

January 2016

A Qualitative Analysis Of Multi-Level Barriers To Hiv Testing Among Women In Lebanon

Kirsty Amy Clark

Yale University, kirsty.clark@yale.edu

Follow this and additional works at: <http://elischolar.library.yale.edu/ysphtdl>

Recommended Citation

Clark, Kirsty Amy, "A Qualitative Analysis Of Multi-Level Barriers To Hiv Testing Among Women In Lebanon" (2016). *Public Health Theses*. 1043.

<http://elischolar.library.yale.edu/ysphtdl/1043>

This Open Access Thesis is brought to you for free and open access by the School of Public Health at EliScholar – A Digital Platform for Scholarly Publishing at Yale. It has been accepted for inclusion in Public Health Theses by an authorized administrator of EliScholar – A Digital Platform for Scholarly Publishing at Yale. For more information, please contact elischolar@yale.edu.

For submission to: *AIDS and Behavior*

**“Women are Not Perceived as Sexual Beings”: A Qualitative Analysis of Multi-Level
Barriers to HIV Testing among Women in Lebanon**

Kirsty Amy Clark¹, Danya Keene¹

Omar Fattal^{2,3}, Nesrine Rizk⁴ & Kaveh Khoshnood¹

¹Yale School of Public Health, New Haven, CT

²Lebanese Medical Association for Sexual Health (LebMASH), Beirut, Lebanon

³New York University, Department of Psychiatry, New York, NY

⁴American University of Beirut, Department of Internal Medicine, Beirut, Lebanon

Corresponding Author:

Kirsty A. Clark

Yale School of Public Health

60 College Street

New Haven, CT 06520

PH: 703-554-9442

Email: Kirsty.Clark@Yale.edu

ABSTRACT

The Middle East and North Africa (MENA) is a region of concern in regards to the global HIV epidemic. In 2015, a call to action was released through the American University of Beirut urging an expansion of research and policy regarding women and HIV in the MENA region. Through individual, semi-structured interviews with sexual healthcare providers and NGO staff, we sought to understand barriers to HIV testing among women in Lebanon. Using purposive and snowball sampling strategies, key informants were recruited from neighborhoods in greater Beirut (N=21; 12 physicians, 9 NGO staff). Data were analyzed utilizing a Grounded Theory inductive framework. Findings identified barriers to HIV testing among women at each level of an adapted social-ecological model (i.e., social-cultural-level barriers, policy-level barriers, interpersonal healthcare provider-level barriers, and intrapersonal-level barriers). Findings can be utilized to inform HIV-related sexual health interventions for women in Lebanon at multiple levels.

Key Words: HIV/AIDS, Women, HIV Testing, Lebanon, Qualitative

Words: 146

BACKGROUND

Research and reporting surrounding women's sexual health in the Middle East and North Africa (MENA) is scarce (1). As of 2016, there is limited reliable multi-country data on rates of sexually transmitted infections (STIs), including HIV/AIDS, among women, level of sexual health knowledge among women, or information regarding access points of sexual health care in the region. While sexual health research and data remains limited, the MENA region is increasingly becoming a region of concern in regards to the global HIV epidemic: new infections in the region have tripled in the past decade. Indeed, while worldwide AIDS-related deaths fell 35% between 2005 and 2013, the MENA region instead saw a 66% increase in deaths (2).

Due to the lack of reliable information surrounding women's sexual health in the MENA region, coupled with increasing concern surrounding HIV/AIDS incidence, a call was released in March 2015 through the American University of Beirut urging an expansion of research and policy focus on women and HIV in the Middle East (3). DeJong and Battistin (3) stress that there is likely an under-detection of HIV infections among women in the region. Recent epidemiological literature focused on the MENA region highlights that the primary route of transmission is through heterosexual sexual intercourse, but that the primary *detection* of newly reported HIV infections is centered only among men (4). The disparity in detection of new cases between men and women, raises concern and requires further investigation.

The global burden of HIV among women is greater than 50% (5). In Lebanon, the reported prevalence of HIV/AIDS is low (0.1%), and out of this figure, just 8.3% of prevalent cases are reported to be women (6). Previous literature points to the fact that underreporting and/or under-detection of incident cases of HIV may be key factors influencing the low reported prevalence of HIV infection among women in Lebanon. While Lebanon does have a number of

Voluntary Counseling and Testing (VCT) centers for anonymous and subsidized HIV/STI testing, women's VCT participation in Lebanon is limited, with one study showing that over 60% of VCT patrons are men (7). Mandatory HIV screening is performed before marriage in Lebanon for both men and women; however, there is no mandatory screening after this point, including during pregnancy.

The MENA region ranks next to last behind sub-Saharan Africa on the UN Development Program gender empowerment measure (8). While Lebanon is often touted as more progressive than other countries in the region, recent literature suggests that sexual health and STI/HIV knowledge among the population remains low (9, 10). Due to conservative ideologies in the region, including high value placed on female virginity and societal taboos surrounding sex, there is an absence of a national school-based sexual health education curriculum, leaving a gap in sexual health knowledge among the population that includes STI/HIV prevention measures (11, 12, 13). A 2014 study among university students (N=1857) in Beirut, Lebanon highlights that a majority of participants feel that they could not talk to their mother about sex (61%), and even fewer would feel comfortable talking to their father about sex (80%) (14). While the lack of available knowledge regarding sexual health in Lebanon may be an indicator of widespread poor sexual health knowledge, it does not fully explain the disproportionately low HIV testing and case detection among women in comparison to men.

Given the pervasive lack of research on HIV and women's sexual health in Lebanon, we conducted a qualitative investigation to better understand potential barriers to HIV testing among women from the perspective of sexual healthcare providers and NGO staff. Utilizing the perspective of providers and NGO staff offers us a unique vantage point to better understand the interaction of multiple levels of structural influence on HIV testing among women (i.e., potential

gender-related biases, sexual health knowledge and attitudes, reported interaction with patients, key similarities and differences in insight from NGOs and providers).

RECRUITMENT AND SAMPLE

Key informants (KIs) were recruited for participation from a number of neighborhoods in Lebanon in the greater Beirut area. 21 KIs participated in the study, twelve of whom were physicians, and nine of whom were staff (non-physicians) at HIV VCT centers and other non-governmental and governmental organizations focused on sexual and reproductive health. All participants are professionals involved in: 1) delivering sexual health promotion and harm reduction programs; 2) working clinically with individuals diagnosed with STIs/HIV; and/or 3) delivering direct sexual and reproductive healthcare to patients.

KIs were initially selected using a based on the nominations of study investigators, two of whom are Lebanese physicians familiar with the landscape of the sexual health medical and NGO community. Additional KIs were identified via snowball sampling. Efforts were made via purposive sampling to ensure that KIs represented a cross-section of sexual health-related occupations, were from a variety of organizations or health services including governmental and non-governmental agencies, and worked with a diverse subset of populations spanning religions, regions, and socioeconomic status.

DATA COLLECTION AND ANALYSIS

Individual, semi-structured qualitative interviews were conducted between May 2015 and July 2015 in and around the greater Beirut region of Lebanon. Interviews covered broad themes, including demographics of population served by provider, perceived sexual health knowledge

among women, condom negotiation practices, perception of HIV in society, and perceived barriers and facilitators to sexual health care among women. The interview guide was created in collaboration with all study investigators, drafts were reviewed for clarity and cultural relevance, and prior to data collection the final interview guide was pilot tested with three healthcare providers who have qualitative interview experience. Feedback from pilot testing was utilized to finalize the interview guide.

Participants were initially contacted via email, with a follow-up phone call if no email response was returned within three days. After a brief description of the study, potential participants were scheduled for an in-person interview conducted in English. All participants provided verbal consent for both the interview and audio recording. One participant consented to the interview but refused audio recording. In this instance, copious notes were taken by the Principal Investigator.

Data were analyzed utilizing a Grounded Theory inductive framework (15), and as themes emerged, subsequent interviews were tailored to prompt questions around those themes. For instance, questions surrounding condom negotiation were not initially part of the interview guide; however, after themes emerged around this topic, we prompted subsequent key informants to expound on their perception of this issue.

Transcripts were transcribed verbatim. Emergent themes and codes were refined and used to develop a codebook (i.e., coding tree) that was utilized by the lead investigator throughout the coding process. Transcripts were coded using Dedoose software. In order to ensure effectiveness of the codebook and relevance of codes to the dataset, two additional coders with extensive qualitative interview and coding experience analyzed selected transcripts for calibration and consistency. Any coding discrepancies were discussed among coders and resolved.

ETHICAL CONSIDERATIONS

We obtained verbal consent from all participants prior to participation, and all interviews were conducted in a setting of the participant's choice, generally a doctor's office or NGO conference room at the place of work of the participant, for convenience. The Yale Human Subjects Committee and the American University of Beirut Institutional Review Board granted approval for the study. We use pseudonyms in the presentation of these data.

RESULTS

Demographics

The demographic characteristics of the sample are presented in *Table I*. The group is highly educated, with a majority of the sample (61.9%) having a Medical Degree (MD). All physicians are specialized in providing sexual health care in some capacity surrounding HIV/STIs (i.e., Obstetrician-Gynecologist (OB-GYN), Infectious Disease (ID), and Sexologist). The average length of experience working in healthcare among the sample is 15.5 years (SD = 11.2). All key informants are citizens of Lebanon and speak proficient or fluent English, as is common among professionals in Lebanon. The sample is predominately male (76.2%), reflecting restraints in employment among Lebanese women (16). Average age of the key informants is 42.3 years (SD = 15.6).

Theoretical Framework

Analysts identified themes through a process of inductive coding to form a coding tree in accordance with the social-ecological model of health: a model that explains the social and

structural drivers of individual health-related behaviors (17). The social-ecological model contextualizes individual behaviors within greater socio-structural dimensions, including intrapersonal-level factors (i.e., individual knowledge, attitudes, and beliefs); interpersonal-level factors (i.e., relationships with friends, partners); community-level factors (i.e., interaction with institutions/organizations); policy-level factors (i.e., laws, policies, regulations); and societal-level factors (i.e., cultural influences) (18). An adapted social-ecological model is utilized here to present the emergent themes surrounding barriers to HIV testing among women in Lebanon (see Figure I): social-cultural-level barriers, policy-level barriers, interpersonal healthcare provider-level barriers, and intrapersonal-level barriers. Each of the four levels of the model, along with each of the themes that emerged within each level, is explained in detail below.

Social-cultural level barriers

People think that if you're clean, quiet, you wear perfume, you dress nicely, that they are not at risk [of HIV], but there is no correlation. – Dr. Zein, OBGYN

Social-cultural level barriers to HIV testing among women in Lebanon are those which are influenced by cultural factors, such as overarching beliefs, ideologies, and norms of a society. Sex as a taboo and specifically, premarital sex as a taboo, is one of the main barriers perceived by key informants as influencing women's willingness and access to HIV testing and other sexual health services. A focus on virginity among young women, as represented by an intact hymen, is a societal and cultural norm that a number of participants used as an example of taboos surrounding premarital sex:

I had a patient two months ago she came here - they come, they want to examine their hymen. They tell you, "I fell down I, want to see if I still have an intact hymen." I know this is not the cause of coming here. I had a 16 year-old girl, she came here and she told me that she fell down, and she came alone...she came alone after school, she came here to examine herself. – Dr.

Hajjar, OBGYN

One participant explained the effects of taboos around sex and sexuality as a hindrance to sexual healthcare and preventative sexual healthcare practices. Due to the overwhelming societal norm of sex as a taboo, a male participant who works in a sexual health NGO explained how something as seemingly simple as buying a condom can be an uncomfortable experience:

It's unpleasant to buy a condom from a pharmacy, especially if the pharmacy has a girl who's veiled. Or if the pharmacy is too close to your home, you have to go to another pharmacy. Or if you go to the pharmacy, you try to look for them, but it's not displayed where you can just grab it, you have to ask for it. Then you're like, "fuck it, I'm not going to do it." There's a lot of hindrances to safe sex. – Elias, NGO

While sex in general is viewed as taboo in Lebanon, women's experiences with sex and sexuality are particularly restrictive. One participant explained that women's sexuality is governed by social expectations:

It's not really accepted by the community, you know, that women have sex just for having sex. There's a lot of supervision, lots of monitoring on what women do, and what they do with their bodies, and how they do with their bodies. – Elias, NGO

Furthermore, a societal norm that was elucidated by numerous participants is the view of women who engage in sex as "dirty,":

When you see, who has sex? What women have sex? It's always, like, sex workers, so as to create a divide between a woman that does and a woman that does not have sex. – Cyla, NGO

This phenomenon of “dirty vs. clean” also emerged as a social-cultural-level barrier to HIV testing and HIV risk perception: by perceiving only “dirty” people (i.e. sex workers) as potentially having HIV, the societal norm is that unless you are selling sex, you are immune to HIV:

It is very taboo, and people talk about [HIV] with disgust and shame because they're not well-aware about the risk, and they feel it's related to dirty sex or something bad...it's not seen positively, and we do not have enough awareness, and we have a lot of misconceptions.

– Dr. Aoun, Sexologist

This social-cultural-level influence was also echoed by another participant:

When the guys come in for tests, and you ask why, they say, “Well, I had sex with a sex worker.” That's their main concern. Like, if they have sex with people who are not – like girls, not for money – it's fine, it's not risky. But if they have [sex] one-time with a sex worker, then they come in for a test. – Cyla, NGO

Due to the fact that HIV is overwhelmingly sexually transmitted, and considered to be spread only among “dirty” people, numerous participants highlighted that the stigma surrounding HIV that is not attached to other non-sexual diseases:

[People living with HIV] have to live with hiding the medications just so nobody could find out, and acting like everything is fine. It's not accepted like any other disease. – Dr. Lebbos,

Infectious Disease

Another provider reiterated this idea of stigma being attached to HIV because it is a disease that is sexually transmitted:

It's still a taboo. People are terrified of this disease, I think. A lot of people give stigmas to people with HIV, and for them HIV means sex. It is how people think about that. It's still a taboo.

A lot of people are not accepting. - Dr. Nasr, OBGYN

One participant explained that HIV is viewed by society as a moral failing, and is often seen as a punishment from a higher power:

If you got [HIV], it means you have been morally wrong and that you have to be ashamed. I think people think that those don't deserve to live or be treated. A majority of people would say:

“Good for him, he gets the God wrath [to] punish him.” – Dr. Lebbos, Infectious Disease

Stigma against HIV, and the perception that only certain people are at risk, negatively influences uptake of HIV testing among women. Further, due to the social-cultural-level barriers to HIV testing detailed above, including sex as a taboo, monitoring of women’s sexualities, and the phenomenon of HIV being perceived as a “dirty” disease, participants explained the difficulties they have faced in trying to institute any sort of HIV-specific awareness-raising or education campaigns:

It is very difficult to do, because [HIV] is a sexually transmitted infection. Sex in this country is taboo. So if you try to talk about sex on TV, which I did a few years ago, and people...they were not happy, “why are you talking sex, this is not acceptable, our kids cannot hear this, blah blah blah.” *It's still a taboo thing.* - Dr. Nasr, OBGYN

Policy-level barriers

Since insurance companies don't recognize HIV, that it is an illness, they don't cover. – Dr.

Kobeissi, Infectious Disease

Policy-level barriers to HIV testing among women in Lebanon are those which are influenced by policies, laws, and regulations (or lack thereof) that impact a women's decision or ability to access an HIV test. One participant highlighted that policies may indeed influence uptake of HIV testing along with the HIV-related data being produced by Lebanon's National AIDS Program:

It is very important to look critically at the numbers that National AIDS Program produced about people living with new [HIV] infections and new incident cases...it's always men, it's always men, there's no women. Is it actually, like, women are at low risk? Or is it that you're not catching enough women who aren't doing tests and therefore, you're not thinking critically about it, and therefore, your policy doesn't target the women? – Elias, NGO

A policy-level barrier that was emphasized by almost every participant is the limited level of sexual health knowledge among women in the country stemming from the lack of sexual health education programs. Due to the aforementioned social-cultural taboos surrounding sex, there is no national school-based sexual health education program. One participant, highlighting the limited sexual health knowledge among his patients, explained his personal frustration surrounding the lack of available sexual health education programming in schools:

It's not something done by the Ministry of Health. In the school where my children go, they brought a dentist to speak about all the benefits of brushing the teeth. A dentist? Brushing teeth? Okay, it's important, but [sexual health] is...something more important. – Dr. Khoury, Infectious Disease

Participants highlighted that there is very little understanding of affirmative sexual health practices among their patients and clients, specifically among women. In order to elucidate the

lack of sexual health education, knowledge, and practices among her patients, one participant recounted a troubling patient interaction:

I have a patient who came last week. She told me that she is married to her husband, and when I examined her I discovered that she knows nothing about intercourse...they thought they had a normal relationship. After three or four months of marriage I examined her and found an intact hymen. They think they are doing the sexual intercourse in the normal way. They were coming because she was not getting pregnant and when examined her I discovered that they know nothing about their sexual life. – Dr. Hajjar, OBGYN

The significant lack of sexual health education and knowledge is also tied to misinformation surrounding HIV. With no national sexual health education program, and limited sexual health knowledge available from other sources, people are left to ignore HIV infection up until the point they are diagnosed, at which time these misconceptions become an issue:

Considering HIV, it's badly still considered as a sin disease like syphilis in the old times. And people think they're going to die, and this is another big problem. Because every time I have a positive diagnosis I have to convince the patient that it is like other chronic diseases. You have to take your medication and continue follow-up with your physician and that's it. – Dr. Makki, Infectious Disease

Financial issues surrounding reimbursement of HIV testing were also emphasized as a policy-level barrier to HIV testing among women:

Umm, here I want to say that we don't do much [testing women for HIV]. Actually barely, even during pregnancy, because of the reimbursement. – Dr. Haddad, OBGYN

In Lebanon, HIV treatment is covered for free by the Ministry of Health for anyone who is diagnosed with the disease. HIV testing, however, is not reimbursed by the government or by insurance companies:

Yes, the treatment is offered for free. But testing is paid for out of pocket. And since insurance companies don't recognize HIV, that it is an illness, they don't cover. – Dr. Kobeissi, Infectious Disease

While VCTs cover the bulk of the cost for an HIV test, women who may instead want to receive an HIV test from their doctor must pay out-of-pocket. A participant explained that the finances act as a barrier:

The problem is insurance companies...they don't pay for the HIV test, and that makes it sometimes a little bit difficult financially for some patients. – Dr. Nasr, OBGYN

In addition to the cost of test themselves, HIV diagnosis, or even HIV testing can result in loss of insurance coverage in Lebanon:

Now medical labs at hospitals are sharing information with [who comes to get an HIV test] insurance companies. So an insurance company...will directly drop you off their premium, just because if you go for HIV. And there's nothing we can do about it. And the insurance contract says that they can drop you off at any moment. – Adeline, NGO

Interpersonal Healthcare provider-level Barriers

Because of the years the providers have judged women for being sexually active, they just stopped seeking help...they don't dare to ask. - Adeline, NGO

Interpersonal healthcare provider-level barriers to HIV testing among women in Lebanon are those which are influenced by relationships and interactions between women and their healthcare provider(s). While sexual and reproductive healthcare providers are often the first access-point to an HIV test for women, participants explained that judgment from healthcare providers is frequently a hindrance to access and affirmative sexual healthcare.

Because of the years the providers have judged women for being sexually active, they just stopped seeking help. And they don't dare to ask. When I first went to a gynecologist, and I heard a lot of that from my friends, they ask if you're married or not. And they don't ask you if you are sexually active. So if you are not married, they will not do any tests. Because they are related to sex, and to being sexually active. – Adeline, NGO

One participant from a sexual health NGO recounted one of her client's traumatizing interactions with a sexual healthcare provider:

One woman came here and she was crying, because she wanted to get a PAP smear. The [hospital she had been to] shamed her. They made her cry and she left the hospital crying. And all that because she's not married and she's asking for a PAP smear. They don't even follow the guidelines. They follow the values and norms, and people who are more vulnerable get shamed for it. – Adeline, NGO

The notion that a woman would be shamed by her healthcare provider for being sexually active before marriage was one that was repeated across interviews. Many participants highlighted that gynecologists often merely assume that if a woman is entering their doctor's office, she must be married. Indeed, there is a 'joke' told among women in Lebanon to elucidate this phenomenon:

There's always the joke...when a woman goes to a gynecologist they always refer to her directly with "Madame", always assume, like, she has to be married if she's here. – Cyla, NGO

In regards to HIV testing, participants explained that physicians often feel uncomfortable in discussing sexually transmitted diseases with their female patients, due to the aforementioned social-cultural taboos surrounding sex. A key informant who conducts sexual and reproductive healthcare trainings for current and future OBGYNs shared the uneasy response he often receives when training medical students, residents, and current healthcare providers on HIV testing among their female patients:

For providers, they say, "She is this, she is that, she is veiled. How can I ask her to do an HIV test?" – Dr. Zein, OBGYN

Providers feeling uncomfortable in regards to administering an HIV test and speaking with patients regarding sexually transmitted diseases was another theme that emerged across interviews. Many participants explained that even in healthcare settings, societal taboos surrounding sex and women's sexuality seeps into discussions of sexually transmitted diseases and often leads to silence around these issues:

Even in family planning and STI clinics they don't talk about it. Even during doctor's meetings or seminars. It's uncomfortable. – Dr. Zein, OBGYN

One participant explained that this occurrence is not solely because physicians feel uncomfortable discussing sex with their patients; but rather, that they are concerned that discussing issues of a sexual nature with their patients may actually encourage their patients to have sex:

Even some doctors do not want to talk about, for example, the HPV vaccine, because she's opening the sexual issue. So it's like you're encouraging teenagers or young people to have sex.

– Dr. Aoun, Sexologist

While in some healthcare facilities, administering HIV tests to female patients, especially pregnant women, are part of the institutional guidelines, a number of participants admitted that it is easier not to offer HIV testing for fear of a negative reaction from female patients, who, as explained above, have limited sexual health knowledge, education, or understanding of why an HIV test should be administered:

In Lebanon, people, they don't like to develop anxiety regarding anything. Any time we order HIV [test] they can't sleep, they start having issues. Sometimes, "Why are you testing me? I've been married!" So they start accusing or, you know, "From where would I get it?", stuff like that. So we don't like to dig into trouble. – Dr. Haddad, OBGYN

Rather than explaining the need for HIV testing, or “digging into trouble,” providers admitted that it is often simpler not to offer an HIV test to their female patients at all:

Unfortunately, we do very little...it's not a routine testing, unfortunately. It is a part of recommendations, but nobody does that. We know that we should be doing routine HIV testing...but we don't do them here. – Dr. Helou, OBGYN

Across interviews with healthcare providers, it was apparent that women's healthcare needs in Lebanon come secondary to men's. For instance, even in situations in which an HIV test is absolutely necessary – for example, a man is found to be HIV positive due to an extramarital affair and his wife does not know and has not had an HIV test – physicians explained that social-cultural norms surrounding marriage and sex often lead them to lie to the wife about the disease in order to protect the husband. In one example, a physician explained that he waited over six

months before testing a woman for HIV after discovering her husband was HIV-positive, and even then, told the woman that he was testing her for malaria:

You need at least to wait, to gain some confidence with the patients, at least six months before telling the wife, or getting the wife to get tested, or even testing the wife without her knowledge. So there are several ways to do this without disrupting or disturbing the couple. Why do we do this? It's not only me. When the wife comes to our office and we say, "Your husband got malaria, for instance, from Africa." They don't argue. "We need to test if you have malaria." This is how we do the [HIV] test, this is one of the tests that we can propose...they don't ask questions...it doesn't fit in their head, or in the culture. – Dr. Khoury, Infectious Disease

Physicians also admitted that if a husband transmits HIV to his wife after an extramarital affair, they may lie to his wife about the origin of the disease so as to protect the husband. Lying to a patient about how a sexually transmitted disease, such as HIV, is spread is a glaring infraction of trust between a patient and healthcare provider; however, one provider explained that a female patient had accepted an erroneous explanation with little question, likely due to sex-related taboos and limited access to sexual health education and knowledge:

It's difficult here to discuss [HIV] with the spouse, to tell his wife about the issue...I had a woman who had HIV, and just telling her, "Yes, it is possible that your spouse did it." But you also have to raise the - we know it's not true – but, "it could always be that he got it from a surgical item that was not clean." You need to give her an excuse not to break the marriage. You know that we are lying to her. – Dr. Lebbos, Infectious Disease

Limited time for provider visits as a result of the overburdened, privatized healthcare system in Lebanon also constrains provider ability to educate their female patients on HIV and sexual health. Lack of knowledge surrounding HIV among patients translates into interactions

between providers and patients. Rather than informing patients of the reality of sexual health, physicians instead expressed frustration that limited availability of time removed any incentive for them to explain the need for HIV testing to their patients:

There's no incentive. As busy practitioners, we don't have plenty of time to counsel these patients and talk to them...about how to do [HIV] testing. – Dr. Haddad, OBGYN

Since women are not receiving sexual health education from any reliable sources, including sexual and reproductive healthcare providers, there are major misconceptions surrounding HIV testing and other important sexual health issues. While HIV testing is supposed to be a part of the routine health screening in many healthcare institutions, misconceptions among women take precedent over affirmative sexual healthcare:

[HIV testing is] supposed to be part of the routine – we don't do it. Even the pap smear, [women] are worried about having pelvic exams during pregnancy – they think that it would increase miscarriage. So we don't do it. – Dr. Haddad, OBGYN

Physicians justified lying to female patients surrounding sexual healthcare, not administering HIV tests, and agreeing with patient misconceptions by reasoning that if they did not do these things then they would be more likely to lose patients. One participant expressed that “less trouble” (i.e., not ordering HIV tests for his pregnant patients) was easier to deal with than potentially losing patients:

In Lebanon we want our things to flow. We want less trouble. Any time a patient is anxious, like, “I'm pregnant, why are you ordering me [an HIV test]?” you would be losing patients for this. – Dr. Haddad, OBGYN

Intrapersonal-level barriers:

The girls, they say “I was hesitant, I don’t really trust that it’s anonymous.” There’s this problem that’s keeping them from actually accessing the [HIV] test. – Cyla, NGO

Intrapersonal-level barriers to HIV testing among women in Lebanon refers to sexual health-related behaviors that are influenced by knowledge, attitudes, and beliefs. While themes emerged surrounding patient behaviors in regards to HIV testing, it is important to recognize that these reports are through the lens of healthcare providers and practitioners.

Societal norms, structural barriers, and interpersonal healthcare provider interactions all serve to influence intrapersonal-level barriers to HIV testing. Due to the societal taboos surrounding sex, especially among women, participants highlighted that women are especially concerned about accessing HIV testing for fear that they will be seen by people they may know who will then assume that they are sexually active. Fear of anonymity emerged as an intrapersonal barrier to accessing HIV testing across interviews:

They are shy. They do tell you that when they come in, the girls, they say “I was hesitant, I don’t really trust that it’s anonymous.” There’s this problem that’s keeping them from actually accessing the test. – Cyla, NGO

One provider tied women’s intrapersonal behaviors surrounding HIV testing to overall cultural issues, highlighting the interconnectedness of the levels:

Sometimes [women] are worried because they feel that people will look at them strangely if they go and do an STI test, sometimes they are worried about the anonymous part of the [HIV] test. For women, if they do the test before getting married that means they are sexually active and, “oh maybe they will tell my parents.” We have a lot of cultural obstacles and barriers.

– Dr. Aoun, Sexologist

Throughout the interview process, participants often mentioned that Lebanon is a country where “everybody knows everybody.” Due to the lack of anonymity in daily life, participants explained that a woman who does access an HIV test will often go to great lengths to conceal her identity or avoid interaction with people she may know:

A lot of people ask under a false name for an [HIV] analysis. – Dr. Nasr, OBGYN

As an example of the lengths that women in Lebanon must go to conceal their identities in seeking an HIV test, one participant from an NGO catering to drug-users explained that many women they see for HIV tests are non drug-users who simply know they will be less likely to encounter people they know at a drug-testing center:

Sometimes they're just non-drug users, sometimes it's just girls who are, you know, reluctant to go to their doctors or the hospital to have [an HIV test] ...so, like, they see this center that is a drug testing center and probably since they're not drug users they're not going to have to interact with the drug users or the people who are working here. – Elias, NGO

Given the fear of anonymity that is pervasive among women seeking HIV testing, participants stressed that without a completely anonymous HIV testing system in place, they would be unable to convince anyone to do an HIV test. Societal and policy-level influences often impact intrapersonal-level barriers to HIV testing. Indeed, one physician expressed frustration in the HIV testing protocol at his institution, citing that since the test is now no longer anonymous, his patients are much less inclined to do an HIV test:

Here, since we were acquired by an American university, now they are mandating the individual to give his ID card when he draws blood, so we have no more individuals who come for HIV testing. People don't come. Before, we had plenty of people doing the test because I was organizing the system in a confidential manner. – Dr. Kobeissi, Infectious Disease

Other than the fear of anonymity as an intrapersonal-level barrier to HIV testing among women, themes emerged surrounding individual shame and guilt. Due to the aforementioned societal norms surrounding sex, women are conditioned to feel guilt when discussing any sort of sexual activity. A participant from a sexual health NGO explained how social-cultural norms affect her clients:

We try to talk to [women] about the notion of virginity, about the hymen, the very different shapes and sizes of the hymen, all of these things, but society has been very... the shame associated with you being sexually active, that makes you feel so much guilt. – Adeline, NGO

These feelings of shame and guilt are tied to avoidance of HIV testing among women in Lebanon. Participants stressed that the notion of a woman choosing for herself to do an HIV test was not an easy decision. A participant who works at a voluntary testing and counseling center explained that hesitation is often at the forefront of a woman's decision to get an HIV test:

With all the hesitation when a woman comes to do an HIV test, she's thought about it twice or three times before she comes. It's not like "I'm just going to go." – Cyla, NGO

The fear of anonymity, shame, and guilt surrounding sex among women in Lebanon act as intrapersonal barriers to HIV testing by negatively influencing a woman's decision to seek out an HIV test.

DISCUSSION

This study highlights that barriers to HIV testing work at multiple levels of an adapted social ecological model (social-cultural-level barriers, policy-level barriers, interpersonal healthcare provider-level barriers, and intrapersonal-level barriers) to negatively influence uptake

of HIV testing among women in Lebanon. Further, these levels influence each other, highlighting the multi-level context in which HIV testing uptake occurs.

Consistent with previous literature, our findings highlight that social-cultural factors have considerable impact on HIV testing uptake (19). Conservative societal norms and beliefs influence sex and sexuality among women in Lebanon (1). Social-cultural norms surrounding pre-marital sex as taboo, emphasis placed on women's virginity, monitoring of women's sexualities, and negative beliefs surrounding HIV all contribute to low uptake of HIV testing among women in Lebanon. Previous literature from the United States highlights that HIV-related stigma and shame is associated with a delay in HIV testing (20, 21). Indeed, across interviews, participants highlighted stigmatizing social-cultural norms surrounding HIV, due to its status as a sexually transmitted disease, as barriers to HIV testing among women.

Findings also emphasized policy-level barriers to HIV testing among women in Lebanon. Participants highlighted that the lack of school-based sexual health education programs greatly inhibits women's awareness of the health benefits of accessing HIV testing. This finding reinforces a study investigating HIV-related knowledge among university students (N=267) in the United Arab Emirates, which found that 75% of the sample had low HIV-related sexual health knowledge, and that misconceptions and misinformation place Arab students at increased risk for contracting the disease (22). Other than limited sexual education resources, financial barriers to HIV testing and discriminatory HIV-related insurance policies also emerged as policy-level barriers to women's access of HIV testing in Lebanon. Indeed, participants highlighted that the potential risk of being dropped from an insurance premium simply for seeking out an HIV test was a barrier to testing uptake. Further, due to the need to pay out-of-

pocket to access an HIV test outside of a VCT center, there is limited incentive for women in Lebanon to access an HIV test unless they feel it is absolutely necessary.

Health care providers also reported that women in Lebanon face barriers to HIV testing through interactions with their sexual and reproductive healthcare providers. Provider attitudes and beliefs surrounding HIV and women, valuing men's health needs above women's health needs, and fear of losing patients to other clinics by administering HIV tests all serve as barriers to HIV testing among women in Lebanon. By corroborating reports of stigmatizing healthcare interactions from sexual health NGO staff with similar accounts directly from sexual healthcare providers, our findings extend prior literature highlighting the importance of healthcare provider interactions with patients in accessing HIV testing and treatment. Perceived stigma from healthcare providers is positively associated with a break in healthcare among HIV infected individuals, with perceived stigma from healthcare providers consistently reported as being higher among female patients than male patients (23). Indeed, literature investigating sexual and reproductive healthcare in a number of Arab countries highlights that healthcare providers do not recognize the sexual and reproductive health needs of young people and are especially unwelcoming to unmarried patients (12).

At the individual level, our findings highlight that a fear of anonymity and shame and guilt surrounding sex both serve as barriers to HIV testing among women in Lebanon. There is limited investigation of intrapersonal barriers to sexual and reproductive healthcare among women in the Arab world. A study investigating AIDS-related stigma in South Africa and its impact on HIV testing uptake found that people who had not had an HIV test attributed higher levels of shame, guilt, and disapproval to HIV than people who had accessed an HIV test (24). Internalized stigma among people living with HIV is associated with avoiding HIV-related

healthcare and medication adherence (25, 26). Our research highlights that HIV and sex-related stigma may also be associated with HIV testing avoidance. Future qualitative and quantitative research is necessary to further explore these foundational results in an Arab context.

LIMITATIONS AND CONCLUSION

This study is the first of its kind to investigate barriers to HIV testing among women in Lebanon and the greater MENA region. By utilizing qualitative interviews with healthcare providers and sexual health NGO staff, we garnered a unique vantage point to better understand the interaction of multiple levels of structural and societal influence on HIV testing uptake.

As with any study, ours has some limitations. The primary drawback of the current research is that interviews were not conducted with women surrounding their perception of HIV testing. While we believe that interviews with sexual healthcare providers and NGO staff provide a unique perspective that is not captured by other research in the Arab region, future studies interviewing women about their sexual healthcare experiences would assist in triangulating the current findings. Further, our research interviewed key informants from the greater Beirut region; however, it is likely that healthcare providers from other regions around Lebanon may have different experiences in providing HIV testing and sexual healthcare that should be explored. Lastly, it is imperative that future research explore the efficacy of HIV testing education interventions in order to increase knowledge amongst both the general public and healthcare providers.

Barriers to HIV testing described in this paper may contribute to the low uptake of HIV testing and the low detection of HIV cases. Greater efforts are needed by qualitative and quantitative researchers in Lebanon and the greater MENA region to better understand the

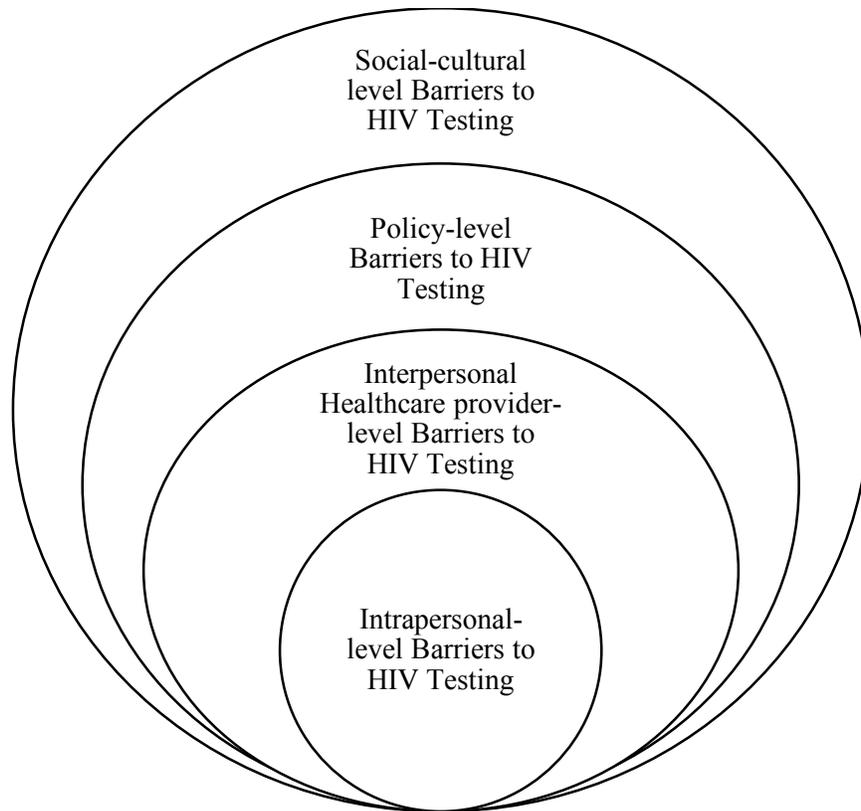
association between women's health and HIV. This research highlights the need for sexual health education for the general population, as well as sexual health-related training for healthcare providers. Further, research to develop culturally-appropriate ways to destigmatize HIV and sex in the region is necessary. Greater attention must be paid to stigmatizing healthcare and insurance policies impacting women's sexual healthcare in Lebanon. Stigma surrounding sexually transmitted diseases and low levels of sexual and reproductive health knowledge contribute to poor sexual health practices, including limited uptake of HIV testing among women.

Our findings suggest that interventions targeting barriers to HIV testing among women must be implemented at multiple levels in order to affect meaningful change at the population level. While the multi-level barriers described in this paper are significant independently, interventions must work to target relationships between levels; indeed, changes that only influence a single level may have limited success to the multi-level context in which they occur. As a result of this research, utilizing an adapted social-ecological model, we have identified barriers to HIV testing among women in Lebanon from the unique perspective of sexual healthcare providers and NGO staff.

Table I. Demographic characteristics of key informants

Pseudonym	Age	Sex	Place of Work	Speciality	Years in Healthcare	Nationality	Highest Education Level
Dr. Haddad	42	M	Hospital	OBGYN	10	Lebanese	MD
Dr. Khoury	40	M	Hospital	ID	11	Lebanese/ French	MD
Dr. Aoun	36	F	Hospital	Sexology	8	Lebanese	MD
Dr. Ghandour	56	M	Hospital	OBGYN	30	Lebanese	MD
Dr. Zein	52	M	Hospital	OBGYN	25	Lebanese	MD
Dr. Hajjar	49	F	Hospital	OBGYN	16	Lebanese	MD
Dr. Kobeissi	62	M	Hospital	ID	35	Lebanese	MD
Dr. Makki	31	M	Hospital	ID	6	Lebanese	MD
Dr. Helou	47	M	Hospital	OBGYN	15	Lebanese	MD
Dr. Nassar	47	M	Hospital	ID	16	Lebanese	MD
Dr. Nasr	40	M	Hospital	OBGYN	10	Lebanese	MD
Dr. Lebbos	47	M	Hospital	ID	16	Lebanese	MD
Elias	28	M	NGO	-	8	Lebanese	Masters Degree
Cyla	30	F	NGO	-	1	Lebanese	Bachelors Degree
Assi	25	M	NGO	-	5	Lebanese	Bachelors Degree
Amal	25	M	NGO	-	6	Lebanese	Bachelors Degree
Elie	36	M	NGO	-	10	Lebanese	Masters Degree
Charbel	52	M	Governmental	-	25	Lebanese	MD
Ayman	83	M	NGO	-	45	Lebanese	Masters Degree
Leyla	47	F	NGO	-	23	Lebanese	Bachelors Degree
Adeline	27	F	NGO	-	5	Lebanese	Masters Degree

Figure I. Adapted social-ecological model of barriers to HIV testing among women



1) *Social-cultural-level barriers:*

- Pre-marital sex as taboo
- Emphasis placed on women's virginity
- Monitoring of women's sexuality
- Dirty vs. Clean phenomenon
- Sex stigma surrounding HIV

2) *Policy-level barriers:*

- Lack of sexual health education
- Cost of HIV test (not subsidized)
- HIV-related insurance policies

3) *Interpersonal Healthcare provider-level barriers:*

- Provider attitudes and beliefs surrounding female patients
- Provider attitudes and beliefs surrounding HIV
- Women's health needs valued secondary to men's
- Fear of losing patients

4) *Intrapersonal-level barriers:*

- Fear of anonymity
- Guilt, shame, and avoidance

ACKNOWLEDGMENTS

The authors thank the Global Health Leadership Institute for funding support and the Lebanese Medical Association of Sexual Health (LebMASH) for logistical assistance. The authors also thank Helene Dabbous and Rawad Chalhoub for transcription assistance in analysis of data.

REFERENCES

- (1) Azar M, Kroll T, Bradbury-Jones C. Lebanese women and sexuality: A qualitative inquiry. *Sexual & Reproductive Healthcare*. 2016 Jan 27.
- (2) Joint United Nations Programme on HIV/AIDS. Lebanon: Country Progress Report. UNAIDS/WHO. 2014.
- (3) DeJong J, Battistin F. Women and HIV: the urgent need for more research and policy attention in the Middle East and North Africa region. *Journal of the International AIDS Society*. 2015;18(1).
- (4) Abu-Raddad LJ, Hilmi N, Mumtaz G, Benkirane M, Akala FA, Riedner G, Tawil O, Wilson D. Epidemiology of HIV infection in the Middle East and North Africa. *AidS*. 2010 Jul 1;24:S5-23.
- (5) Men W. Fact sheet to the WHO consolidated guidelines on HIV testing services. *EMR*. 2015 Jul;31:69.
- (6) Joint United Nations Programme on HIV/AIDS. The gap report 2014. UNAIDS/WHO. 2014.
- (7) Awad, Amr. Can Data Collected by AIDS Voluntary Counseling and Testing Centers in Lebanon be used for Program Planning and Evaluation Purposes? MS Population Health Thesis, Faculty of Health Sciences, American University of Beirut. 2009.
- (8) United Nations Development Programme. Human Development Report (HDR): Work for Human Development. United Nations Development Programme; 2015.
- (9) Barbour B, Salameh P. Knowledge and practice of university students in Lebanon regarding contraception. 2009.
- (10) Santina T, Wehbe N, Ziade FM, Nehme M. Assessment of Beliefs and Practices Relating to Menstrual Hygiene of Adolescent Girls in Lebanon. *International Journal of Health Sciences and Research (IJHSR)*. 2013;3(12):75-88.
- (11) DeJong J, Shepard B, Roudi-Fahimi F, Ashford L. Young people's sexual and reproductive health in the Middle East and North Africa. *reproductive health*. 2007;14(78):8.
- (12) DeJong J, Jawad R, Mortagy I, Shepard B. The sexual and reproductive health of young people in the Arab countries and Iran. *Reproductive health matters*. 2005 May 31;13(25):49-59.
- (13) El Kak F. Gender Differences in Sexual Abuse and Violence among University Students: Results from the First Online Sexuality Survey in Lebanon and the Arab Region. In 142nd

- APHA Annual Meeting and Exposition (November 15-November 19, 2014) 2014 Nov 18. APHA.
- (14)Ghandour LA, Mouhanna F, Yasmine R, El Kak F. Factors associated with alcohol and/or drug use at sexual debut among sexually active university students: cross-sectional findings from Lebanon. *BMC public health*. 2014 Jul 1;14(1):1.
 - (15)Strauss A, Corbin J. Grounded theory methodology. *Handbook of qualitative research*. 1994:273-85.
 - (16)Jamali D, Sidani Y, Safieddine A. Constraints facing working women in Lebanon: an insider view. *Women in Management Review*. 2005 Dec 1;20(8):581-94.
 - (17)Baral S, Logie CH, Grosso A, Wirtz AL, Beyrer C. Modified social ecological model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. *BMC public health*. 2013 May 17;13(1):482.
 - (18)McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Education & Behavior*. 1988 Dec 1;15(4):351-77.
 - (19)Obermeyer CM, Osborn M. The utilization of testing and counseling for HIV: a review of the social and behavioral evidence. *American journal of public health*. 2007 Oct;97(10):1762-74.
 - (20)Chesney MA, Smith AW. Critical delays in HIV testing and care the potential role of stigma. *American Behavioral Scientist*. 1999 Apr 1;42(7):1162-74.
 - (21)Fortenberry JD, McFarlane M, Bleakley A, Bull S, Fishbein M, Grimley DM, Malotte CK, Stoner BP. Relationships of stigma and shame to gonorrhoea and HIV screening. *American journal of public health*. 2002 Mar;92(3):378-81.
 - (22)Gańczak M, Barss P, Alfaresi F, Almazrouei S, Muraddad A, Al-Maskari F. Break the silence: HIV/AIDS knowledge, attitudes, and educational needs among Arab university students in United Arab Emirates. *Journal of Adolescent Health*. 2007 Jun 30;40(6):572-e1.
 - (23)Magnus M, Herwehe J, Murtaza-Rossini M, Reine P, Cuffie D, Gruber D, Kaiser M. Linking and retaining HIV patients in care: The importance of provider attitudes and behaviors. *AIDS patient care and STDs*. 2013 May 1;27(5):297-303.
 - (24)Kalichman SC, Simbayi LC. HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa. *Sexually transmitted infections*. 2003 Dec 1;79(6):442-7.
 - (25)Lee RS, Kochman A, Sikkema KJ. Internalized stigma among people living with HIV-AIDS. *AIDS and Behavior*. 2002 Dec 1;6(4):309-19.
 - (26)Rintamaki LS, Davis TC, Skripkauskas S, Bennett CL, Wolf MS. Social stigma concerns and HIV medication adherence. *AIDS Patient Care & STDs*. 2006 May 1;20(5):359-68.