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Communication between Middle SES Black Women and Healthcare Providers about HIV Testing

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Abstract

Purpose: This article explores the impact of patient and healthcare provider communication (PPC) on the HIV testing behaviors of middle socioeconomic status (SES) Black women in North Carolina. We explore how PPC about STIs and HIV (or the lack thereof) affects the provision of STI/HIV testing by either confirming the need for middle SES Black women to test routinely or potentially deterring women from feeling they need to be tested.

Methods/Findings: After conducting 15 qualitative interviews with middle SES Black women between 25 and 45 years of age, we uncovered the role of patient self-advocacy in promoting HIV testing among middle SES Black women when they communicate with their healthcare providers.

Conclusions: We discuss the importance of healthcare providers engaging their middle SES Black female patients in routine discussions about sexual health and sexual risk reduction, regardless of providers' perceptions of their potential STI/HIV risk. We recommend including SES as a variable in data collection and research in order to better understand how social class, race, and gender affect sexual health behavior and the provision of STI and HIV/AIDS prevention to diverse populations.

Keywords

Black women; middle SES; Patient Provider Communication; HIV Testing; Sexual Health

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1. Introduction

The Centers for Disease Control and Prevention (CDC) recommends voluntary routine HIV testing of all patients ages 13 to 64 as part of standard medical care in healthcare settings¹. In 2012, the CDC reported that 31% of adult Black people had never been tested and more than 70% reported not being offered an HIV test by their healthcare provider². For Black women, the issue of testing is particularly critical given the racial disparities in rates of HIV infection among women. In 2010, Black women accounted for 64% of HIV cases among women, such that the rate of HIV infection in the United States was 40.0 per 100,000 among Black women compared to 2.0 per 100,000 among White women^{3,4}. As recognizable as the racial and gender HIV disparity is there is currently very little literature that examines HIV incidence and prevalence by SES within racial and gender groups. Particularly, the experiences of middle SES Black women have been largely overlooked in HIV/AIDS surveillance data as well as in HIV research and prevention efforts. Instead, most of the literature on HIV prevention and testing among Black women examines women of low SES⁵⁻⁷. Given the growing emphasis on routine HIV testing, it is important and timely to expand the focus of research to ascertain the HIV testing and prevention behaviors and needs of the Black community as they relate to gender and SES.

2. Methods

2.1 Data Collection

Data was collected as part of a qualitative study titled *Sister Circle: Black Women Talking about Health, Sexual, and Relationship Experiences*. This study examined HIV testing behavior and perceived and actual HIV risk among middle SES Black women in North Carolina. In this study we used income and education, as well as occupation, to define middle SES and also included these variables as inclusion criteria. We included both income and education to represent middle SES because they are the most common variables used in U.S. studies that examine SES^{8,9}. In addition, they have been found to have correlations too weak to consider them as proxies for one another⁸. We also included these variables since the relationship between education and income often varies by race, sex, and age⁸. Occupation was collected in the demographic data tool for this study to better understand the prestige, skills, social influence, and power of the research participants^{8,9}. While occupation is a dimension of SES that is not usually measured in U.S. studies, it is common in research conducted in most western European countries⁸.

For the purposes of this study, middle SES was defined as a minimum income of \$26,000 -- the 2000 US Census median income for women in North Carolina¹⁰. Black women between the ages of 25 and 45 who lived and/or worked in three adjacent counties in North Carolina were targeted for recruitment. Black women included those of African descent born in the United States, the Caribbean, Latin America, Africa, or in other parts of the world. Research participants were recruited through flyers, at community health fairs, through community organizations, by word of mouth, as well as through email and social media. To be eligible for the study, the women had to meet the following criteria: be unmarried at the time of recruitment; self-identify as a Black woman; self-identify as heterosexual; have had a sexual

relationship with a Black man within the past year; have completed college or a professional degree; and earn a minimum of \$26,000 annually.

Semi-structured interviews were conducted in local community centers, libraries, and other locations, such as business offices. Interviews typically lasted 60 to 90 minutes. Each participant received a \$50 incentive for their time and participation. The interviews were digitally recorded, professionally transcribed, and verified for accuracy by the research assistants. Two research assistants -- a doctoral student and master's level professional in the field of social behavioral research -- conducted the interviews. Both research assistants were Black women who resided and worked in the target counties and had experience with qualitative research. This study was approved by the Institutional Review Board of the University of North Carolina at Chapel Hill.

2.2 Analysis

The interview transcripts and audio recordings were uploaded into QSR NVivo 9.0 in order to analyze issues and topics that arose related to the research question: "Where do middle SES Black women get messages about HIV prevention and testing?" The other two research questions addressed in the study were: (1) "How do middle SES Black women's perceptions of HIV risk influence their sexual behavior, use of HIV prevention methods, and frequency of HIV testing?" and; (2) "How are sex ratios, sexual networks, and overlapping sexual partnerships in Black communities associated with middle SES Black women's HIV risk?" Only the first research question will be addressed in this article.

The analysis process involved focusing on codes and making notations related to participant discussions of HIV testing and patient provider communication (PPC). The HIV testing codes of interest addressed themes such as women's HIV testing behavior and attitudes, their exposure and vulnerability to sexually transmitted infections (STIs) and HIV, and location and type of healthcare provider who conducted an HIV test. The analysis process included creating memos and coding questions, probes, and responses that addressed PPC practices related to each participant's experience in seeking out, discussing, and/or acquiring an HIV test from a healthcare provider. Codes included deductive themes based on the research question, study aims, and the interview guide questions. Inductive codes were also developed in response to narrative themes brought up by the research participants. After all interviews were coded, narrative excerpts were entered into two spreadsheets. One spreadsheet focused on codes about HIV testing and the other on codes about PPC. These spreadsheets were used to further analyze the content of the interviews, in order to better understand each respondent's experience and to examine potential differences and similarities among them.

3. Theory

3.1 HIV Testing & HIV Incidence

The measurement of HIV incidence is dependent on the reporting of HIV diagnosis, which is also dependent on HIV testing rates¹¹. In order for the estimates of HIV incidence to be accurate, HIV testing must be performed as recommended by CDC. The routine nature of

these recommendations allows HIV incidence estimates to be calculated in consideration of the date of first HIV antibody positive test, date of most recent HIV antibody negative test, and number of negative HIV tests in the two years before testing positive¹¹.

3.2 HIV Testing Recommendations

CDC recommends routine testing not only to improve HIV incidence estimates, but also to increase early detection that allows for treatment and thus reduces the risk of spreading the virus¹². In order to effectively implement this recommendation as routine standard medical care in all healthcare settings the Institute of Medicine (IOM) has also recommended strategies to improve access, increase facilitators, and minimize barriers to testing by training healthcare providers to perform HIV/AIDS education and conduct HIV screening with their patients¹³. These recommendations are critically important to the health of both racial/ethnic, sexual minorities, and injection drug users, due to the fact that 95% of all HIV infections occur in individuals in one or more of these groups¹¹.

3.3 Missed Opportunities for HIV Testing

Despite the CDC and IOM recommendations a significant number of testing opportunities are missed within the health sector^{2,14,15}. Research by Lyons et al.¹⁶ estimates that approximately 25% of HIV infected persons in the US do not know their status and their transmission risk behavior was believed to account for approximately 54% of HIV incidence, indicating that increasing universal routine testing was imperative to implement.

3.4 HIV in the Southern United States

HIV/AIDS prevalence is especially high in the southern region of the US. Between 2008 and 2011, the southern United States had the highest rates of HIV incidence (20.9 per 100,000) and AIDS diagnosis (13.7 per 100,000)¹⁷. The Southern HIV/AIDS Strategy Initiative (2012) reported that eight southern states, including North Carolina, were among those with the highest number of HIV diagnoses in the country. Based on an examination of the CDC's HIV/AIDS Surveillance Report for 2011, ¹⁸ found that the state of Louisiana had the highest HIV incidence rate of 30.2 per 100,000 in the Southern Region, which was well above the National HIV incidence rate of 15.8 per 100,000. In addition, Tennessee was the state with the lowest incidence in the South, 14.5 per 100,000, which fell only slightly below the national incidence rate¹⁸. The same report also found that North Carolina's 2011 HIV incidence rate was 17.3 per 100,000¹⁸. The North Carolina Department of Health and Human Services has reported that HIV diagnoses among non-Hispanic Blacks were more than nine times greater than those for non-Hispanic Whites in 2009 ¹⁹. The largest disparities in new HIV cases were found among non-Hispanic Black women, which were 14 times higher than that for non-Hispanic White women ¹⁹. These trends point to an HIV/AIDS crisis in the Southern U.S. and African American women in North Carolina, with strong implications for how African Americans receive HIV testing.

3.5 Patient Provider Communication: Implications for HIV Testing and Socioeconomic Status

This article explores the impact of patient and healthcare provider communication (PPC) on the HIV testing behaviors of middle socioeconomic status (SES) Black women in North Carolina. We examine the HIV testing experiences of middle class Black women in order to understand how health behaviors within the Black community related to HIV prevention might differ by SES^{9,20}. While a good deal of research and surveillance data has highlighted racial disparities in HIV/AIDS rates, potential differences in HIV testing behaviors within the Black community have not been examined in relation to SES. Kawachi et al. also reports that correlation between race and health disparities are thought to be partly explained by SES²⁰. Because most HIV prevention studies have focused on low-income Black people and the social and structural factors that increase their HIV vulnerability, knowledge about HIV risk and/or testing practices by SES within the Black community is lacking^{5-7,21-24}.

We explore how PPC about STIs and HIV (or the lack thereof) affects the provision of STI/HIV testing by either confirming the need for middle SES Black women to test routinely or potentially deterring women from feeling they need to be tested. We discuss STIs as well as HIV/AIDS since HIV is an STI and diagnosis of an STI increases HIV transmission vulnerability²⁵.

4. Results and Discussion

4.1 Sample

Fifteen women participated in semi-structured interviews. Their mean age was 34.7 years (range 26-45). Their occupations ranged broadly and included law enforcement officers, educators, counselors, graduate students, and human resources managers.

4.2. HIV Testing

All of the research participants had been tested for HIV, which was not a requirement for study participation and is therefore a noteworthy finding. Although all of the participants had been tested for HIV, there was variation in frequency of HIV testing, as well as in the places and providers the women went to for HIV testing. There were generally four categories of HIV testing frequency that women in our study fell into: annual testers (n=9), relationship status dependent testers (e.g. starting or ending a relationship n=3), infrequent testers (tested less than five times in their lives n=2), and diligent testers (getting tested every three to six months n=1). Testing sites varied among the participants (see Table 1). Some women (n=5) were tested at multiple healthcare facilities and providers based on convenience, confidentiality, and privacy. Others were tested routinely by a healthcare provider (n=10) with whom they had an established relationship. Women in this category commonly reported utilizing their Obstetrician/Gynecologists (n=5) for HIV testing services.

4.3. Analysis

The majority of participants in our study expressed that only in rare cases were HIV and other STI discussions initiated by healthcare providers, usually the women had to bring these

issues up in their interactions with healthcare providers. Participants noted how their providers usually chose to focus on reproductive health in their communication and interaction with patients, during medical exams. For those participants in our study who reported that their providers initiated communication with them about STI/HIV, it generally centered on testing that was a part of their annual exams. There were a few women who actually never engaged in discussing STI/HIV with their doctor at all. These women just got the test and results and didn't ask or receive any additional information about why the test was important, how to keep themselves safe, or what their personal risks were that might necessitate behavior change. Participants also discussed how they thought their SES influenced their interaction with their provider related to HIV testing. Finally, research participants discussed ways in which they advocated for themselves to get the STI and HIV testing services they needed.

4.3.1 Lack of provider engagement with STIs/HIV.—Most research participants said they communicated with their healthcare providers about HIV and other STIs during regular health exams. Research participants discussed their doctors' preferences to center discussions around their reproductive health and planning, but not in a way that would directly protect them from STIs and HIV specifically (i.e. providing a recommendation to get tested for HIV). Some said their HIV and STI PPC was patient initiated and commonly occurred when they requested an STI and/or HIV test, which provided an opportunity for the healthcare provider to perform a risk assessment and inquire about the patients' specific sexual behaviors that influenced the request. Other participants described vagueness from their providers when it came to discussing HIV and other STIs.

One participant discussed her belief that HIV/AIDS is an important issue for the Black community in general and for Black women specifically; however, she felt that this concern was not taken seriously by most people, including some healthcare providers. When asked where she got most of her information about HIV/AIDS, she said mostly from community organizations, but generally not from her doctor. She went on to describe these encounters with her healthcare provider:

I: So does your doctor or other medical professional usually discuss HIV or STIs with you?

R: Not that much, I haven't really had a regular doctor either, but usually, especially recently, it has been more like okay, "Here is a pamphlet," especially after having a baby. "Well what kind of birth control do you use?" But not really HIV or STDs. ~
Age 34, tested four times in life

For some participants, passive communication by health professionals (in the form of referring patients to pamphlets) and refocusing the discussion on reproductive health, became a characteristic of what they came to expect from their providers. Participants believed that their providers were more concerned about seeing as many patients as possible and giving quick answers to their questions than providing sexual health education or information about sexual risk reduction. One participant, age 31, noticed how the local health department relied on written materials as a way for patients to educate themselves about STIs, including HIV. This participant relied on the internet for sexual health education

as opposed to her healthcare provider. In addition, she did not speak to her doctor about risk reduction, but instead used health educators from the county health department as a resource to learn about risk reduction.

Some participants commented on their providers' failure to perform HIV risk assessments or provide sexual risk reduction education. They also discussed how they wished their providers did more to encourage healthy sexual behavior and STI/HIV prevention. Because most research participants tended to rely on resources other than their primary healthcare provider to answer questions or address their concerns about sexual health, they did not seem to have ongoing communication with their healthcare providers about specific sexual health risks they might have been facing. It was not until these women were faced with the threat or diagnosis of an STI that their providers took the time to fully explain their specific risks and what they could do to protect themselves and their partners. In one case, although a research participant was tested annually, it was not until she told her provider that her partner was living with herpes that her provider engaged her in communication about STI prevention and risk reduction. This example suggests that healthcare providers might not be operating proactively to prevent HIV or other STIs among this patient population.

4.3.2 Socioeconomic status and HIV testing.—With the common effects of SES on health disparities in mind our analysis explored the potential link between the class-specific experiences of middle SES Black women and PPC regarding HIV testing. In a few cases, participants shared their suspicions of how their SES affected their healthcare providers' perceptions of their sexual risk factors and their sexual health knowledge. One participant shared a unique insight about how she felt her provider neglected to go into an in-depth discussion with her about STI/HIV prevention and risk, potentially because of her provider's belief that she was at low risk based on her socioeconomic status.

I: So does your doctor or other medical professional usually talk about HIV or STI's during your appointments?

R: He has mentioned it and like "are you having safe sex?" But he hasn't said, "Be careful for AIDS." I think it is that whole... to be honest, I think it is that whole middle class Black woman thing, he sees me as that. He doesn't see me as... I think there is a lot of prejudice and I can say so for myself; you do not believe that middle class people have the same risk in that it is dangerous. I have a friend who has a friend who has AIDS and she talks about, she is middle class, comes from a great family and she contracted it from a man when she was in college. So I think... I am 100% sure my doctor doesn't talk to me about it as much because he doesn't view me as at risk and I know that statistically that isn't what the numbers say. ~

Age 33, Partner/relationship contingent tester

This participant describes how she thinks providers treat middle SES Black women differently from lower SES Black women in terms of STI/HIV prevention, education, and testing. Because of her SES, this participant believed she was not perceived as potentially living with or being at risk of contracting HIV. She also notes that statistics and reports regarding HIV have potentially created assumptions among providers that women of low SES are primarily living with HIV/AIDS, which might explain why providers are not

probing or providing much information to their middle SES patients about HIV prevention risk reduction.

The participant further discussed how her doctor did not provide her with any direct information or resources about using condoms as a means of preventing any future exposure to HIV and other STIs. Instead, her doctor only stated that he hoped she was using condoms in her sexual encounters. To determine the participants' current STI/HIV status the doctor provided testing, but no other sexual health prevention strategies for her to remain healthy. When asked about how healthcare providers respond to her when she asks about STIs or HIV she shared her perception of the dynamics that occur because of her being middle SES.

I: So how do medical professionals usually respond if you ask them questions about HIV or other STIs?

R: They respond great to me and I am not afraid to ask about anything. I do not hide stuff from my doctor. I think one time he asked me how many partners I had and I was like three and he was like "three" ... and that was when he was like "you need to be careful." I have that kind of relationship with him. I honestly think, again, it is the middle class effect. Because I ask in a certain way that professionals respond to me in a certain way. And I think a lot of assumptions are made when you are 'lower class'. So I think sometimes you are told more information and then sometimes you are not told enough information. So yeah, they respond well to me.

~ Age 33, Partner/relationship contingent tester

This participant continues the discussion and suggests that her provider should tailor the conversation to her as a middle SES Black woman. She also stated that her provider could challenge her more with relevant STI and HIV statistics and discuss what monogamy is and how it works or does not work to keep her safe sexually in her relationships. This means that this middle SES woman is open to having more communication with her provider about her sexual health and values the expertise of her provider when it comes to maintaining her sexual health and preventing the acquisition of HIV.

4.3.3 HIV testing self-advocacy.—The fact that all of the study participants had been tested for HIV was noteworthy and raised the question: "What did it take for these women to go against the trend of not being tested for HIV?" Most participants advocated for their HIV testing by initiating the discussion with their providers. Many participants clearly expressed with determination to their doctors that they wanted to be tested for HIV. Some respondents described instances when providers did what was asked of them and performed an HIV test, but seemed very reluctant to comply with their patient's request.

One participant stated that medical providers generally did not talk with her about STI or HIV prevention and education. Below, this participant shares an encounter she had with a healthcare provider where she self-advocated for an STI test despite her provider's hesitation:

I don't know what I was reading that said syphilis was making a comeback and I went in [to the healthcare clinic] and asked her [the healthcare provider]. I said, "Can you check for syphilis?" ... and then, even then, she was like, "You don't

have syphilis”. [Participant replies] “Do you know what a syphilis chancre looks like? So, why are you telling me I don’t have it? Could you please just do the blood test for syphilis?” But, I didn’t have it, but you know, it was like, she almost didn’t want to hear me asking about syphilis. ~ Age 39, Annual Tester

Although this interview excerpt discusses syphilis, the respondent is expressing the challenges of obtaining STI testing, and the persistence and determination she demonstrated to her provider who was resistant to her request. In this case, the participant felt that her doctor was trying to talk her out of being tested for syphilis, because the provider’s knowledge or perceptions led her to believe her patient probably did not have the infection. Nonetheless, the participant discussed how important it was to be provided the test, so she could be certain that what she thought could have been a chancre was not syphilis. This participant felt her provider was not comfortable with or open to discussing syphilis. She also stated that the encounter was scary because of the provider’s response. This negative interaction could have created a future barrier when the participant needed to request or receive routine comprehensive sexual healthcare, particularly an HIV test. The same participant went on to state that other healthcare providers who are more compliant with her requests seem to be very nonchalant and do not go any further than checking a box on a lab request sheet. Below she discusses the importance of self-advocacy and the role of providers in helping those who do not have the knowledge or courage to self-advocate.

*R: I mean, literally, we had to sit and have a conversation about her doing a syphilis test, when all it is, is check off another box on the lab requisition. And then, she’s, “You don’t have it. You don’t have to worry about that.” You don’t know that.

*I: Right.

*R: If I don’t know, you don’t. So you know...It’s like, I think they kind of, think, leave it up to your gynecologist, maybe. I don’t know.

*I: Right.

*R: But, um... they don’t... they’re just pretty nonchalant about it.

*I: How do you feel about that?

*R: Um... I’m not... it doesn’t really bother me, because um... I know how to ask for it. If I don’t get what I want from you, then there’s another doctor who will take my twenty-five dollar co-pay and do what I ask them to do. But, I feel bad for somebody, who that might be an issue for and they don’t want to ask, and it should be up to them, the doctor, to um... try to open that conversation with that person. ~ Age 39, Annual Tester

The participant expressed her belief that women who are not assertive about their sexual health needs to their provider might not receive the information about STIs or HIV testing that is necessary to keep them healthy. Other participants made similar observations and stated that once doctors were made aware of their patients’ needs, most were open and responsive in complying with their requests for an HIV test. Missed opportunities for STI and HIV testing sometimes occurs when doctors are not willing or able to create a climate

that is conducive to opening or sustaining the conversation about sexual health related to routine STI and HIV testing during routine medical visits (i.e. patient-centered care), thus making some patients feel uncomfortable advocating for this service to their healthcare provider^{26,27}.

4.4. Discussion

By focusing on middle SES Black women, this study provides new insights about a sub-population that is important but often overlooked in the fight against HIV/AIDS. One key finding from this analysis is that all of the women in our sample had been tested for HIV in the past. This finding is one that has been confirmed by previous research, including Rountree, Chen, Brown, & Pomeroy's analysis of the 2005 Behavioral Risk Factor Surveillance Survey (BRFSS), which found that African Americans with college or technical school degrees were more likely to have had an HIV test (OR = 1.38; CI = 1.10, 1.74)²⁸. Also Onyeabor, Iriemenam, Adekeye, & Rachel analyzed data from the National Health Interview Survey (NHIS) of 2008 and found that African Americans with higher levels of education (including High school graduate up to college/professional degrees) were more likely to report that they had been tested for HIV¹². It is also possible that the recruitment strategies for *Sister Circle: Black Women Talking about Health, Sexual, and Relationship Experiences* unintentionally biased our sample to attract women who were high consumers of healthcare, and thus more likely to be tested for HIV. What also may be important to consider for future investigation is the potential connection between HIV testing behaviors and the period effects of living through the height of the HIV epidemic, considering most of the women in this study sample were between 3 and 16 years old when the epidemic began around 1981²⁹.

Another key finding is that only half of the women in our study were getting their HIV testing done routinely by a personal physician, because some women did not have a personal physician to go to for routine healthcare, and others chose alternative providers specifically for their HIV testing. Also the frequency that women in our study got tested for HIV varied greatly. Utilizing the 2005 BRFSS, Rountree, Chen, Brown, & Pomeroy found that 41% of African Americans were likely to be tested for HIV at a private doctor's office or by an HMO facility²⁸. This study by Rountree et al. also found that unmarried African American women preferred these testing locations²⁸. The Rountree et al. findings²⁸ are similar to our study sample, due to almost half of the women in our sample visiting either their obstetrician/gynecologist (5 out of 15) or primary care provider (2 out of 15) for HIV testing. Mayberry, Mili, & Ofili, as well as Onyeabor et al. discovered a similar phenomenon that African Americans are less likely than Whites to have a primary care provider or to make routine visits for clinical and preventive care^{12,30}. This finding is particularly troublesome, because the lack of an on-going clinical relationship with a primary care physician minimizes the chance for a healthcare provider to know their patients well enough to provide high quality, patient-centered care, and perform routine HIV testing²⁷.

Another key finding of our study is that even though all of the women had been tested, their health care providers rarely encouraged discussion of HIV risk, prevention, or testing. Thus, the middle SES Black women we interviewed often had to engage in patient self-advocacy

to acquire information or health care assistance in these areas. Onyeabor et al. also reports that while most HIV testing occurs in doctors' offices, personal request is the strongest predictor of HIV testing in a clinical settings¹². In addition, research by LaVine, Morris, Holliday, & Martinez underscores a major problem with regard to HIV testing, since providers may inaccurately assume that patients are unwilling to be tested and as a result do not offer HIV tests as recommended³¹. White et al. recommends that physicians should be educated about this common problem to enhance adherence to HIV testing recommendations, allowing patients the opportunity to opt-out, versus relying on patient requests to drive their HIV testing practices³². Research by Zetola et al. supports this recommendation and found that implementing opt-out HIV testing in clinical practice increases HIV testing by 44%³³.

In our study, the theme of patient self-advocacy emerged as a key approach to understanding our research participants' communication with their health care providers regarding HIV prevention and testing. In our research we also found that women were more likely to discuss STIs other than HIV than they were HIV. It is possible that patient self-advocacy was important for the women in our study because they did not fit the "traditional" profile of a woman who is at-risk for becoming infected with an STI, and especially not HIV, due to their education, income, and occupations (SES). Findings from our study indicate that SES may play an important role in shaping health care providers' perceptions of which women are vulnerable to HIV infection, with Black women of middle SES being viewed as at lower risk. Another qualitative study by Schwartz et al. also had similar findings suggesting that healthcare providers failed to test patients that later turned out to be HIV positive due to patients not fitting the traditional risk profiles or because patients didn't discuss their risk behaviors with their healthcare provider²⁶. Even when these patients were symptomatic their primary care physicians referred them for testing or to specialists to inquire about the etiology of their symptoms, but neglected to provide an HIV test with their patient²⁶. As documented in a CDC 2011 Morbidity Mortality Weekly Report (MMWR), patients who are unaware of their HIV status as well as failure to provide routine HIV testing within healthcare practices are influencing the rise in HIV prevalence within the Black community⁴.

Based on our respondents' experiences, we have proposed a model that may explain communication between middle SES Black women and their providers regarding HIV risk, prevention, and testing (Figure 1). Our model illustrates two possible paths that patient self-advocates consider when disclosing threats of and exposure to STI/HIV infection. The first pathway begins with a patient self-advocate having expectations of minimal communication initiated by their provider based on past experiences. These past experiences are specific to previous efforts to communicate with a medical provider about STI/HIV threats and exposure or efforts to communicate with medical providers in general. These past experiences then lead a patient self-advocate to set the tone in the patient provider dyad by initiating communication with their healthcare provider about their sexual health in order to encourage routine communication. Once routine communication has been established, patient self-advocates can feel comfortable or empowered to disclose any sexual health threats or exposures with their providers. This includes disclosing their participation in a lifestyle where they have concurrent sexual partners or relationships in which both partners

do not mutually value monogamy. The second pathway also begins with a patient self-advocate having expectations of minimal communication initiated by their provider, but some patient self-advocates then become self-determined in seeking alternate sources of sexual health information. With this information in hand, the patient self-advocate feels empowered to have specific and targeted communication about sexual health threats or exposures they may experience with their healthcare provider.

Our findings point to missed opportunities for providers to address HIV stigma, correct their patients' misperceptions about HIV, and assist them in improving their efforts to remain healthy. The experiences of our study participants suggest that the focus on women's reproductive health in healthcare settings tends to draw attention away from sexual health. When providers fail to bring up issues of sexual health and risk reduction, the onus is placed on the patient to voice a concern or question. Considering the alarming trends in STIs and HIV incidence, particularly in the southern United States, healthcare providers must be willing and able to be informed sexual health experts for their patients and learn how to engage their patients in routine discussions about sexual health and sexual risk reduction in ways that are accurate, respectful and culturally appropriate³⁴. This means that they must avail themselves of the IOM call to train healthcare providers to perform HIV/AIDS education and conduct HIV screening with their patients¹³.

Because most risk profiles for HIV prevention and risk reduction programs are based on data from women with less income and education than the women in our sample, it is possible that their providers had a hard time making a connection between that data and the middle SES Black women that they see. It is also possible that the middle SES Black women in our study sample had a harder time associating themselves with the group of women typically identified as being high risk for contracting HIV. All of these assumptions have the potential to discourage consistent HIV/AIDS prevention education, testing, and risk reduction counseling in the patient provider dyad.

This study offers insights into the experiences of an understudied and important population of women who are potentially at risk for HIV, particularly given the high rates of HIV incidence and prevalence in the Black community. However, this analysis does have some limitations. The major limitation is that the study is qualitative in nature and uses a small sample of women that is not representative of the target population. Another limitation of this study is that the study's original research questions did not focus explicitly on the relationship between PPC and HIV testing. However, because the research questions explored where women received messages about HIV, the theme of PPC emerged from the interview data. The third limitation of this study is the use of the 2000 US Census median income for women in North Carolina as the definition for middle income for Black women. Because income is known to be stratified differently within racial/ethnic groups, the overall median income for all women is likely higher than the median income for Black women^{8,35}. Unfortunately the 2000 US Census did not report women's income in North Carolina by race, so we chose to use the standard median income for all women to define middle SES for Black women in our sample. Another limitation of this study is that patient self-advocacy was not one of the original research foci, so we did not probe on this topic to uncover what was at the root of how and why these women self-advocate or under what conditions they

first developed this type of communication with their providers. Finally, because interviews were not conducted with providers, they were not asked for their perspective on any part of their clinical relationships with their patients and how they perceive their patients' STI/HIV risk.

5. Implications for Research and Practice

Research should look at the role of insurance in provider HIV testing rates, in light of the Affordable Care Act mandating coverage of preventive services^{36,37}. Future research should also expand the examination of PPC and HIV testing by both SES and gender within the Black community. Exploring what types of PPC practices influence effective STI/HIV testing would be helpful in building a larger intervention study of women and their health care providers, to test strategies that can improve routine STI/HIV testing, counseling, and education among middle SES Black women. Finally, it is important for providers to understand that all individuals, regardless of SES, are potentially vulnerable to HIV infection. To eliminate disparities in healthcare and treatment, Burgess, Fu, & Van Ryn, recommend interventions that assist providers in overcoming unintentional provider bias and structures that impede patient centered healthcare³⁸. These recommendations could improve PPC that women like our participants obtain during routine STI/HIV testing.

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Figure 1:
Features of Patient Self-Advocate Communication

Table 1:

Demographic Data (n=15)

Convenient (Multiple) Provider	5
Obstetrician/Gynecologist	5
Primary Care Provider	2
Community Based Organization	2
Health Department	1