Women's Knowledge, Attitudes, Beliefs & Decisions about HIV/AIDS: A Cross National

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Background

- Globally, pregnant and parenting women of African heritage suffer the greatest burdens of HIV/AIDS
- 64% of the 126,964 women living with HIV/AIDS in the US are AA (www.cdc.gov)
- The rates of new HIV infections and the consequences of AIDS is increasing most rapidly among women of African heritage
- HIV/AIDS contributes significantly to infant and maternal mortality among women of African heritage

Background

- Recent findings suggest that young Caribbean women are 2.5 times more likely to be infected than young men (http://womenandaids.unaids.org/ Retrieved 2/16/06)
- Few studies have simultaneously compared the women of African heritage from different National or International settings
- Cross national comparison among women with similar heritage are critical to examine differences and similarities important in risks or aspects of living with HIV/AIDS that may contribute to effective and sustainable evidenced based care

Purposes

The purposes of this multisite pilot study comparing pregnant and parenting women of African heritage in Baltimore and USVI at risk or living with HIV/AIDS were:

1. Describe and examine the relationships among knowledge, attitudes, beliefs, depression, self-esteem, and abuse.

2. Compare HIV/AIDS status, abuse, knowledge, attitudes, and beliefs among women in Baltimore and USVI.

3. Describe how knowledge, attitudes, beliefs, feelings, and abuse may influence decisions about participating in voluntary testing and counseling, disclosing disease status to family and friends, and decisions related to parenting.

Methods

- Conceptual Model
  - Nola Pender's (2006) Health Promotion Model (HPM)
- Design
  - Mixed methods – Quantitative/Qualitative
    - Descriptive Correlational
    - Descriptive phenomenological method
- Setting
  - USA: Baltimore, Maryland
  - US Virgin Islands: St. Thomas, St. John

Methods

- Sample
  - AA pregnant (medically diagnosed) and parenting women (infants up to 6-months)
  - Afro Caribbean pregnant or parenting women
  - USA Sample sites:
    - HIV Perinatal Services
    - Transitional Housing
  - US Virgin Islands
    - Public health clinics- Prenatal/Postpartum
    - Non Profit Prenatal-Post partum HIV Services

Methods

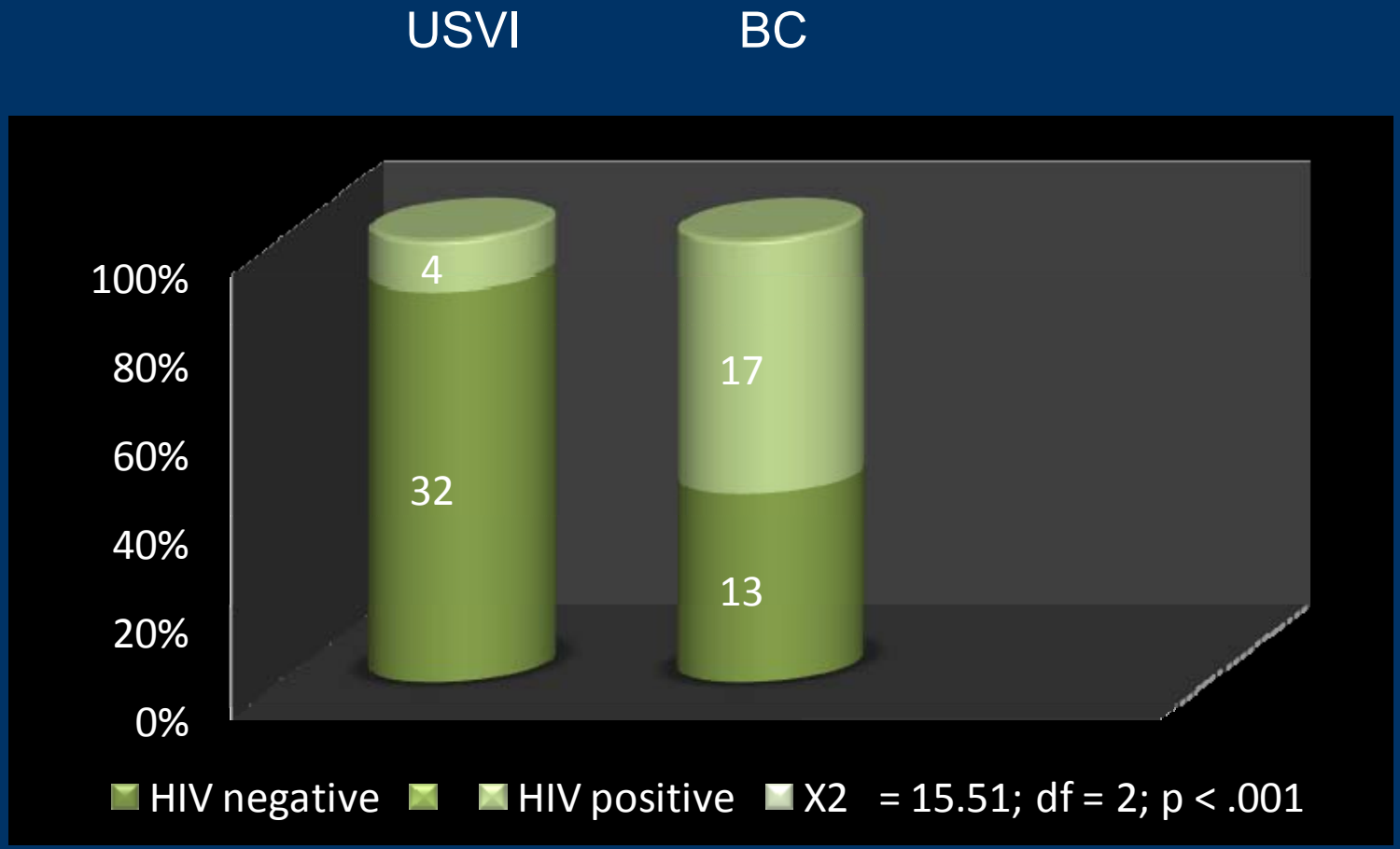
Data Collection Methods

- **Questionnaires** (quantitative)
  - Abuse Assessment Screen (AAS)
  - Rosenberg Self Esteem Scale (RSE)
  - CES-D10 Depression Scale (CES-D10)
  - HIV/AIDS Knowledge, Attitudes, Beliefs Patient Questionnaire (HAKABPQ)
- **Medical Records Review**

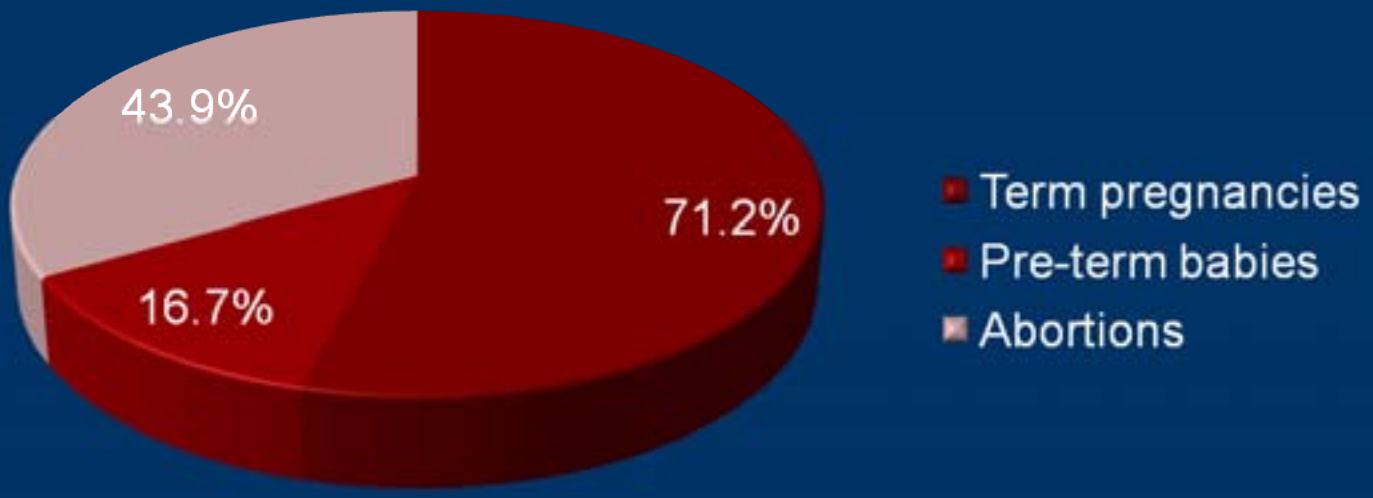
Results

- Total of 66 women of African heritage
  - 30 African American; 36 African Caribbean women
- Age ranged from 18 to 40 years
- Gestational age ranged from 15 to 39 weeks
- Baltimore City had a higher number of participants with HIV/AIDS diagnosis than those in the USVI
- There were significant differences between HIV status and research sites

HIV Status by Research Site



Reproductive History: N= 66



Comparison of Demographic Characteristics N = 66

	USVI: n = 36	Baltimore: n = 30
Age M (SD)	26.4 (5.6)	27.3 (6.3)
Gravida (median)	2.0	3.0
Parenting status: N (%) Pregnant Parenting	 25 (69.4) 11 (30.6)	 24 (80) 6 (20)
Education M (SD)	12.2 (2.7)	12.5 (2.3)
Employment	17 (47.2)	13 (43.3)
Marital status Single Married	 23 (63.9%) 7 (19.4%)	 17 (56.7%) 7 (23.3%)

Statistical Analysis

- **Analysis**
  - Zero-order correlations were computed to determine relationships among self-esteem, depression, knowledge, attitudes, and beliefs
  - Adjusting for multiple variables using Bonferroni procedure
  - Correlations must be $\leq$ .005 to be considered significant
- **Results**
  - No significant associations were found between demographic characteristics and the variables
  - Lifetime and Perinatal abuse were higher in BC vs. USVI
    - BC – Lifetime = 50% (n=15/30 Perinatal = 23.3% (n=7/30)
    - USVI - Lifetime = 30.6% (n=11/36) Perinatal = 8.3% (n=3/36)

Correlation of Variables

Positive Correlations (p<.005)

- BC
  - Knowledge with Attitudes; Social Beliefs; Cultural Beliefs
  - Attitudes with Social Beliefs
  - Social Beliefs with Cultural Beliefs
- USVI
  - Knowledge with Cultural Beliefs
  - Attitudes with Cultural Beliefs
  - Social Beliefs with Cultural Beliefs

Results: Abuse

- Lifetime Abuse (physical & sexual) = 39.4% (26)
- Perinatal Abuse (physical & sexual) = 84.8% (n = 56)
- 3% (n = 2) reported being afraid of their partner/ex-partner/father of the baby
- Women in BC reported more severe lifetime abuse and perinatal abuse than women in the USVI
- No significant differences were found between HIV status and lifetime and perinatal abuse
- Significant differences were found between HIV+ & HIV- women reporting being afraid of their partner/ex-partner/father of the baby

Abuse and HIV status

	HIV positive: n = 21	HIV negative: n = 43
Physical & sexual abuse during pregnancy (3 & 5)	4 (19.1%)	6 (14%)
Physical and sexual lifetime abuse (1, 2, & 4)	10 (47.6%)	16 (37.2%)

Abuse and Mental Health

- Severity of abuse was computed as the total number of times women responded "yes" to abuse items
- Significant differences were found:

1. Depressive symptoms (CES-D) was positively & moderately correlated with lifetime abuse (.327; p = .01); and not during pregnancy
2. Self Esteem (RSE) was negatively and moderately correlated with abuse during pregnancy (-. 350; p = .01); but not with lifetime abuse

“Faith, Courage, and Prayer”: Pregnant & Parenting Women’s HIV, Interpersonal, and Intimate partner Violence Experiences

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Purpose

The qualitative study explored the experiences of HIV-infected women related to decisions about HIV testing, status disclosure, adhering to treatment, and pregnancy/parenting decisions.

Methods

- In-depth interviews using open ended questions were used to ask about women's:
  - Demographic characteristics
  - Pregnancy health history
  - Decision-making about HIV testing
  - Disclosure of test results
  - Behaviors and changes in their relationships related to test results and disclosure
  - Partner relationships

Methods

- The individual interviews:
  - Took approximately 60 minutes
  - Were transcribed and analyzed informed by the descriptive phenomenological method (Koch, 1995; Lopez & Willis, 2004) to gain better insight into the experiences of the women
  - Were re-read multiple times to ensure methodological rigor and trustworthiness of data interpretation

Results

- Sample (N= 21)
  - Pregnant = 16
  - Parenting = 5
- HIV/AIDS diagnosis at time of interview
  - 1 month to 9 years
  - Average was 2.5 years since diagnosis
  - 3 women acquired HIV through vertical transmission
- 6 themes were identified from the interviews with related sub-themes

Themes

1) Perceived vulnerability to be infected with HIV
2) Decision to get tested for HIV
3) Women's behaviors after HIV diagnosis
4) Disclosure of HIV status
5) Women's HIV experiences: Positive, strength, resilience
6) Women's experiences with physical and sexual violence.

Qualitative Analysis

Theme	Sub-theme	Exemplar
1. Perceived vulnerability to be infected with HIV	Acknowledged her own and partner's risky behaviors Seemed unaware of her vulnerability	"I was mentally prepared because I know I was at risk. My partner then was an IV drug user. I was not surprised because at the time I was living a mostly risky and unhealthy lifestyle and I got it from another partner. "
2. Decision to get tested for HIV	Voluntary decision – benefit to baby and/or pregnancy Protect pregnancy and health of baby Part of routine prenatal care.	"… more concerned about the baby versus me. Didn't want baby to be infected…"

Qualitative Analysis

Theme	Sub-theme	Exemplar
3. Women's behaviors after HIV diagnosis	Initial shock and disbelief	"I am going to die. I am going to leave my kids - who am I going to leave them with? [It is] just about my kids."
	Adherence to treatment	"… sleep a lot, eat a lot, walk a lot, talk to baby a lot. Try to be positive and just enjoy life."
	Adopting healthy lifestyle	
4. Disclosure of HIV status		"it was detrimental to me. They ostracized me and my kids and told my kids I was going die."
		"… Before I was positive, it was bad. I was going to leave him. There were a lot of financial problems. …Bad things make things okay. Now he is behaving like a husband. Very caring and willing to do what I tell him."

Qualitative Analysis

Theme	Sub-theme	Exemplar
5. Women's HIV experience: Positive, strength, resilience	Positive HIV experience – strength through reliance on faith, spirituality, and God	: "It is scary but at the same time you have to have faith, believe in yourself; have courage and pray."
	Positive HIV experience – through positive thinking and positive outlook and attitude toward life	"… actually, I was thinking I could not have any more babies. … how can I have babies? But the doctor opened to me to have the baby and that was wonderful."
6. Women's experiences with physical and sexual violence	Childhood victimization	"When I was younger, I had a dysfunctional family. I got raped at 8 years. "
	Intimate Partner violence in partner relationships	"… He freaked out [after learning my HIV status] like he went to the bathroom 2 or 3 hours. … If he was negative he would have penalized me for that."
	Intimate partner violence after disclosure of HIV status	

Limitations

- Self report instruments were used, so women may have failed to divulge important information about their HIV status and abuse experiences
- Convenience sampling limits external validity – women were already receiving health care and HIV testing was part of their routine care
- The sample size was small reducing, statistical power to find an effect, but the descriptive findings and summary statistics suggest that most women experienced lifetime abuse and abuse during pregnancy

Conclusions

- Perceived risks of disclosure, such as being ostracized and afraid, prevented women from disclosing
- Women infected with HIV were more willing to disclose if they had someone they trusted
- Married women immediately disclosed their HIV status to their husbands. Results are similar with Peltzer & colleagues (2008), who found highest disclosure with partners (51.7%; n=116)

Conclusions

- Women's perception of benefits such as keeping their baby healthy motivated their decision to get tested. Same was found in other studies (Kirshenbaum & colleagues, 2004; Minnie & colleagues, 2008; Ransom, 2005)
- When asked about their confidence in parenting, most women reported that taking their medications & caring for themselves will ensure that their baby stays healthy

Conclusions

- Of the 21 women who were HIV positive, only one (1) found out when she was pregnant and wanted to continue with the pregnancy. In contrast to a previous study (Suryavanshi & colleagues, 2008)
- Women were knowledgeable about HIV transmission including vertical transmission & preventive behaviors

Implications

- There is a critical need for structured counseling and educational services in practice settings to increase pregnant/parenting women's willingness to disclosure HIV status
- There is a need for clinicians to offer focused counseling to assist women's decisions about current pregnancy, future pregnancies as well as parenting
- Clinicians could provide opportunities for women to actively participate in community HIV and violence prevention initiatives

Implications

- Clinicians and school nurses need to integrate HIV & violence prevention in school curricula to address prevention efforts during the early years
- There is a need to implement comprehensive opt-out testing recommendation in mainstream health care settings in addition to prenatal clinics

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