

Editorial

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Understanding Barriers to Linking High Risk Heterosexual African American Women to Care in the Upper South

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BACKGROUND

As part of Centers for Disease Control and Prevention's (CDC's) HIV prevention strategic plan through 2010,¹ 4 national goals were identified to reduce by half the new HIV infections in the United States. One of the 4 goals is to strengthen the national capacity to monitor the human immunodeficiency virus (HIV) epidemic to better direct and evaluate prevention efforts. In response to these goals, the CDC awarded funds to state health departments to develop and implement a surveillance system to monitor behaviors that put people at risk for HIV infection in metropolitan statistical areas (MSA) with high incidence of human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS). Three target populations making up the majority of HIV/AIDS cases were selected for surveillance including: men who have sex with men, injection drug users and heterosexuals living in high risk areas (defined by poverty and HIV/AIDS incidence). Each year a different population was interviewed and analyzed in a 3 year rotating cycle.

HIV/AIDS cases acquired through heterosexual contact constitute 34% of all diagnosed adult and adolescent HIV/AIDS cases reported in 33 areas with confidential name reporting in 2010. Over the last 25 years of the epidemic, transmission category has shifted with more cases being acquired through heterosexual contact, less through injection drug use and an increase in females being diagnosed with HIV/AIDS. Most of the HIV/AIDS cases being diagnosed (79%) in 2010 were female adults and adolescents with primary transmission factor of heterosexual contact.¹ In response to the increase of female HIV/AIDS cases, CDC's National HIV Behavioral Surveillance (NHBS) project was awarded additional funds from the Minority AIDS Initiative (MAI) to conduct a one-time study of risk behaviors of male partners of minority women (African American and Hispanic). The supplement survey (referred to as partner supplement) was conducted with minority women who complete the National HIV Behavioral Surveillance-heterosexuals (NHBS-HET) survey and an HIV test during NHBS-HET cycle. Women were then asked to recruit up to 2 of their male sexual partners to take the survey.

The data collected on heterosexuals in high risk areas through NHBS will assist the CDC to monitor behaviors of heterosexuals in high risk areas that lead to HIV infection and individuals access to HIV prevention programs in high risk areas. Information on risk and testing behaviors and access to prevention programs will assist local health departments in funding allocations to increase prevention services and lower the risk of HIV infection.

SPECIFIC AIMS OF HET CYCLE

The goal of NHBS is to “*enhance understanding of risk and testing behaviors and to develop and evaluate HIV prevention programs that provide services to these groups*” (CDC NHBS-HET Protocol, page 1-1). Specific aims include utilizing data collected during the heterosexuals in high risk areas cycle to:

- Assess the prevalence of and trends in risk behaviors, including:
 - Sexual risk behaviors;
 - Drug-use risk behaviors.
- Assess HIV Testing Behaviors
 - Assess the prevalence of and trends in HIV testing behaviors;
 - Assess prevention;
 - Assess the exposure to and use of prevention services;
 - Assess the impact of prevention services on behavior; and
 - Identify prevention-service gaps and missed opportunities for prevention.

The partner supplement for minority women and their partners will also aim to identify:

- Risk behaviors of male sex partners of minority women; and
- To what extent do minority women's perceptions of their male sex partners' risk behaviors match the partners reported behaviors.

VIRGINIA BACKGROUND ON HETEROSEXUALS

The Eastern Virginia health region ranks number one in the number of HIV infections and AIDS cases in Virginia. The Norfolk, VA eligible metropolitan area (EMAs) (defined by Ryan White and based on HIV/AIDS cases) consists of the Eastern health region and parts of North Carolina. Along with Arlington, Alexandria and Richmond, the Eastern region has a higher share of HIV and AIDS incidence in Virginia especially among African Americans with lower median incomes.² As of December 31, 2010, the Norfolk MSA had a total of 3,075 persons living with HIV infection and 2,227 persons living with AIDS. Approximately 30% of HIV and 26% of AIDS cases were female. Blacks are disproportionately represented with 72% of HIV and 69% of AIDS cases. According to the 2011 epidemiological profile released by the Virginia Department of Health, HIV will infect 4.9 black females to every 1 white female.²

According to CDC,¹ HIV/AIDS cases acquired through heterosexual contact constituted 34% of all adult and adolescent HIV/AIDS cases reported by 33 areas with confidential name based reporting in 2010. Through the HIV epidemic, transmission has shifted from homosexual contact to an increasing percent of heterosexual contact. For example, 79% of HIV/AIDS cases diagnosed among female adults and adolescents in 2010 was through heterosexual contact; and 17% of the males diagnosed were attributed to transmission through heterosexual contact. Minority women have also become more affected by HIV over the last half of the epidemic. "*African American and Hispanic women together accounted for 80% of all reported cases of HIV infection in 2010*".¹

Heterosexual behavior is not the only indicator of risk. Studies have found that geographic clustering of the HIV epidemic within cities was identified as an important consideration. Correlations among poverty, increasing AIDS incidence, and higher proportions of single mother households have also been identified. Therefore, more information needs to be gathered to understand not only the role of heterosexual behavior in HIV transmission, but also to explore areas with higher rates of disease and poverty and their access to and utilization of HIV prevention programs.

SUMMARY OF FINDINGS

Initial findings from the analysis of the data reveals perceived barriers to accessing heterosexual women and their partners. This data set consisted of six key informant interviews and two focus groups. Participants were African American women. From this subset the following data is abstracted; barriers or challenges to accessing heterosexual women and their partners; suggestions for improving heterosexual women's participation and a summary of the overall formative assessment findings and the implications for the partner study.

Barriers to Accessing Heterosexual Women and their Partners

The barriers to accessing heterosexual women and their partners resulted in eight themes, specifically, *shame or fear; sex partners with multiple issues; pride; denial; lack of education; stigma; lack of trust; and ultimate responsibility/double standard*.

When comparing the results of this targeted subset of the larger group there is an overlap concerning specific themes, namely, lack of trust, stigma and denial. The new themes that arose were shame or fear of losing primary sex partner, sex partners

with multiple issues, pride, lack of education, and ultimate responsibility/double standard. The overlap of themes and the distinct differences between the two groups suggest a starting point for developing targeted campaigns that address barrier specific challenges. Lack of trust, stigma, and denial are overlapping themes that indicate that there are powerful structural forces inherent in the belief systems of both of these groups. With the exception of lack of education, the new themes that emerged from the groups comprised of heterosexual women are all issues that are gender specific. As such, they offer suggestions for improving heterosexual women's participation, these points will be discussed more fully in the next section.

Suggestions for Improving Heterosexual Women's Participation

The pertinent question for this group of responses is *"How can the operation and participation for the partner study be improved based on these findings?"* Respondents overwhelmingly suggested that one of the most efficient motivators for heterosexual women's participation is monetary compensation for their time. Other points that were discussed were will significantly enhance participation by this group of targeted people included bring them to one place to assess them, provide 'real world' solutions to their complex lives that would benefit them beyond the completion of the study, keep everything anonymous, pass out health education materials that stresses self-preservation, choose office locations that are convenient to parks and community centers frequented by the target population, avoid making judgments or overarching stereotypes about individual's sex lives and to take time to build trusting relationships with the target community before asking for participants. These suggestions address some of the barriers previously mentioned. However, creative and gender specific strategies are needed to improve both partner participation and recruitment. After careful analysis a stumbling block arises concerning the following challenges; shame or fear of losing primary sex partner, sex partners with multiple issues and ultimate responsibility or double standard. These issues are all gender and perhaps culturally specific. One suggestion for mastering these would be to utilize African American women as interviewers, it would also be helpful to sensitize them to the reoccurring issues beforehand. One way that this could be done is to establish a training session for interviewers where they learn more about substance abuse, spousal abuse, alcohol abuse, battered women's issues and the implications of the current shortage of black men in the African American community. Furthermore, interviewers should not be judgmental when asking women about recruiting their sex partners, role playing how the interviewee will ask her partner to participate may provide one solution. Interviewers should also be prepared to give informants referrals to community resources that offer assistance with alcohol abuse, drug abuse, battered women's shelters and financial assistance.

Overall Summary and Implications for the Partner Study

When comparing the barriers and challenges of the general population and the targeted population of heterosexual African American women, the largest issue that arises is that the majority of these theme (e.g. denial, lack of trust, stigma, lack of education) have been a long standing challenge or concern regarding health education (or lack thereof) around HIV/AIDS in the African American community. Perhaps, their continued presence here is an indication that a principle recommendation that comes out of this data set is the dire need for more efficient health education campaigns targeted at high risk African American populations.

The new themes (e.g. shame or fear of losing primary sex partner, sex partners with multiple issues, pride, and ultimate responsibility/double standard) are gender specific and a realistic example of the multi-vocality of African American populations. In this respect, it is wise to address these gender specific themes through education of both the interviewers and interviewees as they are the prime concerns that separate this subset of the population from the previous groups, specifically men who have sex with men and intravenous drug users. Developing culturally sensitive materials that address these matters will strengthen the recruitment process and the sustainability of the intervention.

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