HIV Beliefs Among African Americans with HIV/AIDS in the Deep South Can Time Heal Old Wounds?

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Abstract

This study explored rumors about HIV among HIV+ African Americans in Louisiana, comparing the results of surveys conducted in 2000/2001 and 2010/2011. This investigation sought to determine if the passage of time would diminish malicious intent and benign neglect beliefs. The study employed quantitative descriptive statistics to produce the comparison. This research should be considered exploratory only because of the stated limitations. The results indicated that the benign-neglect belief of government truthfulness about the disease had not diminished in the decade. In contrast, the strength of belief in the malicious-intent rumor of HIV/AIDS as genocide had declined. The study further examined relationships between the HIV beliefs and certain characteristics of the samples. Bivariate analyses revealed that education was not related to HIV beliefs in 2000/2001 but was related to the HIV/AIDS as genocide in 2010/2011. Further, emotional well-being was mildly related to HIV beliefs in both samples. Several recommendations are offered for future research. Although this study frequently used the term “conspiracy” – the common nomenclature for this type of research, the author joins with others to caution researchers to rethink labeling these beliefs among African Americans as conspiracies. That label too easily casts Black Americans in a light as being paranoid rather than understandably suspicious considering the lived experiences of that group in the Deep South.

Keywords

HIV Rumors, HIV/AIDS, African Americans, Louisiana, Deep South

Introduction and Background

This quantitative descriptive study examined the strength of belief in HIV rumors among HIV+ African Americans using data collected in 2000/2001 and 2010/2011 from residents in the metro area of Baton Rouge. This investigation sought to determine if a lapse in time could diminish malicious intent and benign neglect HIV beliefs. Baton Rouge gained national attention from 2000 to 2010 because of the

alarming rate of HIV and AIDS cases. In 2010, Baton Rouge ranked first in estimated AIDS case rates and African Americans represented 78% of the newly-diagnosed AIDS cases and 74% of the newly-diagnosed HIV cases in the state [1]. The disproportionate impact of HIV/AIDS on African Americans continued into the next decade with that racial group representing nearly three-fourths of newly-diagnosed AIDS and HIV cases, although comprising less than one-third of Louisiana's

population. Of any group, African Americans have reason to be suspicious of American institutions.

The year 2021 was ushered in with a mob storming the US Capitol, egged on by the president and ignited by the belief that the presidential election had been stolen. Multiple extremist groups participated in the insurrection with the QAnon conspiracy believers, center front. QAnon embraces not only the conspiracy of a stolen election but a wide variety of other beliefs hovering around a day of reckoning of those controlling the “Deep State” government [2]. Deep State conspiracy theorists may be on the political anti-government fringe, but half of Republicans still contend that the election was stolen from Trump [3].

Beliefs in covert or overt US government manipulations and cover-ups are not new and sometimes even probable. Nonetheless, there is a line that can be drawn between fake-landing-on-the-moon versus conspiracies of malicious intent [4] – the willful agenda by government to harm or even eradicate certain groups. Such malicious beliefs and mistrust can have far reaching consequences for the believers. Prior studies have documented that distrust in government can negatively alter health behavior and decisions [5-7] including HIV treatment [8-11] and, most currently, compliance with Covid-19 protocols and willingness to be vaccinated [12,13].

The “mysterious” AIDS origin first plaguing homosexuals, Haitians, hemophiliacs and heroin users (the 4H disease) [14] was fodder for the rumor mill. Two years after HIV was identified as the cause of AIDS, Black women comprised 51% of all AIDS cases among women, and by 1990, African Americans surpassed whites in new infections and this disparity remains today [15]. Not surprisingly, rumors about the suspicious inception of HIV/AIDS sprouted in the Black community and by 1997/1998, the grapevine among African Americans was up and running with a notable percentage of Blacks believing in a genocidal conspiracy. [4,16-19]. The 2008 pulpit recording of Barack Obama’s pastor, Jeremiah Wright, implicating government in the HIV/AIDS extermination of Blacks [20] shocked White America but not Black Americans. Study upon study in the early decades of the epidemic

confirmed that HIV/AIDS conspiracy beliefs were common among African Americans [21-26].

What matters to reducing HIV rumors? Research on these beliefs is still in its infancy [27] with few insights offered on whether these beliefs can change; and, if so, why. Rational arguments may help as scientific information becomes available, and ridiculing may work on some myths and in some cultures [28]. However, it is indefensible and counter-productive to attempt to delegitimize or to label these beliefs as irrational for African Americans [29] considering the glaring evidence of government’s complicity in breaches of medical ethics and connecting the dots from slavery to current discriminatory treatment.

Medical rumors among African Americans are the surface manifestation of deep-rooted distrust, and while this author agrees that public health officials should try to “patiently” refute medical conspiracy beliefs, that approach could produce a “backfire effect” and increase skepticism [30]. Greater education may or may not matter to the belief in conspiracy rumors, but as Simmons and Parsons [31] discovered, the level of education of African Americans in Louisiana was not a buffer against believing rumors, such as believing in HIV/AIDS as genocide of Blacks. The same findings have been confirmed by other studies as well [24,26].

The current study sought to determine if time is a possible antidote in reducing the intensity of HIV beliefs among African Americans with HIV. Findings in a companion article by Parsons [32] indicated that a decade made no difference in believing HIV/AIDS to be a punishment from God. However, disease-inception conspiracies are different. The lack of scientific understanding of devastating diseases such as HIV/AIDS results in the likelihood of “folkloric” explanations to bridge the vacuum [33]. A mysterious fatal disease can incite insecurity and fear [34] with the resulting rumors often more hazardous than the disease itself [35]. The question remains – does time reduce such beliefs?

Why could time potentially create distance in a medical rumor? First, 10 years may matter because of greater public health efforts, in that decade, to include

consumers on local and regional boards as well as to place more emphasis on support groups. Consumers with HIV also became more visible and active in peer-support and outreach endeavors, thus, building credible bridges to share information with the community. With those efforts, it is likely that a decade made a difference in opportunities to participate in forums and speak openly about beliefs without being judged [36]. Such group member interactions could further the “sense making” process of rumors with an eventual loss of interest in the rumor [37]. Second, time alone may lessen medical rumors. For example, Bierwiazzonek et al. [38] collected longitudinal data on Covid 19 conspiracy beliefs and found that those beliefs decreased over time. Third, while the evidence is slim, the stigma of certain disorders may decrease over time or with interventions [39-42]. HIV stigma decreased in the United States in the decade prior to 2000 [43], and a reduction in stigma could potentially reduce misconceptions about HIV [44].

While the intensity of rumors may lessen with time, it is equally possible that the persistence of HIV rumors among African Americans has not diminished in a decade. Early in the HIV epidemic, a sizable percentage of African Americans believed HIV rumors and the general distrust of American institutions was fertile ground to quickly root rumors about HIV. In-depth interviews with African American veterans, receiving HIV treatment through the Veterans Health Administration, revealed the resilience of both the HIV conspiracy beliefs and the grapevine echoing those beliefs [45]. Although studies rarely track HIV conspiracy beliefs over time, publications in the past decade still provide ample evidence of the persistence of these beliefs [46-52].

Methods

Materials:

Data were collected through multipurpose surveys of participants in the Louisiana Public Health Region II metro area of Baton Rouge, Louisiana, in 2000/2001 and again in 2010/2011. The questions examined in this study were attached to general needs assessment surveys. As a part of the 2000/2001 survey field testing, local practitioners and administrators who

work in HIV services, or who serve a large HIV+ population, were asked to comment on the draft instrument. Revisions were made to the instrument, per the comments received. The survey was last field-tested using a small number of consumers of HIV/AIDS services. Both data collections extended approximately nine months and both were approved by the university IRB. In compliance with the IRB requirements, prior to the administration of any survey, the reason for the study was explained, voluntary participation was emphasized and privacy provided for survey completion. A small incentive was offered to each participant. Approximately half of both samples requested that the questions be read to them and the responses recorded by the investigators.

Demographic questions were included but without any identifier that could personally link the participant to the paper survey. Among those respondent characteristics questions were age/year of birth, race/ethnicity, HIV risk factor, gender, education, emotional well-being, and treatment adherence. Two questions in the surveys, formatted from strongly disagree to strongly agree, examined the strength of belief in rumors about HIV/AIDS and were adapted from the research by Thomas and Quinn [19] and Quinn [53]: *The government is telling the truth about HIV/AIDS* and *I believe that AIDS is intended to wipe blacks off of the face of the*.

Samples and Location:

The 2000/2001 survey data were collected from HIV+ individuals at HIV/AIDS service providers, including a food bank. Participants for the 2010/2011 survey were solicited from both HIV/AIDS service providers and from health fairs held in at-risk neighborhoods in Baton Rouge. It is unknown if any of the participants in the 2000/2001 survey also responded to the 2010/2011 survey. Consider that the survival rate for new AIDS diagnosis in 2001 was 74% after 36 months and for those 50 and older the rate plummeted to between 46% to 69% depending on the age, and if injection drugs were involved the survival rate dropped again [1].

The Louisiana Public Health Region II, in 2010, included both urban and rural parishes (counties):

East Baton Rouge, West Baton Rouge, West Feliciana, East Feliciana Ascension, Iberville, and Pointe Coupee. Most of the respondents for both surveys resided in the city of Baton Rouge. However, among the data collected at Region II HIV/AIDS service providers in Baton Rouge, rural residents would have been represented in those accessing those services.

Louisiana is a state long plagued by poverty, poor educational outcomes, segregated schools and neighborhoods, health care disparities, high incarceration rates, racial inequality, sexually transmitted diseases and HIV. As of 2010 [1], 17,679 (15,178 urban and 2,501 rural) persons were reported to be living with HIV in Louisiana and of those approximately half had been diagnosed with AIDS. Over one-third of those with an HIV diagnosis in 2010 were not in medical care for the disease [1]. Notable also was the high rate of STDs, according to the Louisiana STD/HIV Program Report [1]: first in the rate of primary and secondary syphilis and congenital syphilis, second in the rate of gonorrhea, and third in the rate of chlamydia.

In 2010, the HIV diagnosis rate per 100,000 was 46.0 in the Baton Rouge metro area with a total population in Region II of 663,255 [1]. In that same year, Baton Rouge had the highest AIDS diagnosis rate of all regions in the state [1]. The new HIV diagnosis numbers in the Baton Rouge region per year were relatively stable from 2001 to 2010 (302 and 305, for the latter); the same was true for the new AIDS diagnosis for the region (240 and 238, for the latter) [1]. Most of those new HIV and AIDS diagnoses for Region II were in East Baton Rouge parish, where the city of Baton Rouge is located [1].

Analysis

Profile of the Samples:

Only descriptive statistics (percentages and bivariate statistics) were used to analyze and display the results. First, the analysis will present demographic characteristics of both samples, followed by the comparison of HIV beliefs in the two data collection periods. Last, a small section is dedicated to exploring the relationship between HIV rumors and two concepts of interest to the current body of literature – education

and psychological well-being.

Three hundred and six surveys were collected 2000/2001, with African Americans representing the majority of the respondents. Two hundred and forty-four responded in 2010/2011 with the majority of those African American and those with HIV. The final tally of those African American HIV+ participants was 124 for the 2000/2001 sample and 169 for the 2010/2011 sample in the metro Baton Rouge area. For the primary analysis of the two samples, the categories of disagree and agree were collapsed with “unsure” responses deleted. The rumor belief data for both surveys were archived by the researcher until this current comparison.

Both surveys inquired about age with birth year in the 2000/2001 sample and age categories in the 2010/2011 sample. There was a range of 43 years from the oldest to the youngest in the 2000/2001 sample. Of the 124 responding, 24 were younger than 30 and 21 were 50 or older at the time of the data collection. The mean and median birth year was 1961/1962 for that first sample. Of the 2010/2011 sample, the plurality (49, 30%) were 35 – 44 years old and only 9% (15) were 24 years old or younger with 13% (22) 55 years or older. The sample was somewhat older than the state statistics for those newly diagnosed with HIV 55 years of age or older (8.4%) but reasonably close to the percentage of those 55 and older at the time of AIDS diagnosis in the state (12%) in 2010 [1].

Educational level was low in the two groups; nonetheless, 34% of the 2010/2011 sample did not graduate from high-school compared to 44% the previous decade. Most of the respondents were unemployed. Approximately 10% (12) of the 2000/2001 sample reported full- time employment and 13% (15 of 118) reported part time employment. Eighty-four percent of the 210/2011 sample reported not being employed full time (139) and few (14) reported being part-time employees at the time of the data collection.

There were few meaningful differences between the two samples in terms of their perceived health status. Among the 2000/2001 group, 15% (18 of 119

responding) and 17% (28 of 164) of the 2010/2011 reported their health to be excellent. There was a difference between the two samples in terms of emotional well-being. Twenty-one percent (of 121 responding in the 2000/2001 sample) and 33% (of 131 responding in the 2010/2011) agreed that they were always happy. Interestingly, of the 2010/2011 sample, the plurality (43% of 160 responding) agreed that the quality of life was the same pre- and post-HIV diagnosis. That question was not asked the prior decade.

There were approximately the same number of males as females in both samples of HIV+ African Americans. For more information on the demographic details of the surveys, please see Parsons [32] and Parsons et al. [54]. Of the 2000/2001 sample, one-third reported injection drug use (IDU) as a risk factor -- approximately the same percentage of exposure was reported by the state that year [55]. Only 16% of the 2010/2011 sample reported IDU as a risk factor. In 2009, IDU accounted for 13% of new HIV diagnosis among African Americans and 20% of persons, regardless of race, living with HIV [56]. Questions on incarceration were not asked in the 2000/2001 survey and, as Parsons reported in 2020 [57], approximately half of the 2010/2011 sample had been incarcerated.

HIV/AIDS Rumors

The respondents were somewhat less likely to believe that government was telling the truth about HIV/AIDS in 2010/2011 (Table-1). The finding was not surprising due to the general distrust of African Americans in government; thus, there was no reason to anticipate a reversal of that belief at least in Louisiana. In that decade, Hurricane Katrina destroyed swaths of Louisiana, and rumors about the intentional

destruction of the levees to rid the city of Blacks were rampant [58,59]. Even the decision of some African Americans to shelter in place rather than evacuate New Orleans was due, in part, to the perceived racism and inequities in the state [60]. There is not a corner in the life of African Americans in Louisiana untouched by racism and distrust of the motives of authorities in the state [57,61-70]. Distrust must be understood as history or experienced culture [36], and in the case of African Americans in the Deep South, it is both.

In contrast, the respondents in 2010/2011 were less likely to believe that HIV/AIDS was intended as a means to the genocide of African Americans. As stated earlier, a decade could make a difference in the advancement of information about the origins of HIV/AIDS as well as greater consumer participation and outreach. Some rumors may have a shelf life, not necessarily to be completely dismantled, but still to lack sustainability. Further, the results suggest that the difference between the two rumors is the distinction between benign neglect and the belief in malicious intent. *The government is telling the truth about HIV/AIDS* can be categorized as benign neglect while *I believe that AIDS is intended to wipe blacks off of the face of the earth* is a malicious intent rumor. Beliefs in malicious intent assume a specific plan (by government, large corporations and so forth) to do harm, while beliefs in benign neglect center on a neglectful, but not necessarily genocidal government - possibly knowing about problems but turning a blind eye, a laissez faire attitude, and a failure to protect [4,71]. Benign neglect beliefs are more prevalent and both categories of theories among African Americans are related to powerlessness to influence government and racial discrimination [25].

Table-1: Beliefs among HIV+ African Americans (responses rounded)				
HIV Beliefs	2010/2011 HIV+ AA Responses		2000/2001 HIV+ AA Responses	
	Disagree/False	Agree/ True	Disagree/False	Agree/True
Government is Telling the Truth about HIV/AIDS	38%	62%	27%	73%
	-73	-45	-33	-91
I believe that HIV/AIDS was intended to wipe Blacks off the face of the earth	81%	19%	61%	39%
	-111	-26	-74	-48

This final section is intended as a very limited exploration of the two data sets and highlights a few interesting differences over the decade. First, the two HIV beliefs were not related in 2010/2011 (.104, $p = .299$), but they were a decade before (-.269, $p = .003$). Possibly, in 2000/2001 there was a general distrust with one belief rippling into another, while ten years later the participants had drawn an intuitive line between the two, likely because of the distinctive nature of malicious versus benign beliefs.

Since the original sample in 2000/2001 included 24 white respondents, a comparison of beliefs based on race was restricted but still noteworthy. Surprisingly, a larger percentage of white respondents (63% compared to 27% of the Black respondents) disagreed that government was telling the truth about HIV/AIDS. But, as expected, 88% (21) disagreed that HIV/AIDS was meant as genocide of Blacks, compared to 39% of the African American respondents. There were too few white participants in the 2010/2011 original sample for any comparisons based on race.

The initial sample in 2010/2011 included those who reported that they were HIV negative as well as positive and this allowed a limited comparison of beliefs. Of those responding 'agree' or 'disagree' to the question and reporting that they were HIV-, 44% (16 of 36) disagreed that government was telling the truth and 86% (38 of 44) disagreed that HIV/AIDS was intended as genocide. These findings suggest that those African Americans, both HIV positive and negative, shared the same intensity of beliefs.

Both surveys included questions on medical care for HIV. The 2000/2001 results suggested no clear connection between HIV beliefs and the decision to *not start medical care*, or *come and go in medical care* or *stay in medical care since diagnosis* (uninterrupted). The same number of those in uninterrupted medical care since diagnoses agreed and disagreed (27 each) that government was telling the truth and of the 99 self-reporting uninterrupted medical care and who responded to the questions, 31 disagreed that HIV/AIDS was genocide (compared to 24 who agreed). Of those in 2010/2011 reporting uninterrupted medical care, more (31) disagreed that HIV/AIDS was genocide

than those agreeing (24). Of those reporting that they started medical treatment at the time of diagnosis in 2010/2011, 56 (of 60) disagreed that HIV/AIDS was meant as genocide, and 52 of 65 agreed that that government was telling the truth. Other studies have concluded that conspiracy beliefs are not related to HIV treatment delays or adherence [72,73] although this debate remains ongoing.

Bivariate analyses indicated that the age of the respondents (year of birth, from earliest to most recent) was not related to either of the HIV rumors in 2000/2001 (HIV/AIDS as genocide: -.105, $p = .252$; government truthfulness about HIV/AIDS: -.054, $p = .563$). The relationships between age (categories from youngest group to the oldest group) and beliefs (disagree or agree) in 2010/2011 sample were not statistically significant (genocide, 8.936, $p = .112$; truthfulness, 4.472, $p = .346$) and the cases were too few in each cell to draw any certain conclusions. Nonetheless, of any age category, those 45-54 were less likely to believe HIV/AIDS was genocide (29 of 32) and more likely to believe that government was telling the truth about HIV/AIDS (14 of 17).

Educational level of the HIV+ African American participants in 2000/2001 was not related to either belief, but education was a factor in 2010/2011. Education was measured from lowest to highest (8th grade or less to college degree). A lower educational level in 2010/2011 was accompanied by a greater belief in the malicious intent of HIV/AIDS as genocide. This finding is important and may indicate that education gains traction in disease-inception beliefs with the passage of time.

- 2000/2001 – AIDS as genocide and education level (.041, $p = .655$)
- 2010/2011 – AIDS as genocide and education level (-.349, $p = .000$)
- 2000/2001 – Government telling the truth and education level (-.041, $p = .655$)
- 2010/2011 – Government telling the truth and education level (.046, $p = .624$)

The belief that government was telling the truth about HIV/AIDS was related to greater satisfaction

with medical services (not satisfied to very satisfied) in 2000/2001 (.358, $p = .001$), but the relationship between satisfaction and HIV as genocide was not statistically significant (.184, $p = .051$). A general question on satisfaction with medical care was missing in the 2010/2011 data since that question was asked per service provider.

The survey in 2010/2011 included a few questions related to emotional well-being and the 2000/2001 survey included one such question. The HIV/AIDS genocidal belief, but not government truthfulness, was mildly related to aspects of emotional health. Greater perceived stigma (*People are afraid to be around someone with HIV* - very true to very false), hopelessness (*I do not have a great deal of control over what happens to me* - very true to very false), and mood (*Do you feel happy?* - never to always) were related to stronger genocidal belief in 2010/2011, and the belief was marginally related to mood in the 2000/2001 results.

- 2010/2011 Stigma: (-.198, $p = .021$)
 - Compared to - *government is telling the truth*: (-.018, $p = .848$)
- 2010/2011 Hopelessness: (-.418, $p = .001$)
 - Compared to - *government is telling the truth*: (-.050, $p = .519$)
- 2010/2011 - Mood: *Do you feel happy?* (never to always) (-.239, $p = .012$)
 - Compared to - *government is telling the truth*: (.030, $p = .726$)
- 2000/2001 - Mood: (-.200, $p = .029$)
 - Compared to - *government is telling the truth*: (.117, $p = .200$)

Conclusions and Recommendations

This study offered only a glimpse into the endorsement of HIV rumors among African Americans with HIV in Louisiana, comparing beliefs from the window of one decade to the next. This research is exploratory with major limitations. First, no attempt was made to account or control for other factors that may matter to rumors about HIV/AIDS. Next, participant truthfulness is a persistent issue in all self-reported information. However, if there was one litmus test on the veracity of the responses it was

acknowledging IDU as a risk factor. As the preceding analysis affirmed, the percentages of those self-reported IDU for both data sets, matched or exceeded state statistics. Third, there is an inherent problem in comparing two populations that are unlikely to be the same individuals. It would be then impossible to know if the beliefs had changed over time in the same individuals. Obviously, the 2010/2011 data are now another decade old; therefore, the author passes on that baton to future researchers to determine most current beliefs of African American with HIV in Louisiana.

This study was specific to the metro area of Baton Rouge, Louisiana, and by choice to the use a convenience sample. Most similar research is specific to a certain geographical location, time, and population, and cross-sectional. The choice of Louisiana, or any Deep South state, is likely to matter the most in attempting to compare results to studies in other regions. If there is any place that would germinate rumors among African Americans, it is this region. Louisiana is “Jim Crow’s Last Stand” [74], and the unthinking and deliberate suppression of African Americans in the state created second-class citizens with reasons to distrust the motives of those in authority. One could argue that the puppeteering that maintains the systemic racism in the Deep South is the real “deep state” rather than the odd assortment of conspiracy beliefs of White Americans. The dynamic of “White Fragility” of White Americans can spur a need to “reinstate white equilibrium” [75] including the endorsement of certain conspiracy theories with racial hostility undergirding those beliefs [76]. Consider the success of former Ku Klux Klansman, David Duke, a decade just prior to the first data collection for the current study, goading white voters to reinstate white equilibrium in Louisiana. Duke won a large cross-section majority of Louisiana’s white vote in three state elections [77], using rhetoric that stoked white resentment with “Jewish Plots” and by blaming Blacks (welfare, quotas, and so forth) for the economic downturn [78].

Two notable contributions of this study center on education and psychological well-being. Interestingly, educational level made a difference in the 2010/2011

sample only. Thus, time coupled with education may matter to the intensity of HIV rumors. Higher education and greater cognitive skepticism may act as a counterweight to the skepticism inherent in conspiracy beliefs [79]. Similarly, Zekeri et al. [52], in their 2009 study of HIV+ individuals in a Deep South state, found that greater education was related to reduced HIV conspiracy beliefs. In contrast to the author's study, a sizable percentage of the respondents in the Zekeri et al. [52] survey believed that AIDS was a form of genocide of African Americans (31%) and that government was responsible for producing the virus (43,1%) but not necessarily with the intention of controlling Black Americans (29%). In that study, the benign neglect beliefs were much more readily believed than the malicious intent beliefs; for example, a majority agreed (70%) that government was withholding information and a cure (56%) [52]. Interestingly, distrust in the HIV health care system, governmental or private, may or may not equate to distrust in the providers of those services [80,81].

Other studies, which are not specific to HIV, have hypothesized that malicious-intent conspiracy beliefs are related not only to education but to psychological factors as well [82]. The results of both data sets in the current study suggested that psychological well-being is related to malicious intent rumors. Prior research indicates that health and treatment decisions can be affected by conspiracy beliefs, feelings of powerlessness [83] as well as a distrust of power [84].

The most noteworthy result of this study is the decline in the intensity of the belief in malicious intent from one decade to the next. The more sustainable rumor was the distrust in government to be truthful – a benign-neglect belief. As stated earlier, benign-neglect beliefs can be more resilient and may indicate a generalized suspicion of the motives of government. While the findings should be considered only provocative because of the noted weaknesses, even so, this study makes a novel and significant contribution in attempting to respond to the question: Does time matter to the intensity of HIV beliefs among African Americans? The results suggest that time may matter but not equally across rumors.

This current study joins the body of literature that differentiates between benign neglect beliefs and malicious intent beliefs. Credit goes to the original fieldwork of Patricia Turner [4] and her research on these beliefs among African Americans. Since Turner's [4] pioneering research, other relatively dated studies have noted a distinct difference between malicious intent and benign intent theories [25,31]. Adopting wording from Van Deburg [85], benign intent theories can be viewed among skeptical African Americans, without judgement, as "suspicion over fear". While responses to conspiracy beliefs can range from "healthy skepticism to debilitating paranoia" [85], the sustainability of benign neglect beliefs is by no means evidence of debilitating paranoia but healthy skepticism. In the middle of this Covid-19 pandemic, African American men worry about increased police harassment if they wear masks as mandated [86]. That fear is undoubtedly stronger in Louisiana with the criminal justice system still defined by slavery [87]. As indicated earlier in this study, racial discrimination in Louisiana remains etched as an indelible reality of being African American in the Deep South, even contributing to the high HIV rates in the state [88].

In closing, there are a few recommendations beyond the suggestion to update this study. First, there is an absolute paucity of current studies on HIV malicious versus benign beliefs among African Americans despite the value of such research. The scholarly literature, in the last five years, might have moved forward to other "conspiracy" belief topics, for example, the motivation to think critically and cognitive ability [89] as well as political and social contributors [90], while the circumstances of and knowledge about the beliefs of African Americans in the Deep South has barely inched forward.

Second, this author suggests that more emphasis be placed on systematic reviews of the studies on rumors and medical decision-making among African Americans to allow future research to fill the gaps identified. How are these beliefs measured? How is medical decision-making assessed? In terms of benign distrust of government, what questions are asked to identify distrust or suspicion? This point is important considering that there may be great trust of the

providers of HIV services despite pronounced suspicion of American institutions, such as the health care system [81]. Thus, a question such as *government is telling the truth about HIV/AIDS* begs the question – which government is the respondent mentally picturing to answer that question?

Third, future studies can assess if any difference in the intensity of HIV rumors is a lag in time or education or both. Investigating the contributing factors to these beliefs, as well as determining if these beliefs matter to HIV treatment decisions, would add a significant contribution to this field of literature. This study could not add that contribution through any methodological manner, although at face value HIV rumors did not appear to be a consideration in the (self-reported) timing of treatment. This recommendation would likely be of the greatest benefit to investigate because of the continuing academic debate about the potency of HIV beliefs in testing, treatment or research participation decisions [31,52,91,92]. Interestingly, two studies of conspiracy beliefs among HIV+ African Americans in care for the disease found that HIV conspiracy beliefs were common [45,52], but these individuals were still receiving HIV medical care despite anecdotal information of stockpiling or selling medications, for example [45]. These studies exemplify the lingering question: what role, if any, do these HIV-related beliefs play in medical care decision-making?

Finally, this author joins Jaiswal et al. [93] with a suggestion to rethink the common use of conspiracies in terms of HIV beliefs. The framing of the message as a conspiracy, rather than HIV beliefs, may be a disservice to prevention and treatment efforts as well as to discount the lived experiences of Black Americans, the historic racism and cause for distrust. It takes little imagination, as other authors acknowledge, to then blame minorities for their paranoia and to feed into the lingering stereotypes of Blacks [94] as “gullible conspiracy mongers [95], and believing “mere nonsense” [96]. Medical rumor beliefs are stigmatized knowledge [97,98] that complicate treatment and prevention efforts.

Publications on the subject often emphasize that

health care entities need to address the distrust of African Americans [36,46,99-106] dispel conspiracies [28,30,107] be sensitive to those believers [108] and remember the stigma attached to the disease [109,110]. This author agrees and suggests that the change in messaging should begin with future researchers sparingly using the stigmatized/stereotyped word – conspiracy, in HIV/AIDS research of communities-of-color. If we view this body of research through the “insider” lens of public health critical race theorists [111-113] our mindful messaging as researchers can be the “praxis between research and practice” [111].

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Compliance with Ethical Standards

The research was approved by the University Institutional Review Board.

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Competing Interests

The author has read and approved the final version of the manuscript. The author has no conflicts of interest to declare.

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