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The HIV Risk Reduction Needs of Homeless Women in Los Angeles

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Abstract

Background—Substance use, housing instability, and transactional sex all contribute to HIV risk engagement among homeless women. Because of the increased risk of HIV among homeless women, this study sought to understand the context of sexual behaviors and condom use among homeless women and elucidate modifiable factors that can be targeted by interventions.

Methods—Homeless women ($n = 45$) participated in focus groups ($n = 6$) at shelters throughout Los Angeles County. Thematic analyses revealed that similar to other high-risk women, homeless women engage in sex with multiple types of partners (steady, casual, and transactional).

Findings—Our findings indicate that, similar to use among other high-risk women, condom use by homeless women varied by type of partner. Substance use also contributed to condom non-use. In a departure from previous research, homeless women reported overarching feelings of hopelessness. Participants spoke of hopelessness contributing to risk engagement, specifically the number of ongoing stressors experienced because of homelessness contributing to despair. Without acknowledgement of this unique quality of homelessness, women felt their risk reduction needs would never truly be understood.

Conclusions—Interventions involving homeless women should include self-esteem building, acknowledgment and use of inherent resilience qualities gained during homelessness, respect for current knowledge and skills, and an exploration of when women choose to trust their partners and how they make safer sex choices.

Introduction

Homelessness remains a pervasive issue in the United States; approximately 3.5 million people experience homelessness in a given year (National Coalition for the Homeless,

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2009). Women remain the fastest-growing segment of the homeless population. In Los Angeles county (LAC), there are an estimated 43,000 homeless persons; two thirds are unsheltered (Los Angeles Homeless Services Authority, 2008). Almost half of homeless adults are African American (29% Hispanic/Latino and 21% White); one third are women. More than half of those reporting homelessness in LAC reside in the City of Los Angeles, including 25% who are chronically homeless, 24% who have a mental illness, and 42% who report substance abuse problems. Homelessness is associated with increased behavioral health issues and disparities in morbidity and mortality (Baggett, O'Connell, Singer, & Rigotti, 2010). Although substance use and mental health are predictive of HIV risk engagement independent of homelessness, the association is particularly strong among homeless persons (Elifson, Sterk, & Theall, 2007; Tucker et al., 2010). Residential instability is further associated with increased risk (German & Latkin, 2012). Because of the increased risk of HIV among persons who are homeless, this study sought to understand the context of sexual behaviors and condom use among homeless women, specifically, to elucidate modifiable factors for sexual risk reduction interventions targeting homeless women. Given that homeless women are more likely to have multiple sexual partners and a history of and/or current use of illicit drugs, it is essential to understand the HIV risk reduction needs of homeless women to most effectively engage them in education and skills-building interventions that decrease their risk of future HIV infection.

HIV Risk Engagement among Homeless Women

Sex Risk—Marginalized groups of women engage in a variety of behaviors that place them at risk for HIV infection. Although some of these behaviors may be predictive of homelessness (i.e., drug use), others are often an outcome of being marginally housed (i.e., transactional sex). Homeless women are more likely to report histories of child abuse and adult sexual assault (Hudson et al., 2010), having multiple sexual partners, and a history of and/or current drug use (including injection drug use; Kidder, Wolitski, Pals, & Campsmith, 2008), all which place them at increased risk for HIV infection. When homeless women remain engaged with “deviant” support networks, they are also more likely to show continued engagement in risk sexual behaviors (Nyamathi, Stein, & Bayley, 2000). Thus, links with positive role models are important for decreasing risk (Tucker et al., 2009).

Transactional Sex—Transactional sex is defined as trading sex acts (vaginal, anal, or oral) for money, drugs, housing, or other needs. Transactional sex places individuals at increased risk for several reasons. Individuals who engage in transactional sex have been found to have more partners, more of whom also engage in high-risk behaviors. Further, those who engage in transactional sex are likely to engage in unprotected sex with steady partners (Bobashev, Zule, Osilla, Kline, & Wechsberg, 2009). Homelessness among both men and women is predictive of engagement in transactional sex (Bobashev et al., 2009; Kidder et al., 2008). One study found that more than 50% of homeless women reported trading sex for money, food, and shelter; 48% reported trading sex for drugs (Wechsberg et al., 2003). Another study noted higher rates of transactional sex among homeless women specifically (Kidder et al., 2008). Childhood sexual abuse and partner abuse has been found to be both predictive of (Hudson et al., 2010) and an outcome of (Henny, Kidder, Stall, & Wolitski, 2007) transactional sex among homeless women. Drug use is further predictive of having traded sex for money, housing, or other goods (Bobashev et al., 2009).

Condom Use—Condom use among homeless women is correlated with their condom use self-efficacy, beliefs about HIV risk, and type of partner (steady, casual, or transactional). Homeless women generally report inconsistent condom use (Gelberg et al., 2008). Studies have found homeless women are more likely to engage in sexual intercourse without a condom with steady partners (Kennedy et al., 2010). Homeless women with a history of and/

or current drug use also are more likely to have low condom use self-efficacy (Gelberg et al., 2002) and high engagement in unprotected sex (Kidder et al., 2008; Ryan et al., 2009). Type of partner and perceived trust are also associated with condom use among homeless women (Ryan et al., 2009). Because of their unstable housing, chronic poverty, and impediments related to substance abuse, homeless women utilize condoms on a semi-regular basis at best. Sustained risk reduction may be particularly challenging for homeless women with hopelessness as a significant barrier (German & Latkin, 2012); the influence of this construct has been underexplored.

Methods

Focus groups were conducted with the goal of understanding HIV risk engagement and perceived HIV risk reduction needs among homeless women. A descriptive qualitative design was used to highlight the everyday experiences of participants (Sandelowski, 2000). All protocols were approved by the University of Southern California and RAND Corporation institutional review boards. During July 2009 and May 2010, we conducted six focus groups with 45 homeless women in Los Angeles, California. The first round of three focus groups was conducted as a follow-up to a larger quantitative survey (Kennedy et al., 2010; Tucker et al., 2010) to gain clarification on correlates of sexual risk and further insight on sexual risk and protective behaviors as perceived by homeless women. The focus groups with the initial 24 women (three groups) were conducted at three shelters serving homeless persons in LAC: One in the downtown Los Angeles Skid Row area ($n = 10$), one in the city of Pasadena ($n = 8$), and one in the city of Santa Monica ($n = 6$). These shelters were chosen to maximize geographic and demographic diversity, thus maximizing the range in responses. The second round of focus groups (three groups) included 21 homeless women staying in the same temporary shelter settings (downtown, $n = 7$; Pasadena, $n = 6$; and Santa Monica, $n = 8$). Individuals who participated in the first round of focus groups were not included in the second round. Women were eligible for participation if they were at least 18 years old and had sexual intercourse with a male partner during the past 6 months. A short, anonymous paper-and-pencil questionnaire was administered to the women after each focus group to obtain background information to describe the study sample. Each woman received \$30 for her participation.

Data Collection

All six focus groups were 90 minutes long and facilitated by two women (the study PIs). Each session began with an explanation of the purpose of the focus group and a description of the larger quantitative study. Groups were audio-recorded. All audio files were transcribed verbatim. The focus groups were conducted using a semistructured interview guide. The script was framed by the specific aim of the study—to understand risk perception and safer sex decision making among homeless women. The protocol was developed as a guide for both the facilitator and participants (Krueger & Casey, 2009). First, the facilitator provided an introduction/purpose and group guidelines (i.e., confidentiality). Topics included 1) how women think about different types of sex partners, 2) feelings of trust and safety with partners, 3) what influences women to carry condoms, 4) women's use of condoms, 5) partner communication about condoms, 6) referent groups for sex/condom-related dialogue and topics/content of this dialogue, and 7) HIV prevention needs of homeless women (in groups 4–6 only). These measures have been used in previous studies with homeless and other vulnerable women (Catania et al., 1992; Kennedy et al., 2010; Ryan et al., 2009).

Data Analysis

All audio files from focus groups were transcribed verbatim by an outside transcriptionist. All transcribed files were reviewed for quality and accuracy. Initial review and theme development of the transcripts from the first round of groups was led by a co-investigator with a background in medical anthropology who received feedback from the principal investigators and project director. This process was repeated for the second round of groups with the assistance of a graduate student. In this process, concept clusters were summarized by reading the transcripts and identifying possible recurring themes. Meetings were continuous to confirm agreement regarding the importance of themes identified. A second analysis was led by the lead author with feedback on themes from coauthors. The final code list was presented to the principal investigator and adjustments were made when intent was believed to be not fully captured. ATLAS.ti 6.2 (Muh, 2003) software was used during the coding process. Thematic analysis guided the process of data reduction, coding, and creation of themes (Sandelowski, 2000). Purpose-driven profiles were created; coding was systematic and sequential. The findings presented are intended to outline the HIV risk experiences of homeless women and their prevention needs. Selected quotes are used to highlight the themes. Frequency distributions, means, and percentages were calculated from responses to the anonymous questionnaires.

Results

Forty-five women participated in one of six focus groups. The age range of participants was 20 to 65 years; 60% self-identified as African American. Participants reported steady, casual, and paying partners; more information related to risk engagement with varied types of partners is found in Table 1. Themes and representative quotes can be found in Table 2.

Influence of Homelessness

The theme of hopelessness represented a framework for understanding the HIV risk reduction choices of homeless women. Across groups, women spoke of the struggle of homelessness and the toll it takes on the psyche. This, in turn, was linked with decisions people made related to risk engagement. The women felt that homelessness made them incredibly vulnerable. This was captured in statements such as, “We’re vulnerable, especially in situations like this, our vulnerability, we’re naïve and we want to believe things.” As poignantly stated by one woman, “You’re dealing with a lot of hopelessness here, like I don’t care, whatever, there’s no future.” This was echoed in the sentiments of a second participant: “I’ve seen these people, they’ve been on the streets for so long, it’s like they not going to get it together so they don’t care. That’s what I see—you know what I’m saying?” The hopelessness associated with being homeless was attributed to feelings of despair. Some women felt it would be very difficult to change the behaviors of homeless persons because of this hopelessness. For example,

They can tell, a lot of these women, or a lot of these women can tell a lot of these men, they just don’t care.. When you live in a community that really don’t give a good goddamn about their own damn life, there’s nothing to discuss.

However, there was an underlying desire for something more. Even within the depths of hopelessness, one woman stated, “We want to believe there’s still good.” Although this last statement illustrates the basic human need for hope—the belief that there is something more, something better—the women felt that, without an understanding of hopelessness as a unique quality of homelessness, service providers would never truly understand the risk reduction needs of homeless women or why homeless women might engage in risky behaviors.

Condom Use: Casual Partner

Women discussed the use and non-use of condoms in the varied types of relationships they had experienced. Casual partners were identified as both new individuals one might meet and have a one-time affair with, as well as ex-partners (husbands, boyfriends) with whom they were comfortable and reconnected with to satisfy needs: “[J]ust somebody you just might have sex with because you were in the mood and they were convenient or you were convenient, something like that.” Because of the nature of the relationship, women felt that “you can’t trust a casual partner” because “that’s not someone you are dealing with on a constant basis.. It’s just sex.” These women endorsed condom use with casual partners, noting that both parties typically acknowledge they may also be engaged in relations with others, thus making condom use during casual encounters normative.

Condom Use: Steady Partner

Condom use with existing steady partners was considerably more difficult. Women almost unanimously thought that the introduction of condoms with steady partners was unlikely without triggering concerns about fidelity. As one woman stated, “He would probably think you’re having an affair or something if you’re asking him to put on a condom at this stage.” Another woman declared, “I’m just thinking that it’s going to be, in some ways, the longer we’ve known a partner, the harder it is to have that conversation.” Reasons for not using condoms with steady partners included, “You start to think that they’re safe when you don’t really know.”

Condom Use: Transactional Sex

Among participants, transactional sex was most often not what would be categorized as “traditional” prostitution (women soliciting from unknown paying partners on the street). Women engaged in transactional sex most often to meet basic needs. In the words of some of the participants, “Being that I am homeless and ex-drug user, I had casual partners, I would consider partner for things I needed. You know, sex in exchange for drugs, a place to stay and so on,” and “Yeah, to me, partners for things you need, like ‘I need your money, out of money.’ And the rest of my needs come after I get your money out your wallet. That’s what I need, your money.” Although most women spoke of the ease of condom use with paying and transactional partners, some women noted that being an active drug user often interfered with safer sex decision making, particularly during transactional sex. Women explained that condom use had not always been important to them during active addiction. However, women also noted that “working girls” always carried and used condoms.

Trust and Negotiation

The women in these groups shared a number of ways in which they made decisions about when to discontinue the use of condoms in relationships. Other than situations in which women felt they were not in control (i.e., under the influence of drugs), the most common reason given, across groups, was trust. Trust was reached in a number of ways. Most overtly, women described their requirements for mutual testing of partners (for both HIV and other sexually transmitted infections [STIs]), with some testing every 6 months. However, most women developed a feeling of trust with their partner in a less logical and more emotional way. As a few women stated, “I go by what they do, how they talk,” “You see them as a long-time mate,” and “You’re assuming they’re being faithful to you, so you feel like, well, I don’t need it.” For other women, there was a time frame to their trusting their partner. Feeling safe with a partner was another trigger for trusting them and no longer using condoms.

Your trust is when and the feeling of safety is when you ask for something and he does it for you and take care of you and talks and you understand. That's it. I mean, that's what trust and feeling safe is about.

Women were clearly unable to articulate exactly what helped them to reach the decision to trust their partner and no longer use condoms; as one woman described, "It's just, you know, between him and her." Although there was disagreement among the women about whether or not it was reasonable to trust men, they were in agreement that testing for STIs and HIV should be part of the decision-making process.

Condom use negotiation with partners was difficult for most women who participated. Many attributed this to self-esteem issues, fear of losing a partner, and implications of negotiating condom use (e.g., what others will think of them). One woman shared her concerns: "He might turn you down or he might not call you because he don't want to use it. You know?" Others disagreed and felt that regardless of partner type, women needed to be willing and able to talk to their partner about using condoms. One woman stated, "You know, if y'all been with each other for awhile then y'all should be able to bring up a conversation without everybody huffin' and puffin'." Participants drew connections between condom use negotiation and self-esteem, self-efficacy, and sobriety. Many women who had histories of drug use described how they did not have the self-respect to care about their health when actively using drugs and alcohol. Because they were now sober, gaining the skills to put their needs first and being able to say "no" to men when their desires were not being respected was important to these women.

Discussion

The risk reduction needs of homeless women are not completely dissimilar from those of other groups described as high risk. These women described having multiple types of partners (i.e., steady and casual), episodic and long-term alcohol and drug use, and transactional sex. These behaviors have been found among other women in more stably housed populations, but comparisons to the behaviors and experiences of women who are homeless make it clear that homeless women face greater risks than other women (Kidder et al., 2008). The critical factor that appears to make homeless women different than stably housed women, and at greater risk for HIV infection, is the experience of homelessness itself. As previous studies have documented, the physical and social environments experienced by homeless persons often confer risk (Nyamathi, Stein, & Swanson, 2000). Danger and severe disenfranchisement associated with homelessness has been characterized as traumatic (Goodman, Saxe, & Harvey, 1991). As a result, homeless women have unique HIV risk reduction needs that are strongly tied to the stressors of homelessness. As described by the participants in this study, homeless individuals experience chronic hopelessness. When hopelessness occurs, individuals can lose future orientation, resulting in an "I don't care" or "it does not matter" attitude (Ewart, 1991). Loss of future orientation, in turn, leads to decreased motivation to engage in safer sex behaviors (Ewart, 1991). Interventions must take into account these feelings of hopelessness to effectively increase risk reduction behaviors among homeless women.

The participants spoke a fair amount about partnerships, condom non-use with steady partners, and trust. Trust among these women was often a leap of faith based on rationalized factors. Most often, length of time with partner (however defined by the individual) was connected with feelings of trust. This trust led to a decision to no longer use condoms. Although women knew the risks of unprotected sex with male partners with unknown STI/HIV status, women continued to engage in these behaviors. Consequently, interventions with homeless women need to address how individuals make decisions about condom non-use, ways in which they can make safer sex decisions related to unprotected sex (i.e., joint

testing with partners every 6 months), and ways in which they can communicate to their partners the importance of engaging in these safer sex behaviors. Although the primary message should continue to be condom use during sexual intercourse, we must also respectfully recognize that this may not be the choice that all women make. Thus, providing women with skills to make risk assessments based on facts (rather than emotion) is a necessary component of interventions with homeless women (Jemmott, Jemmott, & O'Leary, 2007).

Although 60% of shelter providers for homeless women in Los Angeles do not offer evidence-based HIV prevention programming (Tucker & Wenzel, 2010), homeless women nevertheless may have been previously exposed to HIV risk reduction information and thus may have basic knowledge about HIV and condoms that should be validated and built on in HIV prevention programming. For example, homeless women may have been engaged in substance use recovery and criminal justice systems, two arenas in which individuals may be exposed to risk reduction information. Further, it should not be assumed that being homeless is equated with difficulties in accessing condoms. Homeless women in this study stated that there are often a variety of types (male condoms, female condoms, and dental dams) of accessible barriers, as well as lubricants available from a variety of sources. Possible prior exposure to HIV information and availability of condoms does not discount the need to engage homeless women in evidence-based HIV risk reduction programming that is tailored to their needs. As few as 25% of homeless women in LAC discussed condoms with their most recent sex partner; as many as three fourths had unprotected sex during their most recent sexual encounter (Tucker et al., 2010).

We know that individuals must not only believe that they are at risk of contracting HIV, but also that they are able to prevent the transmission of HIV. Therefore, along with the knowledge and skills building that HIV risk reduction interventions provide, interventions targeting homeless women should include modules that help them to realize their inherent strength and resilience, and create strategies to harness these innate qualities to reduce their risk for future HIV infection. In addition to hope for the future, homeless women need partner negotiation self-efficacy skills to reduce risky sexual activity. Women may prefer that these interventions be delivered by those perceived to be most like them (e.g., women who have “been through it” and/or women who are HIV positive), such as Community PROMISE (CDC AIDS Community Demonstration Projects Research Group, 1999), Real AIDS Prevention Project Lauby, Smith, Stark, Person, & Adams (2000), and Sistas Informing Sistas about Topics on AIDS (DiClemente & Wingood, 1995).

Implications for Practice

Homelessness is a structural problem that results in social and individual stressors. Programs that prioritize housing have shown the significant effect of stable permanent housing on improving the physical and mental health behaviors of homeless men and women (Padgett, Stanhope, Henwood, & Stefancic, 2011). Access to immediate stable housing, however, is limited for most homeless men and women. Therefore, when women are housed in temporary shelter systems, focused risk reduction programs that meet these women's specific challenges are important. Homeless women are in need of programs that help them to negotiate condom use with a range of different sex partners and that address the contexts of trust and the unique influences of homelessness. Interventions with homeless women should incorporate a more participant-driven, facilitator-guided approach, rather than the traditional facilitator-led model (with participant activities). We should further acknowledge the inherent resilience that results from navigating homelessness. Many of these women, even under very difficult circumstances, make risk reduction decisions. What these women need is hope. They need to be reminded of their worth, supported in building self-esteem, and empowered to make continued change to protect themselves from HIV infection.

Homeless women must be valued, respected, and treated as partners in behavioral change. We must remember that these women lack power and control in many parts of their lives (shelters tell you what to eat, enforce curfews, etc.); providers can create opportunities for women to regain and rebuild their lives by taking control of their health. This guidance will help to facilitate the success of homeless women in reducing their HIV risk behaviors.

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Table 1

Group Characteristics

Age (yrs)	Focus Groups 1 (<i>n</i> = 24)	Focus Groups 2 (<i>n</i> = 21)
	20–65 (<i>M</i> = 42)	25–57 (<i>M</i> = 41)
Race/ethnicity		
African American	50%	71%
Non-Hispanic White	25%	10%
Asian	4%	–
Native American	–	10%
Hispanic	17%	10%
Condom use with steady partner	<i>n</i> = 24 (100%)	<i>n</i> = 16 (76%)
Never	46%	38%
Less to half the time	21%	19%
Half the time	8%	25%
More than half the time	4%	0%
Always	21%	19%
Condom use with casual partner	<i>n</i> = 13 (54%)	<i>n</i> = 10 (48%)
Never	23%	40%
Less to half the time	15%	10%
Half the time	15%	20%
More than half the time	8%	10%
Always	39%	20%
Engaged in transactional sex		
Yes	33%	29%

Table 2

Themes and Representative Quotes

Theme	Representative Quote
Influence of homelessness	"They can tell, a lot of these women, or a lot of these women can tell a lot of these men, they just don't care.. When you live in a community that really don't give a good goddamn about their own damn life, there's nothing to discuss."
Condom use (casual partner)	"You can't trust a casual partner" because "that's not someone you are dealing with on a constant basis.. It's just sex."
Condom use (steady partner)	"He would probably think you're having an affair or something if you're asking him to put on a condom at this stage."
Condom use (paying)	"I mean, they'll use a condom but if somebody give you more money, there's a lot of them out there that take the condom off just for the money."
Trust and negotiation	"Your trust is when and the feeling of safety is when you ask for something and he does it for you and take care of you and talks and you understand. That's it. I mean, that's what trust and feeling safe is about."