Published in final edited form as:

AIDS Educ Prev. 2017 October ; 29(5): 457–474. doi:10.1521/aeap.2017.29.5.457.

Perspectives on HIV Testing Among WIC- Enrolled Postpartum Women: Implications for Intervention Development

Yukiko Washio¹, Elizabeth Novack², Dalmacio Flores², Annet Davis-Vogel³, Jesse Chittams², Claire Anagnostopulos², Linda M. Kilby⁴, and Anne M. Teitelman²

¹University of Delaware College of Health Sciences. Newark, DE

²University of Pennsylvania School of Nursing, Philadelphia, PA

³University of Pennsylvania School of Medicine, Philadelphia, PA

⁴Philadelphia Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), North Inc., Philadelphia, PA

Abstract

Low-income minority women are disproportionately represented among those living with HIV in the U.S and also at-risk for substance abuse and intimate partner violence – collectively called the SAVA syndemic which may impede HIV testing uptake. Views about HIV testing were assessed among women (ages 18–29) enrolled in a federally funded nutrition program for women, infants and children (WIC) in a large Mid-Atlantic city. A survey (n=80) and 3 focus groups were conducted in WIC offices located in neighborhoods with high HIV prevalence. Among this primarily minority sample, most would be interested in getting an HIV test if offered at WIC. Benefits included knowing one's HIV status, convenience, and accessible location while transportation and peer/ partner encouragement were enabling factors. Barriers included privacy concerns and intimate partner violence. Findings will be used to design an intervention to promote HIV testing among women who attend WIC and that proactively addresses reported barriers.

Keywords

HIV testing; women; substance abuse; intimate partner violence

Introduction

In 2014, approximately 7,000 women were newly infected with the human immunodeficiency virus (HIV) in the U.S., and over 80% of them were racial/ethnic minority women (CDC, 2015). HIV related issues including risk-taking behavior, HIV infection, and medication adherence are significantly impacted by psychosocial factors including intimate partner

Corresponding Author: Anne Teitelman; 418 Curie Blvd. Philadelphia, PA 19104; Phone (215) 898-1910; Fax: (215) 746-3374; teitelman@nursing.upenn.edu. (ywashio@udel.edu), (novack@nursing.upenn.edu), (dalmacio@nursing.upenn.edu), (advogel@mail.med.upenn.edu), (chittams@nursing.upenn.edu), (aclaire@nursing.upenn.edu), (kilby@northwic.org).

The authors do not have any pertinent disclosures to make including any real or perceived conflicts of interests. Dr. Washio wrote the first draft of the manuscript with all co-authors contributing to the editing of the final manuscript.

violence (IPV) and substance use, the confluence of which has been labeled as the substance abuse, violence, and HIV/AIDS (SAVA) syndemic (Meyer, Springer, & Altice, 2011). Women living in predominantly racial/ethnic minority low-income neighborhoods are disproportionately affected by SAVA syndemic issues (Burke, Thieman, Gielen, O'Campo, & McDonnell, 2005; Gielen et al., 2007).

Substance use has been a strong predictor of HIV risk behavior and infection in women, doubling the risk for negative health consequences (El-Bassel, Terlikbaeva, & Pinkham, 2010; Hodder et al., 2013; Engstrom, Shibusawa, El-Bassel, & Gilbert, 2011; Stahlman, Javanbakht, Stirland, Guerry, & Gorbach, 2013). Injection substance use in women often occurs with partners, which put women at risk for unprotected sex (El-Bassel, Terlikbaeva, & Pinkham, 2010). Having a main sexual partner with an HIV risk factor and women's drinking behavior are associated with using illicit substances during sex (Engstrom et al., 2011). Methamphetamine use has been significantly associated with sexually transmitted disease infection in women (Stahlman et al., 2013). Non-injection substance use increases the likelihood of unprotected sex (Cheng et al., 2016). The postpartum period has been found to be a time of high risk for relapse to substance use (Jones et al., 2014). Women with a history of incarceration for substance use related issues are significantly more likely to engage in HIV-related risk behaviors (Harris et al., 2003).

According to the Centers for Disease Control and Prevention (CDC), IPV "describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner" (CDC, 2016a). IPV can include interfering with HIV counseling and testing (HCT) as well as violent retribution toward a partner who discloses her HIV positive status (Adams et al., 2011; WHO, 2004). Among adult relationships, IPV occurs most often toward women by men (WHO, 2004). IPV is often fueled by gender power differentials that accord greater power to men and disadvantage women and can lead to reduced ability to negotiate safer sex practices (Brawner, Teitelman, Bevilacqua, & Jemmott, 2013).

Among women living in predominantly racial/ethnic minority low-income neighborhoods with high HIV prevalence, 37% reported some type of IPV (physical, emotional, or sexual) in the past 6 months (Hodder et al., 2013). The prevalence of lifetime IPV is as high as 73% among HIV-positive women (Phillips, Walsh, Bullion, Reid, & Bacon K, 2014). Males who perpetrate IPV have higher rates of STI/HIV than those who do not perpetrate (Decker et al., 2009). Women with severe IPV experiences also have increased exposure to HIV risk behaviors (i.e., forced into unprotected sex with a HIV-positive partner or a partner with high HIV risk; decreased negotiation on condom use; high-risk sexual practice for drugs and money; needle sharing; Engstrom et al., 2011; Meyer et al., 2011; Peltzer, Pengpid, & Tiembre, 2013). Negotiation for safe sex has been promoted as an HIV prevention strategy; however, this can increase the risk for coercive sex practice for women exposed to IPV, furthering the risk of HIV infection (El-Bassel, Terlikbaeva, & Pinkham, 2010).

Many cases of HIV infection in women are diagnosed very late in the course of their illness (unless they are pregnant and seek standard prenatal care) potentially as a combined result of lack of knowledge about HIV prevention and treatment, socio-cultural beliefs and barriers

regarding HIV testing, as well as, lack of convenient access to HIV counseling and testing (Aziz & Smith, 2011; Hernandez, Zule, Karg, Browne, & Wechsberg, 2012; Paxton, Williams, Bolden, Guzman, & Harawa, 2013; Yee & Simon, 2014). Delayed diagnosis not only leads to poor outcomes for women but increases the likelihood of mother-to-child HIV transmission via breastfeeding (Blumental, Ferster, Van den Wijngaert, & Lepage, 2014; Ciccozzi et al., 2014). Therefore, continued HIV testing after delivery is especially important. Increasing HIV testing, particularly among young adults and women, is a key prevention strategy in the Healthy People 2020 goals (ODPHP, 2016). In 2006, the CDC released new guidelines for HIV testing, recommending the integration of routine HIV testing as an opt-out into all health care settings as part of regular care (Branson, Handsfield, Lampe, 2006). Integration of HIV screening into regular care resulted in more individuals being tested for HIV (Mullins, Kollar, Lehmann, & Kahn, 2010). Since then, the CDC has endorsed greater access to HIV testing in non-traditional sites preferably those closer to the communities most affected by HIV (CDC, 2016b; Office of National AIDS Policy, 2010). In order to continue this effort and reduce disparities, particularly for vulnerable groups, an understanding of current HCT practices and existing barriers to access is needed in order to identify promising opportunities for increasing HIV testing.

The aim of this study was to elicit the perspective of mothers, living in predominantly racial/ethnic minority low-income neighborhoods, on HIV testing and the potential impact of intimate relationships and substance use on HIV testing, using short surveys and focus groups. Focus groups were conducted because they allow for a multiplicity of views within a group context where participants can hear and react to one another's perspectives (Fishbein & Middlestadt, 1989). The goal of this research is to develop an intervention to increase HIV testing among women at elevated risk for acquiring HIV. The study design was guided by the Integrative Behavioral Model (IBM), which is one of the most widely used theories to inform interventions for effectively promoting behavior change. The IBM specifies social-cognitive constructs that have been shown in many studies to be associated with behavioral outcomes. The model specifies that intention is the best predictor of behavior and proximal predictors of intention include attitudes, norms and self-efficacy (perceived behavioral control). In turn, behavioral, normative and control beliefs predict the associated proximal predictor. Finally, relevant background factors influence beliefs (Fishbein & Ajzen, 2010). For this study on HIV testing, we examined IPV and substance use as two relevant background factors. For the purposes of intervention development, the relevant HIV testing beliefs, knowledge deficits and logistical barriers in this target population become possible topics to address for promoting behavior change toward greater HIV testing. Furthermore, contextual information relevant to gender, community, age, etc. are needed to determine appropriate format and framing of the intervention content (Fishbein & Ajzen, 2010). We explored with postpartum women their views of having access to HIV testing in a community-based setting where they were already receiving some healthcare and nutrition services. The study was conducted in partnership with the Special Supplemental Nutrition Program for Women Infants and Children (WIC) a federally funded program. WIC services are provided to low income women and they, can receive benefits for themselves or their child for up to 5 years after delivery, which include supplemental foods, health care referrals, and nutrition education. The WIC program provides services in 10,000 clinic sites across the

U.S., which include: county health departments; hospitals; mobile clinics (vans); community centers; schools; and public housing sites (WIC, 2015). Postpartum WIC participants come back to the WIC location for food vouchers every three months. WIC staff typically assesses general health which can include substance and alcohol use, and those who need further services or reveal concerns in HIV risk or treatment needs as well as violence exposure and are referred to local community services (Morrissey, 2016). The findings contribute to the literature by understanding the community-based services that low-income mothers have frequent access to and how they perceive this environment as the place for receiving information about HIV testing.

Methods

The study took place in partnership with a WIC program in a major mid-Atlantic city. The WIC offices were located in community settings and were not combined with other services (eg; such as health clinics). Prior to data collection, extended consultations were conducted with local WIC leaders and staff members who were supportive of the study and helped facilitated recruitment at selected neighborhood WIC centers.

Participants and Recruitment

The survey and focus group recruitment were conducted in two urban WIC offices in neighborhoods known for relatively higher HIV prevalence between August and November, 2016. The appropriate Institutional Review Board approved this study. Written informed consent was obtained prior to study participation. Participants were recruited from the WIC waiting rooms by members of the research team or called the study telephone number on the flyer at the WIC office. Women who expressed an interest in the study were screened for eligibility in a private location at the WIC site or over the phone. To be eligible, women needed to self-identify as postpartum, be between the ages of 18–30, and speak and understand English well-enough to complete the requirements of the study. Once deemed eligible and after the consent process took place, the self-administered paper and pencil short survey was completed, participants were compensated for \$15, and an appointment was made to participate in a focus group meeting later. All responses were collected, entered into a data base and reviewed at a later date. To ensure participants had access to needed resourced regarding the topics in the survey, all participants received a resource guide with information about services in the local area pertaining to substance abuse issues, HIV related services, mental health issues and IPV services. Standard operating procedures (SOP) were also developed in case a participant was in crisis, but these did not need to be activated during the course of the study. Women were informed about confidentiality and privacy and the ability to stop the survey at any time during the consent process.

Short Survey

The short survey was conducted with 80 postpartum women enrolled in WIC services, as a result of continuous recruitment during the study period. The survey collected demographic information including age, race/ethnicity, education, working status, number of children, sexual history, drug and alcohol history (i.e., any current illicit drug use, specific drugs used in past 30 days, number of days for regular and binge drinking in the past 30 days), IPV

history (i.e., one question each for lifetime history of physical, sexual, psychological, and threatening types of IPV by a partner), HIV testing and treatment history, and knowledge of current sexual partner's HIV status. Race/ethnicity were defined using the NIH categories and participants could check all that applied: American Indian Alaska Native, Asian, Black, African American, Native Hawaiian, Other Pacific Islander, and White and also Hispanic or Latino and not Hispanic or Latino (Office of Management and Budget, 1997). Education was measured by asking if participants had a high school diploma or GED, if they attended college, community college, or a technical school, and how many years/months did they attend college, community college, or technical school. Working status was measured by asking if they worked full time or part time outside of the home, or did not work outside of the home. Sexual history questions asked if participants had a steady sexual partner, had unprotected sex in the past 6 months, how often did they use alcohol or drugs before vaginal intercourse in the past 6 months. A steady partner was described as, "someone you have seen regularly for at least one month and with whom you have had vaginal sex more than once." HIV testing history questions asked if participants had ever tested positive for HIV and if yes, were they receiving treatment, if they had been tested for HIV in the past 6 months, and if their current partner has had an HIV test. We also asked participants if HIV testing were offered at the WIC office would they be interested in getting tested for HIV at WIC (yes/no) and if they would like to get HIV tested: by themselves, with their partner, or with a friend. The last section of the short survey included open-ended questions to elicit beliefs about getting an HIV test in the next 6 months. We elicited these beliefs from each individual prior to the focus groups in order to ascertain individual beliefs without the influence of the group setting. Behavioral beliefs were assessed by asking what was helpful and not helpful; normative beliefs were assessed with questions asking who would approve and disapprove; and control beliefs were identified by asking what would make it easy and hard about getting an HIV test in the next 6 months. We also asked: "Who they might talk to about getting and HIV test", "In what ways might using alcohol and other drugs make it hard to get and HIV test in the next 6 months?" and "In what ways might having a partner who hits, threatens or forces sex make it hard to get an HIV test in the next 6 months?"

Focus Groups

All focus group meetings took place in a private room within the WIC offices and were co-facilitated by two members of the research team. There were 4–5 participants in each focus group and all had previously completed the short survey at the time of recruitment. We asked participants to describe their views, rather than their behaviors, and we used scenarios which allowed participants to reveal thoughts and feelings about sensitive topic without discussing their own personal experiences. Topics included: perspectives on HIV testing in general; possibility of getting an HIV test in the WIC settings if it were to become available; and how IPV and substance use could be barriers to HIV counseling and testing. Using hypothetical scenarios topics covered were: asking a partner to get tested for HIV or talking about HIV status with a partner and the impact of IPV and substance abuse on HCT. Focus group participants were thanked for their participation and compensated \$30 for their time. After 3 focus groups were conducted, we determined the information was adequate to reach saturation regarding the relevant content.

Data Analysis

Short Survey.—SPSS software (Version 17.0, IBM Company, Chicago, IL) and RStudio (R Foundation for Statistical Computing, Vienna Austria) were used to analyze the quantitative survey results. Descriptive analysis was conducted to calculate the mean $\pm$ SD and counts (%) for each variable of demographics, IPV, substance use, and HIV testing. Chi-square analyses were conducted to examine the relationship between HIV testing behavior and IPV/substance use. Fisher exact test was conducted for a cell count of below five. For open-ended survey questions on HIV testing beliefs, content analysis was conducted by two research team members independent of each other to descriptively categorize behavioral, normative and self-efficacy beliefs regarding HIV testing. Any coding differences were resolved through discussion until consensus was reached. We considered a belief to be salient if it was endorsed by at least 5% of the sample.

Focus groups.—All three focus group meetings were audiotaped, transcribed verbatim, and checked for accuracy by members of the research team. Preliminary analysis occurred after each focus group by two research team members listening to the audio recordings and taking notes on substantive themes, identifying areas to explore further in subsequent groups and to determine when saturation was reached. After the 3 focus groups were completed, the transcripts were coded and analyzed by two team members, one primary and one secondary, by using the qualitative software NVivo11, using content analysis, (Glaser & Holton, 2004). Any discrepancies between the two coders were discussed and resolved in larger research team meetings. Coding was used to identify patterns and themes related to HIV testing, substance use, and IPV among WIC participants.

Analysis across data sources.—Since the main purpose of this study was to identify salient beliefs and relevant contextual information, the focus of our analysis was on the qualitative data. First, we analyzed the survey and focus group data separately. We then compared the data from the open-ended survey questions with the major themes in the focus groups as a way to triangulate the data.

Findings

Sample Characteristics from Short Survey

The survey sample consisted of 80 participants. All participants self-identified as postpartum women and were between the ages of 18–30. The average age was 24 ± 3.4 , 90% were African American, 56% had more than 12 years of education, 41% were currently working, and the average number of children they had was 2 ± 1 .

For HIV status, 4% (3/77) reported being HIV-positive but none reported currently receiving any HIV treatment (Table 1). None of the three women reported any illicit drug use in the past 30 days nor lifetime IPV history. Sixty-eight percent reported being tested for HIV in the past six months. For sexual history, 78% reported currently having a steady sexual partner, 58% reported having an unprotected sex in the past six months, and 15–19% reported an indicator(s) of IPV lifetime experiences with a partner (Table 1). For the history of drug and alcohol use, 10% reported current drug use (mostly marijuana), and 41%

reported alcohol use in the past 30 days (Table 1). Of those who had alcohol in the past 30 days, 13% engaged in at least one episode of binge drinking in the past 30 days (i.e., >5 drinks on the same occasion; NIAAA, 2017), and 3% engaged in high-risk drinking (i.e., >7 drinks per week; NIAAA, 2017).

Having any type of IPV lifetime experience was not significantly associated with getting HIV tested in the past 6 months (65% vs. 70%; $p = 0.71$). HIV testing in the past 6 months was more likely among participants who reported drinking in the past 30 days (81% vs. 61%; $p = 0.06$); however, drinking before having sex (67% vs. 69%; $p = 0.85$), using illegal drugs in the past 30 days (75% vs. 68%; $p = 0.13$), and using illegal drugs before having sex (88% vs. 67%; $p = 0.13$) were not significantly correlated with getting HIV tested in the past 6 months.

A majority (71%) of the sample had a partner who had an HIV test while 21% did not know their partner's testing status. Notably, of those who had any lifetime IPV ($n=20$), 40% did not know their partner's HIV testing status. Overall, 89% of those who knew their partner had an HIV test, also knew their partner's HIV status, and this was lower for those with an IPV history (72%) and for those with recent drug use (67%). Overall, 90% of participants indicated interest in HIV testing at WIC, while this was somewhat lower for those with a history of IPV (80%). Overall, 41% would prefer to get tested with a partner, while this was somewhat higher for those with a history of IPV (45%) and for those with recent drug use (50%; Table 2).

Beliefs on HIV Testing

Based on the open-ended survey questions we identified salient behavioral, normative and control beliefs (Table 3). Participants reported they would talk to their partner (29%), doctor (14%), mother (13%), and friend (7%) to make a decision about HIV testing. Ten to eleven percent reported that drug and alcohol use would make someone become forgetful and less likely to consider HIV testing as important. Twenty to twenty-two percent reported that an abusive partner would prevent someone from getting HIV testing by making them scared and preventing them from going to get an HIV test, for e.g.: "because you never really know what abusive people will do to hurt you".

Focus Group Findings

The focus group participants' sociodemographics (age, race, ethnicity, education) did not differ from the overall group ($N = 14$). Focus group participants generally thought it was a good idea to offer HIV testing and counseling (HCT) at WIC. They suggested that an HCT service can be enhanced with basic information about HIV including prevention, transmission, and treatment. When probed, focus group participants identified distinct facilitators and barriers to HCT at WIC. Factors related to substance use and interpersonal violence played key roles in determining women's perception of HCT at WIC. Representative quotes for each theme is provided in Table 4.

Facilitators to HIV Counseling and Testing at WIC

Knowledge about HIV.—Focus group participants believe that most women put a premium on being educated about HIV as part of their sexual health. They thus see HCT at WIC, as a chance to educate those who have no information about HIV and as an opportunity to validate what they know, clarify their misconceptions and enhance their level of knowledge. Because women do look up information related to HIV from the privacy of their homes through the internet, the program will complement their information-seeking behaviors. Finally, community awareness about HIV will also be advanced through these programs by challenging negative stereotypes associated with transmission and that still persist.

Convenient testing option.—According to the participants, this program will enable women to accomplish multiple tasks such as addressing children's nutrition and mothers' sexual health during the same visit. They believed that in case of an initial reactive HIV test, this program can link clients to the healthcare system where arrangement for a confirmatory test can be made. They also saw HCT at WIC as an efficient way to enroll and stay in care as opposed to home HIV testing where the shock of an HIV-positive result may handicap clients from determining what to do next.

Woman-centered approach.—HIV counseling and testing at the local WIC centers allow women to receive female-to-female social support and avoid exposure to partner violence in making a decision to get tested for HIV and receive needed care. For the most part, the local WIC staff are women and some are former WIC clients. Acknowledging the gender power inequality that is prevalent in many relationships in their community, participants reported that HCT at WIC will afford women a chance to know their status without the permission of partners. Female-to-female social encouragement and support was heavily emphasized among focus group participants especially for a woman in an unhealthy relationship.

Knowing one's status.—Participants saw HCT as a means to fulfill several roles and responsibilities they have to themselves and their families. First, the need to be certain of their own HIV status would be addressed. Second, they also were concerned about being a vector for transmission to partners and their own children. Participants also believe that routine HCT can be seen as proof that they are taking care of their families by insisting on knowing their health status so they can plan appropriately should they be HIV-positive.

Barriers to HIV Counseling and Testing at WIC

Confidentiality concerns.—Participants reported concern over confidentiality of counseling and test results as the main barrier that would prevent them from participating in HCT at WIC. They believed that potential breaches in confidential information due to numerous people working at WIC might lead to people in their community knowing about the extent of their risky sexual behaviors or their HIV status. For them, WIC clinics are not private spaces and just being seen by other women at WIC clinics as coming for an HIV test would invite scrutiny and raise suspicions about their serostatus.

Psychological impediments.—First, the fear of a positive diagnosis and what that might entail was a concern that might keep women from HCT. This fear of confirming seropositivity and the mental agony associated with knowing that they are HIV-positive leads to denial about the need for HIV testing. Also, low self-esteem or, in extreme cases, post-partum depression may also keep women from HCT because they may not consider themselves as worthy of being healthy or are unable to get out of the home. Participants reported that a woman in an unhealthy relationship may also be scared of broaching HCT to her partner.

Low perceived risk ('It's not me, it's them').—While participants agreed that HCT at WIC would increase awareness about HIV, they did not necessarily see the benefit of the program for themselves but directed it to younger cohorts of women. Also, some participants professed equating HIV/AIDS with other groups traditionally linked to the epidemic, specifically men who have sex with men, which makes testing at WIC not a priority for them.

Intimate partner violence.—While self-disclosure of IPV did not occur in the focus groups, the hypothetical scenarios and specific probing related to IPV and HCT allowed participants to discuss potential barriers for women in abusive relationships. One reoccurring barrier for a woman in an abusive relationship was the fear of the reaction from an abusive partner when asking them to get HIV testing done or talking about their HIV status in general. Participants also discussed mental or emotional abuse may make it difficult to go to WIC to get HIV testing.

Partner drug use.—Probing for substance use as a barrier to HCT elicited many responses about how a partner's drug use could influence one's own ability to talk about HIV testing with their partner. Similarly, if a partner was not sober when talking about HIV results, participants voiced that the partner could lash out at the woman so the woman might not be willing to bring the topic up in the first place.

Mixed views among focus group participants

In addition to the barriers and facilitators noted, findings from the focus group discussions point to three central areas of concern that are marked by ambiguity. These concerns detail mixed views that carry oppositional weight in women's perception of HCT at WIC and are important in intervention development.

Compartmentalization versus expansion of services.

Study participants discussed how expanding services at WIC would be beneficial and timesaving, while some argued that expansion of services would undermine the very reasons why HIV testing at the sites would be appealing. Those who opposed the incorporation of HCT services pointed to the need for training WIC's staff to become medically well-informed – a fact that they saw would funnel services away from a resource that already receives limited budget allotment. While convenient, there was also concern that an expansion of services may make WIC feel like a doctor's office and could make women feel

less comfortable. Participants wanted WIC to be an environment that makes women want to come to WIC rather than making them feel like they have to.

Encouraging male participation versus having a program for women.

Participants also shared opposing views about the extent male partners should be included in HCT at WIC. On one hand, proponents of encouraging male participation pointed to voluntary partner testing as setting a trusting context for relationships as some women voiced that they get tested with their partners. Those who believed that the program should be women-focused identified the pervasive power imbalance in most relationships which would invite negative reactions from male partners if HCT were broached. For some, the local WIC offices were seen as a possible safe space where women could go to get tested without their partners' knowledge.

Ensuring privacy versus inviting stigmatization.

HIV testing at WIC was primarily viewed as a discreet way of staying aware of one's serostatus. Some participants pointed out stigmatization of WIC could result if others in the community became aware of the testing program. Women explained that going to WIC in general may not raise peer concerns about HIV testing, but going to a separate room for HIV testing at the WIC office may cause other women there to talk and make assumptions. The stigma surrounding HIV was a concern. Getting HIV testing done while your child has their finger pricked, for example, was one way to make HIV testing at WIC offices less obvious.

Comparing Survey and Focus Group Data

There were many areas where the responses from the open-ended survey questions and focus group discussions converged. All of the salient behavioral beliefs and most of the salient self-efficacy beliefs identified on the survey were also mentioned in the focus groups. Having partner support for HIV testing, as well as concern that IPV would impede a woman from getting tested were also common themes from both sources of data. There was overall high endorsement of HCT testing at WIC on both the survey and initially in the focus groups. However, the focus groups did provide additional details about barriers that were not elicited from the open-ended survey responses including, a generally low perceived risk for HIV, identifying ways that IPV and substance use were barriers to talking with a partner about HIV testing, as well as, confidentiality concerns and possible stigma regarding HIV testing at WIC.

Discussion

The current study noted a relatively high prevalence of HIV-positive postpartum women enrolled in WIC at 4%, which is much higher than the overall prevalence among adult women in the US, which is less than 1%, indicating women attending WIC are at elevated risk for HIV. Furthermore, WIC offices are often located in neighborhoods with some of the highest HIV rates in the US, suggesting an opportunity for augmenting access to HCT for women most in need. Notably, none of the HIV positive women reported receiving HIV treatment currently. This finding suggests that the WIC setting, which provides referrals for a variety of health concerns, offers an opportunity to link women to HIV care along with

providing the most optimal approaches for infant nutrition for this population, such as providing alternatives to breastfeeding. Illicit drug use and binge drinking were low among the participants who were young post-partum women, relative to the 2013 national prevalence among women in the past year use (13.2% for illicit drug use; 9.8% for marijuana use; 16% for binge drinking; SAMHSA, 2014). The prevalence of lifetime IPV by a partner was 15–19% among the participants. Although this is lower than the 33% lifetime prevalence reported by the CDC in 2014 (CDC, 2013), the survey contained only 4 questions to assess any abuse which may account for our lower rate.

The vast majority of women completing the survey positively endorsed the idea of HCT at WIC and focus group findings provided additional details for this perspective. For some, it was seen as an opportunity to take care of themselves. Also, the convenience of HIV testing at a familiar location they already frequent for other services was the most cited facilitator for supporting the proposed program. The idea of a *one-stop shop* was reported in surveys and focus group discussions, which would allow women to accomplish multiple tasks with one visit. Along with the opportunity to be educated more about HIV, the woman-centered approach participants envisioned would be a hallmark of the program. This idea of a women-centered approach may also be seen as a source of empowerment for women seeking health care services. Peer support and women-focused HCT may help overcome barriers to testing that are exacerbated by gender power imbalances. Women-centered approaches and peer support may help reduce possible stigma among mothers receiving WIC vouchers and HCT at WIC.

Findings were generally similar for those with and without a history of IPV or substance use with a few exceptions. Notably, those with a history of IPV and substance use were less likely to know their partner's HIV status and this may help explain why they also more commonly indicated a preference to get HIV testing with a partner rather than by themselves. Also, those who used alcohol in the past 30 days were more likely to have been tested for HIV in the past 6 months. These trends suggest that women experiencing SAVA syndemic issues may be aware of their heightened sexual risk and would like to be proactive in safeguarding their health by getting tested and by encouraging partner's to get HIV testing. Our prior research suggests that some women view HIV co-testing with a partner as a way to encourage the partner to get tested and learn their partner's test result (Teitelman, Calhoun, Duncan, Washio, & McDougal, 2015). Alternatively, women in abusive relationships may fear partner retribution if he found out she had HIV testing without him and would therefore prefer to get tested together to avoid such consequences. Further research is needed to examine these associations in larger samples and to understand the possible mechanisms of these findings in order to provide nuanced intervention approaches for those affected by IPV and / or substance use.

While women believed their immediate family and friends would not disapprove of them being tested for HIV at WIC from the open-ended survey data, in focus groups they verbalized other people's judgmental attitudes as a concern. This worry over anticipated stigma has been previously reported as a deterrent to HIV testing (Leblanc, Flores, & Barroso, 2016) and underscores the need for offering confidential services and reassuring clients about the confidentiality of test results. Consistent with other studies (Evangelini, Pady,

& Wroe, 2016). we also found that other psychological impediments such as fear of an HIV-positive diagnosis or perceiving themselves at low risk for HIV infection could be barriers to HCT, and these may be compounded among WIC participants experiencing perinatal depression. Approximately 13% of women in the U.S. are affected by depression during pregnancy and perinatal depression disproportionately impacts racial and ethnic minority or low income women such as those who attend WIC (Tabb et al., 2015).

There were also some mixed views about HCT at WIC that emerged primarily from the analysis of the focus group data. Some thought offering screening for other STIs as well as HCT would be an important additional component, while other women indicated providing these services would make them feel less comfortable since it would seem more like a medical clinic. Staff at WIC programs nationally strive to create a welcoming environment for clients as a way to encourage women to return for the needed services (Morrissey, 2016). Our focus group findings suggest women who attended the local WIC centers did feel comfortable there, noting it was a safe space, and others expressed concern that adding HCT testing to WIC could potentially detract from this favorable aspect or even draw resources away from core services.

Findings from the survey and focus groups identified that being in an abusive relationship could elicit a fear response in women who wished to talk about HIV testing with their partners and may negatively impact women's decision to get tested for HIV (Nelson, Ferrance, & Masho, 2016). In terms of drug use, the attention in the focus groups was mostly on partner drug use instead of their own drug use. Partner drug use was considered a facilitator for increased IPV risk. Males who perpetrate IPV have higher rates of STI/HIV (Decker et al., 2009), increasing exposure to HIV risk behaviors among heterosexual women (Meyer et al., 2011; Peltzer et al., 2013). While WIC aims to provide competent and respectful care, it is a common phenomenon for bureaucratic processes to be present in a large service delivery program. Adding screening, for e.g. HIV, IPV, substance use, or depression, into the WIC program, may be seen by participants as added surveillance which could lead staff to have doubts about their abilities as mother and open the possibility for involvement by other government agencies including Child and Family Protective services (Tabb et al., 2015).

Our findings present a complex picture about increasing access to HIV testing among women who attend WIC and all views are extremely important to consider regarding intervention development. While WIC staff are tasked with assessing health concerns and making appropriate referrals among the women they serve (Morrissey, 2016), it may be unduly burdensome to add HCT training and service delivery to their routine duties. For women attending WIC there are mixed views about this type of service integration. Increasing access to HCT for women who attend WIC, who are at elevated risk for HIV, may need to be creatively integrated as a supplemental service. This may take the form of mobile testing units that include a variety of screenings for diabetes, hypertension as well as HIV (to mitigate stigma), co-location of WIC and HCT service teams with confidentiality and privacy protections in place, or offering creative ways to increase access to home testing, augmented with optional counseling.

A few limitations are noted in the current study. Convenience sampling limits generalizability as our sample is not representative of all WIC-eligible postpartum women in the U.S. Also, under-reporting of maternal substance use has been documented, which may also be relevant to the present findings. (Bessa et al., 2010; El Marroun et al., 2011; Garg et al., 2016). We did not ask about other settings women might like to get tested for HIV which is an important topic for future research. Due to the nature of focus group data collection methods, we did not have the ability to identify demographic information related to each comment expressed in focus groups, which may have limited our ability parse out the influence of factors such as age, employment status or education in connection with their views. Future research is needed to link demographic as well as health factors (such as histories of IPV and substance use) with the various views identified in this paper to further inform intervention development.

Despite these limitations, the current study added to the literature by underscoring how having an abusive partner and partner drug use may also interfere with women's decision to get tested for HIV. The current study was focused on a sample of postpartum women living in the neighborhoods with relatively high HIV prevalence, providing preliminary quantitative information of substance use, IPV history, and HIV testing and treatment history. Second, the current study provided qualitative understanding of behavioral, control, and normative beliefs on HIV testing and how IPV and substance use may influence women's HIV testing behavior. Finally, the current study provided community views on increasing access to HIV testing in partnership with a non-traditional community setting.

Conclusion

The current study reported HIV prevalence, testing and treatment history, and preference for HIV testing among WIC-eligible postpartum mothers living in neighborhoods with relatively high HIV prevalence. A strong preference of using WIC offices as an HCT site for women was noted. The survey and focus groups identified beliefs, barriers and facilitators, and perceived social support toward HIV testing among women and the possible influence of IPV and substance use, as well as participant-centered views of how best to access HCT in partnership with WIC. These findings have elucidated benefits and challenges of embedding information about HCT within WIC centers and will be used to inform intervention development to increase access to HCT among women in neighborhoods with high rates of HIV.

Acknowledgement:

This study was funded by the Penn Center for AIDS, Pilot Grant Program during the study period (7/1/2014–12/3/2015) Parent grant: P30-AI-045008 (PI: J. Hoxie). The funding source had no involvement in the study design, data collection, analysis, interpretation, write-up or any decisions regarding the publication of results.

References

- Adams JL, Hansen NB, Fox AM, Taylor BB, van Rensburg MJ, Mohlahlane R, & Sikkema KJ (2011). Correlates of HIV testing among abused women in South Africa. *Violence against Women*, 17(8), 1014–23. <http://doi.org/10.1177/1077801211414166> [PubMed: 21727154]

- Aziz M, & Smith KY (2011). Challenges and successes in linking HIV-infected women to care in the United States. *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*, 52 Suppl 2, S231–7. <http://doi.org/10.1093/cid/ciq047> [PubMed: 21342912]
- Bessa MA, Mitsuhiro SS, Chalem E, Barros MM, Guinsburg R, & Laranjeira R (2010). Underreporting of use of cocaine and marijuana during the third trimester of gestation among pregnant adolescents. *Addictive Behaviors*, 35(3), 266–9. <http://doi.org/10.1016/j.addbeh.2009.10.007> [PubMed: 19896774]
- Blumental S, Ferster A, Van den Wijngaert S, & Lepage P (2014). HIV transmission through breastfeeding: still possible in developed countries. *Pediatrics*, 134(3), e875–9. <http://doi.org/10.1542/peds.2013-3022> [PubMed: 25136040]
- Branson BM, Handsfield HH, Lampe MA, et al. (2006). Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>
- Brawner BM, Teitelman AM, Bevilacqua AW, & Jemmott LS (2013). Personalized Biobehavioral HIV Prevention for Women and Adolescent Girls. *Global Advances in Health and Medicine*, 2(5), 100–8. <http://doi.org/10.7453/gahmj.2013.059> [PubMed: 24416702]
- Burke JG, Thieman LK, Gielen AC, O'Campo P, & McDonnell KA (2005). Intimate partner violence, substance use, and HIV among low-income women: taking a closer look. *Violence against Women*, 11(9), 1140–61. <http://doi.org/10.1177/1077801205276943> [PubMed: 16049104]
- CDC. (2013). Intimate Partner Violence in the United States - 2010 Retrieved from https://www.cdc.gov/violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf
- CDC. (2015). HIV in the United States | Statistics Overview | Statistics Center | HIV/AIDS | CDC Retrieved July 5, 2016, from <http://www.cdc.gov/hiv/statistics/overview/ata glance.html>
- CDC. (2016a). Definitions[Intimate Partner Violence|Violence Prevention|Injury Center|CDC Retrieved July 7, 2017, from <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>
- CDC. (2016b). Implementing HIV testing in non-clinical settings Retrieved from <https://www.cdc.gov/hiv/testing/nonclinical/>
- Cheng T, Johnston C, Kerr T, Nguyen P, Wood E, & DeBeck K (2016). Substance use patterns and unprotected sex among street-involved youth in a Canadian setting: a prospective cohort study. *BMC Public Health*, 16, 4 <http://doi.org/10.1186/s12889-015-2627-z> [PubMed: 26728877]
- Ciccozzi M, Lo Presti A, Andreotti M, Mancinelli S, Ceffa S, Galluzzo CM, ... Giuliano M (2014). Viral sequence analysis of HIV-positive women and their infected children: insight on the timing of infection and on the transmission network. *AIDS Research and Human Retroviruses*, 30(10), 1010–5. <http://doi.org/10.1089/AID.2014.0143> [PubMed: 25103792]
- Decker MR, Seage GR, Hemenway D, Gupta J, Raj A, & Silverman JG (2009). Intimate partner violence perpetration, standard and gendered STI/HIV risk behaviour, and STI/HIV diagnosis among a clinic-based sample of men. *Sexually Transmitted Infections*, 85(7), 555–60. <http://doi.org/10.1136/sti.2009.036368> [PubMed: 19625287]
- El Marroun H, Tiemeier H, Jaddoe VWV, Hofman A, Verhulst FC, van den Brink W, & Huizink AC (2011). Agreement between maternal cannabis use during pregnancy according to self-report and urinalysis in a population-based cohort: the Generation R Study. *European Addiction Research*, 17(1), 37–43. <http://doi.org/10.1159/000320550> [PubMed: 20975275]
- El-Bassel N, Terlikbaeva A, & Pinkham S (2010). HIV and women who use drugs: double neglect, double risk. *Lancet (London, England)*, 376(9738), 312–4. [http://doi.org/10.1016/S0140-6736\(10\)61026-4](http://doi.org/10.1016/S0140-6736(10)61026-4)
- Evangeli M, Pady K, & Wroe AL (2016). Which Psychological Factors are Related to HIV Testing? A Quantitative Systematic Review of Global Studies. *AIDS and Behavior*, 20(4), 880–918. <http://doi.org/10.1007/s10461-015-1246-0> [PubMed: 26566783]
- Fishbein M, & Ajzen I (2010). Predicting and changing behavior: The reasoned action approach New York: NY: Psychology Press: Taylor & Francis Group.
- Fishbein M, & Middlestadt SE (1989). Using the theory of reasoned action as a framework for understanding and changing AIDS-related behaviors. In Mays VAG, Schneider S, ed. *Primary prevention of AIDS: Psychologica approaches* (pp. 93–110). Newbury Park; CA: Sage.

- Garg M, Garrison L, Leeman L, Hamidovic A, Borrego M, Rayburn WF, & Bakhireva L (2016). Validity of Self-Reported Drug Use Information Among Pregnant Women. *Maternal and Child Health Journal*, 20(1), 41–7. <http://doi.org/10.1007/s10995-015-1799-6> [PubMed: 26175273]
- Gielen AC, Ghandour RM, Burke JG, Mahoney P, McDonnell KA, & O'Campo P (2007). HIV/AIDS and intimate partner violence: intersecting women's health issues in the United States. *Trauma Violence Abuse*, 8(2), 178–198. *Journal Article*. <http://doi.org/10.1177/1524838007301476> [PubMed: 17545573]
- Glaser BG, & Holton J (2004). Remodeling Grounded Theory. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 5(2).
- Harris RM, Sharps PW, Allen K, Anderson EH, Soeken K, & Rohatas A (2003). The interrelationship between violence, HIV/AIDS, and drug use in incarcerated women. *The Journal of the Association of Nurses in AIDS Care: JANAC*, 14(1), 27–40. <http://doi.org/10.1177/1055329002239188> [PubMed: 12585220]
- Hernandez AM, Zule WA, Karg RS, Browne FA, & Wechsberg WM (2012). Factors That Influence HIV Risk among Hispanic Female Immigrants and Their Implications for HIV Prevention Interventions. *International Journal of Family Medicine*, 2012, 876381 <http://doi.org/10.1155/2012/876381> [PubMed: 22518308]
- Hodder SL, Justman J, Hughes JP, Wang J, Haley DF, Adimora AA, ... El-Sadr WM (2013). HIV acquisition among women from selected areas of the United States: a cohort study. *Annals of Internal Medicine*, 158(1), 10–8. <http://doi.org/10.7326/0003-4819-158-1-201301010-00004> [PubMed: 23277896]
- Jones HE, Deppen K, Hudak ML, Leffert L, McClelland C, Sahin L, ... Creanga AA (2014). Clinical care for opioid-using pregnant and postpartum women: the role of obstetric providers. *American Journal of Obstetrics and Gynecology*, 210(4), 302–10. <http://doi.org/10.1016/j.ajog.2013.10.010> [PubMed: 24120973]
- Leblanc NM, Flores DD, & Barroso J (2016). Facilitators and Barriers to HIV Screening: A Qualitative Meta-Synthesis. *Qualitative Health Research*, 26(3), 294–306. <http://doi.org/10.1177/1049732315616624> [PubMed: 26631679]
- Meyer JP, Springer SA, & Altice FL (2011). Substance abuse, violence, and HIV in women: a literature review of the syndemic. *Journal of Women's Health* (2002), 20(7), 991–1006. <http://doi.org/10.1089/jwh.2010.2328>
- Morrissey S (2016). *Motherhood, Poverty, and the WIC Program in Urban America* New York, NY: Lexington Books.
- Mullins TLK, Kollar LM, Lehmann C, & Kahn JA (2010). Changes in human immunodeficiency virus testing rates among urban adolescents after introduction of routine and rapid testing. *Archives of Pediatrics & Adolescent Medicine*, 164(9), 870–4. <http://doi.org/10.1001/archpediatrics.2010.161> [PubMed: 20819970]
- Nelson KA, Ferrance JL, & Masho SW (2016). Intimate partner violence, consenting to HIV testing and HIV status among Zambian women. *International Journal of STD & AIDS*, 27(10), 832–839. <http://doi.org/10.1177/0956462415596299> [PubMed: 26185042]
- NIAAA. (2017). Rethinking drinking: Alcohol and your health Retrieved from <http://rethinkingdrinking.niaaa.nih.gov/How-much-is-too-much/Is-your-drinking-pattern-risky/Whats-Low-Risk-Drinking.aspx>
- ODPHP. (2016). Healthy People 2020 Retrieved December 1, 2016, from <https://www.healthypeople.gov/2020/topics-objectives/topic/hiv/objectives>
- Office of Management and Budget. (1997). Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. Federal Register Retrieved from (<https://www.gpo.gov/fdsys/pkg/FR-1997-10-30/pdf/97-28653.pdf>)
- Office of National AIDS Policy. (2010). National HIV/AIDS Strategy | The White House Retrieved June 15, 2017, from <https://obamawhitehouse.archives.gov/administration/eop/onap/nhas>
- Paxton KC, Williams JK, Bolden S, Guzman Y, & Harawa NT (2013). HIV Risk Behaviors among African American Women with at-Risk Male Partners. *Journal of AIDS & Clinical Research*, 4(7), 221 <http://doi.org/10.4172/2155-6113.1000221> [PubMed: 24455447]

- Peltzer K, Pengpid S, & Tiembre I (2013). Mental health, childhood abuse and HIV sexual risk behaviour among university students in Ivory Coast. *Ann Gen Psychiatry*, 12(1), 18 Journal Article. <http://doi.org/10.1186/1744-859x-12-18> [PubMed: 23758850]
- Phillips DY, Walsh B, Bullion JW, Reid PV, Bacon K, O. N (2014). The intersection of intimate partner violence and HIV in U.S. women: a review
- SAMHSA. (2014). Results of the 2013 NSDUH: Detailed Tables, SAMHSA, CBHSQ Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUH-DefTabs2013/NSDUH-DefTabs2013.htm#tab2.42b>
- Stahlman S, Javanbakht M, Stirland A, Guerry S, & Gorbach PM (2013). Methamphetamine use among women attending sexually transmitted disease clinics in Los Angeles County. *Sexually Transmitted Diseases*, 40(8), 632–8. <http://doi.org/10.1097/01.OLQ.0000430801.14841.75> [PubMed: 23859909]
- Tabb KM, Choi S, Pinerros-Leano M, Meline B, McDonald HG, Kester R, & Huang H (2015). Perinatal depression screening in a Women, Infants, and Children (WIC) program: perception of feasibility and acceptability among a multidisciplinary staff. *General Hospital Psychiatry*, 37(4), 305–9. <http://doi.org/10.1016/j.genhosppsych.2015.03.008> [PubMed: 25858684]
- Teitelman AM, Calhoun J, Duncan R, Washio Y, & McDougal R (2015). Young women's views on testing for sexually transmitted infections and HIV as a risk reduction strategy in mutual and choice-restricted relationships. *Applied Nursing Research: ANR*, 28(3), 215–21. <http://doi.org/10.1016/j.apnr.2015.04.016> [PubMed: 26112775]
- WHO. (2004). Intimate Partner Violence and HIV/AIDS Retrieved from www.who.int/gender-equity-rights/knowledge/a85591/en/
- WIC. (2015). About WIC- WIC at a Glance | Food and Nutrition Service Retrieved July 7, 2017, from <https://www.fns.usda.gov/wic/about-wic-wic-glance>
- Yee LM, & Simon MA (2014). The role of health literacy and numeracy in contraceptive decision-making for urban Chicago women. *Journal of Community Health*, 39(2), 394–9. <http://doi.org/10.1007/s10900-013-9777-7> [PubMed: 24105614]

Table 1.

Participant History of Drug Use, Partner Violence Exposure, and HIV Testing (N=80)

Variables	Frequency	Percent
Currently using any illicit/street drugs	8/80	10%
Had alcohol in past 30 days (n=78)	32/78	41%
History of treatment for mental illness (n=79)	13/79	17%
Have a steady sexual partner	62/80	78%
Had unprotected sex in past 6 months	46/80	58%
Any lifetime IPV (n=79)	20/79	25%
Ever called names/put down by partner (n=79)	15/79	19%
Ever threatened by partner (n=79)	12/79	15%
Ever slapped, punched, hit, kicked by a partner (n=79)	12/79	15%
Ever forced to have sex by a partner (n=79)	2/79	3%
Tested positive for HIV (n=77)	3/77	4%
If positive, receiving HIV treatment (n=3) (2, no; 1 did not respond)	0/3	0%
Tested for HIV in past 6 months	55/80	68%

Table 2.

Relationship between the History of Intimate Partner Violence and Substance Use on HIV Testing

	Lifetime IPV (n=20)	No lifetime IPV (n=59)	Drug use (n=8)	No drug use (n=72)	Total sample (n=80)
Partner had HIV test					
Yes	55% (11/20)	77% (45/59)	75% (6/8)	70.8% (51/72)	71% (57/80)
No	5% (1/20)	9% (5/59)	13% (1/8)	5% (5/72)	8% (6/80)
Don't know	40% (8/20)	15.3% (9/59)	13% (1/8)	22% (16/72)	21% (17/80)
Of those who knew partner had HIV test, those who knew partners HIV status	72% (8/11)	93% (42/45)	67% (4/6)	92% (47/51)	89% (51/57)
Interested in HIV testing at WIC	80% (16/20)	93.2% (55/59)	88% (7/8)	90.3% (65/72)	90% (72/80)
Would you rather get HIV tested with					
By Myself	40% (8/20)	54% (32/59)	38% (3/8)	51.4% (37/72)	50% (40/80)
My partner	45% (9/20)	39% (23/59)	50% (4/8)	40.3% (29/72)	41% (33/80)
My friend	15% (3/20)	7% (4/59)	13% (1/8)	8.3% (6/72)	9% (7/80)

Table 3.

Behavioral, Self-efficacy, and Normative Beliefs on HIV Testing (N = 80)

Behavioral beliefs	Helpful	Not helpful
Knowing the status	78%	
Get positive results		18%
Protect themselves	9%	
Protect others	8%	
For having safe sex	5%	
Self-efficacy beliefs	Easy	Hard
Convenience	54%	
Cost		11%
Done at a doctor's office	11%	
Having social support	10%	
Normative beliefs	Approve	Disapprove
Mother	36%	
Partner	34%	
Family	25%	
Friend	24%	

Table 4.

Themes and Representative Quotes

<i>Facilitators</i>
<i>Knowledge about HIV:</i> “That’s the bad thing about Google, because people self-diagnose. They don’t want to get tested for things, ‘coz they feel like they know everything, they Google their symptoms. “Oh I have this, I have that...””
<i>Convenient Testing Option:</i> “It could just be an issue of time management, like sometimes you have different appointments that you need to get to, and you keep putting off going to the doctors [for HIV test] because you have a WIC appointment. It would be better if you get it done here. If you get it done here and you go home and tell your partner, during your next WIC appointment, you could possibly bring your partner in with you and they can get tested too. It would just be better and more comfortable. Basically more convenient.”
<i>Woman-Centered Approach:</i> “It would be helpful because it would encourage a lot of females to know about their body. For example, if I say I know they have testing [at WIC] I feel better. I can go to see if I have this [HIV]. It’s for females who want to take care of themselves better.”
<i>Knowing One’s Status to Take Care of Self and Others:</i> “By knowing [one’s status] you might be able to help somebody else, like the person who gave it to you. You can notify them so they can do better for themselves and make it a chain reaction... I think it’s better to know because you aren’t going to spread it around”
<i>Barriers</i>
<i>Confidentiality concerns:</i> “People are hesitant because it’s so many people working here, they might feel their information may get passed around...I think it’s a matter of everyone knows someone, so they don’t know if everyone in this office will keep their information confidential. They might tell someone that they know and eventually their information may get out there so there was no point in you saying it was confidential if it was going to get out anyway.”
<i>Psychological impediments:</i> “I think a lot of people find it easier to not know and they are so terrified of getting ‘You’re positive,’ so they’d rather walk around ignorant.”
<i>Low perceived risk (‘It’s not me, it’s them’):</i> Moderator: So do you think young mothers your age are at risk for HIV? Participant 3: I think the age from 13+ are at risk. Because a lot of girls are out here and they’ll lose it (virginity) and then they’ll say “Oh no, I have it!”[HIV] Then they blame the boy and the boy blames the girl. I think very young females are especially at riskm Participant 1: Most young people don’t want to get tested. That’s the real thing. At the age of 18 they don’t want to get tested.” And “Yeah, my cousin has it [HIV]. But he’s a guy AND he’s gay. That is the stereotype that I have - that it’s gay men. That’s just what I have in my mind.”
<i>Intimate Partner Violence</i>
<i>When talking about things going on at home that may be a barrier for HCT at WIC:</i> “they could be being abused, not physically, but maybe mentally or verbally, or emotionally”
<i>Re being able to talk about HIV in an abusive relationship:</i> “You might not be able to; it depends on how they are abusing you”
<i>Re scenario about asking a partner to get tested for HIV and how partner would react:</i> “He could snap out, he could be abusive, snapping out meaning he could just yell and scream and be upset on his own. Or he could be abusive.”
<i>Scenario where woman is trying to talk to abusive partner about getting tested for HIV:</i> “I think if it was that type of relationship, then Tasha wouldn’t even say “let’s get tested” she would be a little afraid to speak up for herself.”
<i>Probing about barriers to talking to partner about HIV status:</i> “if you’re in an abusive situation, I think it’ll be harder to ask them any type of question, because you’ll be scared most of the time”
<i>Partner Drug Use</i>
<i>Scenario where woman tries to talk to male partner, who used to inject drugs, about going to get HIV tested and partner may “snap out” at her:</i> “But then, if you look at it this way, it might not be him snapping out. You don’t know what he’s using, he could be using a drug that cause him to snap out anytime he say something”
<i>Re talking about HIV results with a partner who abuses substances:</i> “...alcoholics tend to be aggressive, and violent and verbally and physically abusive, so if he’s not sober then its harder to even mention anything”
<i>Areas of Ambiguity</i>
<i>Compartmentalization versus Expansion of services:</i> “If you are testing for HIV you should test for everything else too. That’s basically telling me that I have somewhere to go to get tested for HIV but I have to go all the way across town to get tested for other STIs. So I think if you’re going to do testing, you should do it all in one spot, make it convenient for everyone.” <i>versus</i>

Author Manuscript	<i>Facilitators</i>
	“If you put it like that [having multiple tests offered at WIC] you really wouldn’t be making it a program. You kind of making it like a doctor’s office. Because you go to a doctor’s office for all of these things.”
	<i>Encouraging male participation versus Having a program for women:</i> “...Don’t just invite the women, invite the men too. If you just invite the women, you’re not giving men the opportunity to say they want to do it...or you’re not making them feel comfortable.” <i>versus</i> “...[in] situations where you are in an abusive relationship you don’t have to fight to go to the WIC office, because you have to take your child with you. So it’s easier for them [women] to get tested here.”
	<i>Ensuring privacy versus Inviting stigmatization:</i> “Well not that I disagree, but I think some women will be reluctant to come and get HIV tested unless it’s somewhere very discreet. Because when you come here you see all the \women in the waiting room and everyone comes up to the counter or sees the nutritionist or go in the back to get their iron [supplements] and weight [checked]. But then if women know there is a HIV testing on site and if they are going in that direction and they might feel like they don’t want anyone to know anyone that they may be at risk or have it.”