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Developing an Effective HIV/AIDS Response for Women and Girls in the U.S. Virgin Islands

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A B S T R A C T

This article focuses on specific culturally and socially based gender issues that enhance HIV risk and complicate access to care and services for women and girls in the U.S. Virgin Islands (USVI). Literature review and interviews with clinicians providing HIV care in the USVI were used to examine causative factors for the high HIV prevalence rates among USVI women. Although the USVI population is almost evenly split between men (48%) and women (52%), females represent 46% of all USVI residents living with HIV and 33% of all people with AIDS. A primary barrier to adequate HIV/AIDS care for these women and girls is the insufficient number of clinicians available to provide that care. A primary barrier to adequate HIV prevention is the fact that, although the USVI are a territory of the United States, their cultural practices are those of the Caribbean. Thus, HIV programs developed on the U.S. mainland are often ineffective in USVI. A lack of consistent and accurate reporting to HIV/AIDS surveillance staff on the part of clinicians also hinders early trend detection efforts, as well as effective HIV management. Strategies to address HIV among USVI women and girls include: 1) increasing awareness of issues that impact them negatively and increase their vulnerability to HIV, 2) developing and funding delivery of effective, culturally appropriate HIV-related interventions, and 3) increasing the size and technical capacity of the USVI clinical workforce. Simultaneously updating current health care professionals on best practices for HIV screening, treatment, risk-reduction counseling and support could also substantially strengthen the USVI's response to HIV among women and girls.

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Introduction

The U.S. Virgin Islands (USVI) are a U.S. territory, but their shared traditions, customs, and values are Caribbean in nature. The prevalence rates of HIV and AIDS in the Caribbean overall are second only to those in sub-Saharan Africa (UNAIDS, 2010), and the USVI's rates are a part of this picture. Among all U.S. states and territories, the USVI have the highest rate of chlamydia and are tied for fifth place in its rate of gonorrhea infections (U.S. Centers for Disease Control and Prevention [CDC], 2009). The CDC's Epidemiologic Profile of HIV/AIDS in the USVI (2008a) ranks it second in its rate of newly reported AIDS cases among women, exceeded only by Washington, DC (CDC, 2009).

In several instances, circumstances described in this article are not exclusively gender specific because so little gender-specific data are available. Instead, several discussions are based on circumstances that affect all genders. As a U.S. territory, the USVI is excluded from Caribbean-based HIV/AIDS research initiatives. Despite its U.S. territorial status, however, it is also generally excluded from U.S. HIV/AIDS research efforts—and is thus deprived of the benefits of research conducted within its shores. An additional challenge is that many federally funded programs developed for use in the contiguous United States lack the cultural perspective needed to be effective in the Caribbean. These programs tend to be fruitless when implemented in the USVI because they fail to address Caribbean cultural issues.

As in most Caribbean countries, HIV among women in the USVI is transmitted primarily through heterosexual contact. Caribbean culture is male dominant, because of the historic, economic, and social factors derived from a diverse mix of historic, religious, and other traditions (Dudley-Grant, 2001). Very distinct gender roles (male breadwinner/female homemaker) are culturally

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accepted. These make women economically dependent on male providers, lessening women's negotiating power in personal relationships in general and limiting their sexual negotiation power in particular (Surratt, Inciardi, Weaver, & Falu, 2005; Braithwaite & Thomas, 2001). This places USVI women at greater risk than men of contracting HIV and other sexually transmitted infections (STI; Surratt et al., 2005; Pan American Health Organization, 2003). Men typically control sexual encounters in the USVI. A woman broaching the subject of condoms with a sexual partner risks the consequences of expressing mistrust and bringing her own fidelity into question. These consequences may include sexual aggression and violent reactions.

Existing Public Funding and Support

The Virgin Islands Department of Health received $1,631,560 in Ryan White CARE Act funds during 2008. These funds covered Ryan White part B services, which include the AIDS Drug Assistance Program, part C (early intervention), and part D (services to women and children; Health Resources and Services Administration, 2008b). These funds primarily supported two outpatient care sites; one on each of the two major Islands, St. Thomas and St. Croix. No federal funding for dental services to clients with HIV/AIDS was provided in 2008 (the most recent year for which data are available).

The USVI is also served by the federally funded AIDS Education Training Center (AETC) Network. Specifically, the Florida/Caribbean AIDS Education and Training Center (FCAETC) subcontracts with the University of the Virgin Islands to provide training and capacity-building services to Ryan White-funded providers of health care and social services. Increasing the level of federal support to the FCAETC, as well as the AETC National Multicultural Center (AETC-NMC), could substantially strengthen the clinical workforce by building their capacity to provide culturally appropriate clinical training and helping to ensure continuity of care for women and girls with HIV.

Challenges to Delivery of HIV Treatment, Care, and Prevention Services to Women and Girls

A major limitation to the sustained delivery of high-quality care is the ongoing shortage of providers serving the 110,000 residents of the USVI. Recruitment and retention of qualified medical providers is difficult. In February 2011, the Department of Health (DOH) employed only two physicians and one nurse practitioner to provide medical care to all people living with HIV/AIDS in the territory. In May 2011, one of the physicians and the nurse practitioner left, leaving only one part-time physician within the DOH responsible for HIV/AIDS care. The only other providers of HIV/AIDS care are two primary care physicians within the Federally Qualified Health Centers who provide limited HIV/AIDS services.

Challenges with the administration of the AIDS Drug Assistance Program program, including drug treatment interruptions, have increased the potential for the development of drug resistance, particularly among patients on salvage therapy. Overall, the level of medical understaffing in the USVI is a constant threat to the ongoing provision of high quality HIV care.

The difficulty of attracting providers to the islands may be due to a number of factors, including noncompetitive remuneration. Additionally, local providers have demonstrated little interest in acquiring the skill sets needed to effectively treat patients with HIV. Few have participated in the mini-residencies in HIV care sponsored by the FCAETC.

Addressing this issue requires concerted effort by the USVI government to recruit experts in HIV treatment and provide incentives for their continuous employment. Alternatively or additionally, the government could provide strong incentives for local physicians and related clinicians (physician assistants, advance practice nurses) to become skilled in treating persons living with HIV/AIDS.

The majority of new HIV and AIDS cases in the USVI are diagnosed in the 25- to 44-year-old age group. Nineteen of the 31 new cases identified in 2010 were among people of childbearing and parenting age (personal communication, Annette Gumbs, Territorial HIV Surveillance Officer, 2010). The most recent available data show that 118 (44%) of those receiving antiretroviral treatment are female (Health Resources and Services Administration, 2008).

Vertical transmission is one area where HIV prevention has been implemented rigorously in the USVI. An aggressive prenatal program administers HIV testing to all pregnant women who present for prenatal care. Prophylactic treatment to prevent prenatal or perinatal transmission is initiated when women test HIV positive. As a result, no one below the age of 15 was diagnosed with HIV/AIDS in 2010.

It is concerning that 54% of the people diagnosed with HIV/AIDS during 2010 in the USVI are categorized as having "risk not reported/other." Six of the 11 females diagnosed were in this category (personal communication, Annette Gumbs, Territorial HIV Surveillance Officer, 2010). It is difficult to target prevention programming effectively when such a high proportion of individuals at risk of HIV infection deny (or are unaware of having) any association with high-risk sexual behavior and/or drug use. The FCAETC is strongly advocating the adoption of opt-out testing, as recommended by the CDC, as part of the standard of care within the Department of Health and in USVI hospitals and other health care facilities.

Currently, prevention and testing programs are largely provided by community-based organizations. The CDC provided $687,190 (CDC, 2008b) in funding to community-based organizations on the major islands in 2009. Working cooperatively with the Department of Health and the two Federally Qualified Health Centers on St. Croix and St. Thomas, these community-based organizations provide outreach and rapid HIV testing opportunities to segments of the communities that are high risk for HIV.

Unfortunately, ancillary data collection continues to be challenging. The lack of a unified epidemiology branch in the USVI hinders early trend detection efforts and analysis of other health markers. These data, which correlate to additional risk factors and are useful in gauging the efficacy of interventions, are woefully lacking.

Currently, no entity within the USVI government is specifically tasked with protecting the interests of women and girls. Sexual and gender-based violence and HIV risk have a reciprocal relationship (International Planned Parenthood Federation, 2011). Women who are victims of violence are also at high risk of HIV infection and women living with HIV are more vulnerable to violence. Although gender violence is a relevant issue worldwide, the rate of gender violence in the USVI is severe and must be recognized. For example, in 1998 the Women's Coalition of St. Croix (1999) reported that nearly 4% of that island's adult women population had been victims of domestic violence. The comparable proportion for the United States at that time was less than 0.5% (Tjaden & Thoennes, 2000).

Despite laws enacted in the USVI and campaigns to raise awareness and promote prevention, domestic violence remains common (Birdsong, 2000). Preliminary data from an ongoing study of intimate partner violence being conducted by the Caribbean Exploratory Research Center at the University of the Virgin Islands indicate that 30.9% of study participants have experienced physical/sexual abuse at some point in their lives (Callwod, et al., 2010). A governmental entity focused on women and girls (analogous to the Office on Women's Health in the U.S. federal government) entity could potentially mobilize increased awareness of issues negatively impacting women and girls, particularly their vulnerability to HIV and gender violence. Furthermore, such an entity could provide a platform for the development of effective culturally appropriate interventions.

Expanding on the Forum Recommendations to Meet USVI Needs

Several of the Gender Forum Recommendations could contribute substantially to reducing HIV risk for women and girls in the USVI and improving access to care, treatment, and support for those living with HIV. The need to develop, enhance, and enforce laws or policies to prevent violence against women and hold perpetrators accountable, for example, is urgent, as is the need to educate communities to reverse the social norms that hold violence to be acceptable and natural on our islands.

We need funding and expertise to develop and implement culturally appropriate strategies to reduce HIV risk behaviors among substance abusers and female sex workers, as well as sexual health education and peer support interventions targeted to these groups. By partnering with faith-based organizations, for example, we could effectively provide outreach in locations where these groups tend to gather and engage in HIV risk behaviors.

Formative research must be done in the USVI to determine the behavioral science theories and approaches that will be most effective in our culture, so that we can develop interventions that address our needs, rather than relying on ineffective adaptations of interventions developed for mainland populations.

Increase Cultural Competency

Resources and explicit guidance are needed to assess the cultural competency of both the USVI Department of Health staff and that of nongovernmental organizations providing HIV/AIDS prevention and care services. Educational workshops and management development trainings that focus on cultural competency should be offered by the AETC-NMC to stimulate improvement in this area.

Prevention Interventions that Work

There are several areas in which USVI HIV prevention outreach and service provision could be made substantially more gender responsive. There is, for example, immediate need to:

- Direct the AETCs, including the FCAETC and the AETC-NMC, to provide postexposure prophylaxis training to all USVI community-based organizations that are funded to do HIV prevention work.
- Provide technical assistance to the Virgin Islands Bureau of Prisons to develop and implement a comprehensive program of HIV and other STI prevention, detection, and treatment.
- Fund and direct the Department of Health to support the expanded provision of female condoms and thorough educational and promotional efforts to increase their use. This initiative needs to include development of culturally appropriate and creative ways to promote correct and consistent use of both male and female condoms, as well as strategies for negotiating condom use and discouraging multiple sex partners, concurrent relationships, and other risk behaviors.

Recognize and Address Known Barriers to Care

Logical and needed steps that could be taken in the following areas.

Stigma

Case-finding efforts that locate individuals at high risk of contracting HIV and provide them with opportunities for voluntary HIV counseling and testing would help to decrease the stigma and discrimination associated with HIV/AIDS in the USVI.

Service location

Stigma could be further reduced and HIV testing encouraged by integrating services so that HIV and other STI services can be offered confidentially at sites that are not associated with HIV, STI, and such testing. Given that many USVI residents live in small communities where people know each other, anonymity can also be preserved by enabling individuals to get testing and support outside of their residential areas when necessary.

Media campaign

Wider public education efforts are needed, specifically in the form of safer sex campaigns and community-based skills building that focuses on the importance of reducing the number of partners, increasing condom use, and alternatives to penetrative sex.

Data Collection

The underfunding of HIV/AIDS services in the USVI is related, in part, to undercounting. Consistent and accurate reporting to HIV/AIDS surveillance staff from all medical providers, not only high-volume providers (those with more than 100 patients), is vital and it is not occurring at present. To improve this, clinicians should be educated about the need to complete reporting forms accurately and update the surveillance staff when patients experience a change of diagnostic status, move to another location, or change providers.

Collection of secondary data, such as those from private practitioners and non-treatment sources, is another major challenge. The lack of a unified epidemiology branch in the USVI also hinders early trend detection and analysis of other health markers, which are essential to gauging the efficacy of interventions and how they correlate to other risk factors. A unified data collection and reporting system—one that informs the community as well as policy makers—is sorely needed.

Conclusion

A number of factors contribute to the high rates of HIV among women in the USVI. To combat the ongoing threat, a larger and sustained cadre of committed clinicians with expertise in HIV and women's health care must be deployed there. It is equally

important that we identify causative factors through a unified data collection process, use these data to develop culturally appropriate systems of prevention and care, and receive adequate resources to then implement these systems to mitigate the ongoing HIV epidemic on our islands.

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