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A one-size-fits-all HIV prevention and education approach?: Analyzing and interpreting divergent HIV risk perceptions between African American and East African immigrant women in Washington, DC

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Abstract

Background—To date, there are very few comparative US studies and none in DC that distinguish between US-born and foreign-born Black women to examine and compare their perceptions of HIV risk. This qualitative study, therefore, analyzes African American and East African women's perceptions of HIV risk in the Washington DC Metropolitan area, which has the highest AIDS rate in the US.

Methods—Forty in-depth, semi-structured interviews and 10 cognitive interviews were conducted among a sample of 25 African American women and 25 East African born women between October 2012 and March 2013 to examine perceptions regarding HIV risk. The in-depth semi-structured interviews were preceded by the cognitive interviews and accompanying survey. Study protocol was reviewed and approved by the American University Institutional Review Board.

Results—Adopting Boerma and Weir's Proximate Determinants conceptual framework to interpret the data, the results of the study demonstrate that African American and East African immigrant women have divergent perceptions of HIV risk. While African American women ascribe HIV risk to individual-level behaviors and choices such as unprotected sex, East African women attribute HIV risk to conditions of poverty and survival.

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Disclosure statement

No potential conflict of interest exists.

Conclusions—Study findings suggest that addressing HIV prevention and education among Black women in DC will require distinct and targeted strategies that are culturally and community-centered in order to resonate with these different audiences.

Keywords

HIV risk; perception; African American; African; black; immigrant; women; HIV prevention; HIV education; Proximate-Determinants conceptual framework

Introduction

Washington, DC has the highest acquired immunodeficiency syndrome (AIDS) rate of all the states and dependent areas and is among the 5 cities in the United States (US) with the highest number of reported AIDS cases [1]. In DC, approximately 2.7% of the population is living with the human immunodeficiency virus (HIV), with rates of HIV higher in areas of poverty [1]. Black women in DC account for an alarming 91% of women living with HIV/AIDS, even though they represent 55% of the female population citywide, most (85%) acquiring HIV through heterosexual sex [2,3]. The estimated rate of new HIV infections for Black women is 15 times higher than the rate for white women, and more than three times as high as that of Latina women [2].

Alongside this high incidence in Black women, DC represents a part of the country with a large Black African immigrant population [4]. While African-born individuals account for 4% of the total population in the US, in the Washington Metropolitan area, there are approximately 114,000 African-born immigrants, accounting for about 11% of the area's total immigrant population [4]. One of every five Black African immigrants is from Ethiopia, which represents 19 percent of the total African immigrant population in the Washington metropolitan area [4]. However, little is known about East African immigrant women (who represent a large share of African population in DC) and their unique perceptions related to HIV risk.

Given that Washington, DC is one of the largest US metropolitan areas where African immigrants reside and the likelihood of differences in their perceptions of and experiences with HIV risk relative to African Americans, any effort to address the HIV epidemic among Black women in DC must be based on an understanding of these differences. To date, however, there are very few US HIV-related studies and none to our knowledge in DC that distinguish between native-born and foreign-born Black women. For example, studies rarely report on country of origin, with foreign-born Black individuals typically categorized as “Black” or “African American.” This can often lead to inconsistent or incomplete data [5,6]. In addition, efforts to engage African American and African immigrant women in HIV prevention initiatives are hindered if there is limited understanding of how these different groups understand HIV risk.

To fill this critical gap in the literature, this qualitative study explored and compared African American and East African women's perceptions of HIV risk and interpreted the data based on Boerma and Weir's Proximate Determinants conceptual framework [7] (Figure 1). This conceptual framework can be used in study design, in the analysis and interpretation of risk

factors, in intervention studies that include both biological and behavioral data, and in ecological studies. The framework orders the complex determinants of HIV infection from underlying contextual determinants (e.g. socioeconomic, sociocultural) to proximate (e.g., condom use, concurrency), with biological factors such as transmission efficiency being the most proximal.

This study was part of a larger community-based participatory research project in collaboration with *The Women's Collective*, a DC-based nonprofit community health and human service agency that serves mainly low-income Black women living with or at-risk for HIV/AIDS. The larger study analyzed HIV and HIV risk-related perceptions; the barriers to testing; and HIV-related communication norms among African American and East African immigrant women. For the purposes of this article, the HIV risk perceptions of African American and East African women are reported.

Materials & Methods

Data Collection

For triangulation purposes, data collection consisted of both in-depth, semi-structured interviews and cognitive interviews. Between October 2012 and March 2013, three trained female interviewers conducted a total of 40 hour-long in-depth, semi-structured qualitative interviews (N= 20 African American and 20 East African immigrant women from Ethiopia, Eritrea, Tanzania, Kenya, and Uganda) followed by 10 hour-long cognitive interviews with a separate group (N= 5 African American and 5 East African women). A subsample of women with similar characteristics to the larger sample was recruited to participate in cognitive interviews. A smaller sample was sufficient for this phase of the study given that the purpose was to administer a pilot quantitative survey and ask questions regarding how each participant interpreted items. Cognitive interviewing is a valuable technique to ensure questions capture intended concepts [8].

Recruiters used a non-probability maximum variation sampling technique [9] to purposefully select a sample of participants who met eligibility criteria and represented diverse experiences and backgrounds (ie, socioeconomic level, education level, religion) related to the phenomenon of interest. Participants were females between the ages of 18 and 49, self-identified as African American or East African, and resided in the Washington, DC Metropolitan area. East African participants had been in the US for 10 years or less. The interviewers did not ask about women's immigration status. East African participants, unlike African American participants, did not perceive HIV as a problem in DC nor in the US in general.

In-depth, semi-structured interviews were all conducted in English, except for one, which was conducted in Amharic. Sample interview questions included: How do you think HIV is spread? What do you think puts someone at risk for HIV? Do you think it is possible to prevent HIV? A brief demographic questionnaire was also collected following the interview. Participants received a gift card worth \$40 as an incentive.

For the cognitive interviews, the interviewers asked participants to rate survey items using a 5-point Likert scale based on their level of agreement or disagreement with each item to examine their perceptions and beliefs related to HIV risk. They then asked participants pre-scripted questions related to comprehension and interpretation of survey items as well as open-ended, spontaneous, probing questions based on the information that the participants provided. Sample survey items included: I feel that the chances are good that I can get AIDS; I am afraid that I might contract AIDS. Pre-scripted questions included: How did you make sense of the survey item? Would you recommend any changes to the survey item to make it clearer? If so, what changes? Participants received a gift card worth \$40 as an incentive.

Given the potentially sensitive nature of signing formal documents, interviewers reviewed the consent form with each participant and obtained verbal informed consent from those who were willing to participate in the interviews. American University's Institutional Review Board approved the study protocol.

Data Analysis

The interviewers transcribed the interviews and a research assistant checked them for accuracy. One of the interviewers first transcribed and then translated the Amharic transcript to English. The transcript was then back-translated for accuracy. Qualitative thematic analysis was used to analyze the in-depth, semi-structured interview data [10,11]. Based on Corbin and Strauss' qualitative analytic methods [11], this analytic technique is grounded in the process of coding similar responses from the sample and using those codes to discern important themes and patterns within and between sample groups. Along with identifying patterns that arise among sample responses we can also identify any distinct differences among sample groups' answers [10,11]. This analytic technique allowed for a deeper understanding of their socially constructed perceptions of HIV risk in their communities. The research investigators followed an iterative process of reading the transcripts, developing a codebook, applying inductive and deductive codes, and comparing and revising codes in ATLAS.ti (version 7.0, Berlin, Germany).

Investigators subsequently identified and explained the data's core meanings, searched for relationships among salient themes, discussed points of disagreement, and identified areas of further research. Color-coded matrices were used to identify similarities and differences in themes across participants as well as by group. Stability and agreement are the most relevant types of reliability for textual data [11]. Following category revision, an interrater reliability of 94% was achieved. To see if this agreement was due to chance, the intercoder reliability was tested using Cohen's Kappa [12]. The overall Kappa coefficient was 0.96. Results were validated through the use of multiple independent coders, triangulation of emerging codes, themes, and patterns across interviews, and the search for negative cases [10,11].

To further ensure data validity, the lead author conducted four member-checks with the project Community Advisory Board (CAB) and two member-checks with smaller subgroups of women who did not participate in the study but possessed similar socio-demographic characteristics as the study participants. Member checks were conducted both during data collection/analysis and at the conclusion of the study. Diagrams depicting findings and

salient notes from data analysis were also provided to the CAB members and subgroups to assist with discussion of the findings. Consensus was reached on key themes related to perceptions of HIV risk.

For the cognitive interviews, three levels of analysis were performed [8]: (1) Within-interview analysis: to examine potential problems with survey items based on cognitive responses for individual respondents (e.g., Does the respondent understand the survey item as intended?); (2) Across-interview analysis: to examine patterned differences and similarities across respondents as well as provide insight into the sociocultural factors that impact the response process (e.g., Are there systematic patterns in their responses?); and (3) Across subgroup analysis: to examine patterned differences and identify comparability problems across the two subgroups (e.g., Does the question mean the same thing for East African respondents as it does for African American respondents?).

Results

Table 1 summarizes the sociodemographic characteristics of the study sample. Although both groups resided in the Washington, DC Metropolitan area, African American and East African immigrant women had contrasting perceptions of HIV risk as evidenced by the results. The triangulation of data from the semi-structured, in-depth interviews and the cognitive interviews revealed a systematic pattern across groups.

Proximal Individual-Level Determinants: 'Reckless' Behaviors

African American participants mainly associated increased HIV risk with the “reckless” behaviors in which they perceived individuals to be engaged. As one African American participant stated: “HIV is because of reckless behavior; you have people sharing needles and stuff; they know what’s out there, everybody knows what’s out there now.” Similarly, another African American participant associated HIV risk with a pattern of individual-level risk behaviors: “If you got addicted to like heroin of course you’re gonna pass HIV around like it’s nothing. If you’re an addict you’re not gonna be caring about getting tested.”

Furthermore, most of the African American participants attributed personal responsibility to their behaviors. As one participant shared: “Because I knew that at the end of the day if I did contract HIV, that would be a fault of my own because there are ways to protect yourself from catching it.” Another participant held a similar view:

“You know if you wanna go out there and do drugs then you’re at high risk for anything. If you wanna go out there and sleep with many people and not protect yourself with condoms then you’re pretty much putting yourself at risk but the main thing is carelessness. You wanna be careless then you run the chance of getting into trouble.”

The cognitive interview responses revealed a similar pattern to the in-depth, semi-structured interview data. When asked to rate survey items related to HIV risk such as ‘I feel that the chances are good that I can get AIDS,’ African American participants stated that the items prompted them to think about their personal actions. When probed further, the participants stated that they interpreted the question to implicitly mean that one needs to think about

whether they are engaged in personal types of behaviors that might potentially expose them to HIV/AIDS (e.g., unprotected sex with a partner, sharing needles). Depending on how one answers these questions related to individual risk behaviors, one can then decide how to answer the survey item.

Furthermore, African American participants stated that to make the survey item clearer, it should be framed more explicitly; for example, the item could be rephrased as “Given my past or current behavior, I am afraid that I might contract AIDS.” Other participants stated that the item could be replaced by more specific and direct items such as: ‘I have had unprotected sex;’ and ‘I have shared a dirty needle for intravenous drug use.’

Distal Underlying Determinants: Conditions of Poverty and Survival

Conversely, most of the East African immigrant women’s perceptions of HIV risk went beyond the realm of individual risk behaviors. Informed by their home country experiences, they perceived increased HIV risk among women as directly tied to gender inequalities and conditions of poverty and survival experienced by many women. As one Ethiopian participant stated:

Because in Ethiopia women are disempowered [...] women have no right to get land. In Ethiopian communities, more than 80% are farmers and every property in the countryside is owned by a man. Everything is male dominant. So if you are poor, you are powerless. You are needing to get money and you will do anything. So you may be a commercial sex worker or you may be dependent on your husband or on your brother, so poverty has a strong relationship with getting HIV.

Similarly, a Kenyan woman also viewed HIV risk among women as being related to the impoverished and dependent circumstances many women face:

Let me speak as a Kenyan: if you look at the way the community is organized [...] well women rely on men for income and everything. If a man is the head of the household and he’s providing for you and your family and you know he is unfaithful... it comes to a point, because of poverty, that you can’t speak out for yourself, for protection, or ask your partner to be faithful.

Many East African women also related increased HIV risk to unsanitary conditions and a lack of resources in public clinics. As one Eritrean participant described:

“I’m from a Third World country. This is a poor country. I know how many people are suffering. You know they go to the hospital and they don’t have no sanitization. They use the same needle for different people. They don’t have no technology, you know. So many people got HIV.”

Many of the East African immigrant women also spoke about sex tourism and sexual exploitation in their home countries and how this also contributed to an increased HIV risk among women. As an Ethiopian participant recounted:

You have to understand that there are a lot of foreigners and there’s all these young girls; these young girls might be catching it from you know the 40-year-old German that thinks you are this beautiful thing so all he wants to do is take you out

[...] he takes you home and has sex with you, but you don't know where this man has been.

East African immigrant participants also spoke about the reality of rape in their home countries, which they viewed as putting women at risk for HIV. One Eritrean woman described it this way: "Women are subject to getting infected with HIV because there is a culture like rape. If you are raped with what you don't know, your life is not guaranteed. Maybe he is HIV positive." An Ethiopian woman shared the same view and then recounted her personal story with rape:

In the countryside many women get raped, and marital rape is also very common in Ethiopia. I also have an experience: I was raped when I was 14 years old. The man who raped me was my brother-in-law, my sister's husband. He had HIV and I also became HIV positive. My sister who was married to him died of AIDS. They also lost two children. I am still living with the consequences.

Contrary to African American women's views, many of the East African participants did not believe that women are at fault if they contract HIV. As one of the Ethiopian participants stated: "It was difficult for me to accept my status because I didn't deserve it, I didn't deserve to be HIV positive and in fact nobody deserves to be HIV positive. It was not my fault."

The cognitive interview responses supported the data that emerged from the in-depth interviews. When asked to rate survey items related to HIV risk such as 'I feel that the chances are good that I can get AIDS,' East African participants had a difficult time responding to these items. They stated that contracting HIV/AIDS depended on so many different circumstances and situations in one's life. They further stated that no one can really state whether they will get HIV/AIDS or not and that one does not always know how one got HIV/AIDS. In other words, the participants were not simply thinking about individual risk behaviors related to HIV. They were critical of these "overly simplistic" HIV risk survey items and described the complex realities surrounding HIV/AIDS in their home countries (e.g., women who are raped and/or sexually exploited).

Discussion

The purpose of this qualitative study was to analyze and compare African American and East African women's perceptions of HIV risk. Qualitative thematic analysis facilitated the identification of important themes across the interviews with African American and East African immigrant women. It allowed for a deeper understanding of their perceptions of HIV risk. In addition, the data from the cognitive interviews revealed a more complex pattern of divergent responses between both groups.

The Proximate Determinants conceptual framework [7] is a useful lens to interpret the study findings (Figure 1). While US-born black women perceive HIV risk as falling mostly within the realm of individual-level behavioral risk factors and ascribe HIV risk to proximal determinants (e.g., multiple sexual partners and injection drug use), East African women attribute HIV risk to underlying distal determinants (e.g., conditions of poverty and survival). They situate HIV risk within a "context of risk," where conditions of poverty and

survival in their home countries characterized by gender and power imbalances put women at increased risk for HIV. Despite their immigration to the US and exposure to western public health messages related to HIV risk behaviors, their perceptions of HIV risk are informed by their lived experiences. Other studies point to similar underlying factors that are associated with HIV risk among immigrant populations, including immigration-related issues and abuse, unequal gender-based power relations, loss and isolation, community and domestic violence, economic insecurity, and lack of legal documents [13,14].

The cognitive interview data revealed that East African participants had a difficult time answering the survey items due to a lack of cultural appropriateness of the items. The cognitive interview data made clear that if a quantitative survey is used in HIV-related studies with African immigrant populations, that it cannot simply be adopted from another community and generalized to African immigrant samples. A culturally appropriate measure of HIV risk perception needs to be developed to ensure that the survey items are culturally meaningful. Other studies have also exposed the limitations of the individualist ontology underpinning quantitative, biomedical-oriented HIV studies that employ self-report questionnaires, while illustrating the utility of qualitative research methods [15,16]. In addition, research that adopts a community-based participatory approach to engage community members is useful to ensure that the research process, from beginning to end, represents the perspectives of those who are most impacted by the issues one is studying [15].

Study Limitations and Strengths

This research study was the first of its kind to investigate and compare African American and East African immigrant women's perceptions related to HIV risk in the Washington, DC Metropolitan area. This study, however, has limitations. As with other qualitative studies, our study comprised a purposeful sample. The findings are based on a small group of participants, which makes it difficult to know whether the findings are valid for the overall East African and African American communities. We attempted to achieve a more representative sample by adopting a sampling method that maximizes variation. Despite the limited generalizability, this study was innovative and contributed to extant literature by generating new knowledge related to differences in HIV risk perceptions among African American and East African immigrant women. Other strengths of the study include the use of a community-based participatory research approach, method triangulation, the use of multiple coders to check reliability, and member-checking with the community advisory board and participants to ensure data validity.

The study findings have important implications for HIV prevention. The findings provide much-needed data on how these groups of women perceive HIV risk, which are vital to understand how best to tailor messages and intervention strategies for each group so that they resonate with these different audiences [17,18]. Indeed, numerous studies have highlighted the need for more research to inform the design of targeted HIV communication and education strategies to address HIV disparities [5,6,19-21]

Study findings suggest that addressing HIV prevention and education among Black women in DC will require distinct and targeted approaches rather than a one-size-fits-all approach,

taking into account the differences in HIV risk perceptions between African American and East African immigrant women. This recommendation is consistent with other studies that demonstrate that cognitive-behavioral intervention models of HIV risk reduction have not been successful with all at-risk groups and have failed to adequately consider a range of social factors that shape risk behaviors [17, 20].

Health practitioners and researchers alike can use these findings to improve existing HIV prevention messages. They can also use this data as a foundation for creating new prevention and education strategies that are targeted towards East African women. This study also demonstrates that East African and African American women need to be active participants in the design, implementation, and evaluative processes to ensure that messages resonate with the intended audience. Most importantly, the study findings suggest that before the necessary messages are created, health researchers and practitioners need to consider the perceptions surrounding HIV within the African American and East African immigrant community. In doing so, the development of specific and targeted messages will more readily reflect the experiences that are relevant to each community, and thusly increase the probability that public health messages about HIV will penetrate the community.

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Summary

Divergent HIV risk perceptions between African American and East African women provides evidence that HIV/AIDS prevention and education strategies must be tailored specifically around the risk perceptions of each group.

Figure 1.

Proximate-determinants conceptual framework for factors affecting the risk of sexual transmission of HIV (Source: Boerma & Weir, 2005)

Table 1

Sociodemographic Characteristics of Study Sample

	African American (n=25)	East African (n=25)
Age		
18-33 years old	14 (56%)	14 (56%)
34-49 years old	11 (44%)	11 (44%)
Education Level		
High school or less	7 (28%)	3 (12%)
Some college, no degree	11 (44%)	8 (32%)
Associate's/Bachelor's degree	5 (20%)	11 (44%)
Graduate degree	2 (8%)	3 (12%)
Employment Status		
Unemployed	10 (50%)	7 (28%)
Annual Household Income		
\$5K-\$24,999K	16 (64%)	8 (32%)
\$25K-\$49,999K	7 (28%)	9 (36%)
\$50K plus	2 (8%)	8 (32%)
Marital Status		
Single	16 (64%)	12 (48%)
Married/In relationship	9 (36%)	10 (40%)
Other	--	3 (12%)
Health Insurance		
Government program (Medicaid/Medicare)	15 (60%)	7 (28%)
Private (Employer-based or self-bought)	8 (32%)	16 (64%)
None	2 (8%)	2 (8%)
Religion		
Orthodox Christian	--	16 (64%)
Baptist	7 (28%)	--
Other Christian	6 (24%)	8 (32%)
Non-Christian	1 (4%)	1 (4%)
None	11 (44%)	--