
HIV and Women in Hawaii: Risk and Protective Factors in HIV/AIDS Prevention

Valli Kalei Kanuha PhD*, Charles W. Mueller PhD**, Kathleen M. Sullivan RN, MS***, Patricia Glancey MSW, MPH****, Pamela Matsumoto MSW*****, and Lise D. Martel MEd**

Abstract

Using semi-structured interviews with adults living with or at-risk for HIV and interviews and focus groups with key informants, the present study examined risk for HIV transmission among women living in Hawaii. Key research findings suggest that women in Hawaii are at risk for HIV infection primarily through sexual contact with their male sex partners, including bisexual and injection drug using (IDU) men. A significant factor in women's HIV risk is sex and gender role dynamics in the context of their relationships with men. Recommendations support primary prevention services for HIV-positive men who have sex with men and women, and IDU men who also have sex or share needles with women. Collaborative efforts between health care professionals and HIV/AIDS agencies to integrate gender-specific and culturally appropriate HIV prevention interventions are recommended.

Introduction

In the United States, AIDS is currently the third leading cause of death for women between the ages of 25-44¹ and HIV infection is increasing more rapidly in females than in males.² With estimates of 75% of all new HIV infections occurring in women, and 80% of HIV-positive women being of childbearing age, the impact of HIV among women is significant, posing a serious threat to public health.³

AIDS cases among women in Hawaii are relatively low compared to national statistics.^{4,5} A total of 175 female AIDS cases were reported in Hawaii between 1983 and 2001, accounting for seven percent of all documented AIDS cases in the state. While women account for a rising percent of cases, the absolute number of new female AIDS cases has not changed dramatically over two consecutive five-year periods.

Similarly, data from the Hawaii Seropositivity and Medical Management Project (HSPAMM) revealed a total of 191 women enrolled, about eleven percent of all HSPAMM'S active cases.⁶ Additionally, HIV counseling and testing data in Hawaii indicate that women account for about one tenth (10%) of all positive HIV test results, a percent roughly comparable to AIDS and HSPAMM

data. Anecdotal data obtained from outreach workers, key informants and Oahu physicians for this study do not suggest an excessively large population of women living with HIV in Hawaii who are unknown to health, medical or social service providers.

Overall, these data point to relatively low HIV rates in females compared to males in Hawaii. With the new state mandatory HIV reporting requirements, a clearer and more timely picture of HIV infection in Hawaii women should emerge. However, if as suggested there is a fairly low HIV prevalence for women in Hawaii, strategies for preventing HIV in women based on interventions from high prevalence areas in the U.S. and other countries may not directly apply. Low prevalence areas are more likely to be a low priority for governmental HIV prevention, to have uncertainty in the choice of intervention target groups, to lack data indicating the epidemic course and to fail convincing the population that the risk of infection is real.⁷

Prior studies have found that Asian and Pacific Islanders (API) women tend to engage in non-explicit, inferential assessments of sexual partners' risk which may contribute to an illusory sense of control and safety, and that cultural values of reticence to talk about sexual matters, accommodation of others and a traditional romantic ideal can inhibit open discussion about HIV or safer sex behaviors.⁸ In Hawaii from 1997-2001, APIs accounted for 41% of all female AIDS cases, higher than the 29% rate of male API cases in Hawaii during the same time period.⁹ Hawaiian/part Hawaiian women account for 20% of all female AIDS cases in Hawaii, higher than that seen in male AIDS cases in Hawaii. Along with low prevalence rates among women, such ethnocultural dynamics may create unique challenges for HIV prevention in Hawaii.

Drugs, Women and HIV

Prior research has identified a link between substance use and HIV risk for women.^{10,11,12} Nationally, use of stimulants is high among female sex partners of male injection drug users or IDUs,¹³ and crack use is linked to other high risk behaviors, including bartering sex for drugs and having multiple sex partners.^{14,15} Compared, to male IDUs, women IDUs report more use of crack/cocaine and less use of alcohol or marijuana.¹⁶

The use of methamphetamines particularly crystal meth or "ice" is a serious public health concern in the state. In Hawaii, Kanuha & Mueller¹⁷ report that "ice" use was nearly as common as alcohol or marijuana use, and far more common than the use of other illegal substances in a cohort of substance-using women. Additionally, most research indicates that men have a strong influence on women's

Correspondence to:
Charles W. Mueller PhD
Department of Psychology
University of Hawaii
2430 Campus Road
Honolulu, Hawaii 96822
E-mail: cmueller@hawaii.edu

initiation to and ongoing use of substances and those women who inject drugs tend to have sexual relationships with men who also inject drugs.

Female-Male Intimate Relationships

Women in more "involved" relationships are more likely to engage in unprotected intercourse than women in newer or shorter-term relationships.^{18,19,20} Many women, in spite of self-acknowledged high risk health, social and other lifestyle profiles of their male partners, expressed confidence in their sexual partners' conduct regarding HIV prevention. "I know my man" is a common statement. Similarly, women who fear disruption to their relationship and who feel their male partners have more control and power are less likely to ask their partners to use condoms.^{18,19,21}

Disclosure of HIV Status

Self-disclosure of a positive serostatus to sex partners is a significant link in HIV prevention, with nondisclosure as a material risk factor for transmission of the virus. A significant number of HIV-positive individuals have difficulty disclosing their serostatus to intimate partners, even while continuing to engage in risky sexual encounters.^{22,23,24,25} In general, disclosure rates are lower when there are multiple sexual partners and earlier in the process of adjustment to living with HIV.²⁸ Ongoing counseling and support increase voluntary self-disclosure among HIV-positive men.²⁶

In summary, Hawaii's fairly low HIV prevalence rates in women and its unique ethnocultural milieu raise particular issues in HIV prevention. While the empirical literature suggests that substance use, gender role expectations with sex partners, and self-disclosure issues are important for HIV risk reduction, no studies to date have focused on women's HIV risk in Hawaii.

Method

A total of 41 individual interviews and five community group meetings were conducted. Face-to-face interviews were completed with nine women and six men at-risk for or infected with HIV recruited via enrolment in other studies, by referral from health and social service providers and by word of mouth. Participants included eight HIV-positive women, and five HIV-positive men. Among the seropositive women, two had histories of IDU that may have led to HIV infection. The remaining six participants reported heterosexual transmission (three with men who had sex with men, two with IDU men, and one with a man of unknown risk) as their likely route of HIV infection. Of the five seropositive men, two had histories of IDU and three reported sex with other men as their HIV risk factor.

Interview questions focused on the context of needle sharing and/or sexual behavior, discussions among intimate partners about HIV status and risk, HIV/STD risk reduction practices, the influence of factors such as ethnicity, culture and gender on HIV/STD risk behavior, and participant recommendations for ways to decrease HIV-risk for women in Hawaii. For the HIV-positive participants, interviews also focused on their history of HIV risk behaviors leading up to the most likely time of infection; the time between likely infection and HIV notification; and post-HIV disclosure and risk history.

Participants signed informed consents and were paid \$20 upon

completion of interviews. In-depth interviews typically lasting one to two hours were tape recorded and transcribed verbatim. Field notes that included theoretical, methodological and observational commentary were documented immediately following each interview and were referred to throughout the data analysis phase.

An additional 26 semi-structured interviews were conducted with HIV prevention outreach personnel experienced in working with women in Hawaii, social service outreach workers involved with youth and sex industry workers, health care providers known to treat women living with HIV, and law enforcement personnel.

Constant comparative analysis was employed across all data sources and throughout the study.²⁷ Periodic focus groups were conducted with members of Hawaii's statewide HIV community planning group and with a community-based women-at-risk advisory panel, along with regular consultation with HIV prevention experts in Hawaii.

Results

Theme 1: Women Are at Risk Primarily Through Their Male Sex or IDU Partners

In our interviews of HIV-positive men and women, we specifically queried what led them to being tested for HIV and how these individuals came to know their serostatus. Many women became suspicious about their own HIV status only after an intimate partner had become ill or diagnosed with HIV, after they themselves became ill, or after their children were found to be HIV infected. As one woman stated: "*He starts getting sick, he just can't deal with anything. He just completely goes into denial. He doesn't come out. He's got nobody to talk to... And I don't blame him.*" Another HIV-positive woman reported: "*I remember one time telling him if you ever have AIDS, I'll kill you. Not knowing that the whole time that was what he really wanted to reveal to me but didn't.*"

If male partners are HIV-positive, knowingly or unknowingly, they place women at risk. This important factor puts women's risk into the context of their relationships with men, and combined with Hawaii's epidemiological findings that many more men than women are currently living with HIV in Hawaii, points to the importance of exploring how gender dynamics influence women's safety.

Theme 2: Sex and Gender Dynamics Play a Central Role in HIV Risk for Women

Dynamics of gender emerged as a core issue affecting women's HIV risk and HIV/STD prevention behaviors and are organized into five specific themes.

Sexual communication. Although all female participants knew about HIV/STD transmission and protection methods, they were unable to consistently implement risk reduction behaviors, citing significant difficulty communicating about sex or negotiating condom use with male partners. "*Most women will not confront men, or even talk to them, about sexuality*" (key informant). When asked to reflect on the time prior to their infection, many of the HIV+ female interviewees reported having either no knowledge of or having unconfirmed suspicions about their partner's risk behaviors or HIV status. Most women with such suspicions were unable to elicit information from their male partners.

There were many reasons women cited for not asking or insisting on condom use, including feelings of gender inequity. As an HIV+

woman argued: “The idea of women asking! ‘Cause women are a minority. So asking a man to put on a condom is like degrading his manhood.” Or as another HIV+ respondent shared:

Even when I asked him about using a condom and stuff, you know ‘Nah, nah, nah’. Yeah, I’d ask him and he wouldn’t use them. Well, he’d go, ‘Okay, okay we’ll use them’ but then when it came down to it, it was like, ‘Uh, too late.’ And that kind of pissed me off, ‘cause I didn’t feel like he was giving me any respect or anything at that point. Because if he could just do that, knowingly infecting me more and more every day, every single day for six months, I think, How dare him? How dare him? I really don’t get it.”

Disclosure of serostatus. Both men and women who were HIV positive reported difficulty disclosing their status to partners, particularly in casual sexual relationships. A typical pattern pointed to low levels of disclosure soon after notification of HIV infection. One HIV+ man, when asked if soon after learning about his status, he initiated using condoms with female partners, replied: “I honestly can’t say that I can recall doing that.” As the interviewees came to grips with living with HIV, disclosure, abstinence, or protective behavior was reported to become more likely. “If I was going to be involved...it would have to be on [the basis of] disclosure,” reported an HIV+ man.

Reasons for nondisclosure of serostatus differed among HIV+ men and women. In general, women feared that disclosure could lead to loss of intimacy or violence from angry partners. For men, non-disclosure related a belief that they didn’t need to share such information with their partners, and that their behavior and health status were private matters. Reported one HIV positive man regarding non-disclosure: “It was none of their business. There was no need for me to put that [HIV status] out to the universe.”

Other themes related to male non-disclosure also emerged, including cultural pride, illness as a sign of weakness, and the perceived inappropriateness of men asking for or insisting on condom use.

Dynamics of relationship. Female participants frequently talked about the importance of and the need to be in intimate relationships. Many did not question their sexual partners’ fidelity for fear of loss or rejection, as reflected by one HIV positive woman: “I don’t know if it’s that we want to believe, or that we really do believe what they are telling us.” Another HIV+ woman stated, “We trusted each other. We had a lot of trust in each other.”

In some accounts, HIV+ men appeared to exhibit anti-social qualities regarding the impact of their HIV status on women partners, including low empathy, unresolved anger, selfishness, poor impulse control and sexist views. While the exception, one HIV+ male respondent recounts:

“Well the psychology is like, it’s a dog eat dog world. Well I’m f—ed up, so I’m going to f— somebody else up... I have it, so I’m just going to feel good whether I’m going to party myself until I die or sex out until I die or I’m just going to do it to be slick, suave, or just take my revenge on those people that have their lives all ahead of them.”

Dynamics of power and control. Issues of male power and violence against women, including forced sex with or without use of protection, were frequently raised. As violence and threat of further

violence increased, women experienced fewer options for sexual assertiveness and open sexual communication. “You’re always up to be abused because women, we’re supposed to be the subservient race. We’re supposed to just sit back and just do whatever the man wants. Most men of course don’t want to wear condoms” (HIV+ woman). “I think men know that they are stronger and that when they put their mind to it, they’re going to do anything they want. It’s a huge power thing” (HIV+ woman).

Behaviors of bisexual men. The stigma attached to bisexuality, homosexuality and clandestine sexual behavior outside intimate heterosexual relationships was a significant barrier to HIV prevention for men who put women at risk in Hawaii. “If it was okay to be bisexual, then it might be okay for these men to be honest with women” suggested one key informant. One HIV+ woman reported: “For me, it was like, it was a shock knowing that he had an encounter with another male.” Or for another woman who expressed disbelief when discovering that her partner was bisexual: “No he’s not. He can’t be bi if he had sex with me.” Or another woman stated: “I just didn’t see it...It was just so foreign and unheard of. I didn’t have any experience with homosexual men. I just didn’t know.” For some study participants, bisexual behavior was also associated with substance use: “There are lots of couples using drugs and getting into ‘bisexuality’ that is really multiple promiscuous sexuality.”

Theme 3: Drug Use Continues to Play a Role in HIV Infection of Women in Hawaii

Nearly every HIV-infected man and woman interviewed for this study reported substance use played some role in viral transmission. Among some participants, drug injection directly led to infection. For several participants, alcohol and other drug use served as co-factors to sexual risk exposure. One HIV-positive man stated, “I mean there’s total disregard...and then you still have people that are, whether just a binge on alcohol and pot, just don’t give a rip.”

Many women in the study initiated drug use through men. One HIV-positive woman stated, “...most of the women that I’ve known statewide or even nationally, they started being substance abusers through the man. If they started shooting needles, it was because of their man, to be with their man.” Some women and men in this study reported they would do anything for a “hit.” For many women, this meant sex in the context of drug use, which sometimes increased HIV risk. One HIV-positive woman stated, “I tried really hard to always use condoms. But when it’s been like a time frame when I hadn’t had a hit, if I told them [sex partners] that they had to use a rubber and they said ‘Well, no’ then I say ‘Okay, then’ because that was where I was desperate, on that chase, then I would [have sex without a condom].”

Discussion

The results of this study identified some core issues related to HIV transmission risk for women in Hawaii. Women’s relationships with seropositive men and/or men engaged in HIV-risk behaviors were identified as their most significant threats for HIV infection, and highlight the dangerous impact of sex and gender socialization for women in Hawaii. The gender-based dynamics of male-female relationships, particularly regarding male concealment of their HIV serostatus and their subsequent reluctance to use condoms emerged

as key factors that compromise HIV risk reduction for women.

Given Hawaii's 10-year needle exchange policy and the subsequently low incidence of HIV infection due to IDU, we believe that the primary risk for women in Hawaii is their sexual contacts with men. As long as power differentials in male-female relationships exist, and women are viewed by their male partners as well as HIV outreach workers and policymakers as those responsible for enforcing male condom use, women will always be burdened with a lethal double-bind: if women "make" men use condoms, they risk male rejection or abuse. However, if women refrain from such assertions they place themselves in jeopardy for HIV/STD infection as well as pregnancy.

Similar to national data, Hawaii women in longer term, high investment relationships were less likely to consistently engage in HIV-protective behaviors compared with women in less "involved" relationships (e.g. sex customers, casual acquaintances).^{28,29} In addition, based on commonly idealized notions of heterosexual relationships or unconditional trust in their partners, women did not perceive themselves as vulnerable to deception or infidelity by male partners.

For many women in Hawaii, the expectation that they could effectively manage the burden of sexual communication and condom use in intimate sexual relationships was limited, as many men preferred and/or expected not to use condoms. Negative consequences for requesting or insisting on condom use, including the threat of or actual physical violence, served as a disincentive for women. Data from this study support previous findings that suggest most women living with HIV in Hawaii report histories of domestic violence in earlier and/or current relationships³⁰ and that women substance abusers report high levels of domestic violence, with drugs and violence as significant co-factors of HIV-risk.¹⁷

Additional factors influencing HIV-risk for women in Hawaii include age, socio-economic status, and ethnicity. Compared to men, women with HIV/AIDS in Hawaii are younger, poorer, and more likely to be Native Hawaiian.⁴ However cultural issues did not emerge as a major theme in the interviews. While the relatively low number of IDU-related HIV cases in Hawaii is likely due to the Syringe Exchange Program, the availability and use of other drugs, particularly ice and alcohol play a significant role in women's HIV risk. While some women in Hawaii may be particularly vulnerable to those situations and contexts that put them at risk for HIV, it is primarily their status as women in relation to male partners that puts them in harm's way for sexually transmitted diseases, intimate partner violence and drug abuse.

Advances in medical treatment for HIV allow persons to live with HIV and to remain healthier and sexually active for longer periods. At-risk individuals should be encouraged to be tested for HIV in order to receive early and appropriate identification, counseling and treatment. Patients who report multiple sex partners and unprotected sex, STDs, anal or rectal infections, or intravenous drug use are a priority for early intervention and HIV testing. Post-test counseling can be initiated to emphasize self-disclosure of serostatus to sexual and IDU partners. Hawaii's recent implementation of mandatory reporting of all diagnosed HIV cases offers a means for tracking the epidemic and identifying emerging trends among women in Hawaii.

Of the 191 women enrolled in HSPAMM, 34 (17.8%) indicated "heterosexual contact with a bisexual male" as one of multiple risk

factors. HIV-positive men who are bisexual face unique difficulties in disclosing their serostatus and sexual behaviors to their female partners or health care professionals. Other research in the continental U.S. suggests that men in relationships with women, who also have sex with men, often seek information and resources to reduce their own HIV risk.^{22,23} Medical professionals in Hawaii are encouraged to convey a nonjudgmental attitude toward human sexual diversity. By offering an avenue for patients to feel unconditional regard, disclosure of sexual behavior and related health risks can be enhanced.

Physicians can also take the first step toward helping male HIV+ clients reduce the risk of transmission to women by allowing open discussion about disclosure and the use of condoms or abstinence when partners are not informed of their status. Physicians and other health care providers need to encourage HIV seropositive individuals to engage in disclosure counseling sessions in addition to initial HIV post-test counseling.

Risk reduction for women must go beyond condoms and "safe sex" education to include strategies for empowering them to protect themselves. Programs already frequented by women such as family planning clinics, medical and women's health clinics, and food stamp programs should be targeted for outreach. More gender-specific substance abuse programs for women may help reduce HIV-risk.

In conclusion, this study indicates that the most significant risk for HIV infection among women in Hawaii is *their intimate and sexual relationships with men*. Health and medical professionals must become well-versed in and sensitive to the gendered perspectives in which women frame their experiences. The burden of HIV prevention in Hawaii women should not focus primarily on women's responsibility for men's behavior; rather, health professionals must remember that condom use is and always must be the responsibility of boys and men.

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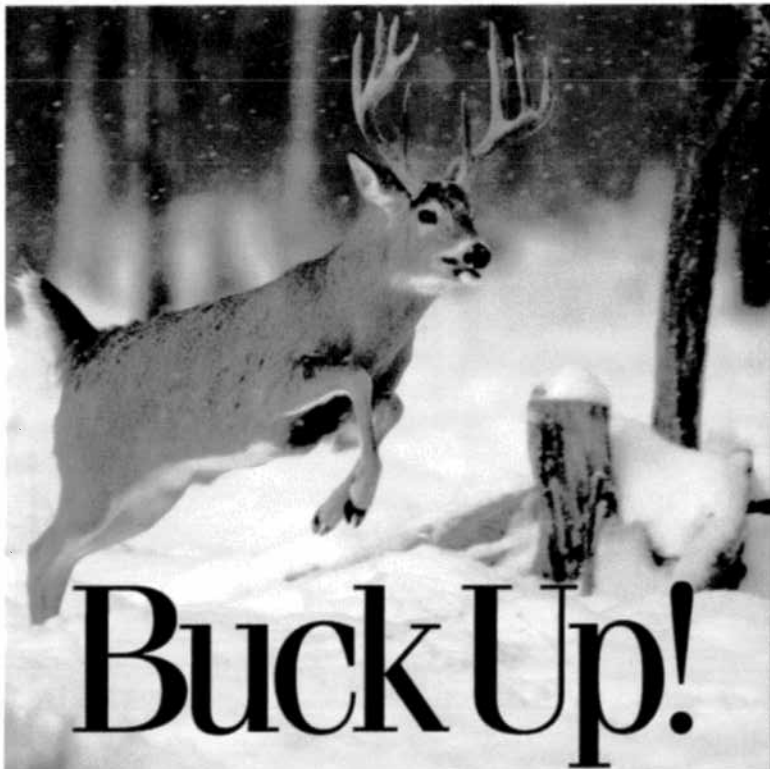
Authors

- * University of Hawaii, School of Social Work
- ** University of Hawaii, Department of Psychology
- *** Kapiolani Community College, Department of Nursing
- **** Waikiki Health Center
- ***** State of Hawaii, Department of Human Services

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