



Lived Experiences of Optimal Aging in Older African American Women Living with HIV

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Abstract

Background: HIV remains a significant public health concern for African American women. Despite successful linkage to HIV care, self-management of HIV is still difficult for older African American women due to co-occurring factors, such as gender, financial insecurity, race, societal expectations, and HIV-related stigma. Few studies have explored optimal aging from the perspective of older African American women with HIV. **Purpose:** This qualitative phenomenological study aimed to examine the meaning of optimal aging among African American women 50 and older with HIV in the Southern United States. The study's primary focus was understanding how older African American women with HIV viewed optimal aging across physical, cognitive, emotional, social, and spiritual domains. **Method:** Ten participants meeting the inclusion criteria were recruited through snowball sampling. Semi-structured interviews explored how African American women 50 and older in the Southern United States viewed optimal aging while living with HIV. Using Colaizzi's descriptive phenomenological method, data were analyzed to describe how participants perceived optimal aging with HIV. **Results:** Seven major themes resulted from the data, including taking responsibility for your health, feeling and looking younger than your actual age, being in “your right mind,” being “kept” by God, social connectedness and support, keeping yourself up and adjusting to your new normal. **Discussion:** Providing culturally appropriate HIV care and support services tailored to the unique needs of older African American women with HIV in the Southern United States could improve their self-efficacy, improve their chances of experiencing optimal, and enhance their perception of optimal aging.

Keywords: African American women, HIV, optimal aging

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Perceptions of Optimal Aging in Older African American Women Living with HIV

The advancements in HIV treatment and care have allowed African American women diagnosed with HIV to live longer lives (Warren-Jeanpiere et al., 2014). Nevertheless, HIV remains a significant public health concern for African American women (Peltzer et al., 2017). In the United States, African American women account for a large portion of new HIV diagnoses (58% in 2018) and the most considerable portion of women living with HIV (59.2% in 2017) (Centers for Disease Control and Prevention [CDC], 2019a; Kaiser Family Foundation [KFF], 2020). Additionally, African American women in the Southern United States are disproportionately impacted by HIV, accounting for 67% of all HIV diagnoses among women in the region in 2017 (CDC, 2019b).

Furthermore, African American women 50 and older are disproportionately affected by HIV (Smith & Larson, 2015). There were 56,607 African American women aged 50-64 living with a diagnosed HIV infection in 2018, as opposed to 20,164 Hispanic/Latino women and 17,328 White women of the same age group (CDC, 2020d). After successfully connecting to HIV care, African American women with HIV remained at risk of HIV-related adverse health outcomes (Fletcher et al., 2016). Older African American women diagnosed with HIV may face additional challenges as they try to self-manage their infection (Warren-Jeanpiere et al., 2014). Often, their challenges are exacerbated by factors such as gender, poverty, race, social roles, and HIV-related stigma (Warren-Jeanpiere et al., 2014). These unique challenges may negatively impact their ability to experience “optimal aging,” which encompasses several ways to age well despite having a disease (Aldwin et al., 2018).

Problem Statement

Several factors influence older HIV-positive individuals' quality of life and longevity (Adam et al., 2018). Older adults with HIV have been described as "underserved, unseen, and

unheard," a description that is even more prevalent among older women with HIV (Durvasula, 2014). African American women disproportionately affected by HIV are among the "underserved, unseen, and unheard." Adam et al. (2018) revealed that for older women with HIV/AIDS, patient-centered approaches should be used to manage HIV and comorbid conditions. Patient-centered approaches should include individualized quality-of-life considerations and behavioral and social interventions that reflect patient goals (Adam et al., 2018). The US healthcare system does not support a comprehensive model that can tailor care to older women with HIV/AIDS (Adam et al., 2018). Despite the growing number of HIV-positive African American women 50 and older, few studies have explored optimal aging from their perspective. For those providing HIV care and treatment services to older African American women with HIV in the Southern United States, it is imperative to understand the facilitators and challenges of experiencing optimal aging from their perspective.

Purpose Statement

This study explored the meaning of optimal aging among African American women 50 and older with HIV in the Southern United States. The perceptions of optimal aging were of specific focus across the physical, functional, cognitive, emotional, social, and spiritual domains.

Research Questions

This study addressed the following primary and sub-question:

- What does it mean to experience optimal aging among African American women 50 and older living with HIV in the Southern United States?
 - What are the challenges and facilitators to achieving optimal aging across the physical, functional, cognitive, emotional, social, and spiritual domains?

Significance of the Study

By acknowledging the unique experiences of older African American women diagnosed with HIV, HIV care and treatment providers can modify, restructure, or improve HIV care and treatment services (Warren-Jeanpiere et al., 2017). Furthermore, this study will provide older African American women with HIV with strategies that facilitate optimal aging.

Definition of Terms

- Optimal aging- the capacity to function across many domains—physical, functional, cognitive, emotional, social, and spiritual—to one’s satisfaction and despite one’s medical conditions (Bowling Green State University, n.d.)
- Successful aging- the absence of disease and disability; high cognitive and physical functioning; and active engagement with life (Bowling Green State University, n.d.)

Literature Review

Human Immunodeficiency Virus

Human immunodeficiency virus (HIV) is a virus that weakens the body's defense against certain infections, resulting in greater susceptibility to disease (World Health Organization [WHO], 2020). HIV can be transmitted through direct contact with bodily fluids such as blood, semen, vaginal secretions, and breast milk (WHO, 2020). A person can contract HIV through unprotected sex, sharing needles with a person who has HIV, or by receiving infected blood products or transplanted organs (National Institutes of Health [NIH], n.d.-a). In the United States, during the early 1980s, HIV primarily affected young, white, middle-class men in urban areas along the East and West Coasts (Moore, 2011; Pellowski et al., 2013). In the United States today, HIV is a disease that affects all ages, genders, races, and income levels, involving multiple transmission risk behaviors (Moore, 2011). In addition, HIV is concentrated in socially

marginalized and disenfranchised communities, with most HIV infections occurring in sexual minorities and communities of color (Pellowski et al., 2013).

HIV disproportionately affects men who have sex with men (MSM) and racial minorities in the United States (Moore, 2011). In 2018, 1.2 million people aged 13 and older had HIV in the United States, including 161,800 (14%) who had not been diagnosed (Centers for Disease Control and Prevention [CDC], 2020e). HIV prevalence is influenced by several social conditions that facilitate HIV transmission, such as poverty, discrimination, and inequality (Moore, 2011). The CDC recommends routine HIV testing for all Americans ages 13 to 64, recommending testing for adults over 64 if they have risk factors for HIV infection (Moore, 2011).

Missed Opportunities for HIV Diagnosis in Older Adults

Routine HIV testing is a productive and cost-effective method for the early detection of HIV infection (Ford et al., 2015). Regular HIV testing entails testing each patient who consents to be tested for HIV regardless of any reported risk behaviors (Ford et al., 2015). Routine HIV testing can help detect undiagnosed HIV infection among people unlikely to seek an HIV test, including those presumed to have little or no HIV risk (Ford et al., 2015). In 2006, the CDC recommended routine opt-out HIV testing of all adults 65 years and younger seeking healthcare services where HIV prevalence is equal to or greater than 0.1% (Ford et al., 2015). However, there are missed opportunities to diagnose HIV in older adults (Tillman & Mark, 2015). According to Kirk & Goetz (2009), late HIV diagnosis leads to a higher rate of AIDS progression in older adults following HIV diagnosis and treatment than in young adults. In addition, at the time of diagnosis, older adults generally have more-advanced disease progression than their younger counterparts (Kirk & Goetz, 2009).

Older adults are less likely to get tested for HIV than young adults, so they may not be aware they are infected, and signs of HIV may be mistaken for those caused by aging (National Institute on Aging [NIA], 2017). Older adults are also vulnerable to late or missed diagnosis and poorer treatment outcomes due to the misconception that they are not at risk (Kearney et al., 2010). Older adults believe HIV is mainly a disease associated with young people (Anokye et al., 2019). Although older adults visit their physicians more often, they are less likely to discuss HIV and HIV testing with their physicians (CDC, 2019a). Older adults have similar HIV risk factors to younger adults, including a lack of knowledge about HIV prevention and sexual risk (CDC, 2019a). HIV-related stigma is also a barrier to older adults being tested for HIV. Because of stigma, older adults are reluctant to seek HIV treatment or disclose their HIV status for fear of losing family, friends, or community support (CDC, 2019a). Kirk & Goetz (2009) stated that healthcare providers are less likely to recommend HIV testing to asymptomatic older adults. However, failure to test older adults not showing signs of HIV infection may result in advanced immunodeficiency and early death (Kirk & Goetz, 2009). The societal assumption that older adults do not engage in sexual activity or abuse drugs hinders access to preventative health information and early HIV testing (The Lancet Healthy Longevity, 2022).

Aging with HIV

A limited amount of research is currently available regarding HIV's impact on aging (The Lancet Healthy Longevity, 2022). However, according to Greene et al. (2015), enhancements in antiretroviral drug regimens have allowed adults diagnosed with HIV to live longer lives. As a result, HIV has become a manageable chronic illness rather than a deadly virus (Greene et al., 2015). As people live longer with HIV, they face multiple challenges and issues, including higher rates of co-morbidities and possible accelerated aging (Womack et al., 2015). Anokye et

al. (2019) mentioned that approximately 45% of patients diagnosed with HIV in 2014 were adults aged 50 years and above. More recently, in 2018, the CDC indicated that more than half of those who received an HIV diagnosis in the United States were over 50 (NIH, n.d.-b). In 2016, out of 39,782 new cases of HIV, 6812 (17%) were diagnosed among adults aged 50 years or above in the United States (Anokye et al., 2019). Based on the CDC (2019a), in 2017, there were 38,739 new HIV diagnoses in the United States, of which 6,640 were among people aged 50 and older.

It has been found that older people with HIV suffer from significant impairments in physical and cognitive function (Montano et al., 2019). According to a report from the Harvard Center for AIDS Research, older people with HIV still face psychological, mental, and comorbid health issues, reducing their quality of life (Montano et al., 2019). Those diagnosed late and starting their antiretroviral later in life tend to have a reduced life expectancy (Baylock & Wortman, 2015). HIV-positive older people are more likely to experience weight loss, exhaustion, slowness, and decreased physical activity levels than their HIV-negative counterparts (Baylock & Wortman, 2015). Brooks et al. (2012) found that median initial CD4 counts, which measure the immune system's strength, were lower in people over 50 than those under 50.

Older adults with HIV are more likely to experience geriatric symptoms, including falls, incontinence, functional impairments, cognitive impairments, sensory impairments, and frailty, according to Greene et al. (2015). Additionally, a more significant proportion of older people were diagnosed with AIDS at their diagnosis (Brooks et al., 2012). Consequently, aging with HIV and experiencing geriatric syndromes can be detrimental to the aging process in older adults. According to The Lancet Healthy Longevity (2022), healthcare systems are incapable of meeting the needs of older HIV-positive individuals. An absence of integrated HIV-related

services and support worsens fragmented care for older people with HIV (The Lancet Healthy Longevity, 2022).

HIV in Women

Although women are living longer with HIV, their life expectancy is shorter than women who are HIV-negative (Womack et al., 2015). Womack et al. (2015) explored the areas where the primary care of women with HIV typically differs from the direct care of aging women who are HIV-negative. There are several risk factors women who are HIV-positive living in the United States may face. These risk factors include belonging to the Black race, smoking, stress, less education, and illicit drug use (Womack et al., 2015). In addition, contextual and sociocultural factors affect women aging with HIV, creating stigma and discrimination that occurs on multiple levels, affecting work, family, friends, and sexual relationships (Subramaniam et al., 2017). Older women with HIV are rarely addressed regarding HIV prevention and care, and societal biases related to age add to the myriad of issues facing older women and HIV (Durvasula, 2014). Durvasula (2014) argued that older women with HIV fare more poorly and are often accompanied by psychosocial and psychological issues. Due to challenges enhanced by socioeconomic status, stigma, discriminatory health systems, and limited healthcare providers adequately equipped to meet the needs of older women with HIV, older women with HIV tend to face unique barriers to medication adherence (Durvasula, 2014).

HIV in African American Women

African American women are over-represented and overburdened among women living with HIV in the United States (Kemp et al., 2019, p. 2). Although African American women represent only 13% of the total female population, they account for 61% of HIV diagnoses among women in the United States (Kemp et al., 2019). HIV affects African American women

with morbidity and mortality rates higher than women of any other race (Subramaniam et al., 2017). Currently, there are few HIV prevention and care interventions tailored for African American women. Bradley et al. (2018) highlighted three essential factors to consider when planning culturally appropriate studies to address HIV-related disparities affecting Black women in the United States. Those three factors include social determinants of HIV risk, determinants of equality of Black women, and perceptions of Black women's sexuality (Bradley et al., 2018). According to Bradley et al. (2018), determinants of equality relate to why Black women in the United States are more likely than White women to become infected with HIV. Racism in healthcare can deter Black women from initiating HIV care or continuing HIV care (Bradley et al., 2018). Existing research suggests difficulties accessing health care or navigating healthcare systems can negatively impact HIV prevention and care outcomes for Black women (Bradley et al., 2018). According to Bradley et al. (2018), the perceptions of Black women's sexuality are the third HIV-related disparity affecting Black women. The perception that Black women are more promiscuous, irresponsible, and reckless than women of other races persists despite research indicating the contrary (Bradley et al., 2018). Awareness of false perceptions sheds light on the historical context and modern-day adverse effects of the sexual exploitation of Black women in the United States (Bradley et al., 2018). Researchers, practitioners, and policymakers likely lack the knowledge to understand how historical representations of Black women's sexuality impact perceptions of HIV risk (Bradley et al., 2018).

African American women are disproportionately affected by HIV, so psychological challenges associated with HIV aging, including depression and suicidal thoughts, must be monitored and managed (Subramaniam et al., 2017). Resilience refers to maintaining stable, healthy psychological and physical functioning levels after exposure to a disruptive event, such

as being diagnosed with HIV and living with HIV (Subramaniam et al., 2017). Several theories are utilized in research to address how African American women experience adversity and oppression while living with HIV. Subramaniam et al. (2017) used the Black feminist theory to highlight African American women overcoming adversity and resisting oppression, emphasizing their voices, wisdom, and resilience. Despite their oppression, low-income African American women with HIV can cope with discrimination (Subramaniam et al., 2017). Supportive social relationships and environments improved outcomes for African American women living with HIV despite racism, prejudice, and discrimination (Subramaniam et al., 2017).

Warren-Jeanpiere et al. (2017) also examined the intersection of race, class, gender, age, and HIV-related stigma in African American women living with HIV. As a result of HIV-related stigma, societal ageism, mainstream views of Black female sexuality, and economic security, older African American women with HIV are less likely to seek informal support for managing their HIV compared to those with chronic illnesses other than HIV (Warren-Jeanpiere et al., 2017). Moreover, psychological distress can pose unique challenges to African American women's ability to manage their HIV infection, causing stress, depression, anger, sadness, and other negative emotions (Peltzer et al., 2017). In order to improve the quality of life for African American women with HIV, HIV care and support providers need to understand their daily struggles and how those struggles evolve (Warren-Jeanpiere et al., 2017). For older African American women living with HIV, HIV care and support providers must provide informational and emotional support beyond the typical clinical visit (Warren-Jeanpiere et al., 2017).

HIV in Older African American Women

HIV is a significant public health concern disproportionately affecting older African American women. Specifically, African American women between the ages of 50–64 comprised

approximately 40% of the newly diagnosed cases in 2010 (Smith & Larson, 2015). In 2018, 56,607 African American women between the ages of 50-64 were living with a diagnosed HIV infection compared to 20,164 Hispanic/Latino women and 17,328 White women between 50-64 living with a diagnosed HIV infection in 2018 (CDC, 2020c). For older African American women, the nature and intensity of HIV-related stigma may be more significant due to social inequities based on gender, race, and age (Sangaramoorthy et al., 2017). For example, Sangaramoorthy et al. (2017) argued that HIV-related stigma could present challenges for older African American women with HIV due to the loss of support, comorbidities, and ageism.

Furthermore, it is suggested that gender and racial disparities are a reality for older African American women with HIV at every step of the HIV care continuum (Sangaramoorthy et al., 2017). Older African American women face multiple co-occurring social and psychological vulnerabilities that reduce their ability to be engaged in the HIV care continuum (Sangaramoorthy et al., 2017). For example, African American women, including older African American women, in comparison to other racial groups, are more likely to experience poverty, violence, gender discrimination, and racial discrimination and live in disorganized neighborhoods (Amutah-Onukagaha et al., 2018). Generally, older African Americans tend to mistrust the healthcare system, which increases their risk of developing complications that result in decreased quality of life (Amutah-Onukagaha et al., 2018).

HIV in the Southern United States

The South or Southern United States is known for its distinctive culture and conservative views. The Southern United States is also renowned for its involvement in slavery and the Civil Rights Movement. The Southern United States has historically and currently been affected by structural and systemic racism. Systemic and structural racism encompasses racism deeply

ingrained in laws, policies, practices, and beliefs, leading to widespread unfairness and oppression (Braveman et al., 2022). Several critical social, structural, and policy factors contribute to poorer health and HIV status among Southerners (Adimora et al., 2014). Many African Americans with HIV in the South are affected by social and structural health determinants rooted in oppression, poverty, racism, and unequal opportunities for education and employment, contributing to HIV disparities (Sutton et al., 2017).

Those living in the Southern United States, where poverty is highest and median household income is lowest, are least likely to have health insurance (Adimora et al., 2014). Patients with health insurance have better health outcomes, including sustained viral suppression, shorter hospital stays, and lower mortality (Furl et al., 2018). As a result, a disproportionate number of people in the Southern United States are affected by HIV, with 51% of the 37,967 HIV diagnoses occurring in the South in 2018 (CDC, 2020d). Although 38% of the United States population lives in the South, eight of the ten states with the highest rates of new HIV diagnoses are in the South (CDC, 2019b). African Americans are disproportionately affected by HIV, accounting for 53% of new HIV diagnoses in the region in 2017 (CDC, 2019b). More specifically, in 2011, the HIV diagnosis rate among African Americans in selected southern states (Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas) was 73.7 per 100,000, compared with 24.8 per 100,000 among Hispanics/Latinos, and 8.8 per 100,000 among Whites (Sutton et al., 2017).

HIV Treatment Adherence and Social Connectedness

Optimal outcomes for HIV-positive individuals are achieved through a continuum of care that includes HIV testing, diagnosis, linkage to care, treatment, and adherence to antiretroviral therapy (Yehia et al., 2015). Older African Americans with HIV can live healthier, longer lives

by participating in the HIV care continuum; however, they are less likely to do so than other older populations (Sangaramoorthy et al., 2019). Compared with other women with HIV, African American women with HIV have higher morbidity and mortality rates because they are less likely to receive antiretroviral therapy, begin treatment later, and stop treatment early (Kemp et al., 2019). Adherence to antiretroviral treatment is essential to preventing HIV replication, AIDS progression, and HIV-related complications (Lee et al., 2017). Having an undetectable viral load is the best thing people with HIV can do to stay healthy (CDC, 2022).

Several factors can hinder African Americans' engagement and retention in HIV treatment, including race, gender, sexuality, drug use, and incarceration (Sangaramoorthy et al., 2019). Sangaramoorthy et al. (2019) discussed several other barriers to African Americans' engagement and retention in care, including multiple morbidities, inability to pay co-payments, inadequate insurance coverage, being too busy, working inflexibly, accessing transportation, or not receiving personalized attention. A person with HIV/AIDS faces many challenges regarding self-management (Warren-Jeanpiere et al., 2014). For African American women who developed HIV at a younger age and are currently dealing with multiple comorbid conditions, getting and staying involved in care might be more challenging (Warren-Jeanpiere et al., 2014). Even though older African Americans are at a higher risk of HIV infection and are underrepresented in HIV treatment and care processes, no literature reviews have examined the factors that may prevent them from receiving HIV care and treatment (Sangaramoorthy et al., 2019). In addition to HIV treatment, according to Dale & Safren (2018a), social support is a crucial resilience tool that enables women to persevere and recover from setbacks such as trauma and HIV stigma. Apart from their family and partners, women also found that support groups with HIV-positive peers helped them to develop resilience (Dale & Safren, 2018a). Furthermore, HIV-positive peers were

viewed as essential in helping women buffer HIV-related discrimination and stigma, heal from trauma, and develop strategies to cope with stress (Dale & Safren, 2018a). According to Sangaramoorthy et al. (2019), culturally appropriate policies and interventions are needed to enhance the effectiveness of treatment and adherence among older African Americans, with further research focused on managing HIV and commonly associated aging conditions to address older African Americans' health and psychosocial concerns effectively.

Resilience, Social Support, and Religion

HIV-related stigma adversely affects the health and well-being of people with HIV/AIDS, including their mental, physical, and social well-being (Travaglini et al., 2018). HIV stigma discriminates against people with HIV through prejudice, discounting, and discrediting (Lipira et al., 2019a). Internalized stigma occurs when a person with HIV experiences negative thoughts or feelings about their HIV status (Lipira et al., 2019a). HIV-related stigma hinders the effective treatment and positive health outcomes for people with HIV (Sangaramoorthy et al., 2017). For women, racial and ethnic minorities, and older adults, the nature and intensity of HIV-related stigma may be more severe due to pre-existing social inequities based on gender, race, and age (Sangaramoorthy et al., 2017). According to Sangaramoorthy et al. (2017), HIV prevalence is extremely high among Black adults older than 40. The stigma associated with HIV can be particularly challenging for older and midlife people because of issues related to loss of social support, management of comorbidities, and ageism (Emlet, 2006, as cited in Sangaramoorthy et al., 2017).

Many African American women with HIV experience adverse health outcomes and high mortality rates due to inadequate antiretroviral medications (Lipira et al., 2019a). Moreover, African American women with HIV experience significant stigma and depression due to their

HIV status (Lipira et al., 2019b). Negative experiences of HIV-related stigma among African American women living with HIV have been associated with depression, decreased psychological functioning, and other symptoms (Lipira et al., 2019a). The impact of existing inequalities can be mitigated by addressing HIV-related stigma among African American women living with HIV (Lipira et al., 2019b). HIV-related stigma can be addressed in intersectionality by promoting resilience, described as identifying and using resources and protective factors to help cope with adversity (Lipira et al., 2019b). For African American women with HIV, religion, social support, and ethnic identity may mitigate adverse psychosocial outcomes such as depression (Lipira et al., 2019b). African American women have traditionally relied on religion to support positive actions and outcomes (Lipira et al., 2019b). Research has shown that religious belief contributes to the psychological well-being of African American women living with HIV (Lipira et al., 2019b). Among African American women living with HIV, Lipira et al. (2019b) found that prayers are extremely common, with most women praying more than once daily. African American women with HIV can benefit from social support (Lipira et al., 2019a). Furthermore, social support reduces loneliness, stress, and depression among HIV-positive women enabling them to resist the adverse effects of the stigma associated with HIV (Lipira et al., 2019b). There is also a positive association between a greater sense of ethnic identity and lower anxiety, depression, and psychological stress among African Americans (Lipira et al., 2019b).

Optimal Aging

Optimal aging is something many people would like to experience as they grow older, especially while living with an illness. Optimal aging is a broader concept focused on a fuller picture of wellness, including the capacity to function across many domains-physical, functional,

cognitive, emotional, social, and spiritual to one's satisfaction and despite one's medical condition (Bowling Green State University, n.d.). Aldwin et al. (2018) suggest that models of optimal aging are multifaceted and indicative of an ultimate goal. According to Aldwin et al. (2018), many studies predicted health in late life using unidimensional outcomes such as longevity, avoidance of disease, and self-reported health. Historically, much of the research on aging with HIV has been related to successful aging, distinguished from optimal aging. Successful aging encompasses three elements: avoiding disease and disability, maintaining high physical and cognitive function, and sustaining engagement in social and productive activities (Guccione, 2012). While successful aging is often used to describe one way to age well, optimal aging recognizes that the aging process can be influenced in many ways. (Aldwin et al., 2018). Aldwin & Igarashi (2015) argued that the term 'successful aging' has implications of competition and could be interpreted as there is only one way to age successfully.

Identifying how older adults cope with age-related changes and respond to challenges in late life is critical to understanding optimal aging (Aldwin & Igarashi, 2015). In Aldwin et al. (2018), *optimal aging* is recognizing and using personal, social, and cultural resources to maintain optimal functioning and find meaning. Fawcett & Foust (2017) contend that stressors within individuals, families, or communities impact optimal aging. By categorizing subgroups of aging adults, different experiences, needs, and resources as an individual ages were identified to learn what contributes to optimal aging from the perspective of varying age groups (Fawcett & Foust, 2017).

Prior Research on Aging and HIV

Current literature on aging and HIV is emerging. The impact of HIV on aging is not entirely clear, as most persons with HIV can live healthy and long lives. In contrast, others struggle with multiple comorbidities that negatively impact their quality of life (Budak, 2020). Understanding age-related contextual sociocultural, psychosocial, and personal factors related to older adults with HIV is crucial to reducing psychological burdens and maintaining their health (Sankar et al., 2011). According to Ford et al. (2015), routine HIV testing recommendations are only partially implemented among older adults. Identifying and resolving implementation barriers to HIV testing among older adults is vital to addressing late HIV diagnosis. The challenge of HIV infection for older African Americans remains substantial, despite advances in clinical and treatment practices (Sangaramoorthy et al., 2019). While most research on HIV self-management in women focuses on young women, age becomes vital in understanding how women with HIV manage their infection (Warren-Jeanpiere et al., 2017). Even though African American women experience significant health and social disparities, few studies have examined factors contributing to their resilience during aging with HIV (Warren-Jeanpiere et al., 2017). Furthermore, there is limited research, if any, related to older African American women with HIV and how they experience or perceive optimal aging.

Method

Study Design

In this study, a phenomenological methodology was used. Phenomenology describes a phenomenon from the perspective of those who have experienced it (Neubauer et al., 2019), while transcendental phenomenology focuses on the meanings of the individual experience (Phillios-Pula et al., 2011). Using this approach, the researcher explored perspectives of optimal

aging across the physical, functional, cognitive, emotional, social, and spiritual domains among African American women with HIV 50 and older. Before recruiting participants, the University of Indianapolis Institutional Review Board (IRB) approved the study with an exempt level of review status (Appendix A).

Participants

To be eligible for this study, participants had to be African American women; aged 50 or older; have at least one year of residence in the Southern United States; have a self-reported HIV diagnosis; and have a history of being treated with antiretrovirals for at least 12 months. Participants were excluded if they could not read or speak the English language (needed for the interview) or if there was a deficit in comprehension that prevented them from giving consent. The teach-to-goal method assessed comprehension deficits (Ahalt et al., 2017). Using the teach-to-goal method, the researcher read the study information sheet with participants, asked them questions, and corrected misinterpretations. All participants stated they understood the content of the study information sheet.

Participants in the study were members of a women's HIV peer support group. Using a method referred to as snowball sampling, participants identified potential participants within their peer support group who met the inclusion criteria. Ten participants were interviewed. The sample size was determined based on information power. The more pertinent information a sample possesses, the smaller the required sample size (Malterud et al., 2016). Further, information power was used to assess whether qualitative findings were adequate based on the study's objectives, the sample's specificity, the analysis strategy, and the quality of interviews (LaDonna et al., 2021, p. 208). Recruitment ended once information power had been determined.

Procedures

Sampling and Recruitment

Participants were recruited using snowball sampling. Snowball sampling is helpful in hard-to-reach populations (e.g., HIV patients) where a network of qualified study subjects is assumed to exist, and the researcher is hoping to be linked into this network through social interaction with the initial subject in the network (Dusek et al., 2015, p. 281). To initiate recruitment, the researcher called the director of a community-based organization that provides housing, healthcare services, and support groups for HIV-positive individuals to request assistance in recruiting participants. Following confirmation to assist with recruiting, the director was sent an email using the content in the UIndy IRB-approved message for social media form (Appendix B). The email also included an UIndy IRB-approved study information sheet (Appendix C) and a recruitment flyer (Appendix D) for electronic dissemination. The study information sheet included a summary of the study, information regarding the length and location of the research interviews, eligibility criteria, methods to protect the confidentiality of participants, incentive information, and the researcher's contact information.

It was considered whether sending recruitment flyers and study information sheets by mail or e-mail could inadvertently reveal participants' HIV status. In addition, it was considered that most participants might not have e-mail or social media accounts. On both concerns, the researcher sought the advice of the director. The director advised that even if participants had e-mail accounts, information on the study information sheet and recruitment flyer could reveal participants' HIV status. Likewise, the researcher was advised that traditional mail carried the same risks. The researcher was also informed that using social media for recruitment would not be effective. The decision was made to share the study information sheet and recruitment flyer

via screen sharing during a Zoom peer support group meeting to facilitate recruitment. Interested individuals contacted the researcher via telephone and expressed their interest in participating. A few participants told the researcher that they had encouraged others in their peer support group to contact the researcher about participating in the study, a strategy referred to as snowball sampling.

Participants began calling the researcher shortly after their Zoom peer support group meeting to enroll in the study. As a result, it was possible that some individuals calling to express interest in the study had not attended the peer support group meeting via Zoom when the study information sheet and recruitment flyer were shared. As such, during the screening call, if an individual had not attended the support group and seen the study information sheet, they were asked if they would like to view a study information sheet before being screened. All participants gave verbal consent to proceed with the screening questions. The researcher used the demographic and background information sheet (Appendix E) to screen participants when they called to express interest in the study. The researcher introduced herself to each participant over the telephone during the screening process. Participants were informed that the researcher was not affiliated with UAB. The study information sheet was not emailed to participants; none had active email accounts. After participants provided verbal consent to be screened, the researcher discussed the study in detail by reading the information on the study information sheet. The researcher then asked participants if they had any questions or concerns regarding the study information verbally discussed. Using the teach-to-goal method, all participants fully understood the researcher's verbal reading of the study information sheet.

Most women lived within the same apartment complex designated for HIV-positive individuals. Only two of the participants lived outside the apartment complex. Following

COVID-19 safety measures, the researcher hand-delivered the study information sheets to participants, encouraged them to read through the entire sheet, and asked them to call the researcher if they did not understand any of the information provided. The researcher informed participants that they would be given one week to decide to participate in the study. After one week, participants were contacted to confirm they had read the study information sheet and were interviewed.

Informed Consent

To avoid collecting identifiable information, the researcher requested a waiver of signed consent from the UIndy IRB, which was approved. Verbal consent was obtained from each participant via telephone at the start of each interview. Before each interview, the researcher and the participant reviewed the study information sheet together. The researcher highlighted the purpose of the study, explained what the participant was being asked to do, and confidentiality of the patient's identity and interview information. Participants were allowed time to ask questions before the start of each interview.

Data Collection Process

This study's primary data collection was a semi-structured interview with each participant, directed by an interview guide (Appendix F). The interview guide was comprised of open-ended questions designed to allow participants to provide detailed information about their experiences related to optimal aging with HIV as an older African American woman living in the Southern United States. A semi-structured interview allowed the researcher to collect open-ended data to explore participants' thoughts, feelings, and beliefs and allowed the researcher to delve deeply into personal and sensitive issues (DeJonckheere & Vaughn, 2019, p. 1). Since safety protocols for the COVID-19 pandemic were still in place and participants were

immunocompromised, the researcher conducted all ten interviews by telephone. Each interview was conducted in a closed office to ensure the privacy and confidentiality of each participant. The researcher used two digital audio recorders to record each interview to guard against device malfunction. The interview lengths varied, with the shortest being 25 minutes and the longest being 70 minutes.

Before each interview, the researcher discussed the aim of the study and provided participants with time to answer any questions. Informed consent was also re-established verbally. Participants were reminded of their right not to answer any questions they wished not to answer. They were also informed that they could withdraw their participation at any time during the interview. The researcher also stressed that protecting their confidentiality and interview information was the researcher's top priority. The researcher informed participants that they did not need to provide their names and that each participant would be issued participant identification numbers. Participants were also reminded that the researcher was not affiliated with UAB 1917 or UAB Family Clinic in any capacity. Participants were reminded that the researcher was conducting research as part of completing their doctoral studies at the University of Indianapolis. Additionally, permission to audio record the interviews was verbally obtained from each participant.

At the beginning of each interview, the researcher re-introduced herself and provided a brief background to establish rapport and build trust with participants to feel comfortable sharing their experiences. The researcher followed the questions in the interview guide but also asked follow-up and probing questions when clarification or additional information was needed from participants. The researcher took handwritten notes to document needed and beneficial contextual information (e.g., participant facial expressions and body language). Throughout the

data collection process, the researcher engaged in reflexivity by writing down any biases, thoughts, feelings, beliefs, and assumptions that surfaced during and after each interview. Reflexivity was a crucial component in removing researcher bias since the researcher worked in the field of HIV/STDs.

Each interview ended with the researcher thanking the participants for their time once all questions were answered and follow-up questions were not required. Participants were once again assured that their confidentiality would be maintained and that their contact information would be stored in a password-protected cloud storage system, with their contact numbers separated from their identifying information. Instead, all contact numbers were labeled with the assigned participant identification numbers. As mentioned, eight participants lived in the same apartment complex, while the remaining two lived nearby. According to the participants, they wished to refrain from receiving correspondence by mail. Therefore, the researcher informed participants that they would be contacted by telephone to schedule a time for member checking. It was explained to participants that member checking entailed reviewing the transcript of their audio-recorded interview (written or typed responses) to confirm the accuracy of narratives shared during the interviews, correcting them where necessary. After each telephone interview, each participant received a \$30 incentive, eight participants requested cash, and two requested their incentive via Cash App. Following COVID-19 safety measures, the researcher hand-delivered the cash incentives to each participant. The researcher logged each incentive payment on a participant receipt incentive form using participant identification numbers, dates, and payment type.

Data Management and Analysis

Audio recordings of each interview were removed from the digital audio recorder, uploaded to a computer, and backed up in password-protected cloud storage. The uploaded data was transcribed using Temi, an audio-to-text service. The researcher confirmed the accuracy of each transcript by listening to the audio recordings of each interview several times while reading the transcribed data. Once the accuracy of each transcript was confirmed, the researcher removed all identifying information. Each participant was assigned a participant identification number to maintain confidentiality. The researcher exported the data from Temi to password-protected cloud storage and the qualitative data analysis software Dedoose (version 8.3.35). Transcripts were printed to prevent the loss of collected data. Hard copies of any printed material and research notes were locked in a file cabinet only available to the researcher.

The researcher engaged in a phenomenological approach to data analysis. Specifically, phenomenologist Paul Colaizzi's approach was used to accurately describe the phenomenon through the eyes of the study participants (Phillips-Pula et al., 2011, p. 68). Colaizzi's seven-step process involves the researcher (1) becoming familiar with the data by reading through participant's responses multiple times; (2) returning to original transcripts to identify significant statements relevant to the phenomenon being studied; (3) formulating meanings relevant to the statements provided by participants; (4) creating themes based on the formulated meanings (5) developing an exhaustive description of the phenomenon to incorporate themes; (6) identifying fundamental structure; and (7) validating the identified fundamental structure with each participant (Morrow et al., 2015; Phillips-Pula et al., 2011; Suryani et al., 2016).

The first step of Colaizzi's method suggests that the researcher read each participant's transcription several times (Suryani et al., 2016). The researcher read each participant's

transcript several times while playing back each interview recording to become familiar with the data and to gain an overall feeling of the experiences described by the participants. While reading each transcript several times, the researcher engaged in memoing by writing short phrases, key concepts, or ideas. Memos are the storehouse of ideas generated and documented through interacting with data, prompting researchers to analyze, code data, and develop codes into categories early in the coding process (Chun Tie et al., 2019).

The second step of Colaizzi's method suggests the researcher return to the original transcripts to identify significant statements relevant to the phenomenon being studied (Phillips-Pula et al., 2011). The researcher carefully read through each original transcript and identified significant statements relevant to optimal aging experiences with HIV in African American women 50 and older living in the Southern United States. The researcher looked for patterns, words, and phrases that were consistent or repetitive, which resulted in comprehensive themes or meanings. The researcher then pulled out all significant statements and coded each statement using Microsoft Excel to create a codebook. Codes were labeled with the name of the code, its definition, and the quotes associated with that code. The transcript page and line number were used to identify each quote corresponding to the code.

Once there was an established foundation for coding the data, the researcher coded segments according to the phenomenon being studied and created a complete description of the data (Phillips-Pula et al., 2011). The researcher entered the codebook into Dedoose to apply the codebook to the remainder of the transcripts. The researcher used the codebook as a qualitative tool to reference identified codes. To reach a consensus on a codebook, the researcher and the analysis expert met via Zoom and discussed the designated portions of the transcript line-by-line. After discussing the codes with the analysis expert, the researcher refined the codebook.

The third step of Colaizzi's method suggests that the researcher formulate meanings relevant to the statements provided by participants (Suryani et al., 2016). Accordingly, the researcher analyzed each significant statement for explicit and implicit meanings relevant to the studied phenomenon. The researcher then categorized each significant statement according to its meaning. Throughout the process, the researcher engaged in reflexivity by recording her thoughts, feelings, uncertainties, values, beliefs, and assumptions that surfaced in a research journal (Carlson, 2010). Reflexivity refers to the researcher's attempts to adopt a blank slate, a perspective of objective distance from which to study a phenomenon afresh (Olmos-Vega et al., 2023, p. 242). Reflexivity allowed the researcher to ensure that the formulated meanings were a true and accurate representation of the participant's responses.

The fourth step of Colaizzi's method suggests that the researcher create themes based on the formulated meanings (Phillips-Pula et al., 2011). The researcher created themes based on the formulated meanings from the significant statements. The formulated meanings were then organized into clusters of themes, and each cluster of themes was compressed into an emergent theme. The researcher created a theme table using direct participant quotes from the codebook highlighting common experiences or information related to the research question. Additionally, the researcher kept careful documentation of all study components and activities throughout the study to maintain credibility using Dedoose. The researcher used Dedoose to capture emerging ideas as the data was collected and analyzed and to record thoughts and feelings that may have played a part in her decision-making process. Memoing in Dedoose also provided documentation to justify why and how decisions and connections were made related to developing codes and themes (Chun Tie et al., 2019).

The fifth step of Colaizzi's method suggests that the researcher develop an exhaustive description of the phenomenon to incorporate themes (Phillips-Pula et al., 2011). The researcher developed an exhaustive description of the phenomenon to incorporate themes (Phillips-Pula et al., 2011). The researcher integrated all the resulting ideas into a comprehensive description of the lived experiences of African American women 50 and older with HIV in the Southern United States by combining all the theme clusters, emergent ideas, and formulated meanings.

The sixth step of Colaizzi's method suggests that the researcher identify the phenomenon's fundamental structure or key elements (Suryani et al., 2016). The researcher condensed the findings by identifying misused, unnecessary, or misinterpreted descriptions. As a result, the researcher avoided repetitions and provided a clear and concise description of the phenomenon. The seventh step of Colaizzi's method, in which the researcher validates the identified fundamental structure with each participant (Morrow & King, 2015), was carried out via member checking. To protect participant privacy and confidentiality, the researcher delivered a copy of the researcher's interpretations of initial themes in person, following COVID-19 safety guidelines. Participants were instructed to carefully read the findings and make corrections if the researcher's interpretation was incorrect. The researcher informed participants that they would be provided one week to review the findings. A week later, the researcher called each participant to discuss possible changes. Two participants could not be reached by telephone by the researcher. Three participants declined to review the researcher's interpretation. Four participants reviewed the researcher's interpretations, but no corrections were made. One participant did not offer corrections but expressed appreciation for the researcher not capturing her name when she accidentally mentioned it.

Rigor and Trustworthiness

Trustworthiness or rigor of a study refers to how much the findings from a study can be trusted (Korstjens & Moser, 2018). The researcher used Guba and Lincoln's evaluative criteria to establish trustworthiness: credibility, dependability, confirmability, and transferability (Forero et al., 2018). A qualitative study is credible when the results are a true reflection of the lived experiences of the participants (Maher et al., 2018). To ensure that the study's findings were true and accurate, the researcher utilized member checking to validate results by seeking input from participants to judge the accuracy of the researcher's interpretations (Creswell & Poth, 2018). Participants were given a copy of the researcher's interpretations of their interviews to review and inform the researcher if any corrections were needed.

The researcher wanted to ensure the study could be repeated by someone outside the study and possibly yield similar results, which is dependability (Maher et al., 2018). The researcher ensured dependability by describing the research process in detail and step-by-step via a thorough and complete audit trail. Dependability was also carried out by the researcher taking careful steps to not make mistakes in collecting data, interpreting the findings, and reporting the results. A codebook was revised and updated from input provided by the researcher's analysis chair.

In addition to ensuring that other researchers could replicate the study outside of the current study, the researcher also wanted the findings to be transferable to different situations or settings, referred to as transferability (Maher et al., 2018). The researcher ensured transferability by describing participants' behaviors, experiences, and context in detail so the reader could determine whether the research context applied to their situation (Maher et al., 2018). Using information power, the researcher also assessed whether qualitative findings were adequate to

the study's objectives, the sample's specificity, the analysis strategy, and the quality of the interviews (LaDonna et al., 2021, p. 208).

To ensure confirmability, the researcher engaged in reflexivity and memoing. The researcher engaged in reflexivity throughout the analysis process by recording any thoughts, feelings, uncertainties, values, beliefs, and assumptions that surfaced throughout the research process (Carlson, 2010). The researcher also utilized memoing to ensure confirmability by writing reflective notes about why and how connections were made from analyzing the data. Reflexivity is another validity tool for researchers to self-disclose their assumptions, beliefs, and biases that may shape their inquiry (Creswell & Miller, 2000). Memoing and reflexivity proved very important since the researcher works with HIV-positive individuals. Both reflexivity and memoing helped the researcher prevent biases or misconceptions about the findings.

Results

This study included 10 participants. All participants met the inclusion criteria of being an African American female 50 and older, residing in the Southern United States, and engaged in active treatment for their HIV diagnosis for at least 12 months with an HIV care provider at the time of the interview. Each participant was assigned a participant identification number to protect their identity and to ensure confidentiality. Table 1 displays the complete sociodemographic sample characteristics of each participant. Seven themes emerged on the perceptions and lived experiences of optimal aging among African American women aged 50 and over with HIV in the Southern United States: (1) staying healthy with HIV-taking responsibility for your health, (2) feeling and looking younger than your actual age, (3) being in "your right mind," (4) social connectedness and support, (5) keeping yourself up, (6) being

"kept" by God, and (7) adjusting to your new normal. Subthemes were also identified and are described within the themes below. Table 2 presents the listed themes in narrative detail.

Theme 1: "Staying Healthy With HIV"-Taking Responsibility for Your Health

Staying healthy with HIV emerged as an overarching theme among participants. This theme included obtaining and maintaining an undetectable viral load, adhering to HIV treatment regimens, and having autonomy in healthcare decisions. There was a strong consensus among participants that obtaining and maintaining an undetectable viral load, adhering to HIV treatment regimens, and feeling empowered to make decisions about their health were all essential factors to experiencing optimal aging with HIV.

Undetectable Viral Load

All 10 participants viewed an undetectable viral load as the best thing a person with HIV could have to stay healthy and experience optimal aging. Participants felt proud and accomplished about having an undetectable viral load, as it reduces the chances of HIV attacking the immune system. As a result of having an undetectable viral load, some participants expressed that life was easier than expected after being diagnosed with HIV. Upon being asked what optimal aging is and what it means to be happy, participant 007 (age 63) insinuated that being undetectable makes aging with HIV easy. She stated:

I feel like aging with this HIV, and I am undetectable, and you know, it's easy, to me, it's easy. Cause you have had it so long; it is just like any other disease. That is all it is. You just have to take care of yourself.

Similarly, participant 002 (age 61) discussed the importance of an undetectable viral load by stating, "That is the only way to keep your immune system. See, you got to keep it and keep up on your numbers and stuff." The maintenance of a low or undetectable viral load can decrease

the chances of HIV progressing to AIDS, as well as decrease susceptibility to other serious diseases.

To assess her health status when discussing aging and HIV, participant 006 (age 64) mentioned that having an undetectable viral load was her benchmark. She stated,

Well, like my doctor told me, I have it, but it is very slim. My, my, how they say it? My T-cells, whatever they say. I do not have a whole lot of HIV in my body. I am undetectable.

Participant 010 (age 69) mentioned getting in the habit of attending scheduled appointments to maintain viral load numbers. As for lifestyle changes to promote optimal aging, participant 010 said, "It is mostly keeping appointments with your doctor. You have to stay on top of your numbers, your viral loads."

Adhering to HIV Treatment Regimens

In terms of optimal aging, all participants reported adhering to their HIV treatment regimens, whether taking medications as prescribed, attending appointments, or maintaining their health. Based on their shared perceptions and experiences, participants indicated they understood the negative consequences of failing to comply with treatment regimens and missing doctor's appointments. Among most participants, adhering to HIV treatment regimens was the initial response when asked for the meaning of optimal aging with HIV. One participant expressed that taking prescribed medications and following doctors' instructions allowed individuals infected with HIV to live and age similarly to those not infected with HIV.

Participant 006 (age 64) stated, "But then if you take your medicine every day, there is nothing wrong with you. I mean, if you take your medicine and do what the doctor tells you to do, you can live just like everyone else."

Participant 007 (age 63) provided a similar answer when asked about optimal aging. She stated:

The first thing I say is, take your medicine. That is the first thing I say. And just live like regular folks. Just live. That is the way I look at things. I am a regular person, and I am just living, you know.

Another participant discussed keeping medical appointments and addressing co-morbidities to ensure optimal aging. Participant 004 (age 61) stated:

Make sure I go do my testing that I have every six months. I make sure all my medical health problems are good. That is my main thing, make sure that I am in good health first and that there is nothing else going on inside my body.

Lastly, participants shared their views on HIV treatment adherence and its importance in staying healthy and aging optimally with HIV. Participant 002 (age 61) said, “So, you just got to do like the doctors tell you. And you got to take your medicine. You do not take the medicine; you end up down, and your immune system go be low.”

Autonomy in Healthcare Decisions

Participants reported autonomy in healthcare as a vital component of staying healthy with HIV and experiencing optimal aging. Most participants said autonomy in healthcare made them feel optimistic about their quality of life. Participants shared experiences of adverse side effects from certain medications, along with feeling empowered to have the ability to express their health concerns openly with their HIV care provider. Participant 010 (age 69) stated, “Medications may affect them [other older women diagnosed with HIV] in the same way, so they can tell you, you know, this medicine worked for me. Um, so ask your doctor. Can you try

that one?” Frustrated with the efficacy of the prescribed medication and not having an opportunity to discuss wanting to stop the medicine, participant 004 (age 61) stated:

But it does not bother me anymore after I had just stopped taking the medicine they were giving me. It helped some, but it did not help a lot. And I said I might as well just gone stop taking it, so I stopped taking the medicine. And suddenly, I do not even feel the pain in my side.

Participant 002 (age 61) shared her frustration over not knowing if her HIV medicine further damaged her kidneys. She was aware that HIV damages the kidneys but was not confident in the HIV medication she was prescribed. Due to her uncertainty, she did not feel comfortable addressing her concerns with her healthcare provider. She shared:

Because I was sick of saying I do not know what was going on with me. But I was dealing with HIV. I was taking my medicine every day at 8:30. I've been doing dialysis, you know. When you are dealing with HIV, it got something to do with your kidney too. So, on the flip side of that, one of the medications I was taking, I believe, caused me to have kidney failure. But it could have been something else. I just can't put it out there like that.

Theme 2: Feeling and Looking Younger than Your Actual Age

From the statements made by participants during their interviews, this theme was divided into two categories to support participants' responses. The two categories were self-perception and functional ability. For this research study, self-perception was defined as a person's attitudes and views regarding their physical appearance and feelings toward aging. Participants voiced feeling and looking younger than their age when asked to describe optimal aging. Participants

considered themselves optimally aging if they appeared to be aging well (not looking old) and had no significant physical limitations.

Self-Perception

Throughout this study, participants proudly voiced that they did not look, sound, or feel their age. Many participants referred to "black don't crack," a saying within the Black community where someone ages gracefully by looking significantly younger than their actual age. Many participants took pride in the fact that they physically appeared to be 50 or 40 years old to themselves and others. However, they were 60 years of age or older. Participant 005 shared, "People really do not think I am 67." As participant 006 (age 64) described optimal aging, she stated, "Not looking old, old, and taking care, keeping yourself fit and up to date." When speaking of the attributes of appearing younger than one's actual age, participants happily embraced their perceptions of not "looking old" in connection with optimal aging. Participant 008 (age 62) stated, "I keep getting told, people keep telling me, you still look like a little girl, so I like to go home in New Jersey, and they say you have not aged." Participant 009 stated, "Uh, like I say, you know, I am 68, but a lot of them say you do not look it. You look like you are 50 or in your 40s. Some even say the 30s."

From participants' responses, self-perception also included participants' attitudes and views on how they perceived themselves. Participants were asked to share their feelings on optimal aging for someone who is HIV positive versus for someone who is HIV negative. Most participants expressed that they did not see any difference between them experiencing optimal aging with HIV compared to their HIV-negative friends. Participants mentioned that many of their family and friends are HIV-negative but live with other ailments such as diabetes, heart disease, and arthritis.

Participant 010 (age 69) explained that although she has HIV, she has friends with other ailments who, from her perspective, are not aging optimally by stating:

HIV is just; it is just a virus that, you know, um, we have, that I have. I know I have friends that have shingles, and they most likely, they deal with things that could affect, you know, the aging, um, in a way that is not optimal, more so than myself.

Participant 003 (age 69) claimed it is also about having a positive perspective on aging by stating, “Well, it is a good thing. I guess how you look at it. Some people say it is a bad thing because some people have more problems with aging than others. You know, it is because of how your body takes it.” Further discussion with participants on feeling and looking younger than their actual age led to the emergence of the category of functional ability.

Functional Ability

Functional ability was the second category from the theme of feeling and looking younger than your actual age. Some participants expressed that their limited functional ability negatively affected their daily lives. In contrast, others expressed that their limited functional ability positively impacted their everyday lives, allowing them to carry out the tasks needed to remain independent. Functional ability was considered to be an indicator of optimal aging and good physical health by all participants. When asked to share her feelings about optimal aging, participant 006 (age 64) stated:

I am on oxygen. I am like a prisoner in my own house. I can't; I cannot move as fast as I used to move around when I am on this oxygen. And that bothers me. If I have to be somewhere, I got to take my oxygen. It is hard for me to bend down, and it is hard for me to tie my shoe. It is hard for me to do a lot of things. I take my time. I cannot move as fast as I used to.

When asked about challenges to experiencing optimal aging living with HIV, participant 007 (age 63) shared her feelings about being unable to perform daily activities.

She stated:

But they gonna' send somebody to help me, but then I might sweep this room. And I will sit down. I sweep that room. And I will sit down. You know, I do not like that. I just do not like that. Not being able to walk and do things for myself. That is the way I am.

In contrast, some participants shared their thoughts on functional ability related to optimal aging by sharing how being independent and mobile influences positive feelings. Participant 010 (age 69) stated, "I do not need assistance. Um, for the most part, I am very healthy." Also, when discussing mobility and independence, a 62-year-old participant (008) said, "Because, like, there is nothing, there is nothing that gets in my way of doing what I need to do for myself." Likewise, participant 002 (age 61) shared:

Because I am walking, I am talking. I got my own mind. I cook for myself. I put my own clothes on. Some things I need help with, like mopping the floor or something. But if I get the right type of tool, I can do it myself.

Despite being HIV positive, having co-morbid diseases, and with limited functional abilities, participant 004 (age 61) said, "I could be bedridden, but I am not." She further elaborated on the positive aspect of not being bedridden by continuing to make the most of the functional abilities she does have by sharing:

Some people get very depressed because they do not know which way to go or what to do. And their minds were set on things when they were young instead of just moving on with their life because we all have something to do as we go on the journey. We just have to find the purpose of what it is to do. So, I always find myself doing something if it is

not nothing but cleaning up or going to visit somebody, getting into a program, or finding a study to get in.

Participant 004 believed optimal aging with HIV embodied her being blessed to be alive. She said, "So, I just feel like it is a blessing to not be among the dead and just live my life as the days go by and make life better."

Theme 3: Being in “Your Right Mind”

The phrase being in “your right mind” is used as participants expressed it. In order to capture participants' perspectives, being in “your right mind” was defined as having a positive attitude, not being diagnosed with a mental illness, and being aware of your surroundings. This theme was divided into three categories. The three categories were self-acceptance, optimistic attitude, and mental strength. Participants described how these characteristics allowed them to experience optimal aging despite being HIV positive.

Self-Acceptance

Participants conveyed the importance of self-acceptance and its positive impact on optimal aging. They discussed how accepting their HIV diagnosis laid the foundation for them to be in their “right mind.” Participants perceived self-acceptance as the catalyst for experiencing mental peace and stopping self-blame. Participant 005 (age 67) reported, “I think I have gotten wiser with it because when I first found out about it, I was like, oh no, I knew better, but I have gotten more understanding about everything.”

Participants' responses suggested that self-acceptance helped them effectively cope with denial, anger, sadness, and depression. Participant 003 (age 69) stated, “Being comfortable with what I am and how I got it.” Despite accepting her positive status, she still experienced negative thoughts. However, she could redirect them by accepting the realities of her situation.

Well, it messes with your mind. Understand. Yeah. Uh, sometimes you can get in that slump where if I did not have this, maybe I can be doing this, and if you do not snap out of it, it really will make you think horrible things and make you do wrong things. But umm, you can catch yourself to say, no baby, I am living a good life. (Participant 003)

Most participants felt that getting into HIV care and feeling empowered to address their needs and concerns were less complicated once they accepted their situation. Participant 001 (age 53) stated, “Well, I had to learn how to accept it. Cause in, one while, I was thinking I was the only one. So, I had to learn how to accept it.” Participant 010 (age 69) mentioned, “It is just the fact you have to realize that you have something that you do not want, and you cannot get rid of it.” Also, when discussing accepting an HIV diagnosis, participant 004 (age 61) said, “Um, living with HIV is what it is. I got it, and I cannot change it. Uh, I have to accept the thing I cannot change.”

Self-acceptance appeared to cover a large spectrum among participants. For some participants, self-acceptance also included forgiving others and loving themselves. Forgiveness and love led to feelings of inner peace and being able to love oneself and others—all of which were considered to improve mental health and optimal aging. Failing to forgive others was viewed by some participants as suppressed feelings that would later cause negative emotions or delay complete healing. Participant 004 (age 61) expressed, “At the age of 61, man, I feel lovable. I feel love, and I return love. I got peace, and mostly, there is a lot of faith in me.” She also shared her experience forgiving the person who raped and infected her with HIV. She stated, “To forgive myself for one and to forgive the other person, you know, that gave it to me.”

Optimistic Attitude

The importance of having an optimistic attitude was also a typical response among participants when asked how their diagnosis influenced critical aspects of their lives over time.

Many participants stressed the importance of having a positive attitude and outlook. Most participants agreed that having an optimistic attitude influenced hopefulness and the desire to live a happy, healthy life. Participant 009 (age 68) mentioned how having an optimistic attitude influenced her outlook on life and aging optimally with HIV.

Uh, as I got older, it is, um, it is okay. It is better. It is like I know more about it. And I am not as scared as I was when I first started. I first, you know, became HIV positive; it is like I was scared. It is like it was a death sentence. I figured I was going to just give myself six months to live. I knew I was going to die, be dead. It is, yeah, I am going to live now.

Participant 007 (age 63) felt as if being diagnosed with HIV allowed her to have more of a positive attitude. She stated, "I think it made me more positive." Further saying, "Yeah, it made me see life better and clearer than I did when I was young." Participant 009 (age 68) mentioned she advises newly diagnosed young women, "Everything will be okay. It is not bad as it seems. You know, and it is going to get better. I tell them it is going to work out." Participant 008 (age 62) mentioned, "Just take everything into perspective." While participant 005 (age 67) stated, "I have something that I know I am going to have to take medicine for the rest of my life, but it is treatable."

Most participants believed that having an optimistic attitude increased their chances of experiencing optimal aging despite them being older and living with HIV. This belief was due to optimism providing the opportunity for individuals to think better and to do better. Participant 008 (age 62) said, "If you think positive, you must think better. As they said, when you know better, you do better."

Mental Strength

Mental strength was also essential to be in “your right mind.” An overwhelming number of participants mentioned being mentally strong comprised of not moping, not getting in a “pity pot,” not losing your mind due to your age and diagnosis, and not experiencing a memory decline. Participants were asked to grade themselves on their ability to function mentally. They were also asked to grade themselves on a scale of 1 to 10 and explain why they scored as they did. Participant 002 (age 61) graded herself as a ten and explained that one of her reasons for doing so was her ability to learn how to get back up when she was knocked down. She stated:

And when you talking about aging. That is because you want to sit there and age. But if you get up and try to do something, and try to, but I know when you dealing with the HIV thang, it is different because you go into a downward spiral because it is something that you was not looking for, so it is going to knock you down for a minute. But you got to learn how to get back up. You know what I am saying.

Also referring to being mentally strong, participant 003 (age 69) stated, “Not get in a pity pot.” Feeling sorry for oneself or displaying emotions of defeat without the ability to recover were viewed by participants as lacking the mental strength needed to be in “your right mind.”

Participant 005 (age 67) stated, “I do not go around here moping and saying, oh, I got HIV.” Participant 002 (age 61) shared how her mental strength allowed her to adapt and adjust to aging while living with HIV. She recognized that if she were not in her right mind, she would need some help. She stated, “Yes, I am in my right mind. When I am not in my right mind, somebody better go get me some help. I have not had those issues yet.” In participant 004's (age 61) view, aging with HIV does not always impact mental health. Adding to her statement, she explained, “Well, just because I am up in age, that does not mean I have lost my mind.” Not all

participants had positive responses or perspectives indicating they were in their right mind.

Participant 006 (age 64) shared her view on feeling as if she were not in their right or best mind due to declines in memory by stating, "Sometimes you start to forget things."

Theme 4: Social Connectedness and Support

This theme was divided into three categories: family and friend support, HIV disclosure/non-disclosure, and participating in constructive activities. Participants reported that help from family and friends, participating in constructive activities, and choosing whether to disclose their HIV status to others contributed to maintaining and developing social relationships. In addition, participants stressed how instrumental social connectedness and support were to them in experiencing optimal aging with HIV.

Family and Friend Support

There was a good deal of consistency among most participants when describing the importance of support from family and friends. Participants mentioned that having support made it easier for them to accept their HIV diagnosis and to adhere to their treatment plans since they did not have to hide their HIV medications. Participant 007 (age 63) stated, "When you first start, you do not, really want nobody to know, and you try to hide, you know, going to different places, who you live with, if you do not live by yourself, you hide your medication." Most participants who were asked about their social life and how family and friends support them reported positive experiences. Participant 002 (age 61) described her positive relationships with friends and family by saying, "Oh man, I have plenty of support. I have uncles, aunts, cousins, and everyone knows me." In like manner, participant 004 (age 61) responded by saying, "Um, being themselves. Knowing they do not have to tell me they love me. I know they love me for what they do for me."

Conversely, a few participants mentioned negative experiences with family and friends after being diagnosed with HIV. Participant 009 (age 68) shared the variations in her relationship with her oldest daughter versus her relationship with her youngest daughter. She stated, “My youngest daughter is real supportive. She [youngest daughter] said, “I ain't scared of you.” She ain't [scared], but my oldest daughter is like standoffish. Like, we do not get along, you know, too good.” Participants also explained the power of social connectedness and support. Participants elaborated on how social connectedness and support allowed them to access HIV treatment without fear, embarrassment, or shame. Participant 003 (age 69) stated, “I use my network the way I should” (implying her family and friends provide emotional, financial, and physical support when she needs it). Many participants mentioned their network utilization in some manner, which led many to express how their relationships tend to be intentional and based on preferences. According to most participants, these intentional relationships provided a sense of safety and understanding needed in relationships for HIV-positive persons.

Moreover, participants discussed the importance of having relationships with someone who could relate to the experiences of aging with HIV. Participant 003 (age 69) stated, “Well, I pick the people I be with and around.” Participant 006 (age 64) also said, “HIV is a different circle that you be in. But it is not a bad circle. It is a good circle.” In the same way, participant 008 (age 62) stated, “They, you know, say little things or whatever, but most of my friends I do have are in my same situation.”

HIV Disclosure and Non-Disclosure

From the participants' responses, they believed their perspectives of optimal aging with HIV centered around whom they could trust to disclose their status. When speaking about HIV disclosure/non-disclosure, participants had different views on disclosing. Some participants mentioned they have partners unaware of their positive HIV status. In contrast, some participants

stated they informed potential partners from the beginning. Participant 009 (age 68) mentioned, “I think you should tell them off from the jump. You know, just be honest and tell the truth. And then that way, they can decide whether they want to talk to you or not.” Participant 001 (age 53) expressed that optimal aging involves being socially connected and receiving support without explaining one's diagnosis. She stated, “Where the point is, I do not have to say or explain myself to them, nobody. And that I should be able to go anywhere or do anything that a normal person [HIV-negative] can do.”

Participating in Constructive Activities

Each participant described how engaging in constructive activities, especially with others, provided the tools necessary to feel like they had a sense of purpose. Participants mentioned having a sense of purpose as essential in optimal aging with HIV. Engaging in group sessions received an overwhelming response to optimal aging with HIV. Most participants talked about the positive impact group sessions had on their lives. As attested by participants, group sessions provided a place for participants to express themselves and discuss ways to improve their lives while living with HIV. Participants also shared that group sessions provided an opportunity for participants to engage in mentally stimulating activities. Through group sessions, participants formed social relationships and engaged in activities that gave them a sense of purpose by assisting other newly diagnosed women. Participant 002 (age 61) stated, “You got to get into a group session.” She further elaborated by saying:

The best thing that will help you is you got to go to support groups. To learn it for yourself. That is the most important thing. Get into the support groups so they can teach you the ups and downs, and you can find out what you are looking forward to.

Participant 010 (age 69) shared:

Just doing groups and what those groups do. They allow you to form, you know, certain friendships, and then people can give you tips on, you know, what they do to, um, that help them live a happy life. And then the groups, they give you something to look forward to.

For most participants, a sense of purpose involved more than just attending group sessions. Participants described how being connected socially and having support allowed their sense of purpose also to include giving their time to their community. Participant 001 (age 53) mentioned, “We like doing stuff for the community—different stuff. We used to go to the building every Monday from 9-11. We would go for the Hope Group, you know.” Participant 001 stated, “I would like to be able to go out and talk to young women, just young women that are coming up.” Lastly, participant 004 (age 61) discussed how engaging in constructive activities provided a sense of purpose as one age with HIV. She stated, “Instead of just moving on with their life because we all have something to do in our life as we go on the journey, and we just have to find the purpose of what it is to do.”

Theme 5: Keeping Yourself Up

Keeping yourself up was a term directly expressed by most participants. Participants identified “keeping yourself up” as one of the positive components of optimal aging while living with HIV. Participants mentioned multiple things they considered as “keeping yourself up.” Among these were maintaining a good physical appearance, practicing good hygiene, eating a healthy diet, and exercising, setting goals, and engaging in pleasurable activities. Also, there was a consensus among participants that refraining from drug use played a role in the success of optimal aging. Consequently, participants believed that “keeping yourself up” facilitated optimal aging.

Personal Appearance and Good Hygiene

Participants were asked about the lifestyle changes made to facilitate their success in achieving optimal aging. Participants emphasized the importance of practicing good hygiene. Participant 001 (age 53) shared her experience with African American women with HIV presenting to their HIV care appointments, appearing "unkept" and smelly. She further explained that being "unkept" and smelly exacerbated the stereotypes against African American women with HIV. Participant 001 stated, "Clean, take baths, and stuff like that." She also stressed, "Go in there and take your bath and wash up or whatever. And be clean. You do not have to be down because of this." Participant 006 (age 64) shared her perspective on practicing good hygiene. She stated, "So, I used to go make sure I washed my clothes. Even though I was out there in the streets living in my car and everything, I made sure I washed my clothes".

Participant 005 (age 67) shared that the key to experiencing optimal aging is to continue doing what you are doing to maintain your appearance. She stated:

You know, do not let, do not get down in the gutter. If you were there, pick yourself up because everything is actually free for you, food, clothes, everything. You do not have to look like you look, and there are some beauty shops. There is some barbershops that will cut their hair free.

According to participant 006, she owns only one pair of sneakers because she wears heels everywhere and ensures her clothes are fashionable and coordinated. She shared:

It is just like me. I got a pair of sneakers. Like today, I put them on today because I was going to get my other vaccination shot. But, if you see me when I go, I got heels on every day. Everyday. And believe it; the shoes are going to match the outfit I got on.

Diet and Exercise

Healthier habits such as diet and exercise were also described as essential components of optimal aging with HIV. Participants associated exercise and diet as direct factors in how well they maintained their HIV diagnosis and how well they aged. Participants described eating healthier and exercising as reasons that prevented them from dying, having a worse prognosis, or having limited functional abilities. Most participants had other co-morbidities such as high blood pressure, diabetes, obesity, and lung issues. During the interview, participant 009 (age 68) was asked what lifestyle changes facilitated her optimal aging with HIV. She replied, “I try to, you know, take care of myself, exercise. We do a lot of walking. Try to eat healthily.” Participant 002 (age 61) answered the question, saying, “You have to listen. They gave me a chart. I stopped eating a lot of [fried foods], and I bake my food now. I do not eat a lot of fried foods. I eat a lot of vegetables.” Subsequently, participant 009 said:

Because, um, there is nothing really different from when I was [HIV] negative. If anything, it is better because now I exercise. I try to eat more of my vegetables. Try to be more healthy, and take my medicine like I should.

Continuing to Establish Life Goals and Doing Things That Make You Happy

Continuing to establish life goals and doing things that make you happy were two critical components to “keeping yourself up” mentioned by participants. Participants shared that experiencing optimal aging while getting older with HIV included seeing life as a positive continuation despite having a disease that negatively affects a person’s life. Participants explained how doing things that make you happy makes positive and happy emotions a reality, leading to optimal aging and a happier life. Elaborating on the perspective of continuing to establish life goals, participant 003 (age 69) stated, “Get out there and challenge yourself.”

Participant 010 (age 69) voiced, “Come up with a goal.” Participant 004 (age 61) shared, “I am still willing to take a chance on learning, just using my mind to think about other things than just not on myself. About what can I do for somebody else along the way.” In addition, participant 007 (age 63) stated, “What is the use in sitting down and worrying when you can just go on about your business? Do something better or do something else.”

Throughout the interviews, participants expressed how doing things that made them happy positively affected their current mindset, outlook on life, and perspectives on optimal aging. Along with continuing to establish life goals, doing things that make you happy was common among participants when sharing their views on "keeping yourself up." Participant 005 (age 67) mentioned that a facilitator for optimal aging for her included "To keep doing what you are doing to keep yourself happy." When providing advice on doing the things that make you happy to "keep yourself up," participant 008 (age 62) stated:

You know, um, go out and continue to do, visit, um, just do all the things that make you happy, whatever makes you happy. That is what you continue to do. Because once you lose those things, they are not making you happy anymore, you, you, you, you start worrying, then they will affect your health.

Lastly, participant 002 (age 61) mentioned, “Life still goes on regardless of what the situation is. You can be old; you can be young. It is what you put in it. That is what you are going to get out of it.”

Theme 6: Being “Kept” by God

"Being kept" by God emerged as an overarching theme among participants when discussing how spirituality played a role in their experiences of aging with HIV and how they perceived optimal aging. Based on the participant's responses, the theme of being "kept" by God was divided into two sub-themes: spirituality and faith. To be "kept" by God, participants

explained that one must maintain a relationship with God and trust that God will always provide grace and mercy. More than anything else, spirituality and faith gave participants the strength to overcome the challenges of aging with HIV and the power to live.

Spirituality

When asked how spirituality plays a role in their life experiences and how they age with HIV, an overwhelming number of participants stated verbatim, "Being "kept" by God." Participants voiced that spirituality is vital to experiencing optimal aging. They expressed how having a relationship with God provided them the comfort needed to have inner peace and resilience after being diagnosed with HIV. Participant 003 (age 69) stated, "He [God] turned me around. He told me to get up, look in the mirror, and look at yourself. This is not you, and you can do something about it. You know, and I did." Participant 004 (age 61) shared:

I just love to call on the Lord and tell him to guide me through the day because I cannot do it by myself. And so, I know he has put people in my life to help me along the way. Participant 007 (age 63) shared how her relationship with God made her feel as a person aging with HIV. She stated, "And just sitting down reading the Bible, listening to God. It makes me feel like I am an older person that's listening to God, that is going to Heaven." Participant 007 mentioned that some people think HIV is a punishment for sin, but to her, the fact that God loves her despite having HIV represents aging optimally.

Faith

Participants distinguished faith as a must-have component to experiencing optimal aging living with HIV. They discussed how faith differed from spirituality because a person could believe in God and be spiritual but not have a strong sense of faith. An overwhelming number of participants described faith as depending on God by trusting He [God] will provide healing and

comfort during times of uncertainty, conflict, or illness. Several participants voiced how faith provided the will to live and the courage to fight HIV even when doctors gave up on them.

Participant 008 (age 62) shared her experience of doctors in New Jersey sending her home to Alabama to die after being diagnosed with HIV.

Participant 010 (age 69) stated:

I do know that if I did not believe in God, I do not think I would have made it through like I did. I probably would have lost my mind and not been able to go on like how I am able to go on now.

Participant 006 (age 64) stated, "You got to have faith, so yeah, it is more, the older I get, the more, the more I have faith in Him [God]." Many participants verbalized how important depending on God is while aging and living with HIV. Participants talked about how they cannot trust medicine or humans. Participants revealed that family, friends, and healthcare professionals could abandon them, but God would not. Participant 001 (age 53) stated, "The Lord plays a big role in my life because I depend on the Lord all the time. You cannot depend on man; you have to depend on the Lord because man is not doing nothing. Nothing at all." Lastly, participant 008 (age 62) described the extent of her dependence on God. By relying on God, she is assured that her life is fulfilled, which correlates to her perspective on optimal aging., "So, if I died today, it is okay. So, I guess there is nothing else to say in that area. I mean, because I lived."

Theme 7: Adjusting to Your New Normal

Adjusting to your new normal was common among participants. Subthemes included coping and adaptability and internalized and externalized HIV stigma. Because HIV is an incurable disease, participants considered living with it as their new life until death. Interviews with participants revealed a significant correlation between overcoming challenges and experiencing optimal aging with HIV. As participants described, overcoming challenges required

more than accepting being diagnosed with HIV and ignoring negative behaviors and attitudes from those unfamiliar with HIV. Moreover, one must possess a strong sense of self-love and a strong desire to live to adjust to their new normal effectively.

Coping and Adaptability Through Loving Yourself

During each interview, all participants shared how overcoming challenges after being diagnosed with HIV impacted their ability to experience optimal aging. Participants shared that learning to love themselves more after being diagnosed with HIV and having the will to live played a crucial role in overcoming the challenges older African American women with HIV face. Among the participants, overcoming challenges involved adjusting to a difficult situation, such as HIV, to overcome depression, cultivate optimism, and overcome the odds most HIV-positive individuals face. Participant 008 (age 62) mentioned:

It made me more outspoken, more outgoing, to care about me, to care about my health, to care about who I am. I love me because I, I did not love me. I love me. And I love who I am today.

Participants were asked to share how they overcame adversity and adapted to their HIV status. Participant 005 (age 61) stated, “I had to adapt because if I had not, I would have gone into a depression. I would have started drinking, probably taking drugs, but I had to get control of the situation that had infected me.” Participant 002 (age 61) stated, “Either you want you to live, or you want to die; it is up to them.”

Participants discussed how the will to live provided them with the drive to beat HIV instead of HIV defeating them. They discussed how pushing themselves and prioritizing their health enabled them to age gracefully and live longer with HIV. Participant 008 (age 62) stated, “I push myself as well.” Participant 001 (age 53) stated, “Cause at first they sent me home in a

wheelchair, and I said oh no. I said I was going to get on this walker, and I have been on this walker ever since.” Likewise, participant 002 (age 61) stated, “Life keeps going on. I just keep moving.” Apart from this, when speaking about pushing themselves, participant 008 (age 62) said, “So, I just had to keep it moving when I found out it was real.” When mentioning the need to put oneself first to experience optimal aging, participant 004 (age 61) stated, “I got to worry about me first. Taking care of myself first.”

Externalized and Internalized HIV-Related Stigma

Several participants described how HIV-related stigma affected their daily lives and their ability to cope with HIV-related stigma. Based on participants' responses, HIV-related stigma affected them on a personal level, family/friend level, healthcare level, and societal level. Participants talked at length about how HIV-related stigma impacted how they formed relationships and how they viewed themselves. Some participants even shared that they experienced HIV-related stigma from doctors and nurses providing their HIV care. When participants were asked about internalized HIV-related stigma and how it affected their feelings, participant 001 (age 53) stated:

I have been through a lot of pain. I have been through a lot of people looking down at me and [inaudible] a different type of way when they find out I am [HIV] positive. They do not want to touch me. I have to go through all that, even with doctors, nurses, or whatever. I have a lot of what you call it stigma.

Participant 004 (age 61) described how internalized HIV-related stigma initially affected her by stating, “At first, I was ashamed.”

In response to a question about externalized HIV-related stigma and how it affected their feelings, participant 005 (age 67) said:

I could say for myself; it is hard because people put, if anybody finds out, they put labels on you and label you, and um, I think they should learn more about it, and they make you feel so bad. So, in our community, it is worse.

Participant 006 (age 64) described the attitudes of her family when she was first diagnosed with HIV.

That first year my brother and them, my brother and his and wife, they were kind of scared. They came into the hospital. I always think back to when I first got diagnosed; they came in there masked down. I said what is wrong with y'all. Ain't nothing wrong with me. Y'all are more dangerous to me than I am to you.

When asked about effectively addressing HIV-related stigma, participant 004 (age 64) stated:

Taking care of myself first. Get rid of all that stigma; it is just like a layer of onions. Anything, an orange, you have to peel; you have to constantly peel something off every day. Being looked down on, and sometimes people turning their noses up.

Participant 005 (age 67) stated, about effectively addressing HIV-related stigma, "I mean, everybody is not going to accept you have it [HIV]." Participant 009 (age 68) shared that HIV-related stigma does not affect her as it once did. However, she continues to have anxiety when disclosing her HIV status. She stated, "I do not have that fear anymore, you know, not as much. So, I can say the only time I have a little fear, I say ugh, I got to tell him I am HIV positive."

In their descriptions of optimal aging, participants wished they could live like HIV-negative individuals. Participant 007 (age 63) stated, "And live, just live like regular folks. Just live. That is the way I look at things. I am a regular person, and I am just living, you know." Participant 009 stated, "I mean now, it is just like living like any other normal person that was negative."

Discussion and Conclusion

Current literature on HIV and aging is emerging (Sankar et al., 2011). However, women with HIV 50 and older remain underrepresented in research (Rubtsova et al., 2019). This study aimed to explore the meaning of optimal aging among African American women 50 and older living with HIV in the Southern United States by focusing on the perceptions of optimal aging across the physical, functional, cognitive, emotional, social, and spiritual domains. The researcher identified themes and subthemes based on the participants' lived experiences. Social and structural factors such as age, gender, race, health care, and socioeconomic status were associated with optimal aging among older African American women (Subramanian et al., 2017; Bradley et al., 2018; Sutton et al., 2017). A visual representation of the correlation between the themes, sub-themes, and social and structural determinants of optimal aging with HIV in African Americans over 50 is provided in Figure 1. By following the themes and subthemes that have been identified, African American women with HIV can achieve optimal aging through HIV care and support services that are culturally appropriate and tailored to their specific needs.

Staying Healthy with HIV – Taking Responsibility for Your Health

Viral suppression remains the most desired outcome when managing HIV-positive patients (Opoku et al., 2022). Most participants in the current study described taking responsibility for one's health as essential to managing viral suppression and overall health while aging with HIV. It was deemed a monumental accomplishment for participants to have an undetectable viral load. One of the main ways to obtain an undetectable viral load is by adhering to medical treatments and care. Participants indicated that being compliant with HIV medications, using HIV care services, and having a voice in health care decisions were critical aspects of optimal aging. There was a consensus among participants that taking prescribed

medications and attending scheduled appointments are two crucial components of viral suppression.

In addition to dealing with co-morbidities, some participants in the current study experienced adverse side effects from prescribed medications. For this reason, participants mentioned feeling empowered and satisfied when allowed to speak to their HIV care providers about stopping or starting a particular medicine. The current study's results align with those obtained by Boehme et al. (2012) on HIV-infected women in the deep rural South. Participants in Boehme et al. (2012) found that patients viewed providers as 'caring' if they let them voice their concerns regarding managing their disease. Among participants in the current study, taking responsibility for their health also included utilizing other HIV care services. Participants described other HIV care services, such as transportation to and from medical appointments, food boxes, housing, and financial assistance. Thus, HIV care services, such as housing, food, transportation, financial aid, case management, and medical care, are critical to optimizing chances of a better quality of life. The findings in the current study resonate with a qualitative study by Mitchell et al. (2022) on older African Americans living with HIV. Mitchell et al. (2022) found a similar theme among participants who identified positive experiences relating to HIV care with improved outlooks on life, greater support, and enhanced well-being. Likewise, Lambert et al. (2018) completed a systematic review of qualitative studies to assess adherence to HIV care in Black women. The authors found factors such as healthcare providers failing to listen, limited access to public transportation, food, shelter, and lack of resources associated with adherence to recommended care plans.

The attitudes and beliefs expressed by participants in this study regarding behaviors related to adhering to HIV treatment can be applied to the theory of planned behavior. The

World Health Organization (WHO) defines adherence as the degree of an individual's behavior, such as dieting, exercising, and following treatment regimens recommended by a healthcare provider (Sabate, 2003, as cited in Rich et al., 2015). Rich et al. (2015) explained that one of the fundamental precepts of the theory of planned behavior is that a person's behavior is predicted by that person's intention to carry out the behavior. The authors also found that perceptions of positive and negative views of behavior, social pressure, and perceived control influence a person's intentions.

In the current study, participants not only viewed adhering to HIV treatment regimens and utilizing HIV care services as critical components to optimal aging, but they also viewed them as their means to be as close as possible to having a HIV-negative status. Participants believed HIV-negative individuals were more likely to accept them if they followed HIV treatment regimens and received HIV care services. A study using the theory of planned behavior that yielded similar results found that participants who perceived the difficulty as low were more likely to take dietary supplements for HIV treatment (Lino et al., 2014). Moreover, when a reputable individual or group deemed taking dietary supplements necessary, participants were more inclined to take them (Lino et al., 2014). Participants in the current study did not specify whether their intention to engage in these behaviors was to enhance their general health or lessen the stigma attached to HIV and gain the acceptance of HIV-negative people. Notably, the women in the Lino et al. (2014) study were from California, aged from 26 to 73 years of age. The women in the current study were from Birmingham, Alabama, in the Southern United States. Birmingham is different from California due to the social and structural determinants, injustice, poverty, racism, and unequal opportunities in education and employment associated with particular geographical locations (Sutton et al., 2017). The current study also found that

difficulty in performing the behavior was a significant factor in addition to perceived behaviors. Participants discussed difficulties adhering to any HIV treatment regimen if they must hide their medications depending on whom they live with and where they live.

Feeling and Looking Younger Than Your Actual Age

Self-perception of aging significantly predicts quality of life (Nieves-Lugo et al., 2020, p. 1). For participants in the current study, self-perception included appearing younger to others and having a positive perspective about aging well with an illness. Participants believed they looked younger than their actual age, and others' judgments of them solidified their beliefs. According to (Barrett, 2003, as cited in Nieves-Lugo et al., 2020), individuals who perceive themselves as older than their chronological age are more likely to anticipate negative health behaviors. Despite their chronological age, most participants in the current study took pride in appearing younger than their actual age.

An individual's age, identity, and perception of aging can influence their motivation to engage in chronic illness self-management behaviors (Stoff et al., 2016). Rubtsova et al. (2017) found that most HIV-positive women aged 50 and older in the United States do not view age as a chronological number but rather as a state of mind. Among African Americans, "black don't crack" refers to those who appear younger than their age or do not exhibit external signs of aging. There was a feeling of pride among participants in the current study that they did not look their age, with one participant mentioning the phrase "black does not crack." Likewise, participants felt strongly about how well or poorly they perceived themselves aging with HIV and other co-morbidities. In a study by Warren-Jeanpiere et al. (2014) on African American women aging with HIV and co-morbidities, participants reported feeling younger than their chronological age, which was associated with the women wishing to remain youthful. In that

same study, there was a consensus among all participants that they did not identify as being older (Warren-Jeanpiere et al., 2014, p. 5). The current study's results showed that participants perceived looking younger than their age as an indication of optimal aging while living with HIV. Although the reason for this is unclear, participants in the current study seemed to find that a youthful appearance counterbalanced any negative perceptions of their health.

Participants in the current study also seemed to associate optimal aging with the ability to function independently by engaging in activities such as driving, living alone, completing daily tasks, and even getting dressed independently. This observation was not surprising as limits to functional ability can hinder an individual from completing daily tasks, accomplishing goals, and engaging in social life. One participant mentioned how being on oxygen and being required to carry an oxygen tank everywhere limited her ability to do the things she loved doing. The participant associated her limitations with being a 'prisoner,' which affected her ability to experience optimal aging.

Being in "Your Right Mind"

Mental health issues such as depression, anxiety, and posttraumatic stress symptoms negatively impact the well-being and quality of life of women with HIV (Waldron et al., 2021). By understanding how African American women with HIV are affected by mental health issues as they age, other aging women with HIV can benefit from the study. Participants stressed the importance of being in "your right mind." African Americans use the term "your right mind" to describe a mentally stable and conscious individual. Participants mentioned that remaining mentally strong, accepting their diagnosis, having a positive attitude, having a positive outlook on life, and not experiencing much decline in memory were all factors that created a mindset

conducive to optimal aging. Most participants said self-acceptance is the first step towards being in “your right mind” after being diagnosed with HIV.

Many participants discussed their experiences of accepting themselves as they are and accepting how they acquired HIV. The responses in the current study resonated with a study by Psaros et al. (2015) examining the reflections on living with HIV over time in women over 50. Psaros et al. (2015) found that accepting an HIV diagnosis resulted in a positive change in the perception of what it means to live with HIV and provided a sense of appreciation of life and the perspective gained because of their diagnosis (p. 124). Emlet et al. (2011) found similar results in HIV-positive participants 50 and older, where they shared feelings of being “okay” with who they were and accepting that they are aging with HIV.

Participants in the current study did not mention having any confirmed diagnosis related to their mental health. However, they shared having symptoms of mental health issues such as depression, feeling miserable sometimes, and being in denial. As a result, participants seemed to focus on positive things, such as changing their views. One participant mentioned that she was initially ashamed, hurt, felt much pain, and depressed. She then mentioned that now at 61, she feels lovable, loves in return, has peace, and has faith. There was an initial lack of self-love among participants in the current study after being diagnosed. According to Hampton and Gillum (2020), HIV-positive individuals initially had low self-love. They later developed the ability to adapt and grow, which aligns with the participant's responses in this study. The current study discovered that participants used self-taught redirection techniques to manage lingering negative thoughts. However, some studies suggest African American women with HIV manage their mental and cognitive health through family or church (Ebor & Jackson, 2020; Lassiter & Poteat, 2020; Messer et al., 2020). As interesting as it may be that participants in the current study

utilized self-taught redirection over seeking professional help, this concept is not new among African Americans.

Similarly, Ward et al. (2013) found that African Americans believe their mental health problems will resolve themselves, which creates a barrier to seeking mental health care. Some participants in the current study identified cognitive problems such as a decline in memory by stating, "sometimes you start to forget things." As noted by Vance et al. (2013), adults aging with HIV will experience a combination of age-related and HIV-related cognitive declines resulting in forgetfulness and cognitive problems. It is essential to consider that aging alone does not contribute to cognitive declines and forgetfulness in individuals with HIV. According to the findings of the current study, African American women living with HIV may be able to achieve optimal aging by enhancing their positive thinking skills and receiving professional mental health care.

Social Connectedness and Support

Social connectedness and support are associated with lower levels of depression, higher self-esteem, and happiness (Nguyen et al., 2016). As perceived by the participants in the current study, social connectedness and support encompassed maintaining positive relationships with family and friends, disclosing or not disclosing their HIV status, participating in constructive activities like group sessions, and participating in purposeful activities. In the current study, there were some positive associations with family support among participants. In contrast, some participants had close family and friends that did not want to associate with them because of their positive HIV status. Some participants could utilize their family network, which played a part in increased self-esteem for participants with support. Participants with HIV who lost family and friends due to negative attitudes felt isolated because of their desire to be with those they love.

Nguyen et al. (2016) found that social connectedness positively impacts older adults' mental and physical health. Nguyen et al. (2016) also pointed out that persons reporting low family closeness and contact had the lowest levels of life satisfaction (p.12).

Dale & Safren (2018a) suggested that Black women living with HIV found that social support from members of their "village" helped to foster resilience (p. 8). Participants from the current study mentioned having social support. However, they did not necessarily rely on social support to help them cope and adapt. Due to the stigma associated with HIV in the Southern United States, people may not be able to rely on social support to assist them in coping with HIV. Although the opportunity for social connectedness and support may be true for some, it is essential to note the geographic area where participants live. HIV-related stigma is deeply rooted within the Southern United States, sometimes hindering individuals from disclosing their HIV status to anyone, even family. The Deep South, including the state of Alabama, tends to be impacted more by HIV-related stigma due to the southern states being more socially conservative (Stringer et al., 2016). In addition to HIV-related stigma from living in the Southern United States, several participants shared experiencing HIV-related stigma within their families, friends, communities, and healthcare providers. A prior study by Fletcher et al. (2016) supported this result. According to Fletcher et al. (2016), regarding HIV/AIDS stigma among African American women living in the South, HIV-positive African American women are susceptible to multilevel HIV stigma in various settings and contexts across multiple domains.

In the current study, HIV disclosure/non-disclosure played a significant role in how participants created friendships and with whom they created them. Most participants avoided sharing their HIV status out of fear of stigma. There was a perception that family members might reveal their HIV status to others for spiteful reasons. According to previous studies

(Sangaramoorthy et al., 2017), disclosing a positive HIV status to family members increased stigma that significantly impacted the lives of older Black women. Most participants in the current study mentioned they do not develop friendships outside of their HIV support group, comprised of HIV-positive women similar in age. Only two women out of the ten mentioned they were in steady relationships. Participants stated they are selective of the people they choose to be around or let in their social circle. Participants' responses suggest that social connectedness and support needs vary based on the individual's current situation, conditions, and history. Dale and Safren (2018a) also found that HIV-positive Black women benefited from social support from other HIV-positive women.

In the current study, participants shared their experiences attending group sessions with HIV-positive women and engaging in constructive activities, such as helping other women with HIV. Participants described group sessions as the best thing that helped teach them the 'ups and downs' of living with HIV. As a result of group sessions, participants formed friendships with other women living in similar circumstances, allowing them to gain advice from others on how to age optimally. The findings from the current study are consistent with Dale and Safren's (2018a) findings which found that social support from HIV-positive peers provided a sense of protection from HIV-related stigma and allowed women to learn valuable coping skills.

Most participants in the current study mentioned having a sense of purpose through volunteering, being active members of organizations for HIV-positive women, and going out to talk to young women about ways to prevent HIV. This finding from the current study matches those observed in earlier studies that show HIV-positive persons 50 and older expressed desires to give back to their communities and educate younger generations on HIV and AIDS by sharing their personal experiences (Emlet et al., 2011). The current study's findings strongly imply that to

promote optimal aging in this population, group sessions that allow the women to develop friendships with other HIV-positive women may prove beneficial and increase the chances of aging optimally. Promoting optimal aging in older African American women 50 and older also includes establishing and maintaining positive relationships with family and engaging in constructive activities that provide a sense of purpose.

Keeping Yourself Up

Participants mentioned that “keeping yourself up” is essential to experiencing optimal aging. In the current study, “keeping yourself up” is comparable to self-care. Self-care is taking care of oneself using a focused set of actions to enhance mental and physical health (Barroso, 1995, as cited in Tufts et al., 2010). From participants' responses in the current study, not only should self-care include a focused set of actions, but it should also include a focused set of thoughts, especially since the mindset was a significant catalyst in participants taking action to care for themselves. Participants affirmed that “keeping yourself up” expanded across a large spectrum of self-care activities to improve or maintain optimal aging. Practicing good hygiene, having a decent appearance with clothing and hair, exercising, eating better than before, coming up with goals, and avoiding stressors were also essential components of “keeping yourself up.” Engaging in self-care behaviors such as taking baths, and utilizing resources offered to individuals with HIV, such as free clothes, food, and hairstyling services, were also mentioned as components of self-care by participants. Several participants said how a person presented to their doctor's appointments affected how providers treated that person. Participants in the current study believed that since having HIV made them more susceptible to experiencing HIV-related stigma, being presentable decreased the chances of experiencing additional HIV-related stigma. Similarly, Tufts et al. (2010) found that pampering was a common theme among participants in a

study on the self-care behaviors of African American women with HIV in a Southeastern United States metropolitan city. Participants in that study recognized pamperings, such as maintaining hairstyles, manicures, pedicures, and shopping, as caring for the mind, body, and spirit (Tufts et al., 2010, p. 42).

Participants in the current study also stressed the importance of exercising and eating healthier. Proper nutrition and physical activity can improve an individual's immune function and decrease complications associated with HIV (Somarriba et al., 2010). Participants opposed older women with HIV taking recreational drugs and “hanging out.” Participants believed a significant part of “keeping yourself up” is setting life goals and doing things you enjoy. This finding is directly in line with previous results in the literature. In a study by Emlet et al. (2011) on resilience in aging with HIV, maintaining a healthy diet, exercising, refraining from drug use, avoiding partying all night, and keeping future-mindedness were all common responses by participants.

The theme of optimism, which included looking forward to what life had to offer and having goals and aspirations, was common among African American women living with HIV in a study by Subramaniam et al. (2017). The results of the current study cast light on ensuring that the “self” is taken care of to the best of one's ability as a contributing factor in the facilitation of optimal aging. Taking care of oneself is accomplished through practicing good hygiene, having a decent appearance with clothing and hair, exercising, eating healthier, continuing to develop goals, and avoiding stressors.

Being “Kept” By God

Spirituality was an emerging theme in this study because all participants expressed that having a relationship with God was meaningful. In a study of healthy aging in older women with

HIV, Rubtsova et al. (2017) also found spirituality and a relationship with God as a common theme. Being "kept" by God was expressed by participants as God's way of providing grace and mercy, blessings, protection, healing, and inner peace. There were many ways in which participants believed God was keeping them, much like the findings of other studies, which found that the meaning of spirituality among African American women can vary even among women from the same background and culture (Dalmida et al., 2012).

Many participants in the current study expressed gratitude to God for saving them from death, AIDS, and hospitalization while engaging in destructive behaviors after being diagnosed with HIV. According to participants, God "kept" them from experiencing negative consequences for engaging in such negative behaviors. The current study's findings strongly agree with those of Dalmida et al. (2012), who found that many HIV-positive African American women believe that despite engaging in high-risk behaviors and being HIV-positive, God gave them a second chance. In some way, most participants in the current study thought being diagnosed with HIV was either a blessing in disguise or the catalyst that brought them closer to their spirituality and God, leading them to change their negative behaviors. In addition, these findings are consistent with those of a study investigating the spirituality of aging with HIV, which found that participants were more satisfied in their lives after being diagnosed with HIV (Vance et al., 2011). A separate study found that older African American women with HIV reported positive feelings about their HIV status, citing that it gave them a sense of purpose and empowerment (Cherry et al., 2018).

Participants expressed strong faith in God to the extent that they could not do anything without him and entirely relied on God over man. The current study found significant positive associations between participants' faith in God and their belief in their ability to survive HIV. To

achieve optimal aging and ensure their survival throughout life, participants lived by having faith in God. Each participant credited God as the reason they are alive and healthy. Gordensky et al. (2015) examined psychosocial factors impacting older women living with HIV in social and spiritual relationships and found that participants felt God gave them the strength to maintain healthy behaviors like taking medications, stopping drug use, and managing comorbid conditions. The current study showed that participants' relationship with God and faith significantly improved optimal aging. Additionally, participants were empowered by being "kept" by God to stop harmful behaviors and sustain positive ones.

Adjusting to Your New Normal

This study showed a noticeable correlation between coping, adaptability and experiencing optimal aging. Participants identified coping and adaptability as key factors to overcoming challenges to effectively manage stress, anxiety, depression, and other issues negatively affecting their quality of life. Adjusting to your new normal was described by participants as coping and adapting to an unfortunate situation to avoid depression, maintain a positive attitude, and overcome unfavorable odds and challenges. The current study's findings were consistent with those of Fletcher et al. (2020) on resilience and treatment outcomes among HIV-positive women in the United States. In the study by Fletcher et al. (2020), women identified resilience as motivation to resist negative feelings and promote healthy behaviors. Furthermore, most participants in Fletcher et al. (2020) were approximately 50 years of age and identified as non-Hispanic black women with HIV. They were recruited from Birmingham, AL, and Jackson, MS, in the Southern United States.

Having the will to live and learning to love oneself more after being diagnosed with HIV resonates with the findings from a study by Emlet et al. (2011) examining the resilient

characteristics across the lifespan among older adults 50 and over with HIV. Participants in the current study also identified learning to love oneself more after being diagnosed with HIV and having the will to live as essential factors in experiencing optimal aging. Emlet et al. (2011) found that participants recognized self-acceptance in the form of loving themselves and doing what is needed for themselves as being central to overcoming the adverse effects of HIV and the complexities of aging with such a stigmatizing disease (p. 105). Qualitative studies have shown that African American women with HIV experience debilitating HIV-related stigma, resulting in diminished psychosocial functioning and decreased antiretroviral adherence (Lipira et al., 2019a). The current study's findings suggest that HIV-related stigma is detrimental to older African American women as it causes shame, pain, embarrassment, and personal resentment, preventing them from experiencing optimal aging. Participants shared their experiences with externalized HIV-related stigma, such as doctors and nurses not wanting to touch them. Moreover, the literature suggests that HIV-related stigma affects adherence to HIV care and treatment recommendations (Lipira et al., 2019a).

In their responses, participants expressed their experience of HIV-related stigma on a personal, family, and friend level as well as a healthcare and societal level. Hence, to effectively address HIV-related stigma, individuals must value themselves, put themselves first, accept that not everyone will accept their diagnosis, and live to improve their physical, mental, spiritual, and emotional well-being. In line with the literature, participants stressed the connection between adherence to HIV care and treatment and optimal aging. The current study suggests that interventions and policies that promote optimal aging in African American women 50 and older should be culturally appropriate and tailored to facilitate optimal aging.

Limitations

This study, like any other, had its limitations. There was a risk of researcher bias in this study since the primary researcher works in the field of sexually transmitted diseases, including HIV/AIDS. The organization where the primary researcher works collaborates with the UAB 1917 Clinic and the UAB Family Clinic to ensure continuity of care for individuals diagnosed with HIV. Participants receive HIV treatment at the UAB 1917 Clinic or the UAB Family Clinic. Therefore, each participant was informed that the study had no connection to UAB or any other organization in Alabama.

Furthermore, the primary researcher had no prior contact or relationships with any participants in this study. Additional procedures were also in place to alleviate researcher bias during data collection and analysis. These procedures included an audit trail, reflexivity throughout the data analysis process by keeping a journal, and member checking. Due to the sensitive nature of HIV, snowball sampling was used to reach a population that would otherwise be difficult to recruit. There was no guarantee that the study sample was representative of the larger population because all participants were members of the same HIV support group. In addition, all participants were from Birmingham, Alabama, rather than from different parts of the Southern United States. Snowball sampling, however, can lead to sampling bias.

Implications for Practice and Future Research

The primary purpose of this study was to explore the meaning of optimal aging among African American women 50 and older with HIV in the Southern United States. Despite the limitations mentioned above, the results of this study can be helpful to HIV care providers, social workers, community health educators, and community-based organizations that provide services for older African American women with HIV. In addition, this study can offer an HIV care model tailored to older African American women interested in experiencing optimal aging while

managing HIV and other co-morbidities. According to Adam et al. (2018), people with HIV experience accelerated aging; therefore, the care of older women with HIV should include patient-centered approaches to manage their HIV and other co-morbidities effectively. However, the healthcare system in the United States does not support a comprehensive approach to providing healthcare tailored to the needs of women with HIV (Adam et al., 2018). The need to design and implement culturally appropriate HIV services and policies for older African Americans with HIV is also demonstrated in other studies (Sangaramoorthy et al., 2019). Research about how African American women with HIV perceive health disparities and inequities in HIV care is essential to developing practical and innovative HIV care interventions. Further consideration should be given to older African American women who do not perceive they are aging optimally. Considering the perspectives of older African American women with HIV who do not believe they are aging well may help researchers design, implement, and evaluate HIV care services to facilitate optimal aging.

The findings of the current study suggested that group therapy with HIV-positive women who are similar in age and who can relate to living with HIV could improve the chances of older African American women with HIV aging optimally. Group therapy facilitates optimal aging through the exchange of ideas, advice, and resources. Similar research on the resilience of Black women with HIV found that social support from HIV-positive peers mitigates the effects of HIV-related stigma, promotes healing from trauma, and provides valuable strategies for dealing with stressors effectively (Dale & Safren, 2018b). Future qualitative studies involving older HIV-positive African American women who have participated in group therapy in the past could provide insight into how group therapy can be tailored beyond the standard care currently provided by healthcare providers.

Conclusion

The challenges associated with HIV and disadvantageous life experiences, including childhood trauma, economic hardship, domestic violence, gender, and race, tend to have a more significant negative impact on HIV-positive African American women living with HIV in the Southern United States (Qiao et al., 2019). However, despite getting older with HIV and facing challenges associated with HIV, African American women 50 and older living in the Southern United States can achieve optimal aging. Using the themes developed from participants' lived experiences, factors that facilitate optimal aging include taking responsibility for their health, feeling, and looking younger, being socially connected and supported, maintaining their "right mind," being "kept" by God, and adjusting to their new normal. The identified factors that can facilitate optimal aging in African American women 50 and older are unique to the needs of older African American women living with HIV. Therefore HIV-related care and treatment services must be tailored and culturally appropriate to meet the individual needs of African American women aging with HIV.

For older African American women with HIV to experience optimal aging, it is essential to understand the concept of optimal aging and its significance in planning and implementing HIV-related care and treatment services. Several studies have focused on successful aging, which is aging without disease or disability. Considering the case of someone viewed as not aging successfully, Brummel-Smith (2017) questioned whether it is acceptable to conclude that they have failed to age successfully. It is more valuable and realistic to describe the desired experience of growing old and coping with changes associated with aging and HIV as optimal aging (Brummel-Smith, 2007). The findings of this study could encourage HIV-positive African

American women aged 50 and older to maintain an optimal quality of life as they age, based on the study's focus on women in the Southern United States.

African American women must have access to HIV services that facilitate optimal aging as they age. To maximize the effectiveness of HIV-related care and treatment services for older African Americans 50 and older, HIV care providers should consider the lived experiences of patients who are aging optimally with HIV. It is essential to consider the theory of planned behavior. Its importance should be recognized when making optimal aging the goal and outcome of HIV-related care and treatment services for older African American women with HIV in the Southern United States. By utilizing the theory of planned behavior, those who provide HIV-related care and treatment services can identify noteworthy and fundamental beliefs that can be used to develop interventions targeting HIV-related care and treatment services within the population being studied (Lino et al., 2014).

HIV-related care and treatment services should help older African American women living with HIV maintain spiritual wellness, physical and mental health, and social relationships. It is also vital that HIV-related care and treatment services help enable older African American women to look and feel better and reduce HIV-related stigma. These findings support the concept of optimal aging, which is characterized by the ability to function across many domains - physical, functional, cognitive, emotional, social, and spiritual - to one's satisfaction, despite any medical conditions one may have (Bowling Green State University, n.d.). Furthermore, implementing HIV-related care and treatment services for older African American women with HIV that are culturally appropriate, tailored to meet their needs, and address their physical, functional, cognitive, emotional, and spiritual needs can facilitate optimal aging in African American women over 50 with HIV.

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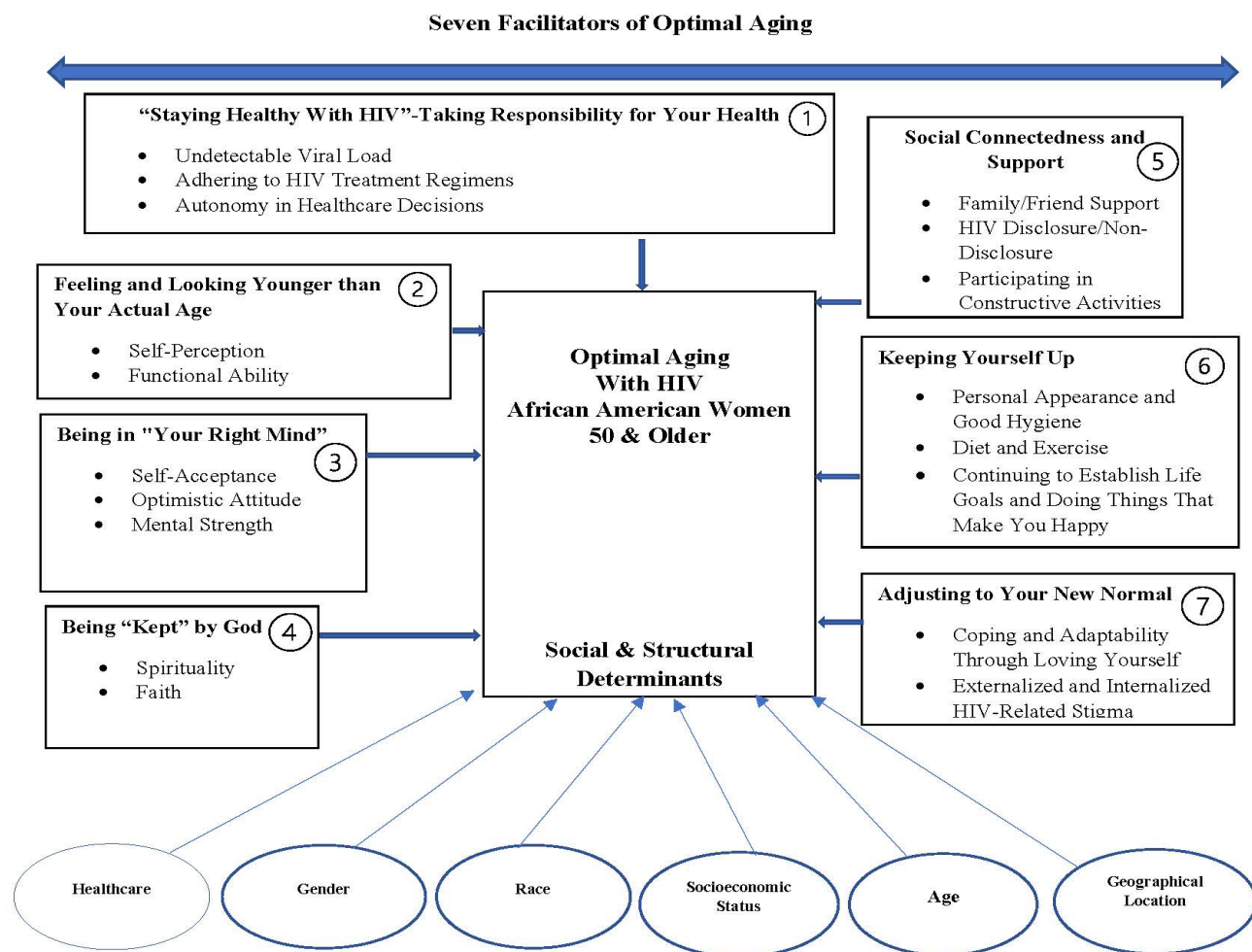
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Table 1*Participant Characteristics*

Participant ID#	001	002	003	004	005	006	007	008	009	010
Age	53	61	69	61	67	64	63	62	68	69
Sex	F	F	F	F	F	F	F	F	F	F
Race	AA	AA	AA	AA	AA	AA	AA	AA	AA	AA
Year of HIV Diagnosis	1995	1997	1992	2005	2014	1992	1998	1989	1991	1987
Time Lived in the Southeastern United States	53 Years	42 Years	69 Years	61 Years	67 Years	26 Years	23 Years	25 Years	24 Years	60 Years
Actively in Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Time Taking Antiretroviral Medications	26 Years	24 Years	15 Years	16 Years	7 Years	29 Years	12 Years	20 Years	6 Years	29 Years
Place of HIV Care	1917 Clinic	1917 Clinic	1917 Clinic	1917 Clinic	1917 Clinic	1917 Clinic	1917 Clinic	1917 Clinic	1917 Clinic	1917 Clinic
Highest Level of Education Completed	11 th Grade	12 th Grade	10 th Grade	11 th Grade	Trade School	College	Some College	GED	12 th Grade	College
Current Employment Status	No, disabled	No	No	No	No	No	No	Yes	Yes	Yes
Marital Status	Widowed	Single	Single	Single	Single	Single	Single	Divorced	Divorced	Single

Table 2*Themes & Example Quotes*

Theme	Sub Theme	Participant Quotes
“Staying Healthy With HIV”- Taking Responsibility for Your Health	Undetectable Viral Load Adhering to HIV Treatment Regimens Autonomy in Healthcare Decisions	<p>"That is the only way to keep your immune system. See, you got to keep it and keep up on your numbers and stuff."</p> <p>“So, you just got to do like the doctors tell you. And you got to take your medicine. You do not take the medicine; you end up down, and your immune system go be low.”</p> <p>“Medications may affect them [other older women diagnosed with HIV] in the same way, so they can tell, you know, this medicine worked for me. Um, so ask your doctor. Can you try that one?”</p>
Feeling and Looking Younger than Your Actual Age	Self-Perception Functional Ability	<p>“People really do not think I am 67.”</p> <p>"I could be bedridden, but I am not."</p>
Being in Your “Right Mind”	Self-Acceptance Optimistic Attitude Mental Strength	<p>“Being comfortable with what I am and how I got it.”</p> <p>“I have something that I know I am going to have to take medicine for the rest of my life, but it is treatable.”</p> <p>"Well, just because I am up in age, that does not mean I have lost my mind."</p>
Social Connectedness and Support	Family/Friend Support HIV Disclosure/Non-Disclosure Participating in Constructive Activities	<p>“Oh man, I have plenty of support. I have uncles, aunts, cousins, and everyone knows me."</p> <p>“I think you should tell them off from the jump. You know, just be honest and tell the truth. And then that way, they can decide whether they want to talk to you or not.”</p> <p>“We like doing stuff for the community—different stuff. We used to go to the building every Monday from 9-11. We would go for the Hope Group, you know.”</p>
Keeping Yourself Up	Personal Appearance and Good Hygiene Diet and Exercise Continuing to Establish Life Goals and Doing Things That Make You Happy	<p>“Go in there and take your bath and wash up or whatever. And be clean. You do not have to be down because of this.”</p> <p>“I try to, you know, take care of myself, exercise. We do a lot of walking. Try to eat healthily.”</p> <p>“I am still willing to take a chance on learning, just using my mind to think about other things than just not on myself. About what can I do that for somebody else along the way.”</p>
Being “Kept” by God	Spirituality Faith	<p>“He [God] turned me around. He told me to get up, look in the mirror, and look at yourself. This is not you, and you can do something about it. You know, and I did."</p> <p>“You got to have faith, so yeah, it is more, the older I get, the more, the more I have faith in Him [God].”</p>
Adjusting to Your New Normal	Coping and Adaptability Through Loving Yourself Externalized and Internalized HIV-Related Stigma	<p>“It made me more outspoken, more outgoing, to care about me, to care about my health, to care about who I am. I love me because I, I did not love me. I love me. And I love who I am today.”</p> <p>“So, I can say the only time I have a little fear, I say ugh, I got to tell him I am HIV positive."</p>

Figure 1*Visual Representation of Themes*

Appendix A
Notification of Exemption Determination

**Human Research Protections Program (HRPP)**

1400 East Hanna Ave 1 (317) 781-5774
Sease, Room 201L <http://irb.uindy.edu> Indianapolis, IN
46227 hrpp@uindy.edu

April 29, 2021

NOTIFICATION OF EXEMPTION DETERMINATION

Study Number: 01416

Study Title: *Perceptions and Lived Experiences of Optimal Aging in Older African American Women Living with HIV*

Exemption Determination Date: April 29, 2021

Principal Investigator: Laura Santurri, PhD, MPH
Director, Health Sciences Program

The above-referenced protocol has been reviewed in accordance with the US Department of Health & Human Services (DHHS), Office for Human Research Protections (OHRP) regulations, specifically 45 CFR 46.104. Based on these criteria, this study is exempt from IRB Review.

This exemption is valid unless changes in the project may impact the eligibility for exemption under the federal regulations. If you need to make any changes to the study, please contact the HRPP office hrpp@uindy.edu for guidance on whether additional review is required.

Please submit all personnel changes through IRBManager as a *Modification of Approved Protocol*.

Upon completion of your study, please submit a closure report through the IRBManager system.

A handwritten signature in black ink, appearing to read "Yvonne Wakeford".

Yvonne Wakeford, Ph.D.

Director: Human Research Protections Program (HRRP)

Appendix B

Recruitment Message for Social Media

Recruitment Message for Social Media

Subject Line: University of Indianapolis Doctoral Student Requesting Assistance Recruiting Participants for Research Study to Complete Doctor of Health Science Degree

Hello,

My name is Valencia Cotchery. I am a student in the Doctor of Health Science Program at the University of Indianapolis. I live in Birmingham, AL and I have been working in the field of public health and HIV for 10 years. I completed my undergraduate studies at UAB. I am also active with the Jefferson County HIV/AIDS Community Coalition. I have gained an interest in African American women ages 50 and older living with HIV and their perceptions on optimal aging with an illness. As a result, I have decided to conduct research on this topic for my doctoral project.

This study involves participation of an African American female aged 50 and older living in the Southern United States, diagnosed with HIV, and engaged in active treatment for HIV for at least 12 months with an established HIV provider at the time of the interview. Participants will participate in a confidential, 30–60-minute semi-structured interview with the primary researcher. Participants who complete the interview and the follow-up will be provided a \$30 incentive via Visa or Master Card gift card, cash, or cash app.

To achieve successful recruitment of research participants, I would like to request your assistance in recruiting participants for my research study by posting my research study information sheet in your private group for all group members to see. Please note that confidentiality and privacy will be ensured for all persons seeking interest in participating in my research study. At your convenience, I would like to establish a date and time to provide you with more information on the research study.

If you have any questions, please contact me at 205-603-3184 or cotcheryv@uindy.edu

This research project has been approved by the University of Indianapolis Institutional Review Board (IRB). Approval date 4/29/2021 Approval number 01416

Appendix C

Study Information Sheet



Minimal Risk UIndy Study # 01416
 Study Version: 1
 Study Version Date: 4/29/2021
 Informed Consent Form (ICF) Version: 1
 ICF Version Date: 4/29/2021

Department of Interprofessional Health & Aging Studies

CONSENT TO PARTICIPATE IN RESEARCH STUDY

Lived Experiences of Optimal Aging in Older African American Women.

Study Principal Investigator (PI): *Laura Santurri, Ph.D., MPH, CPH*

UIndy Email: santurri@uindy.edu

UIndy Telephone: 800-232-8634 x 2409

Doctoral Student Investigator: Valencia Cotchery

UIndy Email: cotcheryv@uindy.edu

Laura Santurri, Ph.D., MPH, CPH, and Valencia Cotchery from the Department of Interprofessional Health & Aging Studies, at the University of Indianapolis (UIndy) are conducting a research study.

Why is this study being done?

The purpose of this study is to explore the meaning of optimal aging among African American women ages 50 and older living with HIV in the Southern United States.

What will happen if I take part in this research study?

If you volunteer to participate in this study, the researcher will ask you to do the following:

- One semi-structured phone interview lasting 30-60 minutes about your lived experiences aging with HIV.
- One follow-up interview one week after initial interview via email or phone to review answers of what was shared during the initial interview.

How long will I be in the research study?

Participation will take a total of about 30-60 minutes, with a follow-up one week after original interview.

Are there any potential risks or discomforts that I can expect from this study?

There are no anticipated risks or discomforts.

Are there any potential benefits if I participate?



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You will not directly benefit from your participation in the research study.

The results of the research may enhance the understanding of the experiences that older African American women face while living with HIV, improving treatment plans, and promoting optimal aging interventions that meet this population's needs.

Will I be paid for participating?

- You will receive \$30 incentive via Visa or Mastercard gift card, cash or Cash App.

Will information about me and my participation be kept confidential?

The results of this study may be published in a scholarly book or journal, presented at professional conferences or used for teaching purposes. However, only aggregate data will be used. Personal identifiers will not be used in any publication, presentation or teaching materials.

Will the data from my study be used in the future for other studies?

It is possible that de-identified data from this study could be used for future research or shared with other researchers for use in studies, without additional informed consent. De-identified means that any codes and personal information that could identify you will be removed before the data is shared.

What are my rights if I take part in this study?

- You can choose whether or not you want to be in this study, and you may withdraw your consent and discontinue participation at any time.
- Whatever decision you make, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any question/s that you do not want to answer and still remain in the study.

Who can I contact if I have questions about this study?

• **The Research Team:**

If you have any questions, comments or concerns about the research, you can talk to the one of the researchers. Please contact:

Valencia Cotchery at (205) 603-3184, cotcheryv@uindy.edu
 Laura Santurri at (317) 788-2409, santurri@uindy.edu

• **The Director of the Human Research Protections Program (HRPP):**



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If you have questions about your rights as a research participant, or you have concerns or suggestions and you want to talk to someone other than the researchers, you may contact the Director of the Human Research Protections Program, by either emailing hrpp@uindy.edu or calling 1 (317) 781-5774 or 1 (800) 232-8634 ext. 5774.

Follow up studies

We may contact you again to request your participation in a follow up study. As always, your participation will be voluntary and we will ask for your explicit consent to participate in any of the follow up studies.

How do I indicate my informed consent to participate in this study?

You do not need to sign this, or any other document to indicate your consent. We will ask that you verbally indicate consent at the beginning of the interview.

This research project has been approved by the University of Indianapolis Institutional Review Board (IRB). Approval date 4/29/2021. Approval number 01416.

Appendix E
Demographic and Background Information

Participant

1. What is your age?
2. What is your sex?
3. What is your ethnicity?
4. What year were you diagnosed with HIV?
5. How long have you lived in the South?
6. Are you actively in care for your HIV diagnosis?
7. How long have you been taking antiretroviral medications?
8. Where do you receive HIV treatment services?
9. What is the highest level of education you have completed?
10. Are you currently employed?
11. What is your marital status?

Appendix F

Semi-Structured Interview Guide

Hello, my name is _____. I am a Doctor of Health Science student at the University of Indianapolis and the primary researcher for this project. I will be conducting this interview for my doctoral project. This interview aims to explore the meaning of optimal aging among African American women ages 50 and older with HIV in the Southern United States. The study will focus on the perceptions of optimal aging across the physical, functional, cognitive, emotional, social, and spiritual domains. I appreciate your participation and thank you for agreeing to be interviewed today; however, your participation is voluntary. The interview will include collecting demographic information and questions related to HIV, your life experiences, and aging. I want you to feel comfortable saying what you think and how you feel. There are no right or wrong answers during this interview. Everything you say today will be confidential, and portions of your interview may be used for the final research paper. However, no identifying information will accompany it. The interview will take 30 minutes to one hour. Writing everything down and engaging in an attentive conversation is difficult; therefore, the interview will be audio recorded. Do you have any questions about the interview or how the data will be used? By continuing this interview, your consent is assumed. You may terminate the interview anytime and skip any questions you prefer not to answer.

1. What is it like living with HIV?
 - a. How would you describe being an African American female with HIV?
 - b. Tell me what it has been like to be older with HIV.
2. What does optimal aging mean to you?
 - a. In what way or ways would you define optimal aging?

3. If you had to explain what it means to experience optimal aging living with HIV and to be age 50 and older, how would you do so?
 - a. What are your feelings about optimal aging among someone with HIV versus someone who is HIV-negative?
 - b. Tell me about the challenges to achieve optimal aging while living with HIV.
 - c. What lifestyle changes have you made to facilitate your success in achieving optimal aging?
4. If you had to grade yourself on your ability to function at your best physically, functionally, cognitively, socially, and spiritually, describe how you would grade yourself and why?
 - a. Tell me about what you do physically.
 - b. What is it like to meet your basic needs and be mobile?
 - c. I am wondering how you feel about your cognitive health.
 - d. Tell me about your social life. How do your family and friends support you; how do you maintain relationships living with HIV, and in what ways do you contribute to society?
 - e. In what way does spirituality play a role in your life experiences and how you age with HIV?
5. Tell me a little about how you believe living with HIV may have influenced critical aspects of your life over time.
 - a. How has being an African American woman with HIV influenced the course of your life and how you age?
 - b. In what ways have you adapted to your positive HIV status?

- c. Tell me how you overcame adversity related to being an older African American woman living with HIV.
6. What are your suggestions on how to experience optimal aging being an African American woman aged 50 and older?
7. What are some recommendations for specific interventions to promote optimal aging in African American women ages 50 and older?
8. Explain how being an African American woman plays a role in the suggestions and recommendations for specific interventions to promote optimal aging in African American women ages 50 and older.
9. Is there anything else that you would like to share about this topic?