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What High Risk Women are Telling Us about
Access to Primary and Reproductive Health Care and
HIV Prevention Services

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Abstract

Focus group discussions on barriers to health care and attitudes toward family planning, reproductive health services, and condom use were conducted with 63 women at high risk for HIV due to their own injection drug use, sex with injection drug users, sex industry work, or a history of multiple sexually transmitted diseases. Barriers identified include: the high cost of health care, perceived poor quality of care and experiences of discrimination and stigmatization, geographic accessibility, fear of legal/social services punitive actions, misperceptions about the efficacy of birth control methods and condom usage, lack of sterilization services, and lack of male involvement. Where possible, findings from the focus groups are supported with quantitative survey data from sample of high risk women (n=723). Recommendations are made for improving care for high risk women.

Keywords: high risk women, access to health care, HIV prevention, focus groups, injection drug use.

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Women now account for 20% of total reported AIDS cases in the United States , an increase from 14% in 1992 (Centers for Disease Control and Prevention (CDC), Feb. 28, 1997). Heterosexual contact accounted for 38% of all cases in 1997. Of these 29% were attributable to sex with injection drug users (IDUs) and 64% resulted from sex with HIV-infected partners.

Women of color and inner city poor women are being disproportionately affected by this epidemic. (Young & Tabnak, 1996). Sexual partners who are IDUs, low rates of condom usage (Wagstaff et al., 1995) and higher rates of infection with sexually transmitted diseases in inner cities populations (Aral & Holmes, 1991) increase their likelihood of contracting HIV (Wasserheit, 1992).

Prevention of HIV infection in women at high risk may be difficult since women who are sex partners of HIV-infected men and IDUs are difficult to identify and provide services to. Many of these women, especially those who exchange sex for money or drugs, are financially dependent on male partners and are at a disadvantage in negotiating condom use. In addition, high-risk women are often burdened by poverty, unemployment, substance abuse, alcoholism, violence, and unplanned pregnancies (Guinan & Leviton, 1995) and lack of health insurance (Fronstin, 1997).

Poor women, especially those from ethnic minority groups, experience decreased access to a regular health care provider (Reisinger, 1995), and increased use of emergency departments as a regular provider of primary care (Cohen, 1989). Rakowski, Rimer, & Bryant (1993) found that receiving usual care in a hospital clinic or emergency room was associated with less

screening for breast cancer. Low income women, in general, are less likely to receive breast cancer screening (Brown et al., 1995), more likely to die from breast cancer (Breen & Kessler, 1994; Wells & Horn, 1992), and are more likely to report not getting the care they need (Reisinger, 1995). Lack of health insurance has been found to be associated with receipt of fewer clinical preventative services, including pap smears, clinical breast exams, mammograms, and blood pressure screening (Breen, Parsons, Milcarek, Evans, & Brundage, 1996; Brown et al., 1995).

As the HIV epidemic is disproportionately affecting low-income minority women, the barriers to receiving other preventive health services are also likely to impact the provision of HIV prevention with this population.

In San Francisco county, the initial HIV prevention strategy was to offer HIV counseling and testing within the existing network of subsidized family planning clinics which had traditionally served low income, uninsured minority women. However, despite the wide availability of these services, many women at high risk did not utilize them for HIV prevention (Darney, Myhra, Atkinson, & Meier, 1989). HIV seroprevalence studies done at that time showed a seropositivity rate of 15-20% for injection drug using women, 4 % for women who exchanged sex for money or drugs, 2% for women seen in the county's sexually transmitted disease clinic, but only .03% in the family planning clinics (San Francisco Department of Public Health, 1990).

Prior to initiating a new CDC-funded perinatal HIV prevention project, a series of focus group discussions of barriers to health care were conducted. Focus group results were incorporated into a survey instrument administered as part of the recruitment process for the project clinics. A second survey was administered to enrolled women at the clinics.

The purpose of this paper is to identify barriers to care for women at high risk for HIV through analysis of both the qualitative data from the focus groups and the quantitative data from both the outreach and the clinic survey. A set of policy and program recommendations to improve the delivery of women's HIV prevention services, based on these analyses, is presented

Methods

Focus Groups

Target Population and Subject Recruitment. Flyers were distributed to drug treatment programs, social service agencies and health care provider agencies in target communities selected for high rates of drug use and sexually transmitted infections. Potential subjects were screened to ensure that participants were in the childbearing population and fit at least one of the following eligibility criteria: personal use of injection drugs, sex partner's use of injection drugs, personal sex industry work, or having a history of multiple sexually transmitted diseases.

A total of 63 women participated in 6 focus group discussions, with 6 to 13 women in each group. Participants received a stipend of \$40. Each participant filled out a brief questionnaire containing data on client demographics and individual risk factors.

Data Collection. The following questions formed the framework for focus group discussions: 1. What are your most pressing problems? 2. What good/bad experience(s) have you had with the health care system? 3. What are your attitudes toward birth control and family planning? What forms of birth control have you used and how important is family planning for you? 4. What has been your experience with HIV risk reduction and initiating safe sex practices? 5. How do you feel about community health outreach workers? What kind of person would you be comfortable talking to? What kind of services could that person offer that could help you?

Two hour group discussions were conducted in professionally designed focus group facilities. Refreshments were served and child-care provided. Sessions were taped and transcribed by professionals experienced in this technique.

Data Analysis. Verbatim responses from the focus groups was analyzed according to a method described by Zemle and Kramlinger (1985). The process consisted of generating a list of key ideas, words, phrases, and verbatim quotes and capturing sentiments. The ideas were used to formulate categories of concerns. Quotes and ideas were then placed in the most appropriate categories. This process was repeated by two other coders to verify categories and appropriate placement of quotes. The most useful quotes and illustrations of the various ideas were selected.

Quantitative Data

Target Population and Sampling. Community Health Outreach Workers (CHOWs) recruited women from five neighborhoods in San Francisco selected for their high rates of drug use, prostitution, and sexually transmitted diseases as indicated by San Francisco Public Health Department surveillance data. A total of 794 women met the following enrollment criteria: SF resident, age 16-44 years, able to get pregnant, not currently pregnant, and inconsistent or no use of birth control in the last year OR no reproductive health care services in the last year. Each subject also reported at least one of the following risk factors: 3 or more new sex partners in the last month; any injection drug use since 1978; infection with HIV; regular or compulsive use of crack cocaine; or sex with a male partner who is HIV+, has used injection drugs since 1978, or who has had sex with other men.

Data Collection and Instruments. CHOWs administered a 45-item survey to women recruited on the street. This outreach survey collected data on high-risk behaviors, knowledge of

HIV, and self-efficacy.

When these women came into the clinic and agreed to participate in our ongoing research study, they also completed an additional 166- item instrument developed collaboratively with the CDC, which was designed to measure the participants' knowledge, attitudes, beliefs and practices (KABP) concerning condoms, contraceptive use, and reproductive health care use. It also explored high-risk behaviors, social isolation and mental status. Women who had never seen a doctor for a "female" reason or whose questionnaires were missing data of reproductive health service use were excluded from analyses leaving 723 women in the analysis.

Quantitative Data Analysis. Data from both surveys was analyzed using SAS statistical software to obtain basic frequency data on variables of interest. Cochran-Mantel-Haenszel statistics were also used to compute odds ratios for categorical data using whether or not a woman reported going to the emergency room when sick as a grouping variable and examining how this related to negative experiences at last visit

Results

For a description of subjects, please refer to Table 1.

Financial Barriers Despite the availability of subsidized family planning , women still identified cost as a barrier to care. As one woman put it, "I got three kids. They all need things for school, and every time we think we're gonna maybe get back on our feet again, it's just....."

Many of these women indicated that they did not get medical treatment because they could not pay for it. In this particular area, having children is seen as an asset.

As one young, employed respondent pointed out, "I don't have no kids, so I don't have no welfare, which means I don't have no Medi-Cal... How is somebody who only makes \$150 a

week gonna pay the doctor bill without a Medi-Cal sticker?"

Although most respondents are aware of other ways to get free care, all consider it vastly inferior to Medi-Cal (California's Medicaid program), echoing the respondent who felt that, "as far as dental, psychiatric, stuff like that, if you don't have Medi-Cal, you're screwed."

Several respondents indicated that health benefits provided to pregnant women and mothers is a factor in some women's choosing to bear a child, noting that, "Some of them even have babies because they can't afford to have the abortion. [They] collect the money while they're pregnant, and give their children up. That's their intention from the beginning.. to give them up."

Only 29% of women responding to the Outreach Survey reported any form of medical insurance. Those with insurance coverage overwhelming have Medi-Cal.

Perceived Poor Quality of Care. Many drug-using women reported negative experiences with medical providers and only sought health care when they were so ill they had no choice. The women generally felt that medical personnel were hostile and did not take their problems seriously.

One woman stated:

I went in and was having real bad pains inside, in my stomach and in my cervix, and I couldn't walk... And when they seen tracks on my arms, doctors were saying... it's her imagination. She's on drugs. And then the female doctor came in and said no this is an emergency. My temperature was 105, and they found out I had disseminated gonorrhea.

That it went through my whole body, and they kept me in the hospital for a couple weeks.

Many women reported feeling pain and discomfort during vaginal exams because doctors used the wrong size speculum or conducted the exam in a rough or rushed fashion.

Most of the women agreed that care at publicly funded institutions was worse than in the private sector, especially treatment by students, interns or residents was inferior. One woman stated, "We get students instead of doctors even if we're seriously ill."

Others echoed these concerns:

... three or four different students come in, looking at you like you're some kind of experiment ... they keep you there about three hours, then finally here comes the real man telling you that we got to do a little research on that. And by that time you could be dead. I hate being told that, but young doctors especially, that he knows what's good for me. Doesn't even ask me what I would like, give me a choice. I know myself. I'm 44-years-old ...and he's some young whippersnapper that's working as an intern, telling me he knows what's good for me, because he's a doctor.

As one focus group respondent stated:

Mine...goes back to money. If you're poor, you're not going to have a family doctor. You get sick you go to emergency. There's no one-to-one relationship in the emergency room. It's more so the higher class you are going to have a family physician. And they're going to talk to this person just seeing them grow, you know. Being concerned, knowing them...

In the Outreach Study 97% of the women reported at least one negative experience at their last health care visit, with 53% reporting three or more bad experiences. Bad experiences include: long waiting times (83%), being seen by a student (35%), seeing a different person every time (73%), and providers not listening to their problems (41%). Nearly 33% reported that their providers did not show sincere concern, and 20% reported that their providers did not seem to care about them. Additionally, only 23% reported having a regular medical provider.

Outreach survey data also confirm that many high-risk women (52%) go to a hospital

emergency room (ER) when sick. Of these women (97%) reported that they had a bad experience at their last health care visits citing lack of privacy, discrimination, poorly educated medical staff and maltreatment as primary concerns. Those who reported going the ER when sick were 2.3 times more likely to have had a bad experience during their last visit ($p < .05$) (CI 1.3-4.2), and 1.6 times more likely to say that their providers were rude to them ($p < .05$) (CI 1.1 - 2.4) than women who go some place other than an ER when sick.

Perceived Experiences of Discrimination and Stigmatization. Many women in the focus groups felt that their social class or use of drugs was a basis for being treated differently from other patients. As one respondent stated: “and what happens is just that many women die, and middle class and upper class, of course they have the best treatment 'cause they can pay, ...”

Others reported that providers refused to provide care once they learned of their drug use: With the pregnancy of this baby I did not tell the doctor that I was a drug user. At the end, just before delivery, I told him that I'm on methadone... he dropped me from his caseload! ...He says, well, if you have the baby... we don't know anything about methadone and if we give you something it could jeopardize my position as a doctor. I said, what am I gonna do now about healthcare?

Many women reported feeling stigmatized by procedures that label or segregate them.

When I was pregnant with my last child, I was going to the hospital. Everybody else has a different kind of card. You have a red card. The minute you go in, you give it to the nurse. She knows that you're a dope addict, okay?

One respondent felt that the stigmatization extended to her baby:

And what made me very angry was after [name] was born... They kept her in a little isolated room away from the other babies like she had some kind of germ. First thing

they put [in the chart] is white female addict.

One woman summed up the experiences of many others when she said, "It is rare to find a doctor that looks upon addiction as a disease...you're just a weak person and a character flaw."

Women reported that providers often thought they were feigning illnesses to get drugs. They also reported that hospital personnel were afraid to leave them alone for fear they would steal things. Women who were afraid of having their blood drawn were told that they should be use to needle sticks because they "poke" themselves all the time.

Focus group respondents all suggested that health care providers needed to be better trained in order to meet the needs of a drug-using population. As one respondent articulated:

People who work with us have to be educated more about drugs and alcohol ... within family planning, people have to be educated about drugs and alcohol because it's a family disease... I think that they should have some first-hand experience at working, some kind of internship or something, so they're are not coming in with pre judgmental ideas and thinking that they have all the answers when they don't know what's going on.

Findings from the Outreach study again confirm that other high-risk women have had similar experiences. Nearly 26% reported that their providers acted like their sickness was their fault. This figure increases to 31% among women whose primary provider was an emergency department provider. A large proportion of women (30%) reported that their provider did not take them seriously when they found that they use drugs. Some women (14%) also reported that medical staff had talked about their illnesses, e.g., sexually transmitted infections, in a loud voice which could be overheard by others. Approximately 5% reported being refused medical treatment at their last visit because of their drug addiction.

Geographic Accessibility. All of the women in the focus groups expressed frustration

about finding the time and transportation to get to existing clinics. One woman said, "This is gonna sound silly, but, like up at Westside Projects, if they had a little family planning, right there in the projects ... that might make whole lot difference."

Another suggested:

Sooner or later that girl on Mission gonna get five minutes. She's gonna get five minutes to think and that person's gonna be there...sooner or later she's gonna slow down a bit and say, oh well, I can go to my appointment... I can get this right here.

Women also expressed a great amount of enthusiasm for street outreach workers who work in their neighborhoods and bring education, condoms and bleach with them:

We're pretty much all educated on AIDS and condoms, and we're not stupid. We're pretty smart for being drug users, and that's because of the outreach ... But if you had that person ... constantly getting familiar with the people and getting the confidence of the girls and all that, they'd begin to trust that person. They'd eventually begin to listen to that person.

Participants suggested that outreach workers be people from the community who could be there regularly delivering a consistent message and distributing bleach and condoms.

Fear of Legal/Social Service Punitive Actions. All of focus group participants had negative experiences in dealing with the legal system and the Department of Social Services. Many stated that fear of punitive action by these agencies kept them away from health care. This is especially true for mothers or pregnant women who fear losing their child(ren).

A lot of women don't go to doctors because if they find out that you're using they get CPS (Child Protective Service) on you instantly... They take all babies; they test every baby born in the hospital now, every baby. And if you have drugs in your system or the baby's system, they take your baby instantly...

Women suggested that guaranteeing protection from punitive action could increase use of health care. An example given was:

Like, more people used to die because they'd be scared the cops would come. Now that the cops don't come, less people die 'cause more people call 911. It's the same thing, I think more women, if they weren't so scared of losing their babies, or getting into trouble, more people would get health care.

Perceptions about the Efficacy of Birth Control Methods and Condom Usage. Women in the focus groups had a great deal of misinformation about contraceptive methods. Most were aware of the contraceptive methods, but had used them sporadically or not at all. The majority of women in the focus groups considered all methods to be failure-prone or even cause pregnancy. One woman said: "I have 2 children and both .. came from taking birth control pills."

Another respondent stated,

I've tried everything on the market as far as birth control ...Like, I've tried the diaphragm and that didn't work. I had my second son on that...And condoms, they always end up breaking. And pills, if you miss one or two, you've got a chance of getting pregnant again.

A number of respondents immediately equated the phrase "birth control" with "the pill" and were concerned about the health hazards. As one woman put it, "It's enough I use drugs."

Another respondent flatly stated, "They're not sure about birth control. They need to do a 20- or 50-year study on it, so we're being used as guinea pigs."

Women also reported receiving confusing information from providers.

I smoke cigarettes, and every time I go to the doctor and I say "Can I have birth controls," and they say, "Well do you smoke cigarettes," and I say, "Yes." They say, "Well, that's a

quick way to get breast cancer." And I always take them home and throw them away.

The participants did state that the fear of AIDS was having an impact, however. A number of them agreed with the woman who said, "When you say family planning, birth control, the first thing I think of is condoms and AIDS." Another respondent remarked: "I never was really big on birth control... I would use a birth control not to get AIDS."

In marked contrast to birth control knowledge, respondents were very well informed about HIV infection and credited this to the street outreach workers and the media.

Outreach survey data confirm that almost 47% of the respondents had used no method of birth control in the last year, 63% used no birth control at last intercourse, and 98% reported having had intercourse without birth control in the last year. Among women who did use birth control, condoms were the most frequently reported method. Similar to focus group finding, when asked about what methods of birth control they would want to use or not use, 86% indicated that they would use condoms, while 53% said they would not use birth control pills. Of those women who stated that they would not use birth control pills, the most frequently cited reason (68%) was that the pill is bad for your health or has bad side effects.

The majority of respondents to the outreach survey (67%) reported putting a lot of energy into preventing AIDS, most often by increasing the use of condoms. However, only 30% of the women survey reported using condoms during their last intercourse.

Lack of Access to Sterilization Services. The majority of women expressed great frustration at not having ready access to tubal ligation. One said, "I wanted to get my tubes tied, but the doctor wouldn't let me. He said, 'You're too young.'"

Another commented:

When I had mine done I had been pregnant about 7 times...and I had to go to the

psychiatrist just to get my tubes tied instead of 'Look, I'm 30 years old, my son is 15, and I'm a career person, you know.'

Lack of Male Involvement. Women expressed the concern that clinic services and educational programs that excluded men were not likely to be effective since the women could not change their behavior without the cooperation of their partners.

The following quotes give a flavor of the groups suggestions: "I tell you, it's got to start early. Try to get boys when they're in fifth grade and fourth grade. You don't wait until they're eighteen years old..."

I think you should be serving all this information up to the guys, 'cause they're the ones who are making the decision. It's like, you can give the information to young girls, but even if they're not on drugs they pretty much go with what the guy says.

One woman related an experience she had had with coed education program to illustrate the importance of male involvement:

... I wish you guys could have been at this demonstration. It was great. People (women) were walking out, they were embarrassed. But the men in the audience, would you repeat it, would you demonstrate it again? They really got off it.

Discussion

Focus group discussions are well received by women injection drug users (IDUs), partners of IDUs and women who trade sex for drugs or money. Many of the findings from the focus groups were confirmed by survey data. The results of the focus groups, supplemented by the quantitative data from the two surveys, provided a rich source of information on the underlying barriers to accessing health services and on possible intervention strategies.

The results of the focus group study indicate that women at high risk for HIV are concerned about both pregnancy prevention and HIV prevention. Although they had very difficult life experiences and very negative experiences with the health care system, they were interested in providing input to improve the system.

Although all women expressed interest in obtaining medical care, they identified barriers that prevent them from accessing needed and wanted services. Many of the barriers to care identified by other researchers (Melnik, 1988; Armstrong, Regina, & Samost, 1991), including high costs, lack of insurance, lack of time and transportation, provider availability, fragmentation of services, a lack of a primary provider, feelings of discrimination, and a poor provider-consumer relationship were echoed by the women in both the focus group study and in the outreach study. As other researchers have identified (Rakowski, Rimer, & Bryant, 1993), use of emergency departments as primary care providers -- a function they were not intended for -- can result in the provision of fewer preventive health services. Our study indicates that women seeking care in the emergency departments also had more negative experiences which may make them reluctant to seek health care in the future.

This study revealed additional barriers that may be specific to this very high-risk sub-population of women. Women expressed fear of punitive or legal consequences related to their illicit behaviors due to the reporting relationship between health care providers and legal and social service providers. This may be a result of a very stringent child abuse law in California and may not be generalizable to other communities.

Women also reported feeling stigmatized and labeled in a way that made them reluctant to access care. They expressed beliefs that this resulted in lower quality services when they did seek care. What appeared most important to the women in the focus groups was the desire for a

place to go where they would be understood and treated in a caring and respectful manner.

These barriers were experienced by most respondents despite the wide availability of subsidized family planning services and the community acceptance of such services in San Francisco. Current data suggest that these barriers still exist. Seroprevalence rates in women attending family planning clinics (0.5%) remain much lower than those for women at local health departments (2.0%), rural primary care clinics (1.5%) or mobile vans (4.0%) (California Office of AIDS, 1998).

Another important piece of information that emerged from this study was the pervasive misinformation about the efficacy and safety of available contraceptive methods. Kline, Kline, & Oken (1992) and Armstrong et al. (1991) also found this in studies in high-risk women in New Jersey and Pennsylvania. Obviously if the information out in the community is that condoms often break and can't be relied upon and that birth control pills cause cancer and heart attacks in smokers, then women will refrain from coming to clinics offering these methods however conveniently located or well staffed.

The importance of involving males in the utilization of contraception and safer sexual practices has been a point of controversy in developing HIV prevention programs for women. Kline et al. (1992) conclude from their work with Black and Latina women that the women were primarily responsible for reproductive decision making and forcing use of condoms. Armstrong et al., (1991) on the other hand, found that the attitudes of the male partner were decisive factors in women's acceptance of either contraception or use of condoms for HIV prevention.

The findings from our focus groups and the outreach study support the latter. Women in the focus groups were very reluctant to go against a steady partner's wish. These women did not generally use condoms with their main "romantic" partners. This was a result of both their

partners' attitudes about condoms and their own need to differentiate between customers and partners by not using condoms. On the other hand, these same women were willing to insist on condom use in situations of trading sex, except where their need for money for drugs or drugs themselves was in jeopardy.

Based on the data obtained from high-risk women, the following represent the conclusions and recommendations of this study:

1. Financial barriers are still important for low-income women. Many women are unaware of the free or low cost services in their communities or are afraid to access them. To address this:
 - Outreach effort efforts targeting high risk women should inform them of the availability of low-cost or free care.
 - Medicaid coverage needs to be extended to cover primary care and reproductive health services for those women who are not currently eligible for existing services because they do not have children living with them.
2. Most high-risk women do not have a regular primary care provider and many often use emergency rooms as their usual source of care. In order to improve the care they receive:
 - Women need to be diverted from receiving most of their health care at hospital emergency rooms and referred to primary care clinics which are prepared to address their multitude of health and social problems.
 - Clinicians in emergency rooms, primary care clinics serving low income women and family planning clinics need to be educated on the clinical issues, psychological characteristics and service needs of drug-using women.
 - Staff with experience in drug addiction needs to be available on a consistent basis,

through the development of specialized clinics or the provision of expert consultation.

3. High-risk women believe that the care available to them is inferior, especially that delivered in teaching institutions. Clearly, clinicians and medical students need to be educated on the clinical issues and service needs of a drug-using population.
4. Drug using women experience a significant amount of discrimination and stigmatization in the health care system accessible to them. Again, staff training, regular client feedback surveys, and modification of clinic procedures in response to the survey needs to be instituted.
5. Women experience geographical barriers to care. Thought should be given to providing services in locations easily accessible to identified high-risk target populations.
6. Community health outreach workers (CHOWs) have been highly effective in delivering HIV prevention, education and are well accepted by high-risk women. CHOWs should be used more extensively in contraceptive education and outreach to family planning clinics.
Funding for community health outreach workers needs to be available on an ongoing basis as part of any government funded family planning service or HIV prevention effort.
7. Drug-using women avoid health care for fear of punitive action by legal and social service agencies. Clinic policies should be developed which protect client confidentiality while assuring access to drug treatment rather than active reporting to social service agencies. This will require developing agreements with social service and law enforcement agencies as well as substance abuse treatment programs.
8. Much misinformation exists among high-risk women regarding risk of pregnancy and safety and efficacy of contraceptive methods. Culturally appropriate educational materials and opportunities providing consistent, simple and clear information must be provided in all

locations where high-risk women are known to congregate. This may be street-based, emergency room-based or based in housing projects, shelters, or jails.

9. Lack of access to sterilization results in unwanted pregnancies, births, and abortions.

Medical facilities need to reevaluate sterilization policies to better suit the needs of high-risk women. Government policies need to be modified so that regulations designed to protect clients from coercion or guarantee informed consent do not act as barriers to access for those clients desiring female sterilization.

10. Lack of male involvement in educational efforts makes more effective use of condoms difficult or impossible for drug-using women and for women in the sex industry.

Reproductive health and HIV prevention services for high-risk women need to develop policies and programs that actively encourage and facilitate male involvement. This may include alternative hours or funding for a male counseling component.

11. Women at high risk for HIV and unintended pregnancy have a multitude of social and economic problems that take precedence over obtaining health care. Health services that hope to effectively meet the needs of women at high risk for unintended pregnancy and HIV need to incorporate a comprehensive set of services or referrals to appropriate services which address their social, economic, financial, substance abuse and mental health problems.

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Table 1

Description Of Subjects

CHARACTERISTICS	FOCUS GROUP	OUTREACH/CLINIC SURVEYS
Mean Age	35 Years (M=34.85; SD=6.39)	31 Years
Age Range	21-47 Years	16-44 Years
RACE/ETHNICITY		
African American	42% (n=26)	70% (n=503)
Latina	10% (n=6)	17% (n=122)
White	42% (n=26)	14% (n=98)*
Other	6% (n=4)	
RISK FACTOR		
Injection Drug Users	71% (n=44)	47%
Bisexual Male Partners	10% (n=6)	N/A
Male Injection Drug Using Partners	57% (n=35)	51%
Traded Sex for Drugs or Money	40% (n=25)	N/A
Histories of Multiple Sexually Transmitted Diseases	10% (n=6)	N/A
Heroin Use	N/A	30%
Crack Use	N/A	49%

*The 98 women surveyed were White or from another ethnic group.