did not answer the question. Of those who answered yes: 29% tested 5 times, 18% tested 3 times, 12% tested 2 times and 24% tested 1 time. There were those who responded with set timing in which they were tested every year: once a month; every six months; twice a year but not necessarily every six months; and every three months. Some respondents had taken the test but were not committed to testing. For example Ruth (African American, female, age 62) responded: "Maybe once or twice. Long time ago, I don't even remember the last time." She was unsure whether she had gotten results or not. Rogue (African American, male, age 45) also was not committed to getting tested, although he had been tested twice, he did not get the results because "I didn't feel like waiting." Cowboy (African American, male, age 54) reported that he had been tested three times over a period of seven years.

In probing those who were committed to testing: Denny (African American, female, age 50) reported: "Every three months. I'm still getting checked: Clinics, Riverport, the Knights of the Street, the Church. And I go to two or three different places. I just know to go every 90 days. Even though I haven't had active sex, I still go get my blood tested" and Kemomo (African American female age 31) reported the most times being tested; she had tested 8 times. Such individuals as those who took testing seriously and frequently tested, were concerned about their status. HIV testing was a method to ensure they were HIV free.

The majority of respondents (51%) did not answer the question. The reason so many respondents were not willing to answer the question stems from a number of factors. Cinch (African American male, age 67) reported: "No, I never have been tested. I'm scared. How would you tell somebody you got it?" Joy (African American female age 36) demonstrated the trepidation that many respondents held: "I would kill myself because I would be embarrassed. Well I mean 'cause I'm already there and they gone tell me that-so no I don't want talk to nobody I want to do what I got to do." As seen previously the perception of HIV is that it is a killer disease and here Joy finds it useless to seek help or take medication to prolong her life. At the same time Joy related to the question 'Have you ever refused to be tested for HIV?': "Well that's why I started, because of the blood transfusion, and then when I started messing with-you know, I don't know who Mandingo was messing with before me but you know, or who he-because you know, men lies. He probably messing with somebody, I don't know. So you know I got to cover myself." This indicates the dilemma, uncertainty and confusion over what to do and what steps to take and when. At the same time it indicates testing may be seen as prevention.

Conclusion

This paper explored patterns of behavior, knowledge and common practices around HIV/AIDS among African Americans who were impacted by Hurricanes Ike and Gustav in New Orleans, Louisiana, Houston and Galveston Texas. One goal of the study was to look at the attitudes, beliefs and behaviors of drug using African American males and females. This research found that respondents learned of HIV in many ways which includes both Primary and Secondary agents of socialization. Cultural values and modes of transformation of information were displayed in their various forms. The street/drug subculture values from which respondents were socialized was the way in which they viewed their world. Some respondents took a dooms day attitude which was shown frequently as a response when talking about HIV/AIDS; it was seen as a killer disease even if medication was received.

Numerous respondents' knowledge was indistinct even though they had acquired information about HIV/AIDS in school and through other reliable institutions, i.e., clinics. Findings indicate that culturally sensitize knowledge and important information around HIV/AIDS need to be explored especially with drug using populations. Although people learned through reliable social institutions, the messages, in some cases, were not clearly understood. When giving out written information, great care should be considered in the wording and the level of reading material.

Although a large percentage of respondents felt they were not at risk for HIV/AIDS, they were concerned about acquiring it and regularly tested for HIV. A number of respondents related they took HIV tests frequently, while a substantial percentage was unaware of their status. At the present time, as seen by respondents, emphasis is placed upon taking HIV test. While various approaches such as testing are practiced, future activities must focus on what people know, where they acquire their information from, the level of reading when dispensing written information and making sure people understand what is being told/given to them.

Neighbourhoods with high drug use/sale activities could be targeted through more community based organizations providing preventive and information services for drug using populations. Such information should be geared toward understanding the mindset of the street/drug subculture. In so doing, information given would take into consideration the educational level of the people, their behaviors, conduct norms and especially values of the drug subculture.

Lastly, this paper examined ways in which HIV information is understood and how this may impact on beliefs, and behaviors. Basically, there was an overwhelming fear of the disease, not well practiced protection, and most knew about the disease if not knowing what to do about prevention.

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