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ORIGINAL PAPER

"Not in My House": Perspectives on HIV/AIDS of Afro-Caribbean Adolescents Living in South Florida

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Abstract

Florida has the highest number of PLWH in the USA, with the highest incidence being among young African-Americans. The purpose of this qualitative inquiry was to gain an understanding of the knowledge and attitudes to HIV/AIDS among Afro-Caribbean adolescents. Using a faith-based community, we conducted four focus group sessions with 40 Afro-Caribbean teens. Descriptive content and thematic analyses were used to examine the data. Themes identified include awareness gap, temptation everywhere, testing anxiety and stigma. Recommendations include continued exploration and interventions to address stigma in faith-based communities. Implications are discussed.

Keywords Afro-Caribbean · Adolescents · HIV/AIDS prevention · Faith-based

Introduction

It is well documented that the African-American (AA) population which includes the Afro-Caribbean (AC) group bears the disproportionate burden of HIV in the USA (CDC 2018). Like other minority underserved groups in the USA, the AC

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population is faced with a myriad of barriers, such as culture-specific beliefs and stigma to HIV, which according to the UNAIDS (2017) is the single obstruction to care in Caribbean countries. Unfortunately, those unique beliefs also migrate when Caribbean people move to America (Archibald 2007, 2011). For example, in the Caribbean, HIV is perceived as the result of irresponsible sexual behaviors (Harris 2010; Dijker and Koomen 2003) which might be grounded in religion. Simultaneously, people of African descent are among the most religious racial ethnic groups as reflected in their church attendance and prayer (Pew Forum on Religion and Public Life 2009). Faith leaders have responded to their membership in providing spiritual guidance and life instructions (Avent and Cashwell 2015) and strong support during times of hardships (Aycock et al. 2013). In recognizing the "omnipresence" of churches in Jamaican communities, and the power of faith communities in shaping beliefs, norms and attitudes, Muturi (2008) examined strategies for HIV prevention among faith leaders in Jamaica. Muturi found that church community is a culture where education on topics like HIV, though necessary for community health, is best when conducted in small group settings since sexual matters are not discussed in public church forums. Indeed, African-American churches have communicated interest in HIV collaborations to researchers while other churches are reluctant to participate in the war on HIV (Francis and Liverpool 2009) due to moral issues (Harris 2010) and availability of the necessary tools and skills to conduct such messages in the natural faith-based setting (Moore et al. 2016). Still, churches have teamed up with health agencies in reducing high-risk sexual behaviors (Wingood et al. 2013), improving mental health (Zewczyk and Weinmuller 2006), reducing smoking habits (Berkley-Patton et al. 2010), improving healthy eating habits (Bangurah et al. 2017) and exercise (Wingood et al. 2013). The evidence for these studies places the church as a valuable agency for addressing the HIV burden among AC community.

Similarly, black youth exhibit comparable attitudes toward the church, as they are most likely than other ethnic youth to report that their faith is important in their daily lives (Smith et al. 2002). Earlier investigations indicate that youth involved in religious activities are less likely to engage in high-risk behaviors including sex (Archibald and Newman 2015; Jemmott et al. 2010; Smith et al. 2002) as the church activities may allow youth to adopt beliefs about sexual immorality (Boyatzis 2003; King and Boyatzis 2004). The rigor of previous studies informs researchers that in order to yield more effective health behavioral changes in African-American youth, faith messages should be included in health information (Campbell et al. 2007). Lightfoot et al. (2014) added that faith messages that are infused in secular interventions for adolescents reduce contradiction and add applicability to the church. In fact, church youth endorse the importance to learn the facts about HIV and AIDS but prefer faith-oriented concepts that are grounded in scriptural dogma (Mpofu et al. 2014). With the exception of one study, none of the reports cited in this review included Afro-Caribbean church youth because AC youth in Florida were understudied as a church-going group. In addition, the multiple recent HIV prevention efforts that are available statewide, address key populations such as men who have sex with men, sex workers and injection drug users, and the Latino groups (Li et al. 2016). Those

interventions might not be culture-specific to the Afro-Caribbean church youth at this point, for members of the key populations might be hidden among adolescents of the Caribbean church.

Given that African-American adolescents rank the highest in new HIV diagnoses (CDC 2014), and the influence of the church is extensively accredited in the black culture (Harris 2010; Muturi 2008), the church community is primed for interventions that are contextual and relevant to address HIV prevention. Therefore, the purpose of this pilot study was to explore knowledge and attitudes to HIV/AIDS among Afro-Caribbean church-going adolescents aged 13–17 years. The overall goal is to use such perspectives to refine an existing culture-specific intervention that was developed to reduce HIV risk in the Afro-Caribbean church community.

Method

Design and Sample

The study utilized an exploratory descriptive design as its central premise to address the need for initial in-depth examination of a concept that has not been studied in a particular group (Tashakkori and Teddlie 2010). We received clearance from the Institutional Review Board of the University and from the parents and recruited a convenience sample of 40 adolescents that this pilot study could facilitate. Majority of the participants were of Jamaican and Haitian descent. Inclusion criteria were male and female adolescents between ages 13 and 17 years, who (a) lived in South Florida, (b) were able to read and provide written consent for participation and (c) attended church regularly. We operationalized "regular church attendance" as being present in a church service at least once per week (Williams et al. 2016). Afro-Caribbean adolescents with dual parents' custody or those visiting South Florida were excluded from the study. There were four focused groups comprising of 10 adolescents each, males and females were in their respective group. One adolescent from each group who demonstrated advanced knowledge of HIV/AIDS beyond that of their peers in the discussions was selected for personal interviews.

Procedure

In collaboration with the churches, invitations were issued to the parents of eligible adolescents to attend an initial meeting, by way of announcements in Sunday morning worship services and at youth meetings. We then met with the parents who responded to the invitation. The youngest eligible child was selected for participation in families with several qualified children. Confidentiality, anonymity and the selection of key informants were also explained to potential adolescents and their parents. Those adolescents who signed the assent and whose parent signed the consent were allowed to participate, and a time and place of their convenience was set for the discussions.

In order to maintain homogeneity, the participants were assigned to gender- and age-specific groups; the age-group was further divided into 13–15 years and 16–17 years age-groups. Group assignment was based on age at last birthday. Each adolescent was eligible for participation in one focus group discussion session. Seventy-five percent of the sample was male and 38% lived with both parents; all adolescents were at their grade-appropriate levels, and the majority was from Jamaica and Haiti (Table 1).

There were two sessions: (1) focus group discussion; (2) interviews. The sessions were conducted sequentially. The discussions were held in a quiet and private room in the church hall. In order to reduce the Hawthorne effect, experienced counselors and focus group facilitators, who were not known to the participants, conducted the sessions. The counselors and facilitators were under age 25 years and have years of experience in working with adolescents.

Table 1 Demographic table

Characteristic	Frequency	Percentage (%)
Age (years)		
13–15	24	60
16–17	16	40
Gender		
Boys	30	75
Girls	10	25
Living with		
Both parents	15	37.5
Mother	10	25
Father	2	5
Other relative	13	32.5
Highest educational level		
Middle school	10	25
High school	20	50
Some college	10	25
Islands represented		
Antigua	1	2.5
Bahamas	2	5
Haiti	15	37.5
Jamaica	20	50
Trinidad	1	2.5
St. Kitts	1	2.5
Primary confidant		
Father	10	25
Mother	20	50
Other relatives/guardian	5	12.5
Friends	5	12.5

The discussion sessions were targeted at discovering the extent of adolescents' knowledge and attitude toward HIV/AIDS and innovative ways in which risk behavior messages may be taught. Each focus group session lasted for about 60 min and the questions included: "What do you know about HIV/AIDS?" and "Why do you think young people your age engage in risky sexual behaviors?" After the four groups, the data were clearly saturated as no new information was received. This is consistent with previous work involving focus groups (Archibald 2011; Struthers et al. 2008). Each individual interview was conducted with the same facilitators and lasted about 45 min; the interviews included questions like: "Do you think you are at risk of HIV/AIDS?" and "How do you feel about the person with HIV/AIDS?" Follow-up questions were used as appropriate in both focus group discussions and individual interviews. All the sessions were digitally recorded, and field notes taken within the context of each discussion. The recordings were then professionally transcribed for analysis. After the analysis, the researchers used member checking and concurred with other investigators to ensure accuracy and credibility of the findings.

Analyses and Results

Thematic and content analyses were used to identify themes and patterns in the raw data. This approach, according to Kim et al. (2017), "allows the researchers to stay close to the data with minimal interference and enables readers who are familiar with the topic to recognize their own experience of the phenomenon" (p. 24). The unit of analysis was partial and complete sentences of the transcripts. We read the transcriptions line-by-line to become familiar with participants' responses and then conducted open and axial coding as recommended by Strauss and Corbin (1998).

Consistent with works of Ewens et al. (2014) and Chen et al. (2014), descriptive statistical analysis of sample characteristics was reported using frequency distribution and percentages including frequency counts of codes or themes. This process gave rise to four themes each with subthemes: (a) awareness gap which also includes (i) HIV knowledge gap and (ii) scriptural interpretation; (b) temptation everywhere including (i) normalization of risk behaviors and (ii) social pressure; (c) testing anxiety including (i) accessibility to resources and (ii) anonymity; and (d) stigma including (i) fear of HIV and (ii) parental influence.

Awareness Gap

Both genders in their respective groups responded appropriately to the first research question that addressed HIV knowledge. The participants demonstrated accurate levels of knowledge about HIV, modes of transmission and prevention strategies. This is clear in statements such as "You can get it [HIV] if you have sex with somebody who has it…," "you have to use a condom with everybody cause you don't know" and "You can't look on a person and know that they have it." Regarding a perspective that HIV is fatal, as no cure exists, another male replied that like other diseases for which there are no cures, people can live healthy lives: "They just have to take care of themselves from now on." (Male interviewee). However, it was clear from

the discussion that two areas of confusion exist in the sample of AC teens which include "knowledge gap HIV transmission" and "scriptural interpretations."

Knowledge Gap HIV Transmission

Male and female teens indicated that based on the information they received at school, from friends, and the media, HIV is a disease in body fluid and that it is only transmitted through humans—not animals or inanimate things. Simultaneously, there is talk about the message being sent to intravenous drug users, hence the importance of sterilizing needles:

> So, they want the drug users to sterilize needles but nothing about toilet seats. I do not want nobody's sweat or urine to touch me; so, I don't sit on toilet seats. If they come to our house and use our bathroom, we don't know if urine is on the seat like that. When they drink from our cup, that is saliva; so, we must clean with bleach. Then you go to our church and I see people crying on my mother's shoulder, that look like body fluid to me. (Female Focused Group Discussion).

The female teens raised the idea that information about HIV was especially confusing. Although teachers and the media were willing to provide data regarding HIV knowledge, the adolescents needed additional support to clarify misconceptions regarding the extent to which they should take information literally (Female interviewee).

The general perspective of the groups and key informants is that HIV/AIDS is unique to homosexuals since they heard about HIV/AIDS and differences in sexual orientation almost simultaneously.

> …it is for gay people for they have sex a different way like men with men, women with women and all that; you know what I mean?" I don't think I have that problem. How would we all get here if that was the way to go?" (Gestures of quotation marks around "way to go") (laughing ensued). They get HIV because they are doing some things that they not supposed to… like sex and stuff. (16–17-year-old male).

Scriptural Interpretations

Participants were enthusiastic and seemed prepared to articulate their knowledge of the Bible to strengthen their position on PLWH.

> Things like HIV is what happens to people who disobey the Bible; when God is over us because of how we act, he punish people… like what happen in the Garden of Eden. God pushed them out, so we have to suffer the consequences, and AIDS is one of them and they pass it on to babies. Don't you see all the wickedness in the world? People killing each other … and people doing drugs and smoking ganja, those things let you get AIDS and is because they be disobedient to God. (Male interviewee).

Temptation Everywhere

This theme highlights the problem of sexual inducements that the adolescents described. In response to "Why do young people your age engage in risky sexual behavior?" many of the adolescents normalized risky behaviors, while others attributed their actions to pressure from their peers and bombardment of information from social media. This theme will be addressed through the "normalization of risky sexual behavior" and "social pressure."

Normalization of Risky Sexual Behavior

"…it's everywhere, and everybody is doing it [sex]. One male participant was vocal about the pervasiveness of sexual activities:

"Sex is everywhere at school all [even] on the roof of the portables; they don't care if someone sees them or if they roll off" (laughing). "Even at lunch time … some having sex behind the tree, they don't care if people see them!"

One participant expressed the fear she felt upon arrival in the USA and witnessed her classmates having sex. "I didn't want to speak to them… I thought they would hurt me for seeing them… I have to say a prayer sometimes for this is a lot…." "It is a lot going on," interrupted another. Eventually, those teens expressed understanding that sex was not as tabooed in the USA as in their country of origin. "I think that sex in America is not a big deal like that…it is not private cause you see it everywhere, and people not shame; they brag about it and nobody not suppose to say nottin' cauz nobody not perfect (Female interviewee).

Social Pressure

Female adolescents described the pressure they face to engage in risky sexual behavior and subsequent acquiescence.

> My friend says she daydreams about it [sex] but nobody ask her [for sex]"). "Boys ask me all the time, but I told them to go 'way; they call me names, but I don't care." Another girl chimed in: "they bother me too but I don't say anything. They think if they keep on asking, one day you will say yes." Another member spoke about the same boy who "took out his stuff [penis] and showed me…I was embarrassed for myself, for they looked at me as if I should do something." The clear social pressures that the teens expressed might be directed to the new kids as a female interviewee expressed: "I think they try you when you just come to school; and if they think that you are a foreigner, then you might agree to do what they ask… and sometimes they just playing around but is no joke for us; for some of us what to focus on our school work. But sometimes they make it so hard that you don't want to go to break.

Three male adolescents in the 13–15 age-group indicated that they felt similar pressure from their female peers: "The girls will tell you they want you and listening to these girls… gives you an erection and everything…" and "yes; and then

you have a boner and stuff." "Some don't say anything; they just act and wear sexy clothes and trapping you."

> Some guys give in and have sex with the girls; we will know because we can tell when they just did it. Yes, they look different… like guilty yea, … and the guys brag about it… and if you want to be in that conversation, you gotta have something to say. I say my prayers every day for I don't know what I might do. I have gotten in trouble before, but not with my parents, there are two sides to who you are; one for your parents and one for your friends. My dad tells me … that he is not my friend; I have to show him respect. My friends don't ask for that, so it's ok to try new things and talk with your friends. So, when the girls dressing like they ready for sex and you struggling for all you can hear is your friends' voices, it's a struggle (Male interviewee).

Several male participants in the 13–15 age-group spoke about the role of online media platforms in normalizing risky sexual behavior and how conflicted they become when there is no convergence between the messages on social media and those from their parents:

"The social media does not help, for my parents taught me that sex is sacred, social media makes it look like it's ok… Lots of kids in my class having sex, and you feel left out.

"Well my mother would know [if I have sex] … she said when I start having sex, it's time for me to have my own place" to which most of the others agreed.

Testing Anxiety

There was robust discussion surrounding HIV testing following risky sexual behaviors, social pressure and subsequent acquiescence. However, HIV testing for this group may be summarized in accessibility to resources and protection of their identity.

Accessibility to Resources

Participants indicated that they were aware of the availability of testing facilities, but demonstrated reluctance to access those places as they felt that those amenities were intended for adults:

> I know they have testing places for free, but what if someone you know sees you going there… you know what I mean?" another teen added: "I am not going to no family-planning place; that is for grown people who trying to plan family….

Another participant expressed that since she was not old enough for a driver's license and her parents had close watch on her, so asking them to provide transportation to the testing center was not an option. "I can't imagine telling my grandmother [that] I want to get tested; can they take me to the family-planning place?" On closer examination of that idea, a key informant had this to say: "We find a way to get

everything we want whether our parents know or not… like condoms and stuff, but to go get tested? That is a big one for that's like telling everyone that you having sex and we know that is big people stuff… my dad smokes so cigarettes are in my house, so I take them to school… But my mother would kill me. She is not having that…."

Anonymity

Participants said they were apprehensive about testing, primarily due to privacy: "People will scorn me [if they know I have it]," and "…yea or even if they know you got tested." My grandma is a nurse at that clinic, and she knows everybody… I would need a place to live." "Are you going to erase that tape?" asked a male in the 13–15 age-group, "…for my mother would kill me if she hears me say certain things…." Another asked: Can you all figure out how to get tested and nobody else know but you? I'm just saying…not for me but for my friends." Such statements speak to perceived intolerance from parents of risky sexual behaviors and the need for privacy. "My grandmother talk to me about these things, but I still wouldn't want her to know that I want to be tested. I think I am at risk for HIV for it is hard to keep resisting when all your friends are doing it…and I know it's the same for a lot of girls my age…some of them have done it[have sex] they just not saying it in the group.. they want to be tested but afraid that people will know."

Stigma

The opinions of the adolescents were clear as they expressed fear of HIV, mistrust of health care messages and the influence of parents on their decisions.

Fear of HIV

The discrimination against HIV-infected friends was clear in statements such as "… my friend is my friend … but you can only go so far with your friendship. I have to look out for myself first…" and "that don't mean they have to come to my house… plus my mom said: 'not in my house' she is not having it." Other statements include, "I would invite them, but I know my mom would wash the sheets with bleach and use paper plates…" and "I know you can't get HIV like that, but you don't know… that's why I am not inviting anyone to my house who has AIDS" (female focused group discussion). Non-disclosure of status did not mean absence of HIV or AIDS to these adolescents. This position is evident in the statement from a key informant, "How are you gonna know that someone has HIV. We take it for granted that if they don't tell us that means that they don't have it and we would treat them like we do normal people, and if they even tell you that they don't have AIDS how are you gonna know that they are telling you the truth?" As a result, the teens are cautious with all visitors to their homes.

A mistrust in health care advice emerged: "I am not sure I believe anything they [health care providers] tell us, for everyday they have something different to say [who knows]…." "Yea" (interrupted another) "that's true; for they say it's body

fluids, [mode of HIV transmission], but we don't hear anything about drinking out of the same cup, or if they cry on your shoulders like they do at church." "We don't know, for 1 day you hear that something is good for you; the next day you hear it is bad" added another. This salient message emerged throughout all the discussions."

Parental Influence

It was noteworthy that the teens value the opinions and guidance of their parents although the message might need clarification, but the adolescents were paying attention. This is clear from the following statements: "Knowing my dad, he would probably say 'no', if I want my friend to come home for the weekend…and my mother would agree with him, but she would do it in a more caring way." At the same time, the male adolescents were more opened to sustained friendship with an HIV-infected friend. Their position was clear from statements such as "I am not having sex with them, so they could come to my house," and "I don't look at them differently, for my friend is already judged by all… but I would do the research for my dad before asking him permission," and "… it's not like you ask them, 'hey I want to be your friend, but do you have HIV…?" (laughing). "It seems like we don't know enough about HIV, so I don't want to be around people with it. They got carried away and did something wrong…Look I'm not judging them or nothing like that… I'm just saying that if I am going to get HIV it must not be because I was hanging out with some dudes with it." (Male interviewee).

Discussion

The results of this study that was conducted among Afro-Caribbean adolescents in South Florida are quite promising and provide a range of perspectives on HIV. Afro-Caribbean adolescents in this study are knowledgeable about the science of HIV/AIDS, progress and mode of transmission. However, their inability to transfer such knowledge to attitudinal changes results in fear of social contact; hence, HIV remains stigmatized in this population, a finding that has been isolated in previous work (Archibald 2011). While we did not assess for sexual preferences, Afro-Caribbean heterosexual teens transfer liability of HIV or AIDS to other groups that are dissimilar which Hart et al. (2009) describe as *Selective Exposure* where individuals choose to receive information that aligns with their own opinions and beliefs in order to avoid dissonance. Mistrust in health care identified in this study has been isolated in our previous works among Afro-Caribbean teens (Archibald and Newman 2015) and Afro-Caribbean women (Marshall and Archibald 2015). Perhaps, such pervasive disbelief among Caribbean people has foundations in the history of healthcare abuse of the African-American population as in the Tuskegee study, since people identify with skin color before other demographic variable (Nurse 2004).

Portrayal of sex in school and on social media creates interference with parental advice of abstinence; consequently, adolescents' concerns about their HIV status are legitimate, but trepidations surrounding disclosure prevail. This finding speaks to

the proclivity of people of African descent for privacy, which prohibits access to care. Ojukutu et al. (2014) support this finding in their study where they investigated barriers to health care and found that this need for privacy was greater for recent immigrants than for those who had been in the country for a longer period. Like in other populations, anxiety in testing for HIV found in Afro-Caribbean adolescents is not unusual and can occur at any stage of HIV diagnosis (Ashraf et al. 2017).

Parents and influential leaders in communities like Afro-Caribbean (Archibald 2011) and Native American (Lowe 2011; Lowe and Struthers 2001) are significant to young people and are embraced with a steadfast principle of respect for guidance. Afro-Caribbean adolescents in this study perceive rebellion against advice of influential church leaders as precursors to life-threatening outcomes, such as HIV/AIDS. While the link between adherence to parental advice and risky behaviors is not traced in our search, this finding indicates a legitimate area of inquiry to aid in understanding behaviors that potentially expose people to harm, preventing them from attaining their maximum potential. Perhaps, the non-conformity to parental advice identified in certain sectors of the groups in this study might be related to a myriad of factors, including delayed developmental milestones (Erikson 1968).

Additionally, as this immigrant group of adolescents forges new relationships in the USA, they straddle two cultures (Choi 2001); so, they acquiesce to peers' influence over parental advice. Hence, the gravity of the statement, "I have to say a prayer," indicates the struggle to simultaneously live in two worlds.

Whereas earlier assessment of a similar population in the Caribbean revealed teens as more forgiving of peers' risk behaviors (Barnes et al. 2016), perceptions of Afro-Caribbean young people reflect a more disparaging view of people with HIV/AIDS, as participants perceive the disease as a result of non-adherence to scripture. This intolerance for PLWH might be consistent with doctrine and practice to which they have are exposed or might be a Hawthorne effect of being in a church setting and facilitators were ministry leaders. This assumption also means stigma rather than accessibility to HIV testing might be the barrier to care in this population since testing is available at no direct financial cost to South Florida residents.

Limitations

Although we used youth facilitators who were unknown to the participants, issues of sexuality in open discussions like our use of focus groups might have created some discomfort for the adolescents being raised in an environment where sexual behavior is not openly discussed. Therefore, some of the adolescents might simply agree with the "not-in-my-house" refrain of the majority of the group. It is also possible that some of the adolescents were HIV + or had family members with the disease and are afraid of disclosure. We used a convenience sampling approach, which was accessible; however, that method contributes to selection bias. Also, the design was purely qualitative; therefore, the results could not be generalized to any other adolescent group even those of Afro-Caribbean descent. While there was diversity in the islands included in this work, the majority of the participants were of Jamaican descent, which might be because of Jamaica's proximity to South Florida. Another

limitation to this work is that it included only church-going groups, and the majority of participants lived with both parents, again which might not be representative of the Afro-Caribbean teens in general living in South Florida.

Implications for Practice

In agreement with government recommendations, teaching risky sexual behaviors cannot be exhausted for "a new generation needs the benefit of the previous effective HIV prevention interventions" (CDC 2011). Therefore, HIV prevention approaches are necessary and there is a call for HIV testing as a strategy for HIV prevention for at-risk groups (UNAIDS 2017) within the faith-based settings, in particular the Afro-Caribbean church community in South Florida, a population that is still understudied and a community resource that is underutilized. With the influence of church forerunners for HIV testing, the membership would be more likely to comply with testing as their teaching mandates "…to obey them that have the rule over you for they watch out for your well-being" (I Timothy 4:12, KJV). Just like the generation of Issachar who had knowledge of the times and who understood how to lead the people of God (I Chronicles 12:32, KJV) in the same way church leaders today ought to know that the current generation needs HIV prevention messages beyond abstinenece and use approaches such as Snapchat that resonate with the millennial generation. In that way, adolescents who receive information through those mediums will be able to make informed decisions regarding their sexual health.

Since risk behaviors are associated with a range of psychological predisposing factors, and Afro-Caribbean teens are fearful of testing, we recommend clinical counseling for this population within the community (Catona et al. 2016) since they are at risk or might be living with HIV.

Sexual communication information from parents to teens is twisted with half-truths, which suggests that parents might need assistance with sexual communication with their adolescents. This finding converges with Hutchinson et al. (2012) who identified this gap in their study of Jamaican parents and their teens. Sexual education could be conducted in the church settings, where members expect their leaders to provide guidance beyond spiritual well-being.

Recommendations for Research and Conclusion

This exploratory inquiry is part of the sustained effort to engage faith-based communities in South Florida in HIV/AIDS research. As a result of this work, we discovered the need for further research into attitudes to PLWH, stigma and testing anxiety. Therefore, we recommend replication of this study to gain perspective from a more heterogeneous Afro-Caribbean population of adolescents, including non-church-going groups, a larger sample size and Afro-Caribbeans living in other areas of the USA. We also recommend further study to assess tolerance for PLWH among church leaders and adolescents. The creation of a technological application for HIV prevention for Afro-Caribbean adolescents is also indicated. Finally, we recommend quantitative approaches using transdisciplinary designs. Such study will allow

scrutiny of risky sexual behaviors from multiple perspectives and provide evidence for practice.

The purpose of this study was to assess the knowledge and attitudes toward HIV among Afro-Caribbean adolescents in the USA. The intention of this work was to refine an existing HIV prevention intervention that was developed for this population, this time including male adolescents. The findings of this work add to the body of literature regarding HIV prevention using faith communities in South Florida. Although stigma to HIV was present, which could be attributed to a number of factors including parental influence and church teachings, the adolescents had challenges articulating faith and media messages, which in turn might have been what contributed to the stigma and risk behaviors that we found. Our work is a preliminary step in reaching the goals of the National HIV/AIDS Strategy 2020 for the USA, which purports as a federal action plan to intensify HIV prevention efforts in communities where HIV is most heavily concentrated, and to educate all Americans with easily accessible scientifically accurate information about HIV risk prevention and transmission (CDC 2015).

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Compliance with Ethical Standards

Conflict of interest The authors report no real or perceived vested interests that relate to this article (including relationships with pharmaceutical companies, biomedical device manufacturers, grantors, or other entities whose products or services are related to topics covered in this manuscript) that could be construed as a conflict of interest.

Ethical Approval We received permission from the IRB at Florida Atlantic University before the recruitment and data collection began. We also received parental permission and adolescent assents for participation.

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