

KENNESAW STATE UNIVERSITY ORAL HISTORY PROJECT
INTERVIEW WITH BARBARA J. BLAKE
CONDUCTED, EDITED, AND INDEXED BY THOMAS A. SCOTT
for the
KSU ORAL HISTORY SERIES, NO. 110
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Part I - Friday, 14 September 2012
Location: CETL House, Kennesaw State University

TS: Today I'm interviewing Barbara J. Blake, the recipient of the Distinguished Professor Award for 2012. Barbara, why don't we just begin by asking you about your background and where you grew up and where you went to school and such as that?

BB: I was born in Camden, New Jersey. It's located about thirty miles outside of Philadelphia. I lived there until I was about twelve years old. I was in the sixth grade when my mother and father decided that we were going to make a move to Florida. That's primarily where I lived for a good part of my adult life. I graduated from high school in Florida and then actually started nursing school in Florida back in 1972. I did not complete that initial nursing education. I quit about half way through. I was enrolled in a diploma program in Miami. I was fresh out of high school and thought I knew what I wanted to do with the rest of my life. But once I got started, I realized that I didn't think that's what I wanted. Eventually, I did go back to school and finished and got an AA degree and then went back and got a two-year degree in nursing and ended up doing the step stone to my baccalaureate and my master's and my doctoral program.

TS: I was wondering from what you have on your website. It looks like one semester at Florida Junior College that led to the Associate of Arts degree, and I wondered how you got through so fast. So you started actually in '72 in a nursing program?

BB: Correct, in a diploma nursing program in Miami.

TS: In a hospital?

BB: Yes, it was Jackson Memorial. If you want to equate the type of hospital setting, it would probably be equal to Grady here.

TS: We've got an interview with Janice Long where she talks about the transition from nursing programs being in hospitals to nursing programs being on junior college campuses. Kennesaw started its nursing program in '68.

BB: They started as an associate degree, so two years.

TS: But you didn't like it at first and then changed your mind later to go back to nursing?

BB: Well, let me give you the details. I started [nursing school] fresh out of high school—I tell this story to my students in my community health class, so I’ll tell you how I tell this story—started out in a diploma nursing program. The main reason I selected nursing was neither one of my parents had gone to college, but my father did believe in higher education; it was a period in time when women’s primary choices were to become a secretary, a teacher, or a nurse. I happened to have an aunt that was a nurse, and my father looked at me and said, “You know, your aunt’s a nurse; she’s always been able to get a job; so why don’t you try nursing school?” So that’s how I started off into going into nursing.

TS: But you didn’t like it at first?

BB: The program was thirty-six months long. We were on a hospital campus, and when you went the first year, the majority [of students] were females. We did have maybe a half dozen males. The females lived in one dorm, and then the males were across the campus. You had to be in your room at six o’clock at night for quiet hours. We spent a great deal of our time working in the hospital setting. We were like free help. I tried very hard to adjust to nursing school. I even went as far as to get a job as a nursing aide to see if maybe that would help me embrace the profession. I was working a three-to-eleven shift then, and, I’ll never forget, I had a patient who was not very old. He was in his mid-forties, and he had a severe sinus infection that had actually gone into the meninges of his brain. At that point in time, they didn’t know how to treat him. It had become, basically, that it was going to kill him; he was going to die from it. He was what we call a no-code. We weren’t going to do anything, to do any CPR or anything to resuscitate him. At eleven o’clock, his friend came out to me at the nursing station and said, “I think you need to come check on my friend; I think he’s died.” I walked into the room. I took the blood pressure, and checked the pulse. There were no respirations. I walked out to the nurse who was in charge. She looked at me, and I’ll never forget. She tapped her watch, and she said, “Let’s just leave it for the next shift.” So I packed my bags that night. The next morning I told the school administration that I did not like nursing. I did not want to be a nurse, and I was quitting. I was all of nineteen years old, and I thought to myself, “This is not a profession I want to get myself involved in.”

TS: What happened next? You went to work for awhile?

BB: Actually, I was dating my husband at the time. He was teaching elementary school full time, and working for a building supply company part time. I was in Miami, which is on the east coast [of Florida]. He actually lived on the west coast in the St. Petersburg/Tampa area. So I went back home, and we got married shortly thereafter. I had two jobs when I first got married because we were very poor. I obtained my first job through the Florida State Employment office. I went to them, and they ran aptitude tests to see what jobs I would qualify for.

TS: What were your aptitudes?

BB: They put me in an orange juice plant where I worked in the laboratory. I would pull a bottle of orange juice off the line and take it back and make these agar plates and see if they would grow any bacteria. That was my day job. Then at night, I worked at a store you probably are familiar with—J.M. Fields. For my second job, I was a cashier in the evening. We had one car, and we had no phone because we couldn't afford a phone. There was no such thing as a cell phone. About 8:30 or 9:00 o'clock at night before the store closing, they would make an announcement that the donuts were going to go on sale because they would be considered day-old. So I always took my break then. I was allowed to take the orange juice I pulled off the line home with me. So we always had O.J. and day-old donuts the next morning for breakfast. Anyway, my husband, shortly after we got married, looked at me, and he said, "I don't care what you do, but I believe that women should have some kind of education. You might have to take care of yourself someday; you never know." He was five years older than me, so he said, "I don't care what you do, but you're going to go back to school." When I had been in my diploma program, I actually had attended Miami Dade Community College, so I had some credits. That's how I was able to get through my associate's degree rather quickly. I got through with that, and I still didn't know what I wanted to do.

TS: How do you get back into nursing?

BB: I felt bad because I had never been a quitter in my whole life. So now, because my husband is in this management position, we moved to the Ft. Pierce/West Palm Beach area. I had never been a quitter, so I decided, "Well, I want to go back to nursing school." At that point in time, just like the nursing programs are today, they were hard to get into initially and even harder to re-enter. How was I going to convince somebody that I really wanted to be a nurse after my transcript says I hated nursing? I went to the local community college—West Palm Beach Junior College—and they told me I'd have to wait a year before they would let me in. So, instead, I went about forty or fifty miles north to Ft. Pierce to Indian River Community College. They said they would accept me. I had to take a battery of tests to make sure I met certain expectations and they'd know where to put me in the program. I decided rather than waiting the year, I could get done in a year. So I decided to make the drive. I drove sixty minutes every day to Ft. Pierce, and I finished nursing school.

TS: Indian River Community College.

BB: The last semester I was supposed to finish, my husband got transferred to central Florida, and he wanted me to quit school. He said, "Oh, why don't you just quit and go to University of South Florida in Tampa and get your baccalaureate degree?" Well, at that point in time, I was, "Oh my goodness; I've only got one semester left." So I looked at the baccalaureate program, and they told me it would be at least another two years before I could finish. So I told my husband I

- was not moving, and I stayed in Ft. Pierce, going to school Monday through Friday, left school on Friday, drove back for the weekend, and then drove back and forth that semester until I finished. That was kind of it. I will tell you I still wasn't thrilled about nursing. I tolerated it at that point, but it wasn't my love; it wasn't my passion.
- TS: So you really weren't convinced.
- BB: I was not convinced.
- TS: I was noticing that it looks like as soon as you graduated, or maybe even before, you became a staff registered nurse at a hospital in Clearwater.
- BB: Correct. My first job was in Clearwater. When I graduated, it was recommended that you work at least one year on a medical surgical unit. So I went to work on a medical surgical unit in Clearwater.
- TS: Then you continued to work for a doctor, I guess, as a registered nurse.
- BB: Correct. Yes, that was in a clinic.
- TS: Oh, yes, the Diagnostic Clinic.
- BB: Yes. I met the physician when I was working on the medical surgical unit in Clearwater. It was a large clinic of multi-specialty practice, and he was a hematologist. So we got talking, and he needed to replace the nurse that was presently working with him. I went in to interview and went to work for him. I liked that.
- TS: That's when you're beginning to think maybe nursing's not so bad?
- BB: Nursing's not so bad. And I liked it because he was following people with chronic illnesses, and I got to know my patients that came in. They got to be like second family and friends.
- TS: What was it that turned you off about nursing? I know that first experience, but what was it that kept you from being totally excited about nursing? What aspects of nursing didn't you like, and what aspects attracted you to the field?
- BB: I liked the aspect of helping to take care of people. I mean, I enjoyed that. What I didn't like was you went to nursing school, you learned what I call the gold standard. You had a lot of hands-on care. You offered to help get people bathed in the morning; you helped them to eat; if you were working with a male patient you made sure they were clean-shaven; you took total care of them. You were not just concerned about the illness, but while they were there you tried to improve their quality of life. What I didn't like was that I was taught that gold standard,

but what I found out when I got into practice was you're just putting out fires. You're doing the best you can to get through the day. I didn't like the fact that I would leave my shift at the hospital, and the whole time on my way home all I could think about was what I did; did I chart this, did I forget to do that—all the things in my whole eight-hour day rolled through my head about what I did or didn't get done. When I graduated, you were lucky if you got two or three weeks' worth of orientation. So here I was a new graduate with two weeks of orientation, and the next thing you know, I'm on a three-to-eleven shift. I'm the only R.N. there. Everybody's a LPN, and I'm in charge. So if it hadn't been for the very mature, understanding, older LPNs that I worked with when I first graduated, I probably wouldn't have survived. Because of their guidance, they helped me get through each evening. In nursing education you start out with the basics, however it's not until you walk out of that door that your real education begins. Nursing education really begins when you start working independently in the clinical setting.

TS: Are the LPNs the ones that went through the hospital nursing program?

BB: At that point in time, LPN training was a one-year program, usually at a technical school.

TS: I was just thinking, you were talking about being in the hospital at a thirty-six month program. That's a pretty long program, three years, wasn't it?

BB: Correct, but that was because they were using you as free help. I mean, in today's nursing education, we don't spend near the time in the clinical setting as I did in that diploma program. I was probably in the clinical setting four days a week then.

TS: I would think all these experiences are invaluable now that you're in a teaching position at Kennesaw.

BB: Absolutely! Let me tell you, in the classroom there's all those experiences that I can draw from that bring nursing alive. However, the students perceive that they're always going to work in hospitals, so I, as the community health faculty, have to bring to their attention that people are really only in hospitals for short periods of time. The majority of healthcare has migrated from the hospital to community settings. So my mantra is to try to get them engaged in what it's like to be a nurse outside of that acute care setting.

TS: Looks like after the Diagnostic Clinic you went to a Catholic Hospital in Pensacola. Sacred Heart has got to be a Catholic hospital.

BB: Yes it was.

TS: You spent about a year there, and then to Tampa General Hospital in Tampa, Florida, as a staff registered nurse.

BB: There was a break in-between Sacred Heart and Tampa.

TS: Oh there was—four-year break.

BB: A four-year break because when I was at Sacred Heart, I was pregnant with my first son. When we were in Pensacola, my husband got transferred again, and so once we moved, I became a stay at home mom for that period of time. In fact, during that four years, I had my first son in 1980 and my second son in 1982.

TS: Well, you were busy then.

BB: Yes I was.

TS: So in '83 is when you start working on your Bachelor of Science degree at Florida Southern College.

BB: Right. I'm a stay at home mom. I love my children dearly, but I was not great at being a stay at home mom. I needed an outlet, so I went back to school in 1983 for my baccalaureate degree. That was my evening out. My husband would stay at home with the kids, and in the evening I went back to school.

TS: Oh, it was an evening program?

BB: It was primarily an evening program. That is where I was first introduced to community health nursing. It's interesting; some things don't change. One of the unique things about baccalaureate education that's not part of the associate degree in nursing program is the community health course. You get exposed to community health in a two-year degree, but not to the same extent that you do in a baccalaureate education. Even today in our KSU nursing program, our RN to BSN students have to take my community health course. That's exactly what I had to do. I had to take a community health course when I was in my baccalaureate program. I was assigned to the Polk County Health Department as a public health nurse, and that's when I found my niche. That's when the passion began.

TS: Is that what you're doing at Tampa General?

BB: Tampa General was a staff nursing position. I was still on a medical/surgical unit. Sacred Heart was medical/surgical also.

TS: I see. In July of '85 you went to the Polk County Health Department.

- BB: I went back to work at Tampa General because I had been not working as a nurse for three years. If you're out of nursing for too long, they make you go back to school to take a refresher course. I think it is if you are out five years. So after the first year of my baccalaureate program, I went back to work part-time at Tampa General just so that I could keep my nursing skills current, so that I wouldn't have to go back for a refresher course.
- TS: This is where it really grabs you is in '85 when you are a community health nurse.
- BB: Exactly. I went to the Polk County Health Department; fell in love with public health nursing. I had one more course in my baccalaureate program after that course, finished it, and went back to the health department to look for a job. They only had a six-week temporary position available. It was in a program called WIC, which is the Women's, Infants and Children program. It is a nutritional program for pregnant women and children. You not only have to be financially eligible for the program, but there also has to be a nutritional need. I took a leap of faith. I looked at my husband, "I've got to take this job; I know it's only six weeks; but I'm taking a leap of faith." I took the six-week job and didn't look back. With that leap of faith, everything worked out. After those six weeks were up, then they had another position open, and I never looked back to work at a hospital again.
- TS: What all were you doing as a community health nurse?
- BB: There are two different kinds of public health nursing. There's what they call the generalists and what they call the specialists. It depends on how the health department is set up. When I was in Polk County, Florida, we worked as generalists. So, basically, I worked in all the clinics, I worked in child health, I worked in maternity, and I worked in the STD clinic. I also worked in what we call the walk-in clinic. This is where people are coming in with head lice or other problems that they would need help in managing. Then I was also assigned a certain geographic area within the county. I was responsible for managing certain public health issues such as immunization follow up. I was also responsible for making sure that women came back if they were due for their family planning appointment. If somebody needed tuberculosis or TB follow-up, then it was my responsibility to make sure they kept up with that. I was also responsible for the women who came to the health department for prenatal care to make sure they stayed in care. I also made home visits to new mothers to make sure that they had their first postpartum and new baby appointments scheduled. Usually that was done within the first week the mother and baby were home. I also checked the baby at the home to be sure there was no jaundice, made sure the baby was gaining weight, and made sure the mother was doing okay.
- TS: It looks like you went pretty fast into the master's program after that too.

BB: One of my benefits of working with the state of Florida was I could go to school at no charge. They would pay my tuition, and I had a certain amount of money for books. So I was able to negotiate with my nurse manager for time. I lived in Lakeland, which is central Florida. The University of South Florida in Tampa was about an hour's drive. I was able to negotiate with her to flex my hours, and so I went straight on to my master's degree.

TS: What did you think of the University of South Florida?

BB: My husband graduated from there in '69, I graduated in 1989, and my youngest son graduated from there. He went to medical school there, and he graduated in 2008. When I went back to the school when he graduated, I was impressed with how it had grown.

TS: The reason I ask is I think of the University of South Florida as a generation ahead of Kennesaw but where Kennesaw is going.

BB: Exactly. When I went there, they didn't have a doctoral program in nursing. They did have a medical school, but it wasn't that big. But you're right; it's Kennesaw thirty or forty years from now.

TS: Our future.

BB: Definitely our future.

TS: So you got through the master's program. Looks like you spent about three years going through the master's program. Working full-time the whole time?

BB: At the health department—and raising my two kids with my husband. Thank goodness for him. Without the support of my husband, I never would have made it through.

TS: Was he still teaching?

BB: No, he was working in business fulltime. If you notice, when I graduated from my master's program, I walked across the stage, and we got in the car, and we drove to Atlanta.

TS: I see that.

BB: My husband had taken a new position with The Home Depot.

TS: I'm trying to think when The Home Depot started [1978-79], but it's about that time that they established their headquarters in Atlanta, actually in Cobb County.

BB: Yes.

- TS: Okay. I also see that you were an itinerant health educator for a year.
- BB: Actually I did that when I left the health department in Florida and before we moved to Atlanta. In Florida, we lived in what I would call a rather rural county outside Tampa—and the county had a high teenage pregnancy rate. So the public school system decided to develop and implement a personal growth and development program that was comprised of four teachers and two nurses. It started in kindergarten and went through the eighth grade. It was intended to build self-esteem and to talk about other issues or concerns that children experience as they are growing up. The other nurse and I taught hand washing in kindergarten. Then in the third and fourth grade, we started talking to the girls about the menstrual cycle. In sixth grade we taught reproductive health, and in the seventh, eighth and ninth grades we built on that information with both the girls and boys. We also taught the students and teachers about HIV/AIDS. That was taught in junior high as well as high school. That year was the pilot program.
- TS: So you did that for a year, and when you came to Atlanta you worked at the AIDS Research Consortium of Atlanta. I was going to ask if that was your first exposure to AIDS, but I guess if you were teaching about it already
- BB: I was teaching about it, and, interestingly enough, when I reflect back, my first exposure to people living with HIV and AIDS was in Tampa General. I worked on a medical/surgical floor, but one end of our floor happened to be an isolation unit because it used to be for the TB patients.
- TS: Tampa General was May of '84 through July of '85.
- BB: Right, that's very early in the epidemic.
- TS: Yes, that's only three years into the epidemic or what we knew about.
- BB: Right, but at that time HIV was considered to be primarily a gay, white man's disease. I remember very, very clearly the isolation wards where we put these gentlemen – it had a little anteroom. Then they had their hospital room, so everything that was delivered was put in the anteroom before it was given to the patient.
- TS: Because everybody was afraid of it at the time.
- BB: Exactly. For example, all meals were on paper plates, all the silverware was plastic and we would actually gown and mask and put gloves on before entering the room.
- TS: You wore a mask every time you went in?

BB: Yes, and we put a gown on, put gloves on, and put a mask on. If we were doing a procedure with the physician where we might be exposed to blood, we double gloved. Half the time the patient's food was probably cold by the time it got to them. Family and friends would bring in coolers with food and other stuff. I remember one of my first patients. They were doing some experiment where they put this implant in his head with some medication. They put it through his spinal cord to see if that would make a difference in his HIV status. But what I remember most was the stigma related to the disease.

TS: So you're saying even in a hospital, there's still phenomenal ignorance.

BB: The stigma was horrific. I had two other patients that I'll never forget. I had an African American woman, very thin. I remember, she was from California—it's funny the details you can remember—but she told us all that we needed to be more careful because she had HIV, and in '85 women had not really been diagnosed with HIV. We all looked at her and laughed and said, "You can't have HIV; only gay men get HIV." Then we had another patient who happened to be a white Lutheran minister. Now I remember that he was Lutheran because that happens to be my religious affiliation. What had happened was the day he was being discharged we found out that he had been tested for HIV without the nurses' knowledge. The physician had ordered some lab work. He had gone to the laboratory. He had told the techs to run an HIV test, and he came back and told the gentleman that he had HIV. Here, at that point, we didn't have universal precautions, so here we were gowning and gloving and masking for the patients who were in isolation, but not the people who were in the general population. The only time we put gloves on, usually, was when you were cleaning somebody up, to draw blood to start IV's. We didn't wear gloves at that point in time, so the nurse manager—let's just say that she was not very polite to the physician because as far as she was concerned he had put all of us at risk. What had happened was because this gentleman was a Lutheran minister the physician was trying to protect his personal life. He was engaging in behaviors, having sex with other men, and you just didn't talk about it at that point in time.

TS: No, he was going to be in trouble with his church.

BB: The doctor was trying to save the minister's reputation or whatever, but the nurse manager politely told the physician that "you put all my staff at risk because you suspected it, you went and had this gentleman tested, and we're not finding this out until the day he is going to leave."

TS: She politely told him?

BB: Yes, she "politely" told him. So I had some early exposure, and those are some of my early memories. So to go back to the AIDS Research Consortium in Atlanta (ARCA). The reason I ended up there was because when I was in Florida working in the health department, my husband accepted a new job with The

Home Depot in Georgia, and we had two children, and I knew I needed to work. So I went out looking for a job, went to the Cobb County Health Department and they had a hiring freeze on. I went into panic mode because I knew I did not want to go back to a hospital. So I went through the classified ads of *The Atlanta Journal Constitution*. There happened to be a classified ad in there that they needed a research nurse to do community-based clinical research trials. I went and interviewed for the job, and next thing I knew, I was working for what's called ARCA, the AIDS Research Consortium of Atlanta.

TS: A research nurse, you hadn't been called a research nurse before, had you?

BB: No. The physician who runs the organization still runs it today. She had been funded to run what they call an AIDS Clinical Trials Group or ACTG. At that point in time AZT was the only drug out there that we were using to treat people. So we were testing some of the other early medications, pharmaceutical drugs. The physicians within the community had joined ARCA, and they would refer their patients to us. So I went to different physicians' offices throughout the Atlanta metroplex enrolling patients into different pharmaceutical research trials.

TS: Okay, so you get involved in that, and actually it's just a year that you're there.

BB: That's because there were multiple physicians that were working with ARCA, and one of them, an ID [infectious diseases] doctor, convinced me to come to work for him. He was starting a new research group called the West Paces Clinical Research Group. So I went to work for him as the research coordinator there. Instead of just doing HIV trials, we did multiple types of clinical research trials. I worked with oncology, orthopedics, and gastrointestinal physicians.

TS: But everything is research oriented from now on.

BB: It was primarily pharmaceutical funded research, yes.

TS: So you do that for about two and half years, and then you go to work for the Cobb County Health Department.

BB: Well, community health is my first love. After about two and a half years of doing clinical research I thought, "You know what? I've done this long enough. I'm going back to the health department." I applied to the health department, they happened to have an opening, and I decided it was time for me to move on.

TS: Now were they on County Farm or County Services Road?

BB: County Farm. Same building is there when I went to work for them. I still go out there periodically for meetings. It's the same building. It's like walking into an old home of mine.

TS: I went out there to get a flu shot one year, I think.

BB: Same place—looks exactly the same.

TS: It looks like all of a sudden your husband must have been transferred to Texas because next thing you know, you're out in Texas.

BB: Correct. My husband was transferred to Dallas, so we moved out to Dallas.

TS: Richardson Independent School District. You become a school health nurse?

BB: Right. Here in Cobb County as well as when I was in Florida, we didn't really have real school nurses. When I was in Cobb, the school system would call the health department periodically if they needed some nursing expertise, but most of the time any health issues were handled by the school themselves. The same thing occurred when I was in Florida. As a public health nurse, I was assigned a couple of schools, and I went to visit them two or three hours each week, but there was no real school nursing. Interestingly, other parts of the United States have always had nurses fulltime in their schools. When I was a child in New Jersey, we had a school nurse. When I went out to Texas, I realized that they actually had school nurses in the school system, and they were paid on a teacher's salary, so I decided I'd try something different. So I went and tried school nursing for a while.

TS: It looks like you did that for a couple of years.

BB: Yes. However, during that first year I was a school nurse, I contemplated going back to school for my doctorate. Texas Women's University had a program that started in the summer semester. Since I was a school nurse, I had summers off. I applied to the doctoral program and was accepted. I went that first summer I was not working. I wanted to see if the old brain cells would still kick in, so I figured I'd try that semester to see if that was really what I wanted to do. I really didn't know what I was going to do with the degree. It was just one of those things that was personal self-fulfillment. Ironically, my husband was very supportive because even though he had left teaching many years ago, his original goal in his life was to teach—not only be a school teacher, but he wanted to get an EdD and teach education. Since he had foregone his personal career goals, he decided to let me live mine.

TS: He's going to do it vicariously through you.

BB: Yes.

TS: Well, so you graduate in 2000 with your Ph.D.—it was a Ph.D. program, wasn't it?

BB: Yes.

TS: I was doing a little checking the other day and realized that Kennesaw's actually unique in having the DSN degree as opposed to the Ph.D. If you went to the Medical College of Georgia [Georgia Regents University Augusta], they've got a Ph.D. in nursing.

BB: Right, they do. And Emory has a Ph.D. Nursing's a little confused about their terminal degree. We have several different credentials. The Ph.D. is still considered the gold standard as more of a research degree than the other ones.

TS: But at this point you're not thinking I want to be a researcher or I want to be a college professor; you're just doing self-fulfillment.

BB: Right, at that point in time I'm just doing self-fulfillment.

TS: So you graduate in 2000, and it looks like you spent another three years in Texas at Parkland Health and Hospital System in different positions. Maybe the next question is how did you get to Kennesaw State?

BB: My husband got transferred again. We had been in Texas, and he'd now been transferred back to Atlanta. Again, I went to the Cobb County Health Department to apply for a job. I saw this job posting in administration. So I applied for the position, and I knew the people there, and they called me and said, "Barbara, we're so sorry, but there's a job freeze on."

TS: It seems like this is happening to you every time you need a job.

BB: Yes. I don't know where I saw the ad, but I saw that Kennesaw—we moved here in January, so this was in the fall—had a community health nursing position open. I decided to apply for the position, and, ironically, when I came here I didn't realize David Bennett at that time was the chair of the department. I had worked with David when I was at Cobb Health Department previously. I had volunteered at the MUST clinic, and I had gotten to know David through the MUST clinic. Small world! Ironically, Richard Sowell [college dean], I knew of because of my HIV work. So they offered me a position, and then six months later the health department called and said, "Barbara, guess what, the position has been unfrozen, would you like to come in for an interview?" I said, "You know, I just took this position six months ago at Kennesaw, and I think I'm really starting to enjoy it. I think I'd like to ride this one out for a little while. Thank you very much, but I'm not going to do it."

TS: That's good. Good for us! So you came in 2003. Were you teaching in the master's level programs?

- BB: No, I was hired to teach in the undergraduate program. I only received graduate level status last year. I'm doing some guest lecturing this semester, but it won't be till January 2013 that I teach my first graduate course. I will be teaching graduate research.
- TS: Okay, so an upper level class in Community Health becomes your bread and butter for the next nine years?
- B: Primarily.
- TS: What else have you been teaching? What courses?
- BB: I taught undergraduate research once, and I currently am teaching in the palliative care end-of-life nursing course along with community health. I know some faculty members want multiple course sections or different topics, but community health nursing is what I love. We have the theory as well as the clinical component in the course, so I've enjoyed the last nine years solidifying that course and making it so, hopefully, the students walk away with a greater appreciation of what community health nursing is about.
- TS: What was your impression of Kennesaw's nursing program when you came here in 2003?
- BB: Not having been in academe before, the first thing that struck me when I was doing my interview presentation was the longevity of the faculty, how long they've been here. Most of the faculty had been here ten plus years. As you can see from my CV, I moved around a lot, not always because of my own personal choice, but because of my husband's career. I was impressed with the fact that it must be a great place to work if the faculty members are here that long.
- TS: I know some of those that you've done research with: Annette Bairan and Gloria Taylor certainly were here a long time.
- BB: Dr. Taylor has been my mentor at KSU. She was teaching the community course when I was hired. She was the course coordinator. I still perceive that she's my mentor, but we've also become very good colleagues and very good friends. We've worked very closely together on almost every research project that I've done.
- TS: Is Gloria still full time? She hasn't retired yet?
- BB: She hasn't retired. She keeps talking about it, but she hasn't done it. I tell her, "We've just started another research project." In fact, we started another project yesterday, and so I told her she had to wait another year before she retired.
- TS: That's good. Well, Annette finally retired. I thought she would never retire.

- BB: Actually, she taught the graduate research courses for the master's program, and those are the courses I will be teaching.
- TS: Okay. What about facilities? You have been in what now is the Mathematics and Statistics building. I guess that had been renovated just a few years before you arrived from the old Science building.
- BB: I liked the building. It was comfortable to me. I did quickly learn, however, especially when we expanded our program to increase the number of students, that space was an issue in that building.
- TS: And nursing had been bounced around all over campus. They had been out on Chastain Road at one point.
- BB: That's what I heard. To me, all I know is the current Mathematics and Statistics building and Prillaman Hall.
- TS: Well I guess you've got plush facilities now with your new Prillaman Hall Health Sciences Building [opened August 2010]. So you started here in 2003, and you did research projects from the beginning.
- BB: Yes. Dr. Timothy Akers had just started. I came in January, and he had started at the beginning of the academic year. He came from the CDC where he was involved in HIV and AIDS prevention programs. Between Richard [Sowell], Tim and myself, we brainstormed together about how we could work together to do HIV related work. Tim then contacted the state HIV prevention branch to see how we might be able to collaborate together. The state is required to have a HIV community planning group. It's called the Georgia Community Planning Group, the GCPG, and is comprised of state organizations as well as representatives of people who are living with HIV. They meet four times a year and are responsible for providing direction to the HIV Prevention Program about where monies are spent, which populations should be targeted, and what resources are available. Usually, the state contracts with an outside vendor to help the group.

When Gloria, Tim, Richard, Annette and I started working together, we conducted the Community Services Needs Assessment for Georgia that year and wrote the HIV Comprehensive Plan. We worked very closely with the GCPG and the state's HIV prevention branch in completing this work. Even after Tim left five years ago, Gloria and I continued to work with the state's HIV prevention program and the community planning group. In completing the work, Gloria and I traveled all across the state of Georgia. We first started doing this [traveling] because we weren't a big believer in just making a phone call to try and get information. Gloria and I literally got on the road, and we would drive to southern Georgia and back up to north Georgia. We made sure that we got outside of the Atlanta metroplex. Part of the problem was that people who are

living with HIV felt like all the resources in the state were being geared to people in the Atlanta area, with no monies being spent on HIV prevention and care outside the Atlanta area. We went outside the Atlanta area to gather data and brought it back to the state and the GCPG. Then we compiled, based on the data, information on all the organizations that provide HIV prevention and care services across the state. We looked at the HIV services provided—was it prevention, was it care, was it provided to African-Americans, the gay community, women, or was it children? We teased out whom the services were for—and then provided basic information, so people knew where services were located, the phone numbers, and hours. Our work also helped us to identify the gaps in HIV services and what the needs were for people living with HIV or at risk for HIV infection. The data were helpful to local organizations because they could use it for writing grants to provide more HIV services.

TS: Were there major revelations from your travelling all over the state?

BB: Well, one of the things that came out that I had known for a little while, but which became much more evident to me, was the fact that for years HIV prevention and care programs worked in silos. The people working in HIV care were over here and the prevention people over there, and they didn't talk to each other. So there was a duplication of services. The right hand didn't know what the left hand was doing. We need to think about HIV disease as being on a continuum. It's not two silos. Therefore, one thing needed was to get HIV prevention and care services to talk to each other and realize that if you do prevention you do prevention, but if somebody gets infected, they're just going on along a continuum, and there's not a break. Also, the fact that we always talk about HIV in isolation—and you realize that there are a lot of other variables driving the epidemic. People don't have houses to live in; they don't have food on the table; the fact that they're HIV positive isn't that important to them because they have other needs that haven't been met—that need to be addressed before they can address their HIV.

Working with the state was a major part of the HIV work that Gloria and I did over the last several years, but we also completed other projects. For example, we did two program evaluations of the African American Outreach Initiative. The African American Outreach Initiative is a two-day educational program for people living with HIV. We also did a presentation during the event on aging with HIV. We've done that presentation now for four out of the last five years. When we first started doing the presentation, the participants were maybe in their thirties and forties, but over the years, the participants have gotten older. People attending most recently were forty, fifty, and sixty years of age. They would come to this hour-long presentation with some very basic questions, like women would want to know, well, they're having night sweats, and they realize menopause causes night sweats, however they thought their night sweats were a reflection of their HIV disease progressing. Some basic stuff that we as people who are not living with HIV take for granted because we know we're going to have to deal with the problems of aging. These people didn't have a clue how to

deal with these issues related to aging because their health care providers only worried about treating their HIV and what they'd have to do to keep them alive.

We talked to them about exercise. We talked to them about nutrition and how what they eat can affect their HIV medications. Nobody really talked to them about the impact of smoking on their health because everyone figured they were going to die from their HIV disease. The healthcare community is starting to get it, but the people who, unfortunately, are suffering from this lack of education are the forty, fifty, sixty year olds who are now saying, "Hey, I'm a long term survivor. I've been living with this disease for twenty-five years. I know nothing about how to prevent diabetes or heart disease, but I know how to manage my HIV."

TS: I was thinking that we probably have thirty-one years of data now on HIV, but do we know enough to know whether you live a normal life span with HIV?

BB: Absolutely. It's now considered a chronic illness. It's no longer a death sentence. It's categorized now with diabetes and heart disease.

TS: So you don't age any faster because

BB: Yes, you do. The data are showing that because of the inflammation related to HIV—because it does cause inflammation in the body—people are aging faster. The issue is if they're aging faster, then what we need to do is to start younger with teaching people about how to prevent some of these chronic disease problems and teach health promotion activities. Let's not treat chronic disease after the fact; that's more expensive.

TS: Any sense of how much faster?

BB: No, I don't, not really. I'd say it's probably very individualized because it also depends on how early you were diagnosed.

TS: How is Georgia compared to the rest of the country?

BB: The last time I looked at the epidemiology, we're still number seven or eight up there in the number of people diagnosed with HIV/AIDS.

TS: From the bottom?

BB: We've got the highest, seventh or eighth highest number of people diagnosed with HIV/AIDS.

TS: Highest number that have it.

BB: Yes, we're still way up there.

TS: Is this because of lack of education?

BB: Interestingly enough, I think it is two things. First off, like you said, the epidemic is thirty-one years old. We have a generation that never knew what it was like not to have HIV in the world. If you remember, early in the epidemic they had the organization called ACT UP. People were out there getting the word out, trying to get people involved and getting monies geared toward the problem. Now we have complacency and people don't talk about HIV as much. Second, people know now they only have to take one pill a day. So it's kind of scary to me for young people that are saying, "Well, gee, what's the big deal; all I have to do is take one pill a day." Or you have young couples, "Well, let's go get an HIV test, and if you're negative and I'm negative, we'll go ahead; that means we can have unprotected sex." You know, at the pharmacy, you can now buy a home HIV test and test at home. So there's good and bad. That's good that maybe we have these tests available, and people can test themselves, but what they do after they obtain the results could be problematic.

TS: That one pill a day is still pretty expensive isn't it?

BB: It is very expensive, but we have what we call the Ryan White program. It's a federally funded program that people, if they qualify for it, can basically get their health care and medication for free. It's a safety net program. The program was developed because of the fact that we had people who were so outspoken about the lack of access to medical care. The problem is, there's not a program like that for heart disease; there's not a program like that for cancer; there's not a program like that for diabetes. So now that we're saying that HIV is a chronic illness, how long—especially when you think about healthcare reform—is that program going to continue as a separate entity? If HIV is a chronic illness, why are we not managing those dollars just like we manage dollars related to people with heart disease or diabetes or something else? There's concern in the community from an economic perspective, of how are we going to continue this program because HIV care is very expensive.

TS: In addition to the young folks that take it for granted, I guess people that are older
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BB: There are older individuals who don't believe—like females for example—if I'm going through menopause now, I don't need to be worried about using a condom because I can't get pregnant. I taught a Sunday school class at my church, and the people who attended didn't think about the fact that somebody could be infected and look well. When I started my HIV work, people looked sick, and everybody died. Some of the people I enrolled in my first clinical research trials were healthy-looking young men, and the next thing I know, eighteen months later they're forty pounds thinner, very emaciated, and just really looked sick. Now people don't look sick. People used to think I'm not going to have sex with you

because you look sick, but if everybody looks healthy, then people are less reluctant to say no to sex or use a condom. Now we take a pill, and everybody look healthy.

When you think about it there are really three groups influencing the HIV epidemic in the United States. There's the group who don't know or don't care; there's the people who don't look sick anymore and engage in risky behaviors; and then there's the older individuals who don't realize that they're at risk of becoming infected.

- TS: How would you rate Atlanta in taking care of people that are HIV positive? I know we've had Sisters of Mercy in Atlanta.
- BB: There's the Mercy Care Clinic that is managed by St. Joe's [St. Joseph's Hospital, Atlanta]. I think Atlanta is a good steward of the dollars. However, the epidemic has shifted. When this epidemic started, it was considered a gay-white-man's disease; and in parts of the country that was a high socio-economic group. Here we have two men; they were employed; and, a lot of advertisement was targeted to them for their money. What we didn't realize was that, in reality, the people that were most impacted were probably the most disenfranchised people. Like I said, we do the best we can, but it's problematic keeping people in care when they're living on the streets, can't put a roof over their head, or maybe are substance users. If you're a substance user, you've got to be clean for sixty to ninety days before you can get housing. Well, if you're living on the streets, you can't remove yourself from that exposure. So how are you supposed to stay clean? There's this vicious cycle going on. Until we as a country start to think about those other variables that impact the epidemic, we are still going to have a problem. Okay, so we have a substance user; we've got to get him off the street. Maybe they're not clean today, but maybe if we get them off the street, we can help keep them clean and at least get them back into care.
- TS: So you're saying we've got a long way to go.
- BB: We still have a long way to go. There's still a lot of stigma out there and will be for a long time. HIV is a sexually driven disease, and we still do not talk about sex in this country very easily.
- TS: I think one of the things that was a revelation to me when I interviewed Gloria Taylor was that what you were talking about—being a gay-white-man-affluent disease—that AIDS may have existed a long time before 1981. It's just that nobody identified it as such until affluent, gay, white men started getting it.
- BB: In the United States we're very, very fortunate that we have the resources that enable us to treat the people. I have been very fortunate and very humbled by being able to go to Africa to do some work related to HIV. I was in Lesotho [in the southern part of Africa] for four weeks and then went back again for three

weeks. When you go over there, you see how resource poor parts of the world are. They don't have the medications they need, and they have to travel forty or fifty miles on a dirt road to get care. Many people don't get medical care because they've got to stay at home and work and take care of their families. When you see the AIDS orphans and there are no relatives to take care of them, it humbles you to the fact that here in the United States we are very blessed, and we have a lot of resources. You go into those other parts of the world, and they don't have the resources they need to survive.

Recently I was doing a focus group in Cobb County, and there was an African lady who participated in the group. As part of the focus group, we always ask them, "What are your needs?" Everybody says, whenever you ask that question, "We need more money, we need more money." She was the last person to leave the group, and she came up to Gloria and me and said, "You know, I'm from Africa. I feel very, very lucky to be living here in the United States. I can get access to medications. I have these resources here, but people in this room are very spoiled. They don't know what it's like to come from some place else where you couldn't get the medications or could get [only] part of them. You need at least three drugs, and maybe they only had two, so you can't get the third one, or maybe you run out of your medications and you have to wait sixty days to get them again. I feel very fortunate that I have access." So it's all depending on the lens that you look through. When I teach in the classroom, like I said, I try to bring those experiences to the students because we are becoming a much more culturally diverse population, and people bring different perspectives. Like I said, I was very fortunate to have that experience.

TS: How did you get to Lesotho? Was that some kind of grant?

BB: Actually, through the Association of Nurses in AIDS Care [ANAC]—it's a national-international nursing association. Georgetown University received a grant from HRSA [U.S. Health Resources and Services Administration], and they partnered with ANAC. The grant from HRSA was to provide nurse mentors to go into Lesotho, Swaziland, and South Africa. You had to apply to become a mentor, so I made the application to become a mentor and went through an interview process through ANAC. I was selected to go to Lesotho for four weeks. Four of us went together. One person was from Missouri, one was from North Carolina, and the other person was from South Carolina.

TS: Was that in the summertime or between semesters?

BB: No, actually, the University gave me permission to take the month off. Then, the second time, I went back in January for three weeks. I went back with one other person. The reason I was sent back the second time was because they needed somebody who had already been there once. There was a specific need for a mentor for one of the nurses there.

- TS: So you've been there twice then?
- BB: I've been there twice, yes. And then Gloria and I went to Uganda. We wanted to develop a community health nursing study abroad course in Uganda. We were fortunate enough to go to Uganda and spent ten days and visited the [capital city of] Kampala. We went to several different AIDS organizations in Uganda. Again, I had an experience to see what resources they have or they don't have and the hundreds of people that descend on a clinic in one day. Unfortunately, because of the way our curriculum is designed, the study abroad program was not successful. I still have dreams of being able to do it. Our focus was too narrow. We went after a very specific course, and we needed to broaden the course to open up to all nursing students.
- TS: So you're saying you didn't have enough students?
- BB: Correct. After having travelled abroad as a nurse versus just being a tourist, I truly believe that the experience really changed my perspective on nursing and nursing care in general. I'm a firm believer that somehow we need to get all our nursing students to participate in a study abroad program to see how the healthcare system is in other parts of the world. They could go anywhere because I think they would gain something whether the country was a resource-poor or a resource-rich country because healthcare delivery is so much different no matter where you go.
- TS: So you're working now to bring about the study abroad?
- BB: We're still trying to do something.
- TS: That would be wonderful.
- BB: Like I said, we have two study abroad [opportunities] in the School of Nursing, but we would like to see more opportunities for the students.
- TS: What other study abroad programs did you have?
- BB: One is in Mexico. That's Dr. Carol Holtz. She's been taking students there for a long time, to Oaxaca. Then Christie Emerson started one in Abu Dhabi, and she's been taking students there for the past two years.
- TS: That would be great if we could do one in Africa too.
- BB: Yes, we would like to still get something in Africa.
- TS: Well, maybe this would be a good time to talk about the award that you've just won, the Distinguished Professor Award. One of the ingredients of the award is that it's supposed to honor people who have integrated their teaching, scholarship,

and service together. Why don't you talk about what you've been doing that brought you the award?

BB: Well, when I first came to Kennesaw, I focused my research on HIV. At that time my mentor, Dr. Taylor, gave me some great words of wisdom. Gloria inspired me to think about how I could tie my interest in HIV with my teaching and service. When I first started off with the research in HIV, it was a perfect match to be able to bring to the classroom, things like the community services assessments that we did. In the classroom I talk about problem-oriented community assessments. That's exactly what I did. Students can read about that stuff in books, but I think unless you make it real for them, it's just still stuff in a book. Here, I was able to go into the classroom, and I could bring an actual hard copy document and say, "Nursing is involved in this."

This [community services assessments] was a multi-disciplinary project where we used a team approach to complete the task. We had nursing involved in it. We had Tim Akers who had worked with the CDC and had a background in criminal justice. We had Carole Mauge-Lewis involved as a graphic artist to help with developing it. We had Mark Patterson from Geography who helped with some of the mapping. This is something that you should do as a community health nurse. You can take the expertise that you have and actually focus on community networking and solving community problems.

As far as community service, education to me is not just in educating my students; it's also about educating the general community. It's about educating other disciplines. It's about educating everybody in general because education can be very powerful. Of course, we all know that education is only beneficial if we apply what we've been taught. A lot of us know, for example, that we should exercise, and we should lose weight. We know all the facts, but it's about how you use it. So I guess part of my mantra related to education is it's important to educate my students, but my education goes beyond just my students. It goes into the community. As far as the service piece of it goes, part of being a nurse is that you are supposed to provide service to the community. I don't perceive this to be a job. It's a profession that requires that you do some service.

As an academician who is doctorally prepared, part of service is giving back to the profession. For example, doing peer manuscript reviews, so that there is a dissemination of information. I've been a reviewer for the *Journal of the Association of Nurses in AIDS Care (JANAC)* as well as *Pediatric Nursing* and for some other journals as well. I've also sat on grant reviews related to HIV for the CDC as well as for HRSA. So that's part of my service. The Cobb County Health Department has an HIV clinic. Part of their Ryan White grant requirement is that they do an annual assessment of the services from their patients' perspective, as well as having what they call a Ryan White Program Part B consortium. Being a part of the consortium is a privilege. So the service came naturally. I didn't go out looking for it. It just came to me. It's seemed natural to

do it. In fact, sometimes, I wish I could say “no” because it gets too involved. I’m the planning chairperson for the annual Association of Nurses in AIDS Care conference. It’s going to be in Atlanta in 2013. So it was a natural fit for them to pick someone from Atlanta. The service just came naturally.

Then the research—for my master’s program I had to do a thesis. It was part of the program requirements. This is when I began to appreciate research. When I became involved in the HIV world, the inquiry became natural because HIV is such a changing, ongoing [subject]. It’s not changing as rapidly as it was, but it’s still changing. We’re not going to eliminate this epidemic unless we continue the research. I don’t think I purposely—maybe, I semi-consciously linked it all together. It just naturally came together. When I did my tenure portfolio a couple of years ago, that’s when I realized it came together. I think because of my background in community health, as well as my interest in HIV, it was a natural blend. I’m not sure how purposeful it was, but it just blended together because of my passion and my concern related to HIV.

TS: Are you involving students in your research at all?

BB: I’ve had graduate research and student assistants involved in my research. My college has been very fortunate because we have interested students who participated in helping with development of surveys, with data analysis, all different components of the research process. I’ve had graduate research assistants during the last academic year that participated in conducting focus groups. I was also part of a dissertation committee for a nurse at Georgia State. I was asked to sit on that committee because of my expertise in HIV. The nursing faculty at Georgia State didn’t have a nursing faculty member who had the level of expertise that they needed. I helped her with data collection, and I think it was good experience for the student. I have a graduate research assistant right now who is also helping with focus group transcription and data analysis, so we do try to get students involved.

TS: I see that you won a number of awards before this award, including one of our flame awards—the Foundation Prize, back in 2008. It’s hard to believe it’s been that long ago.

BB: Right, that was with Drs. Gloria Taylor and Annette Bairan. Interestingly, that article was on HIV disclosure and it evolved from one of the state projects we conducted. Because of that award, we were invited to participate in a conference at the University of Virginia. They extended an invitation for us to talk about our work at a conference on health disparities. Annette received the invitation, and Gloria and I followed up on it and actually did a synopsis and a summary of all the work we’ve been involved in.

TS: You also had an award in 2007 for clinical article of the year with the *Journal of the Association of Nurses in AIDS Care*.

BB: Yes, we did an article that reflected back on the epidemic among men. It was a portrait of HIV infection among men. So we did an historical piece.

TS: Was that with Gloria?

BB: That was with Gloria, yes.

TS: Also Researcher of the Year Award from the Georgia Association of Nurse Educators.

BB: Again, because of all the work I'd done with HIV. I've been very honored that people have acknowledged my work. However, my work has not been done alone. I'm a firm believer that most people don't work in isolation, so I've had very good partners in Gloria Taylor and Annette Bairan and other people with great expertise; Mark Patterson with his geographical mapping and Carole Mauge-Lewis with her artistic background.

One of the things I didn't stress and I'd really like to talk about is the importance of mentoring students. We've talked about students involved in research. I have a former student right now who is at Duke University in their Ph.D. program in nursing. He was in our undergraduate nursing program, graduated from our institution. I got to know Dennis, and we worked together on some community projects, HIV/AIDS work. He went to school at Emory to get his master's degree. While he was at Emory, he wanted to do research on gay, young men, less than the age of 24 because he was inspired by the phenomenon that we know HIV has been around, and yet gay men still getting infected. We worked on it together. He would sit at my dining room table, and we would work together on his research project. He finished his research and wrote an article about it, and it was published. He also went to the International AIDS conference and presented. It's the good things in life, I think, from students that keep us going as faculty.

Dennis called me last week about ten o'clock in the morning. I'm thinking, "Okay, he's now at Duke; he's in Chapel Hill." My phone rings, and he says, "Hey, Dr. Blake how are you?" I said, "Fine, Dennis, something wrong?" He usually doesn't call me in the morning. He's become like my third son. He said, "I just wanted to call and thank you." I said, "Thank me for what?" "Well, thank you for the going away party, but I also want to thank you for your guidance that you've given me and my research." I said, "What do you mean?" He said, "Well, I was sitting in my research class, and all these people are trying to talk about what their research is going to be about, and they've got all these big ideas—health disparities and all these other broad topics. All I can remember is sitting at your dining room table, and you're telling me, 'Dennis, you've got to narrow your focus.' I could sit there and tell them exactly what I want to do my research on, and the faculty just looked at me and said, 'Okay, Dennis, we're glad that you

- have it.' Then they'd go on to somebody else.'" Then he said, "Gotta go, break's over."
- TS: What's Dennis's last name?
- BB: Flores. I think he graduated from here about six years ago.
- TS: That's fantastic. I've been impressed for years with our nursing program at Kennesaw. I think you're maybe the sixth or seventh or eighth that I've done oral histories with that have won awards on campus, and it sounds like all the faculty are doing a great deal of service work in the community and doing scholarship on their service in many cases.
- BB: This has happened to be my only academic appointment, but one of the things that has impressed me over time is how dedicated the nursing faculty are. I'm also very proud of the fact that we have the largest program [in Georgia] and we have one of the lowest attrition rates. That is because once our students are accepted, we take responsibility for them graduating. Our students are successful, so I'm very proud of that.
- TS: I don't think very many people understand how selective the nursing program is at Kennesaw, compared to most of the programs. It's pretty selective isn't it?
- BB: I think this last time around we had over 800 eligible applicants for about 150 or 200 slots.
- TS: In the bachelor's program?
- BB: In the bachelor's program. So we attract a lot of qualified students. We try not to stay focused just on GPA, though that's important, because we know that it just doesn't take grades to make a good nurse. So we try to look at other components as we accept people. GPA, of course, is the driver, but we try to look at other stuff too.
- TS: I know we keep the doctoral program very small in size and, I guess, the master's program too, isn't it?
- BB: We have three tracks in the masters nursing program. The nurse practitioner program is pretty big. It's about thirty-five students. Then the nurse leadership and the nurse education tracks are relatively small. I'm okay with us not being too big because I think that gives students more opportunity to interact with the faculty and give the faculty more time to spend with the student. Over time I've seen the undergraduate program grow. I don't get to know my students as well as I would like to get to know them. Unless you're my clinical student, I'm looking at sometimes the faces of eighty or ninety students out there.

- TS: How has moving into Prillaman Hall changed things in the nursing program?
- BB: Probably the greatest asset at Prillaman Hall was we were able to have a state of the art laboratory facility for our students as well as simulation. That gave us the space to be able to give students the opportunity to not be on top of each other. They have all the latest and greatest equipment there to practice with. Now, I'm not a firm believer that nurses should learn just about equipment—this is from a community health nurse—but it is important for them to know the technology and to be able to practice and to give them the best education that we can give them.
- TS: I remember walking through that building before you actually had classes over there, and one of those floors, I guess the middle floor, seemed liked a hospital ward when you walk down the hall.
- BB: Oh, yes. It has hospital beds; it has the blood pressure cuffs, the oxygen, the suction, and all of the stuff you would have at a bedside. Oh, yes, it's just like a hospital. It is a 500 percent increase in benefit compared to what we had over in the other building.
- TS: Well, you've been at Kennesaw probably longer than any other place that you've stayed in your career.
- BB: It has been a long time.
- TS: Hopefully you're going to stay here for the rest of your career.
- BB: I don't have any plans of going anywhere.
- TS: I ask folks what keeps them here. What is it in your case?
- BB: Interestingly enough, as I told you earlier, when I went back to school to get my doctorate, teaching was not my intent. It was just a self-fulfillment opportunity. Now that I have started teaching, it's what keeps me going. And it's not just the teaching. It's the three things [teaching, service, and research] together. But part of the issue is that I believe that the students really need to be able to understand community health nursing and to have somebody who is experienced in community health nursing teaching it. Even though I've had students tell me, "I wish this course was an elective because I will never work in the community," it's amazing the students that I have come back to me three or four, five or six years later and say, "Hey, Dr. Blake, guess what? I'm working in the Health Department" or "I'm working in the community."

A student called me a couple of years ago and said, "Can I come and talk to you?" I said, "Sure; anything in particular?" She said, "I just need to talk to you." She remembered my story about how I hated bedside nursing, and she was having that same experience. She was struggling with her personal dislike of bedside nursing.

She wanted to talk to me about it and was that really what happened to me. Did I really dislike it; and I had to reinforce and tell her, “Yeah, that’s okay not to like the hospital. That’s the great thing about nursing. You can find your niche. There are so many different things to do.” We talked about it, and, fortunately, she was able to secure a position at the Cobb County Health Department and is currently working in child health where I used to work. It's those things, I think, that keep you motivated. I work with some great faculty, and they’ve all been very supportive of my work. So there are a lot of good reasons to stay. I can’t think of any reasons to leave.

TS: What about the intellectual life at Kennesaw? Has that changed at all in the nine years you’ve been here? How would you describe it?

BB: Kennesaw has had a lot of growing pains since I’ve been here. Part of that is we are transitioning from just being a teaching institution to becoming a more research-oriented school. Research and creative activity has many forms. But that transition has been painful, but then any kind of growth or change can be painful for people. However, I think it’s important that we have that transition because of the fact that we need that if we’re going to have doctoral education. You can’t teach people to be good researchers if we don’t have research going on. I think it’s great that we are getting people to be more involved intellectually and not just focused on teaching.

TS: I guess one thing that we didn’t talk about is you’ve actually been part of the team that has brought in some pretty significant grants over the years.

BB: That was our work with the state. We were very fortunate for several years that we had a great relationship with the state. The state has had its own growing pains and problems. That’s part of the reasons why we’re not currently engaged with them.

TS: It looks like maybe about a half million dollars?

BB: Almost close to a million. I enjoyed the work with the state, but I also wanted to move my own research forward. So the break from doing work with the state gave me the opportunity to say, “Okay, Barbara, let’s look at your research and your interest in HIV and aging.” I have had to keep that on the back burner for the last three or four years because of the other work that we were being paid to do. Now I have been able to focus on it. I’ve applied for some external funding; haven’t been successful yet, but you just keep plugging along.

TS: You said at the start of the interview one of your sons went through medical school at the University of South Florida?

BB: Yes, my youngest son. My oldest son graduated from here. He has a degree in English education from Kennesaw State, graduated from here about four years

ago. My youngest son is a physician. He's in his last year in residency in dermatology. He got his undergraduate and his medical degree from the University of South Florida.

TS: How is it to have an MD in the family?

BB: It's funny because he tells me that I will always be the first doctor. He tells me, "You will always be the first doctor, ma."

TS: He's doing dermatology; he's not doing AIDS research?

BB: No AIDS research. We have a lot of conversations about skin because there's a lot of dermatological issues related to HIV. So we do have a lot of discussions, but he does not work in HIV directly. In fact, he was just here last week, and he asked me if I had read about the man that supposedly had been cured of HIV. He's called the Berlin patient. Supposedly, there are two other patients that have been cured recently. He asked me if I had read about those two patients. So we do have some intellectual conversations even though we're on two different planes as far as research and health interests go.

TS: Well, I'm about out of questions. What should we have talked about that we didn't?

BB: I can't think of anything.

TS: Well, then we'll just wind it up at this point.

BB: Good.

TS: Thank you.

BB: Thank you.

Kennesaw State University Oral History Project
KSU Oral History Series, No. 110
Interview with Barbara J. Blake
Conducted, edited, and indexed by Thomas A. Scott
Part II - Tuesday, 15 March 2016
Location: KSU Archives, Sturgis Library, Kennesaw State University

TS: Barbara Blake received the KSU Foundation Distinguished Professor Award in 2012, and we did an interview at that time. This is a follow up because she was a recipient of the KSU Foundation Outstanding Professional Service Award in 2015. Barbara, you were deeply involved in research and service with regard to HIV and AIDS when you won the Distinguished Professor Award. I assume that your service has continued along that same vein. Maybe I could just ask you to talk about what you've been doing since 2012.

BB: Okay, thanks, Tom. I guess what I'd like to talk about is related more to the reason why I received the award. When I received the Distinguished Professor Award, that award recognized the three components of being an academician, service, teaching, and research. When I won that award, my teaching was probably the least strong of the three, and my service and research were probably tied for second. Since that time I've continued my scholarship on HIV and aging, but I got away from working with the Georgia Department of Public Health on HIV prevention. Actually, my service seemed to blossom a lot more from an overall perspective on HIV. When the call came out for applicants that reflected on what I had been doing in the area of service, I realized that I had probably given a significant amount of my time not only to service to the university but service to the community as well as service to the profession.

TS: Most of your service has been off campus hasn't it?

BB: Correct. When I reflected on it, I have done very minimal service on campus. I've served, of course, on college or departmental committees because that is required, and I have served on some university committees. I was actually on the faculty senate between 2004 and 2008 when they developed the department faculty council (DFC). The DFC was created so there would be transparency within the departments. Since I was the senate faculty representative for the School of Nursing, it was my responsibility to put the DFC in place. I was relatively new to academics at that point in time, so that was a real unique experience to me. Of course, I served on college committees like T&P [tenure and promotion], but as you've identified, most of my service was really done outside in the community, either serving the HIV-related community or serving my professional nursing community. I've blended HIV education into my professional career because part of my personal goal is to make sure that all nurses are HIV nurses. We have this mantra in the HIV nursing world that's all nurses are HIV nurses because the disease is a chronic illness just like diabetes and cardiovascular diseases. We don't have enough specialty professionals who

are capable of managing it (HIV). So your primary care doctor as well as your ID [infectious disease] doctor should be able to manage someone living with HIV. All nurses also need to know what HIV is and how to take care of people living with the disease.

When I teach in my classroom, I actually have some RN-to-BSN students, and I'm always amazed when they say, "Oh, I don't take care of any HIV patients." Well, people that live with HIV don't look differently anymore; they look like you do because they're doing well. So part of what I do is work from that perspective. Also in the community, because there's still a lot of stigma related to HIV, people still think that it's strictly a gay disease or people deserve to get it because they've done drugs or they've been promiscuous or something. So from my perspective it's important for me to have educated nurses. I also had the opportunity to in the last five or six years to go to Africa to educate nurses in Africa. I actually went to Lesotho, which is a country that I'd never heard of until I had the opportunity to go there . . .

TS: You mentioned that in the previous interview.

BB: Yes, okay. Then I started a study abroad with my students to go to the Kingdom of Swaziland, which is also in southern Africa. I've been working with an NGO, a nongovernmental organization, in Swaziland. So a lot of things all came together, and I decided I really do spend a significant amount of my time in service.

TS: How much time do you spend in Africa would you say?

BB: Lesotho was four and three weeks over a course of two years. Now, I go to Africa once a year, and I take students for about three weeks.

TS: How many do you take?

BB: I take between eight and ten students every time.

TS: And they're working in hospitals there and working with patients?

BB: Yes. I have a good colleague friend of mine from George Mason University, Dr. R. Kevin Mallinson [associate professor of Nursing and assistant dean for doctoral programs]. He actually went to Lesotho in 2012-2013 as a U.S. Fulbright Scholar. Between 2006 and 2009 he was principal investigator on a grant administered by HRSA [Health Resources and Services Administration] entitled *Nurses SOAR!* [Strengthening Our AIDS Response] *Global HIV/AIDS Nursing Capacity Building Program*. So Kevin lived in Swaziland for a year, and took student groups from his university. We were talking and I said, "Hey, I'd love to bring students from KSU because I think it would be a great experience for them." So I went over on a site visit, and then this will be my third year

coming up in May 2016 taking students to Swazi. He pays his own way over, and then he helps facilitate the group. They spend some time in a hospital called Raleigh Fitkin Memorial [Manzini, Swaziland]. It's a hospital that's religious based [Church of the Nazarene].

There is a physician there, Dr. Pawelos Beshah, a pediatrician that we work with. Because they have a lot of international visitors, he is kind of in charge of students that come through. He helps to facilitate the experience, and the students rotate through the maternity unit, through pediatrics, to the surgery suite, through the men's ward, and so they see a very different perspective of nursing in a developing country. As part of it they also have to do a service-learning project. So we give back to the community while we're there. The first year that we were there the students gave back by working on the waiting room. There's a small building there called the waiting room, and it's a room where women who live in the mountains who are pregnant come down and stay because they're not sure exactly when they're going to go into labor. So they want to be close to the hospital in case something happens. So they call it the waiting room. These women sit and some of them wait there as long as a couple of weeks. Well, the building had an outside area that was just all dirt and kind of nasty. The students came up with the idea that they were going to put a garden there. They tilled all of the soil. They went to the garden center in the country and bought all the plants and everything and put stones down and everything so they could make it visually appealing for the women who were waiting there rather than them just staring at this plain dirt. They also spent time picking up all the trash around the building.

TS: You call it the waiting room, but there must be bedrooms so they can stay overnight?

BB: I wish there were.

TS: Cots or something?

BB: No, actually the first year I saw it, there were those little gym plastic mats that people lay out for their kids. If the women had those they were lucky, and if they were covered in vinyl they were lucky.

TS: Covered in vinyl?

BB: Because some of the mats didn't even have any vinyl on them. They were just a flat piece of foam. Some people just lay on their blankets on the ground. There are actually two separate rooms, and then there's a bathroom. When I was there the first time, the bathroom door was a piece of plywood. Between the first year I went and the second year, they did get a donation from a church in the Netherlands. So they were able to do some painting on the inside, and they did

- get some new foam mattresses for the floor. Instead of being an inch or two thick, now they're about four or five inches.
- TS: Do the students that go over pay their own way? Do they get credit for this like a study abroad?
- BB: Yes, they pay a fee to do the education abroad, and it's an elective for nursing, and you have to be a nursing student.
- TS: And they have to pay for their airfare, but they get these scholarships from Kennesaw through the activities fee for study abroad, right?
- BB: Yes they do. The cost is not inexpensive. This year it's \$4,300. Then they get \$850 back. We're gone seventeen days, and as part of that they also have some cultural experiences.
- TS: Well, if they were going on a vacation it would be roughly about the same.
- BB: Yes. Actually probably more expensive. The students work in places where they see a lot of things they wouldn't normally see, like there's a lot of babies with malnutrition. They see things that are probably very disheartening and kind of shocking.
- TS: I think this would be a life-changing experience to go on one of these trips.
- BB: When I read their journals, they do express that they'll never see things the same. They have a greater appreciation for what they have here in the United States. Then it also impacts their future nursing career because they understand taking care of people that are culturally diverse.
- TS: I remember in the previous interview you quoted someone who was, I guess, in a discussion group, and everyone was complaining about lack of funding for AIDS and all that, and she was saying, "Well, at least they get the pills over here."
- BB: I remember that. That was a lady in a focus group that I did in Cobb County.
- TS: I would think they would come back home and be grateful for what we've got.
- BB: Yes, they do. Yes. It's a different perspective. I'm very fortunate to have had the experience. I am also active in my HIV nursing professional group. We have a local chapter of the Association of Nurses in AIDS Care (ANAC). I served as president and secretary before, and I'm again the president for the local chapter. I've also done service with the national organization. In 2013 I served as the chair for the annual conference for national members. Usually, there are 300 or 400 nurses that come to update their HIV education and see what the latest and greatest is on research and nursing care. In 2013 I served as the conference

committee chair when it was actually held here in Atlanta downtown. We had about 400 nurses there. Then there is also a board called the HIV/AIDS Nursing Certification Board, which provides an opportunity for nurses to take a test about HIV nursing that shows you have a level of expertise that other nurses don't have. That national certification board is under the umbrella of the national office. I served as treasurer for that organization for several years. Part of why I serve in professional service roles is because I want students to realize that they have a responsibility to the profession. Just because they graduate and they get a job and they earn a paycheck, there are other responsibilities that are important to nurses. I need to role-model that so they can see that, "Hey, I need to think about my career as more than just going to work every day and punching a clock."

TS: Are these undergraduate or graduate students that are going to Swaziland?

BB: The last two years I've only taken undergrads that had finished their first semester of nursing. This year we're taking two nurse practitioner students. I've not done that before. They are going to be under the supervision of Dr. Pawelos Beshah, the gentlemen I told you about, and I will supervise the undergrad students. So it will be a new model of the education abroad component, and I'm curious to see how it works out.

TS: Is this a May-mester class?

BB: Yes, it's May-mester. You don't know this Tom. Since I've seen you last, I now take students to Nicaragua too.

TS: You started to mention Nicaragua a little bit earlier, and you caught yourself. Why don't you talk about that?

BB: I work with a colleague, Johnathan Steppe, who is a clinical assistant professor of nursing in our program. He actually went through our undergraduate program. When he was in our master's program for nursing education, he wanted to learn more what it was like to do an education abroad. So he did an elective. He and another student went to a Nicaragua study abroad program with a faculty member from a sister institution. When he came back it was hoped that maybe he would be able to recommend an education abroad for graduate students. Well, what he found out was that really that experience was more relevant to undergraduate students, specifically community health.

So currently we work with a NGO (Comunidad Connect) in Nicaragua. The organization was founded and is currently run by a gentleman from Atlanta who was educated to be a social worker. He travelled to Central America with some friends after he had earned his undergraduate degree. He fell in love with Nicaragua and decided to stay there for a few years and ended up buying a coffee plantation with some other folks. He then incorporated different trips for mission groups, high school kids or whatever. He developed this program, and on the

coffee plantation he actually took the old barn and turned it into ten double rooms, so you've got a bedroom and bathroom. We were able to develop an education abroad to Nicaragua that is a clinical experience for our community health nursing students. They go down there for about eleven days. As part of their project down there they go to a very small community, about 2,000 people, called Los Robles. It's in the mountains. They help with laying concrete floors in people's homes and painting walls with paint that's mosquito repellent because malaria and other mosquito-borne illnesses are a big deal down there. They also build ovens that use less wood. In those homes all of their stoves and ovens use wood. If you take a look at the ceilings of the houses, they're all black from the smoke, which creates a lot of respiratory problems for the mothers and children who are home all day. So they (the NGO) actually developed a way to build stoves and ovens that now require less wood, which means less smoke coming out.

The students also rotate through the small clinic that is located there. Part of what we also do when we go down there is work with the *brigadistas*, the lay community health workers. In addition, students develop and implement, *charlas*, which are short health education sessions. We ask the community what they'd like to know about. Last time the students did *charlas* on stress management and exercise. We try to make them culturally specific to the community because they don't have a tape recorder or a CD player to play and do exercise. We have to think about what their environment is like and be able to tailor the educational program for them. Again, the students are learning that there's a broader component to what nursing is all about than just bedside nursing care. I believe that's part of them learning about the professional roles.

TS: Sure, what time of year do you take them to Nicaragua?

BB: We take students in December, and then they get clinical credit for their spring semester. We take twelve students down there for that. Johnathan is the one who developed that program, and he teaches in the community health course during that semester. He and I have gone together twice, working with Comunidad Connect, and it has gone well. So it's just a good experience for the students.

TS: So you never get a semester break.

BB: No. That's okay. I enjoy what I do.

TS: What percentage of our undergraduate nursing students would you say actually do a study abroad sometime in their education?

BB: There are four study abroad programs, so let's say maybe about 10 percent. Nursing students are limited in the amount of time they have in the program because it's only the junior and senior year. So there's only a small window of opportunity. I think it's more the time frame that they can fit it in.

- TS: Ten percent seems pretty significant.
- BB: Yes. Like I said, I think an experience like that can change somebody's life, and I have to tell you that it wasn't until the Lesotho experience that I realized how important it was for these students to get that experience. You can read about it all you want in the books, but it's not the same thing until you actually participate and visualize and observe it from an insider and not from just being a tourist.
- TS: In terms of community outreach is most of your outreach abroad or are you doing similar things in Atlanta and Cobb County?
- BB: Well, as far as working with the local community, I have been very fortunate to be able to work with the Cobb County Board of Health. Actually, Dr. Gloria A. Taylor and I did a needs assessment for their HIV clinic for about four or five years in a row, so they could help identify what their strengths, weaknesses, and gaps in services were. So from a Cobb perspective, that's one of the things that I've done for the community. Then also there's an organization called Someone Cares, Inc. There are two offices, one in Marietta and one in Fulton County, but the primary office is Marietta. They serve people who are infected or affected with HIV. They focus on the African American community, the gay community, and the transgender community. I've sat on their board several years, and I just rolled off as president in December of 2015.
- That's another component of some of the professional service I've done. I'm involved in a lot of teaching within the community. Again Dr. Gloria Taylor and I were involved in an educational program [the Atlanta Area Outreach Initiative] that's been going on in Atlanta since 1999. The original name of the educational program was the African-American Outreach Initiative. It was reaching into the African American community to teach people who were either infected with HIV or affected by how to manage their disease or how to help a friend or a family member. For six years we did the HIV and aging component of that program.
- TS: In the previous interview you talked about aging and HIV and how inflammation caused people to age a little faster. Is that right?
- BB: That's true, but they've actually been learning how to manage the inflammation. So now what's happening is most of the people who are aging with HIV are probably going to live to a normal life expectancy and die from something other than their HIV. I mean, it's amazing how far we have come with that.
- TS: Wow, it sounds like even since 2012 we know more than we did then.
- BB: Many things in the HIV world have changed, and HIV continues to be my passion. But my community experience for several years also included the merit badge university on campus. I'm not sure if you're familiar with that.

TS: No.

BB: We stopped it maybe two or three years ago now, but we had a Boy Scout merit badge university on campus. It was once a year, and Boy Scout troops would sign up to come. People with different expertise would develop a curriculum so that the boys could earn a merit badge in a four-hour period while they were here on campus. One of my students came to me in my community health course and asked if we could, in conjunction with community health and the Student Nurses Association, develop a curriculum where the boys could earn their first aid badge? The reason that badge is so important is because it is needed to become an eagle scout. It's very hard sometimes for the boys to be able to find a venue to be able to do that. Dr. Janice M. Long had started it the first year. She was teaching community health. The last time we had the merit badge university on campus, we had over 1,200 people here on campus participating. I actually incorporated that (the first aid merit badge) into the community health course, so the students could earn clinical credit and at the same time give back to the community. It was held on a Saturday, so students had to be committed. They had to develop the curriculum, and they had to come in and take the boys throughout the different stations to earn their badge. So HIV is my biggest area of professional service, but there are other areas where I am involved in community service. And of course with professional service, as you well know, you need to be involved in reviewing articles for different journals. So, of course I have that component too.

TS: Are you still writing papers about all of this?

BB: Oh, yes, in fact, Gloria Taylor, Richard L. Sowell and I just got an abstract accepted to the Sigma Theta Tau 27th International Nursing Research Congress. Sigma Theta Tau is our nursing honor society. It's an abstract on African American men living in rural Georgia who are aging with HIV. We collected that data last spring, and so we were quite honored to have that accepted. It will be in a conference at the end of July [July 21-25, 2016] in Cape Town, South Africa. Richard will probably be doing the presentation. There are a couple of other manuscripts related to HIV and aging in the pipeline that I am working on. I also collaborate with other faculty members in my department on HIV related work, so for example Dr. Marie N. Bremner, Dr. V. Doreen Wagner and I did a study on Reiki among people living with HIV. Are you familiar with Reiki?

TS: No.

BB: Reiki is an alternative or a complementary therapy that has to do with energy. She's the Reiki expert, and she would do the Reiki treatment. Then I would interview them afterwards to understand their perspective about the treatment. So we collected that data and submitted the manuscript. It came back for revisions, and now we're waiting to hear about that. Then Dr. Judith Hold and I are currently collaborating on a study related to HIV aging with people who are long term survivors about how they felt when they were diagnosed twenty or thirty

years ago and were told they were going to die and now thirty years later are still living. That's been very interesting. We actually pulled in a consultant from the community who is a long-term survivor who is really giving us some great insight.

TS: I would think that if you felt you only had a short time it would focus you in a way that maybe young people typically wouldn't be focused. I think it would be fascinating to see what they're thinking now thirty years later.

BB: It was very fascinating to listen to them because they made their decisions based on the belief they were going to die within a short time. The gentleman who is serving as the consultant was a highly educated man, had a great job, and was told he had only six months to live. He said after six months he woke up that morning, and he was still there. So he said, "Okay, now what am I supposed to do? It's been six months, and I'm still alive." Here he had gone out on disability and all this time thinking he was not going to survive, and I think it has been almost twenty-eight years now.

TS: Wow. You've talked about prejudice continuing. Do you think it's as bad as it was thirty years ago? Do we have a profile, for instance, of whether young people are more accepting and older people still more prejudiced? How do the attitudes of whites and blacks and Hispanics differ if at all?

BB: I think for everybody you've identified, the stigma is there. For example, in our spring 2015 study in rural Georgia we talked to these older African American men, and one of the gentlemen told us about a family member who is not accepting of him. When he went to family gatherings where they were having barbecues or buffets or other meals together, he was handed a paper plate and plastic forks and spoons and knives. And this is 2015! Despite the fact that we know as much as we know there are still a lot of people who are fearful. I don't know why they don't want to become educated. It's not just local folks or people who are not in healthcare. One of the gentlemen said that a physician was getting ready to schedule surgery for him, and once the physician found out he was HIV positive, he referred him to somebody else because he didn't want to do the surgery.

TS: This is a physician?

BB: Yes. So I think, there are still a lot of issues out there. There's a long way to go to get people educated about the disease and make people less afraid.

TS: I used to think that the situation in Africa was almost hopefulness because so many were HIV positive. What's the situation today?

BB: Interestingly, down in Swaziland 33 percent of the population is infected. They have one of the highest prevalence rates. But one of the major things they're

doing is if the mothers are put on adequate treatment while they are pregnant, the chances of delivering a child that is HIV positive is less than 1 percent. The issue becomes as long as we can get the mothers on treatment, we can decrease the mother to child transmission. The other thing that's happening is, if you take a look at the data, we are making a significant difference in getting people started earlier on treatment because the earlier you can get someone on medication, the better for their life expectancy and quality of life. I have a great example in Swazi last year when we were there. In the United States if you are diagnosed with HIV, it doesn't matter how well or poorly your immune system is functioning, the recommendation is you should go on medication, just like when people have high blood pressure you don't say, "Hey let's just wait a little bit longer, and then we'll put you on medicine."

But in developing countries like South Africa and Swaziland they didn't have the resources to put people on medications right away. So they were still working on the premise, "We'll wait until the immune system isn't working as well and the CD4 count is down to 350," while the normal CD4 count is usually 800 or plus. When I went last year, the Ministry of Health changed the recommendation. Now they're treating people at 500 and not waiting until 350. Now they have access to more medications and more testing because it's not just about the CD4 count but also how much virus you are carrying. They never could have those blood tests to measure the virus before, and now they can do that. They're expensive and they can't do it like we can in the United States, but at least they have the capacity to do that.

TS: Some of those patents ought to be expiring by now shouldn't they?

BB: Yes, they are. It's interesting because in Africa they can get medications a whole lot cheaper than we can get them here.

TS: Well, that's good. Good for them.

BB: I do want to acknowledge the fact that I have been recognized for my service to the HIV world. In 2014 the Association of Nurses in AIDS Care acknowledged my work. I received the national Distinguished Service Award from the organization. I don't do it for the awards. I do it because I love to do it. But it's nice also to be acknowledged at the same time.

TS: We talked about this in the previous interview but in terms of support on campus now that we're defined as a doctoral institution under the Carnegie classifications, is the support there for all the service and scholarship that you're doing?

BB: My department chair has been very supportive of my service. I had my annual review and my director said, "Barb, I don't know how you keep up with it all." That was her comment. I looked at her and said, "Sometimes I'm not sure how I keep up with it either." So it's a balance. I think there's no hindrance put in the

way of what I want to do. The dean has been supportive in providing seed money to help with the research like the African American older men study we did. So I think the university is very supportive. It's just that sometimes I have to come up with my own balance, and that's what I'm trying to do. I'm currently in the process of re-prioritizing what I should do because sometimes I get so passionate about it, I don't know how to say no. Sometimes I need to be able to learn to say "no." But I feel that the university has been very supportive. If I'm overburdened, it's not because of the university. It's my personal problem.

TS: It has nothing to do with them?

BB: Yes, and the other issue is, I want to be a good mentor for other faculty members. You know, I got Johnathan Steppe. Now he's gotten very comfortable with the Nicaragua project. He's going with me to Swaziland this May. So he'll learn a little bit about that component. Then again reaching out to my colleagues, HIV and aging is really a great topic—or HIV in general. So getting other colleagues involved, the more brainpower you have out there the greater the changes you can make.

TS: You mentioned Richard Sowell. He retired as dean recently, but is he still on the faculty? Or is he just still doing research in retirement?

BB: Richard stepped down as dean, but he teaches with me in community health. He's one of my clinical faculty. Because of his long-term expertise in HIV, and because now he has more time, he has been able to collaborate on this recent project and hopefully we'll collaborate some more in the future.

TS: Well, in terms of achievement, in 2012 you were still an associate professor, and in 2015 you were listed as full professor. So it looks like you got a promotion along the way too.

BB: Yes. I just felt I had met the expectations for full professor. I put in my time for associate professor and decided to move forward with that promotion. Again, I was grateful for the acknowledgement that I was doing what I was supposed to do in that rank.

TS: Well, we've talked a lot about community service, both abroad and in the Atlanta area. Have we left out anything on community service that we should have talked about?

BB: No, I think we've pretty much covered the waterfront on that.

TS: So in terms of professional service you list presidencies and what-have-you of a number of organizations and book reviews and things like that?

- BB: Yes, I guess I feel my community service is in combination with my professional service because it's my professional expertise that helps me work with the community. Sometimes I can't separate the two in my own head. Because I'm a nurse I'm able to provide that expertise not only to the community members but also other nurses that are working in the community. Like I said, part of my professional service is reviewing articles for journals, getting involved in grant reviews, mentoring, and those sorts of things. I can separate the two, but sometimes my community and my professional get tied together.
- TS: As you mentioned earlier, the Distinguished Professor Award really is for the integration of teaching and scholarship and service. It sounds like that hasn't changed—it's hard to know where one stops and the other starts.
- BB: I agree with you 100 percent, but I will admit that when I received the Distinguished Professor Award, it's almost like the stars aligned.
- TS: People ordinarily get the service award before the distinguished professor award.
- BB: Yes the stars aligned for some reason. Usually, you'll do one and then you will do the other. I did it backwards. It was interesting because you just don't purposely go out to win awards. It just kind of happens. Just like the community service, it's not that I do it purposefully. It's just that people reach out to you and say, would you do this or would you do that? In the last six months several students have said, "I sure hope I have as much energy when I'm as old as you are." I just shook my head and said, "Yes, I hope you do too." But I just to want to make that small difference somewhere, it's just means a lot. I'll never know if I made a difference, but I try.
- TS: Well, you definitely are making a difference.
- BB: We have our *Art AIDS America* exhibit going on right now [February 20 – May 22, 2016]. I don't know whether you've gone and seen it, but if not you should. It's in the Zuckerman Museum of Art. Carol S. Holtz and Richard Sowell and I sat on a panel just after the art exhibit came, and we were asked to talk retrospectively about the HIV epidemic. I was really impressed with how many students came—probably fifty or sixty students, faculty, and community members—which I thought was a lot to hear three older people talk. But the students had a lot of good questions about the epidemic and about what's going on and how it impacted and changed things. It's our younger generation that's now being impacted because they don't know a world without HIV. They perceive it as part of the world. You always have that young folk invincibility: "It's not going to happen to me." So we have a new generation that we really need to educate because we'll be heading right back with an increased number of infections if we don't.
- TS: You said about a third in Swaziland are infected. What about here?

- BB: I knew you'd ask me that question. I forget what it is, but it's not a high percentage. If you take a look at the global epidemic, we're very low, but I don't know the percentage.
- TS: So education is working in America?
- BB: It's working, but we're flat. The issue is we're not decreasing the number of new infections; we're keeping it steady. It's about 30,000 new infections every year if my memory serves me.
- TS: In the country?
- BB: In the United States every year.
- TS: Well that's not too bad.
- BB: Yes, but the issue is that number needs to be going down. It's more expensive to treat people than it is to prevent the disease. So we need to figure out why we're still having this problem. It's not mother to baby transmission. That's almost insignificant in the United States. But it's among the eighteen to twenty-four year olds that new infections are the highest.
- TS: Anything that we haven't talked about that was part of your service?
- BB: No, I think you've asked all the good questions. I guess the only other question would be why did I go up for the award? I guess that I just felt there was a culmination and someone suggested, "Hey, you really have done a lot even since you won the Distinguished Professor Award." So I put it on paper. I almost hemmed and hawed if you want to know the truth, and I thought, "You've already won the Distinguished Professor Award. Should you really do this?" But I was encouraged to do it because I've continued to grow that aspect of my career.
- TS: I think it's great that we've got the awards and that you keep going up for them. I think it's a measure of just how many exciting things are happening on this campus and how many good things are being done.
- BB: Tom, this university has grown significantly since I've been here.
- TS: Since 2003?
- BB: Yes, in thirteen years it has really had a tremendous growth. I can't think of anything that's been negative about the growth. I mean, it's not been without growing pains, but I think the university itself and the administration really foster people to grow in areas where they have their expertise or where they think they can contribute the most. I've been particularly pleased at the university's

embracing community and global engagement. That's great for the students because the world is growing smaller and smaller, and I think students need to know how they can give back to the community. It's not just about taking, but how they can give back, and also how they can work with people from around the globe because no matter where you go now you're going to run into somebody who looks differently or talks differently from you. You need to be able to show some cultural sensitivity and respect for those individuals. Especially nurses need to do so because they're going to be dealing with them when they're most vulnerable.

TS: Now that we've got a vice president for community engagement and economic development I've got a feeling we're going to be doing a lot more community outreach in the future or at least it's going to be more organized than it has been in the past.

BB: I'm looking forward to seeing how that manifests itself because like I've said, I hope to continue to be engaged in the community and hope I can contribute where I can to help with the university's growth in that direction. Hopefully we can get not only the Kennesaw campus but can engage with the Marietta campus on some cross collaborations. I haven't really had that much exposure to the faculty on that campus, but I would love to see if there's anybody there who's interested in HIV and that aspect of community engagement.

TS: Fantastic. Well thank you very much.

BB: Thank you Tom. I appreciate the opportunity to add an update.

INDEX

- Abu Dhabi, United Arab Emirates, 21
- African American Outreach Initiative (Atlanta Area Outreach Initiative), 16, 35
- Akers, Timothy A., 15, 22
- Association of Nurses in AIDS Care (ANAC), 20, 23, 32-33, 38
 - Journal of the Association of Nurses in AIDS Care (JANAC)*, 22-24

- Bairan, L. Annette, 14-15, 23-24
- Bennett, David N., 13
- Beshah, Pawelos, 31, 33
- Blake, Barbara J.
 - Childhood, 1
 - Parents, 1-2
 - Enrollment in diploma nursing program, 1-2
 - Initial rejection of nursing as a profession, 1-2, 4-5
 - Early married life, 2-3
 - Decision to enter an A.S. in Nursing program, 3-5
 - Professional career as a registered nurse in hospitals and clinic, 1976-85
 - Morton Plant Hospital, Clearwater, FL, 4
 - Diagnostic Clinic, Clearwater, 4
 - Sacred Heart Hospital, Pensacola, 5
 - Tampa General Hospital, 6-7, 9-11
 - First exposure to patients with AIDS, 9-11
 - Children, 6, 8, 27-28
 - B.S. in Nursing program, 1983-85, at Florida Southern College, 6
 - Excitement over community health course, 6
 - Start of professional career as community health nurse, 1985-89
 - Polk County (FL) Health Dept., 6-7
 - Itinerant health educator for Polk County School Board, 9
 - M.S. program in Community Health Nursing, 1986-89, at U. of South Florida, 8
 - Move to Atlanta, 1989 to 1995
 - Reason for move to Atlanta, 8
 - Work at AIDS Research Consortium of Atlanta (ARCA), 9
 - Research coordinator, West Paces Clinical Research Group, 1990-93, 11
 - Employment at Cobb County Health Dept., 1993-95, 11
 - Move to Texas, 1995 to 2003
 - School health nurse, Richardson Independent School District, 12
 - Ph.D., 1996-2000, at Texas Woman's University, 12-13
 - Work for Parkland Health and Hospital System, 13
 - Move back to Atlanta area, 2003
 - Application to KSU for a faculty position in community health nursing, 13
 - Impressions of the KSU nursing program in 2003, 14
 - HIV research at KSU, 15-19, 23

Work with colleagues on Georgia Community Services Needs Assessment
 and HIV Comprehensive Plan, 15
 Program evaluations for African American Outreach Initiative, 16-17, 35
 Travel to Africa on AIDS-related projects, 19-21, 30-31
 Attempt to develop a study abroad course in Uganda, 21
 Article on African Americans aging with HIV in rural Georgia, 36-37, 39
 Study on Reiki among people living with HIV, 36
 Study on long term HIV survivors, 36
 Recipient of 2012 KSU Distinguished Professor Award, 21-23, 29, 40-41
 Efforts to involve students in research, 23
 Recipient of 2008 Foundation Prize, 23
 Recipient of 2007 clinical article of the year for *JANAC*, 23-24
 Researcher of the Year award from Georgia Association of Nurse Educators, 24
 Recipient of the KSU Outstanding Professional Service Award, 29, 40-41
 Mentoring students, 24
 Reasons for staying at KSU, 26-27
 Grants, 27
 Professional service activities
 Member of faculty senate, 29
 Service to HIV-related community, 29
 Service to professional nursing community, 29-30
 National service with ANAC, officer in local chapter, 32-33, 38
 Treasurer of HIV/AIDS Nursing Certification Board, 33
 Professional service in Atlanta and Cobb County, 35
 Work with Boy Scout merit badge university at KSU, 35-36
 Article and grant reviews for professional journals, 36, 39
 Recipient of 2014 Distinguished Service Award from ANAC, 38
 Study abroad program in Swaziland, 30-33, 38
 Study abroad program in Nicaragua, 33-34, 38
 Promotion to full professor, 39
 Bremner, Marie N., 36

 Centers for Disease Control and Prevention (CDC), 15, 22
 Cobb County (GA) Health Department, 11-13, 22, 27, 35
 Comunidad Connect, 33-34

 Duke University, 24

 Emerson, Christina F., 21
 Emory University, 13, 24

 Flores, Dennis, 24-25
 Florida Junior College, Jacksonville, 1
 Florida Southern College, 6

 Georgetown University, 20

Georgia Community Planning Group, 15
Georgia Department of Public Health, 29
Georgia Regents University, 13
Georgia State University, 23

Heath Resources & Services Administration, 30
HIV/AIDS Nursing Certification Board, 33
Hold, Judith, 36-37
Holtz, Carol S., 21, 40
Home Depot, The, 8, 11

Indian River Community College, Ft. Pierce, 3-4

Jackson Memorial Hospital, Miami, 1

Kennesaw State University

Nursing program

Old Nursing Building (presently Math & Statistics), 15

Prillaman Hall, 15, 26

Involvement in HIV research, 15-19, 23

Dedication of the faculty, 25

Quality of the program, 25

Nursing graduate program, 25

Intellectual life, 27

Student Nurses Association, 36

Support for faculty research and service, 38-39

Art AIDS America exhibit, Zuckerman Museum of Art, 40

Growth, 2003-2016, 41-42

Community and global engagement, 42

Lesotho, 19-20, 30, 35

Long, Janice M., 36

Los Robles, Nicaragua, 34

Mallinson, R. Kevin, 30-31

Mauge-Lewis, Carole, 22, 24

Mercy Care Clinic, St. Joseph's Hospital, Atlanta, 19

Miami Dade Community College, 3

Oaxaca, Mexico, 21

Patterson, Mark W., 22, 24

Pediatric Nursing, 22

Raleigh Fitkin Memorial Hospital, Manzini, Swaziland, 31

Republic of South Africa, 20

Ryan White program, 18, 22

Sigma Theta Tau 27th International Nursing Research Congress, 36-37

Someone Cares, Inc., Marietta, Georgia, 35

Sowell, Richard L., 13, 15, 36, 39-40

Steppe, Johnathan, 33-34, 39

Swaziland, 20, 30, 37-38, 40-41

Taylor, Gloria A., 14-16, 19-24, 35-36

Texas Woman's University, 12

Uganda, 21

United States Health Resources & Services Administration (HRSA), 20, 22

University of South Florida, 8, 27-28

Wagner, V. Doreen, 36