HIV-Risk Factors for Midlife and Older Women

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Purpose: The number of women aged 45 years and older infected with the HIV virus continues to increase. This study sought to identify, from the voices of midlife and older women living with HIV, the factors in their lives that put them at risk for HIV, so as to improve HIV-prevention efforts for women of this age group. Design and Methods: In this qualitative study, we conducted in-depth interviews with 24 HIV-positive women, aged 45 to 71 years, regarding their exposure to HIV. Results: From these narratives, we identified five individual factors or themes that put women at risk for HIV: drug and alcohol abuse; not knowing the HIV-risk histories of male sexual partners; mental health issues, including physical or sexual abuse and life crises; taking risks for the sake of relationships; and lack of HIV-prevention information. These individual factors and sociocultural factors related to gender, age, and race and ethnicity were organized into a model of HIV-risk factors for midlife and older women. Implications: This model identifies themes to be addressed in HIV-prevention policy, practice, and research in order to reduce the number of new cases of HIV infection among midlife and older women.

Key Words: AIDS, Risk factors, Women’s health

Introduction

In 2003, women accounted for 27% of all new AIDS diagnoses among adults in the United States, up from 7% in 1985 (Centers for Disease Control [CDC], 2005a). Among women with AIDS, women at midlife and older are increasingly represented. In 2000, 25% of all women diagnosed with AIDS were aged 45 years or older at the time of their diagnosis, up from 17% in 1994 (CDC, 2005b). Little is known about the factors in the lives of midlife and older women that influence their exposure to the HIV virus (Zablotsky & Kennedy, 2003). Yet, as the work of infectious-disease specialist Dr. Paul Farmer and a Haitian proverb suggest “beyond mountains there are mountains” (Kidder, 2003): Behind AIDS, there is poverty, inequality, and inadequate health policy toward the world’s poor. Understanding how these and other factors contribute to HIV-vulnerability in midlife and older women in the United States is essential for effective HIV-prevention efforts for this population group. The purpose of this study, therefore, was to identify, from the voices of HIV-positive women aged 45 years and older, the factors in their lives that put them at risk for HIV.

Midlife and older women living with HIV comprise two groups: those who became HIV-infected at midlife or older and those who were infected at younger ages but, as a result of advances in HIV-treatment, survived to midlife and later. Both groups are increasing in size (Mack & Ory, 2003).

Women of all ages are exposed to HIV by the same routes. In 2003, 27% of women diagnosed with AIDS were exposed through intravenous drug use, and 71% were exposed through heterosexual contact; among women exposed through heterosexual contact, 13% had sex with an intravenous drug user (IDU), and 58% had sex with high-risk partners, such as bisexual men or HIV-infected men with unidentified risk factors (CDC, 2005a).

There is evidence, however, that older women and younger women differ on several HIV-relevant behaviors. As age increases, the prevalence of multiple sexual partners and other risky sexual behaviors decrease (Catania et al., 1995; Holtzman, Bland, Lansky, & Mack, 2001). However, older women are less likely than younger women to use condoms (Schable, Chu, & Diaz, 1996; Stall & Catania, 1994), especially if they are women of color (Zablotsky & Kennedy, 2003). Older women often have difficulty talking with sexual partners about condom use for HIV prevention, particularly if they are married or in...
long-term relationships, where requesting condom use may indicate mistrust of a partner or suggest one's own violation of monogamy (Zablotsky & Kennedy). Among African American women, older women are less likely than younger women to be assertive about inquiring into a potential partner's drug or sexual history (Dancy, 1996; Zablotsky & Kennedy). Yet, sexually active older drug users engage in risky sexual behaviors at a rate similar to younger drug users, with the majority of both groups reporting never using condoms during sex (Kwiatkowski & Booth, 2003). Sexual history includes whether or not the male partner is “on the down low,” that is, secretly having sex with men, a phenomenon that has been receiving increasing attention as an HIV-risk factor threatening African American women (Denzet-Lewis, 2003). Women who feel that they cannot ask about their male partners’ behaviors or request condom use may fear that such actions will provoke the men’s anger or violence, an indication of women’s lack of sexual power. Low sexual power predicts low condom use, regardless of age or race and ethnicity (Gomez & Van Oss Marin, 1996).

Older adults, compared to younger persons, have received less information about HIV because they have typically been omitted from HIV-prevention programs (Linsk, 2000). HIV risk-reduction materials tailored for older adults are scarce (Orel, Wright, & Wagnner, 2004). Moreover, older adults are unlikely to discuss sexual and drug-use behaviors and HIV protection with their primary care physicians (Linsk).

However, at all ages, HIV disproportionately affects women of color. African Americans and Hispanics each comprise approximately 12% of the U.S. population. Yet, in 2003, African Americans accounted for 68% of all new AIDS diagnoses among adult or adolescent women, Hispanics accounted for 16%, and Whites accounted for 15% (CDC, 2005a).

Social and economic inequities contribute to women's vulnerability to HIV all over the world (Gross, 2004). In the U.S., areas with high prevalence of AIDS are major metropolitan centers, most of which have high proportions of poor and vulnerable minority residents, high concentrations of illicit drug use and sex work, and, consequently, increased probability of HIV exposure if engaging in unprotected sex or sharing unclean needles (Levy, Ory, & Crystal, 2003; Schensul, Levy, & Disch, 2003). Examination of these structural socioeconomic inequities, however, was beyond the scope of the present study, except as the women described how their economic and social backgrounds influenced their individual lives.

Despite the evidence for the increasing impact of HIV on U.S. women, little is known about factors that contribute to HIV acquisition among middle-aged and older women (Zablotsky & Kennedy, 2003). Rarely are the voices of HIV-positive women of this age heard (Fowler, 2003). A better understanding of women's sexuality and drug use, the sexual choices they make, and what influences those choices across a woman's life span is needed. In addition, existing theories that attempt to explain health-seeking behaviors are inadequate for explaining HIV-related behaviors. For example, the health-belief model (Flack, Siegal, Wang, & Carlson, 1995) posits that a person's behavioral response to a health threat is determined by perception of susceptibility to the threat, seriousness of the threat, benefits of preventive actions, and barriers to implementing those actions. Yet, the power of the health-belief model to explain HIV infection is low because of the complexity of the behavioral responses necessary to prevent HIV infection, as well as the inability of the variables in the model to capture racial and ethnic, as well as gender, differences (Flack et al.; Neff & Crawford, 1998). For the present study, we chose a qualitative methodology, based in grounded theory (Strauss & Corbin, 1998), in hopes of capturing, from the voices of HIV-positive midlife and older women themselves, the factors in their lives that they associated with their acquiring HIV. From their narratives, we aimed to develop a model of risk factors for HIV among midlife and older women that included individual psychosocial factors, as well as sociocultural factors associated with age, gender, and race and ethnicity.

**Design and Methods**

**Sample Selection**

The study was approved for protection of human subjects by the Institutional Review Board of Menorah Park Center for Senior Living. The sample of women aged 45 years or older was purposely selected to represent the two groups of midlife and older women living with HIV: those diagnosed with HIV at age 45 years or older and those diagnosed earlier who survived to midlife and older (Mack & Ory, 2003). To make sure the voices of the first and smaller group would be heard, we required that approximately half the sample be diagnosed with HIV at age 45 years or older. We sought a distribution of African Americans, Whites, and Hispanics of approximately 60%, 20%, and 20%, respectively, similar to the distribution by race and ethnicity of women with HIV in the United States.

We recruited the sample by asking health care providers working in HIV clinics and social service agencies within two northeast Ohio metropolitan areas to identify women aged 45 years or older who were living with HIV. These service providers briefly explained the study to potential participants and obtained their permission to release their names and phone numbers to the principal investigator (PI; Neundorfer). Three women who participated in the study referred friends who met the study criteria. The PI called all potential participants, explained the purpose of the study, and informed them that the interview would be in...
This research involved interviewing HIV-positive women to gather information about their experiences and behaviors through tape-recorded sessions. Consent forms were signed by participants, allowing for the recording of interviews and the release of medical information, including HIV status, laboratory data, and current medications. Each interview was conducted in person by two investigators, with one primarily conducting and the other observing, to ensure consistency and maintain interview quality. Participants chose their preferred location for the interview, with 15 selecting their homes, 8 choosing private meeting rooms in public libraries or social service agencies, and 1 opting for a quiet, familiar restaurant during off hours. All interviews took place from November 2002 to October 2003.

The sample comprised 24 HIV-positive women aged 45 to 71 years, with half aged 50 years or older. The table below provides a sample description and the distribution of themes:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Age at Diagnosis</th>
<th>Race and Ethnicity</th>
<th>Education, Years</th>
<th>Drug or Alcohol Abuse</th>
<th>Not Knowing Partners’ Histories</th>
<th>Mental Health Issues</th>
<th>Taking Risks for Relationships</th>
<th>Lack of HIV Knowledge</th>
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Notes: IDU = intravenous drug user; MSM = men who have sex with men.

Sample Description

The sample included 24 HIV-positive women who ranged in age from 45 to 71 years; half the sample was aged 50 years or older (See Table 1; all participants have been given pseudonyms to protect confidentiality). Eleven women were diagnosed with
HIV or AIDS at age 45 years or older, and the rest were diagnosed at a younger age. Age at time of diagnosis ranged from 30 to 63 years. Duration of time since HIV or AIDS diagnosis ranged from 6 months to 18 years. Fourteen women (58%) were African American, 6 (25%) were White, and 4 (17%) were Latina. All the women were English speaking, except for one woman who spoke only Spanish. She consented to have a Latina social worker translate during the interview. Eight women had less than a 12th grade education, 7 finished high school, and 9 had some college education. All resided in inner-city areas, except for one woman who lived in her mother’s home in a more affluent suburb of the metropolitan area.

As shown in Table 1, modes of HIV exposure were intravenous drug use with needle sharing for 3 women (13%) and heterosexual contact for 19 women (79%); the remaining 2 women (8%) could not identify a mode of exposure. One of these women thought she must have been exposed through a blood transfusion received in 1995, although, given the HIV screening of blood in the United States, she recognized that this was unlikely; the other woman thought she may have been infected through sharing tattoo needles or unprotected sex with a drug-using partner. Among the 19 women infected through heterosexual contact, 12 had partners who were IDUs, 4 had partners who were men who had sex with men (MSM), and 3 had partners whose risk history was unknown to the women. Women diagnosed before age 45 years and those diagnosed at later ages were approximately equally represented across the modes of exposure, except that all 4 women infected by MSM were diagnosed before age 45.

The severity of HIV status of the women ranged from asymptomatic HIV to AIDS: 12 women were asymptomatic, 4 were symptomatic, and 8 had AIDS (defined as HIV infection with CD4+ T-lymphocyte counts of less than 200 cells/mm³ and one or more AIDS-indicator diseases; CDC, 1999). Twenty women were receiving antiretroviral therapy; the others reported that, according to their doctors, they did not yet meet guidelines for beginning antiretroviral therapy.

### Table 2. Interview Guide Questions

1. How do you think you contracted HIV?
2. Were there things going on in your life that put you at special risk for HIV?
3. There are still a lot of women who are not protecting themselves from HIV. What would you tell them?
4. Do you have any special advice for women aged 45 and older about protecting themselves from HIV?
5. Are there special things—positive or negative—about being a woman in your culture, that is being (African American, Latina, White), that we should understand to better prevent HIV in women?

### Interview

The interview included five key questions (see Table 2) that were designed to elicit factors in the lives of the participants that they associated with their acquisition of HIV, as well to determine how, in their view, gender, age, and their particular race and ethnicity influenced their acquisition of HIV. We described the interview as a conversation and asked each woman to begin from wherever it made sense to her. The majority of the women began with how they were infected and what was going on in their lives at the time. During the interviews, we checked the interview guide to see that each question was answered, and if it was not, we guided the conversation so that the participant would address it. The majority of participants, including the one woman who required a Spanish translator, disclosed their stories with apparent candor; two women with histories of mental illness, however, may not have been entirely credible. Although we included these women’s narratives in the tabulations of modes of exposure and the frequency of the themes, we did not include any of their statements as supporting quotes.

### Analysis

The two investigators read each transcript separately, identified repetitive phrases or concepts, recorded supporting quotes from the participants, and then listed these concepts as core categories that contributed to HIV exposure (e.g., drug use, life crises). We then compared analyses of each case and discussed similarities and differences in categories across cases in a “constant comparison” technique, guided by procedures for building grounded theory (Strauss & Corbin, 1998). Four transcripts were read by the two consultants, Dr. Britton, who is an HIV counselor with both clinical and research experience with women living with HIV, and Ms. Lynch, who is the executive director of an inner-city senior-service agency and a key resource on cultural issues affecting African American women. These consultants then met with the two investigators to compare, revise, and add categories to a master list of all categories. We then collapsed the categories into two sets: themes or individual risk factors and the sociocultural factors associated with age, gender, and race and ethnicity. We developed a tentative model of HIV-risk factors and then reviewed the transcripts to confirm that previously identified quotes from the narratives supported these factors. This iterative process led to refinements of the original risk factors and the proposed model. We then counted the frequency of each factor across the whole sample, as well as between the two age-at-diagnosis groups to determine if the risk factors differed for those women diagnosed at or after age 45 compared to those diagnosed at earlier ages. We organized the individual factors and sociocultural factors into a final model of...
risk factors for HIV infection, as identified by HIV-positive midlife and older women (see Figure 1).

Findings

As shown in Figure 1, the model of risk factors for HIV infection for women in this study included three sociocultural factors (age, gender, and race and ethnicity) and five individual factors or themes that influenced the women’s HIV-risk behaviors and subsequent HIV infection. The five individual factors were: (a) drug and alcohol abuse; (b) not knowing the HIV-risk histories of sexual partners; (c) mental health issues (sexual abuse, domestic violence, and life crises); (d) taking risks for the sake of relationships; and (e) lack of HIV-prevention information. The frequency and distribution of the individual factors across the sample are shown in Table 1.

Themes

Drug and Alcohol Abuse ($n = 17, 71\%$)

Drug and alcohol abuse was the most frequently occurring risk factor, with 17 of the 24 women reporting a history of substance abuse. Substance abuse is defined as regular use of alcohol or drugs despite recurrent adverse consequences (Center for Substance Abuse Treatment, 2003), including failing to fulfill obligations at home or work, recurrent social or interpersonal problems, and alcohol- and drug-related legal problems. All 17 women, none of whom reported currently abusing alcohol or drugs, described their past use as either addiction or dependence. Six women reported past use of heroin; 10 women reported a history of cocaine use and 13 reported past alcohol abuse, with many women reporting simultaneous abuse of multiple drugs and alcohol. All the women who had histories of alcohol and/or drug abuse were long-term substance abusers, with the duration of use ranging from 8 to 34 years, often with multiple cycles of recovery and relapse.

Loretta, diagnosed at age 45, represented the 3 women infected through past intravenous drug use, with needle sharing, the highest risk behavior for HIV. She stated, “You are using drugs, and you want what you want. You don’t have a clean set. Well, I want that drug, and so to hell with it.” Tanya, diagnosed at age 36 and a cocaine and alcohol abuser, represented the women at risk because of non-intravenous drug use. She said, “Being a drug user, it makes you vulnerable to a lot of men. You need money to get drugs, or you need drugs to be given to you by men. It makes you do things you normally wouldn’t do. It makes you cross the line.” Although 8 of the 17 substance-abusing women indicated that they were aware that their behavior put them at risk for HIV, they blamed drug and alcohol abuse for interfering with their judgment about protecting themselves. As Thea, diagnosed at age 45 when she chose to go to the hospital for testing, said, “AIDS was in the back of my head, but I was into my addiction and didn’t want to look at it, but my health started declining. I was basically dying.”
remaining 9 women seemed to be unaware of or denying their risk and were tested because of pregnancy, hospitalizations for other illnesses, or service requirements. Loretta, tested because it was a methadone clinic requirement, said: “I really believed that I wouldn’t get it (HIV), partly because my behavior was not allowing me to think.” Desiree, diagnosed during pregnancy, said, “I never thought I would have HIV.”

In addition to the 17 women who were addicted to drugs and/or alcohol, 5 women who were not drug abusers reported that their sexual partners were drug abusers. Therefore, for 22 of the 24 women in the sample, HIV infection resulted either directly or indirectly from drug or alcohol abuse. There were no meaningful differences between the two age-diagnosis groups on the frequency of drug and alcohol as an HIV-risk factor.

The contribution of gender to drug abuse is suggested by the fact that all the substance-abusing women had substance-abusing partners and/or shared homes with other drug-using family members. This may indicate economic dependency on these partners and/or family members, although we did not inquire about the economic nature of these relationships. At least, these relationships suggested a social network that supported substance abuse. As Desiree said, “I have people, even family people, that sells it. It was easy for me to get. It’s always there.”

The influence of race and ethnicity on the theme of drug and alcohol abuse could not be separated, based on the narratives, from the influences of the women’s social networks, neighborhood, and economic status. At the time of their HIV acquisition, however, all but 1 African American and 1 White woman lived in economically depressed inner-city neighborhoods. None of the women commented directly on the link between drug use, their social networks, and economic status. Tanya, however, distinguished drug addiction from race, its going on everywhere.’’ Vera, infected by a husband who was having sex with men “on the down low,” said, “I knew that he was probably messing around with women, but I never thought he was messing around with guys.”

Angela, representing the women who were not able to identify an HIV-positive partner and who had no other HIV-risk behaviors, said: “I was a good woman. I wasn’t the type that ran around with a lot of men—never did no drugs or needle drugs or anything like that. It must have been from one of the guys over the years. I wasn’t the type to go from guy to guy. I was with one guy that I stayed with for 5 to 6 years—just one guy. When the test came up positive, I just couldn’t understand.”

The majority of the women’s partners did not know that they were HIV positive because they had not been tested, but 6 men knew their positive status and failed to disclose it. Lorraine said, “I should have known to protect myself, but I took more confidence in him telling me the truth, because I did ask him, and I said, ‘Are you sure?’ and he said, ‘Yes.’”

Several women attributed their not knowing their partners’ risk histories to gender roles within their racial and ethnic group. African American and Latina women described relationships in which they could not ask men about their sexual or drug-use behavior. Diana, an African American woman, divorced at age 49 and newly remarried to a husband who disappeared for years, said, “I know that he was probably messing around with guys, but I never thought he was messing around with women, but I never thought he was messing around with guys.”}

Not Knowing the HIV-Risk Histories of Sexual Partners (n = 16, 67%)

Sixteen women reported that they did not know the HIV-risk histories of their sexual partners; that is, the men had engaged in (or were currently engaging in) behaviors that were high-risk for HIV or that they had tested positive for HIV. Three women did not know that their partners had injected drugs; 4 did not know that their partners had sex with men; 5 had partners who had not disclosed their HIV-positive status; and 4 were not able to identify an HIV-positive partner or did not know how their partners had been exposed to HIV. Ten of these 16 women were in long-term relationships, ranging from 5 to 20 years, with the men who had infected them. Since these 16 women did not perceive themselves at risk for HIV, they did not use condoms for protection.

Joy, who did not know that her husband of 20 years was injecting drugs, reported: “I knew as a younger person he had used drugs. He was an intelligent person with a good job, a wonderful father and husband . . . . You think, ‘Okay, he is not using drugs now.’ Sometimes he would go on the road for work and he would be there 2 or 3 days and that is when he was using. He would come home and be fine, so he was a functioning addict. What you don’t know is that this person is doing this, and they are doing it right under your nose. I had been nauseated, I had diarrhea, I couldn’t eat and was losing weight, but never did I associate that with AIDS or HIV.”

Vera, infected by a husband who was having sex with men “on the down low,” said, “I knew that he was probably messing around with women, but I never thought he was messing around with guys.”

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within their respective cultures for men having multiple sexual partners. Vera said, “In the Black race, we are sharing men—dating married men or he is seeing other people.” Renee explained, “Hispanic men need to have their wife, mistress, and lover . . . . Then the men got this macho thing, if you are my wife why should I have to use a condom with you?” There were no meaningful differences on the frequency of the “not knowing” theme between the two age-at-diagnosis groups.

**Mental Health Issues (n = 11, 46%)**

Eleven women reported that mental health issues associated with childhood sexual abuse, domestic violence, and/or life crises contributed to their vulnerability to HIV. Eight of these 11 women reported domestic violence from husbands or boyfriends, with 3 abused women reporting being sexually abused as children. Four women reported that life crises contributed to their acquisition of HIV: 3, including 1 abused woman, experienced divorces and 1 became homeless. Mental illness also played into this theme. After years of injection drug use and multiple incarcerations, 1 abused woman was diagnosed with bipolar disorder; the 1 homeless woman had schizophrenia.

Vanessa’s story illustrated how childhood sexual abuse within a drug-using family can progress to early sexual activity, immersion in a drug-using social network, domestic violence, and HIV infection. She reported, “My brothers and their drug buddies abused me. My father and his drug buddies abused me, too. Later, I met Carlos. He was beautiful, macho, and everything . . . . (He) was a heroin IV user and it was a very, very bad relationship. He used to rape me and beat me. He stabbed me and said he was going to kill me. I remember him always telling me, ‘I’m taking you with me with this,’ and I never understood what ‘it’ was.” “It” was AIDS. She learned that she was HIV positive when she delivered her third child.

Candy’s narrative revealed the effect of a life crisis. “When I turned 40, I got divorced and lost my mind basically. I lived in the suburbs and had the ideal life and a beautiful home. I turned to drugs and got addicted to cocaine . . . . I went from Susie-homemaker at age 40, and at age 42 I was a drug dealer.” Promiscuity associated with drug use and drug dealing led to her HIV infection.

Clearly, gender put these women at risk for sexual abuse and domestic violence, which began either in their childhood or when they were young adults. Although as part of their HIV care, most of the women were receiving or had received mental health interventions, none reported any earlier help with these mental health issues. These mental health issues occurred in 3 out of the 4Latinas, 3 out of the 6 White women, and 5 out of the 14 African American women, which indicated that in this small sample there was no clear pattern of race or ethnicity influencing the mental health theme. There were no significant differences between the age-at-diagnosis groups on the frequency of the mental health theme.

**Taking Risks for the Sake of Relationships (n = 9, 38%)**

Nine women reported that they engaged in high-risk sexual behaviors, at least in part, for the sake of relationships that provided male companionship and intimacy. They all engaged in unprotected sex, 5 in new relationships and 4 in long-term relationships. Lorraine, representing the women beginning new relationships, said, “I was getting ready to get a divorce. I knew him and I knew his family. He was such a nice guy. I should have known to protect myself, but even though I was married for 30 years, for the first time I found someone who really cared about me.” Lois, further explaining unprotected sex in new relationships, said, “A few years ago with the way I felt about myself, my self-esteem was lower, and you want a man to like you. If they say, ‘If you want a condom then I’m out of here,’ a lot of women would give in.” Rosa, a long-term drug abuser who had a history of sexual and physical abuse, stayed in a long-term relationship with an IDU even after friends told her that he was having sex with men. She said, “I didn’t know what love was and grabbed it because I never shared it with family members or male companions.”

Although the theme of taking risks for relationships was approximately equally represented in the two age-at-diagnosis groups, many women reported that age influenced taking risks. As Diana said: “(Older women) are happy when someone wants to look at them. At our age, I wonder if I am going to find someone, but then we look in the wrong places.” Vera added: “A lot of women my age have never been married and they are so lonely, so if someone comes along, if they get one guy who’s decent, even though he is with someone else or won’t wear a condom, the women will take it . . . . Women don’t want to use condoms either. We want to put if off on the men, but it’s not . . . . Women of color, we have been taught that you don’t do that.” Thus, gender, age, and to some degree, race and ethnicity interacted to create the theme of taking risks for relationships.

**Lack of HIV-Prevention Information (n = 9, 38%)**

Nine women reported that women of their generation were not aware of the risks of HIV because they had not received HIV-prevention information. Lorretta, infected in 2002 at age 45, said: “I didn’t know how to use a condom. I very rarely had sex with someone that a condom was
used . . . . We weren’t taught those things, it was ‘Don’t get pregnant.’” Similarly, other women reported that they were “naïve” about HIV, thinking “Don’t get pregnant.” Similarly, other women used HIV protection is due to lack of education as far as what was put out there to us (African Americans) in the beginning. The prevention programs I see now go to the west side first, downtown second, and then to the east side (where the majority of African Americans live) last.”

There was no meaningful difference in the frequency of the theme of lack of HIV-information between the two age-at-diagnosis groups. Yet, all 9 women noted that being a woman at midlife and older contributed to a lack of HIV information. First, many rightly pointed out that women were not considered a risk group in the first decade of the HIV epidemic, and, therefore, they were not targeted for prevention information. Since then, they noted that HIV-prevention messages have been largely marketed to the young.

Discussion and Implications

This qualitative study of 24 HIV-positive women, aged 45 years and older, identified five individual risk factors or themes that influenced these women’s HIV infection. In descending order of frequency, they were: drug and alcohol abuse; not knowing the HIV-risk histories of one’s sexual partner; mental health issues, including sexual abuse, domestic violence; and life crises; taking risks for the sake of relationships; and lack of HIV-prevention information. Sociocultural factors of age and gender contributed to each theme. Race and ethnicity contributed to each theme except for mental health issues. Based on this data from the women’s narratives, we developed a model of risk factors for HIV infection among midlife and older women.

Limitations of the study include the small size of the sample, which limits the generalizability. Also, 13 of the 24 women were diagnosed when they were less than 45 years old, which might have reduced how specific the identified risk factors are for midlife and older women. Women in the two age-at-diagnosis groups (younger than age 45 and 45 or older), however, were approximately equally represented in each theme. This may be because in the interview they were specifically asked about how women aged 45 or older might protect themselves from HIV. Also, due to the fact that at the time of the interview all the women were at least aged 45 years old and half were aged 50 years or older, they were attuned to HIV risk from their current perspectives as midlife and older women. Another limitation is that the participants’ recollection of the factors in their lives that led to their HIV infection may have been influenced by the wide range of time since diagnosis (6 months to 18 years), as well as differences in the severity of their HIV status and their histories of substance abuse and mental illness. Compensation of $40 for the interview was undoubtedly an incentive for the women to tell their stories. Most of the women, however, appeared committed to candid participation, as Sandra said, “to keep other women from being in my shoes.” Finally, the influence of race and ethnicity and social network on HIV risk could not be separated from the influence of economic status. Despite these limitations, this study outlines the “mountains beyond mountains” (Kidder, 2003), that overshadowed the women’s lives and contributed to their HIV vulnerability.

As the women’s stories make clear, drug and alcohol abuse, the most dominant theme of the study, casts a dark shadow over HIV. An implication for public-health policy is that drug-and-alcohol-treatment programs that are designed for women, including women at midlife and older, must be expanded. The 2 women who were interviewed while they were residents of a drug rehabilitation center said they were “lucky” to be admitted to such a place since availability was limited. Drug counseling needs to include harm-reduction principles (Springer, 2004) that support women in using condoms and clean syringes when they are under the influence of drugs.

The second most predominant theme, women not knowing the HIV-risk histories of their male sexual partners, implies that primary-care and mental health practitioners need to acknowledge midlife and older women’s sexuality and provide them with culturally appropriate HIV-prevention education. This education needs to help women recognize signs that a partner may be abusing drugs or having sex with men or other women, teach them sexual communication skills, and empower them to make safer sexual behavior decisions.

The third theme, mental health issues, which includes sexual abuse, domestic violence, and life crises, brings into focus the need for better mental health services for women, especially minority women living in economically depressed urban environments (Tangenberg, 2002). As Tanya said, to prevent HIV in women, “You have to have women wanting a future. From the time they are little girls, they need to hear that ‘you have the right to make choices for yourself.’ When you relinquish those rights, you say, ‘I’m not worth it.’ You have to be responsible for your body. It’s not about, ‘Oh baby, if you love me enough . . . .’ It’s about, ‘Oh baby, I love ME enough.’”

The fourth risk factor, taking risks for the sake of relationships, underscores the need for providers in aging, mental health, and HIV services to address low self-esteem in midlife and older women in a society that values youth (Tangenberg, 2002). These service
providers need to understand the cultural context that contributes to women taking risks. Part of that context is limited opportunities for male companionship, as confirmed by data showing that the number of males for every 100 females was lowest among African Americans, compared to other racial and ethnic groups, both nationally and in Cleveland, the primary site of this study (Nelson & Young, 2004). Additionally, more than a quarter of Cleveland’s women live in poverty. Thus, women’s low self-esteem, reduced opportunities for male companionship, and poverty may all contribute to women taking risks for the sake of relationships.

The fifth and last theme, lack of HIV-prevention information, confirms the need for HIV-prevention programs that are targeted to and relevant for midlife and older women. More HIV-prevention programs targeted to older adults are currently being implemented and tested (Altschuler, Katz, & Tynan, 2004; Nichols, 2004). Mility and older women, however, have issues—such as discomfort in sexual communications, inexperience with condoms, low self-worth in a youth-oriented society, and powerlessness within traditional gender roles—that require HIV-prevention programming specific for them.

From the voices of women aged 45 years and older who are living with HIV, this study developed a model of risk factors for HIV infection for midlife and older women. The model identified individual psychosocial risk factors, while suggesting the outlines of the mountains that overshadow these risk factors, including sociocultural factors related to age, gender, and race and ethnicity. It is our hope that this model contributes to future policy and practice initiatives, as well as to the development and testing of HIV-prevention programs specific for midlife and older women, that together will lead to the reduction of new HIV infections in this population group.

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