HIV Education and Contraceptive Planning Among At-Risk Postpartum Women in an Underserved Area

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ABSTRACT

This paper examines a model for providing HIV education and pregnancy planning to women, in underserved communities, at risk of HIV infection and unintended pregnancy. A total of 272 women, who had a history of chemical dependence (primarily crack or cocaine usage), designated the Special Prenatal Care group, or had recently delivered with limited or no prenatal care, assigned to the No Prenatal Care group, were recruited into the program. A questionnaire was administered to collect demographic data, data on health histories, patterns of drug use, contraceptive use and to determine knowledge and attitude levels about HIV prevention and contraceptive use. This information was used by the program's designated health care provider to structure counseling sessions tailored to the needs of the individual woman. Behavioral goals for the project's participants included keeping the postpartum appointment; for those women, who so chose, adopting a method of contraception at the first postpartum visit; increasing the correct usage of contraception; and reducing the frequency of having unprotected sex.

The design and implementation of this project provided the women with enhanced methods to navigate the health care system, a designated health care provider, individualized care, a flexible appointment system, education and instruction in HIV prevention methods and contraceptive use, and linkages to needed social services. The rate of return for the postpartum visit was higher for women who participated in this program than that of the general hospital population, with the highest rates evidenced for women in the Special Prenatal Care group. The demographics of the AIDS epidemic point to the importance of continuing to shape programs to meet the needs of underserved communities.

Introduction

This paper discusses a health education research project (1989-1992), the Perinatal HIV Reduction and Education Demonstration Activity project, situated in an underserved, inner city area of the U.S.-- New York City's Central Harlem. Due to historical factors such as episodic health care, behavior patterns and a fear of genocide (Gould, 1984), it had been reasoned by some practitioners and researchers that minority women in underserved areas would not be willing to embrace educational interventions targeted at HIV education and the selection and usage of birth control methods (Gould, 1984). In other words, traditional methods had not worked and it was time to try something new. This project's investigators sought to document that minority women, at risk of HIV infection and unintended pregnancy, would be receptive to educational messages when they are delivered in an appropriate medium. Behavioral objectives for the project's participants included: keeping the postpartum appointment; for those women, who so choose, adopting a method of contraception at the initial postpartum appointment; increasing the correct use of contraceptives; and, reducing the frequency of having unprotected sex.

Although this project ended over six years ago, the project's message is a timely one for AIDS is still impacting disproportionately upon minorities (The Centers for Disease Control and Prevention (CDC) Combating Complacency - Geneva '98). Through October 1991, the end of this project's recruitment cycle, there were 20,309 cases of women with AIDS reported in the U.S. (HIV AIDS Surveillance Report, 1991). By the close of December, 1997, this number had escalated to 98,468 (HIV AIDS Surveillance Report, January 1998). Minority women account for 76% of the cases of AIDS among women. Of this number, 56% are African American women and 20% are Hispanic women (HIV AIDS Surveillance Report, January 1998). Heterosexually acquired AIDS among women, in the U. S., has escalated from 34% in 1991 to 39% in 1997. The number of pediatric cases of AIDS has accelerated from a total of 3,372 cumulative cases reported in 1991, to 8,086 cases reported by the

end of 1997. African American children make up over half of the pediatric AIDS cases in the U. S. (53% in 1991 and 58% in 1997).

While 53% of the pediatric cases in New York City were among African Americans in 1991, today that number has grown to 56%. (AIDS Surveillance Update, Fourth Quarter 1991; AIDS New York City, Third Quarter 1997). In 1998, African American women make up more than half of the AIDS cases among women in New York City (AIDS New York City, First Quarter 1998). Thus, AIDS was, and still is, of particular concern in New York City, where it became the leading cause of death for women between the ages of 25-34, and impacted disproportionately on African American women and children.

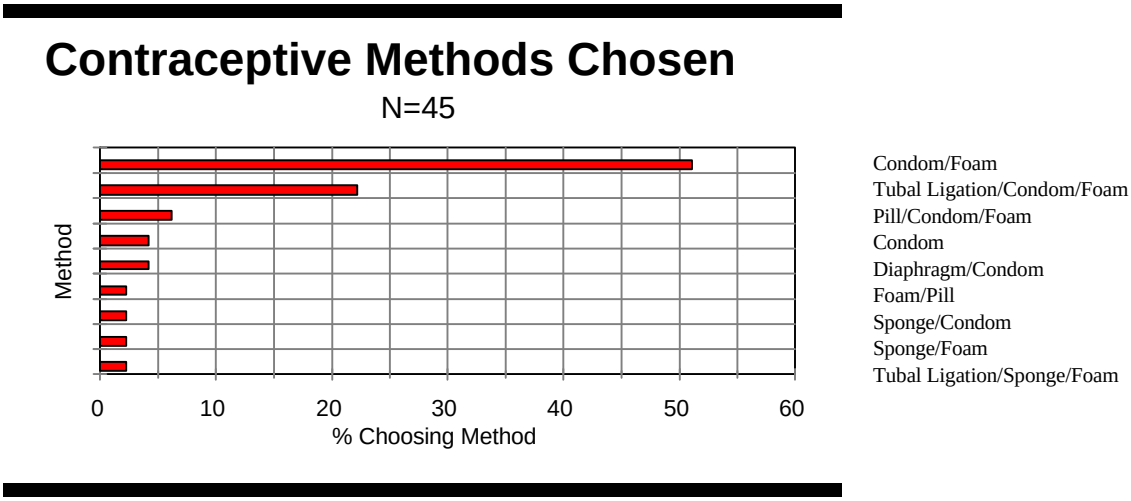
Despite these demographics, a vacuum still exists in the availability of education and prevention services targeted specifically to underserved communities (Stolberg, 1998). According to the CDC report on recent AIDS epidemic trends, "the majority of perinatally acquired AIDS cases continue to occur among African American and Hispanic children. This indicates a need for intensified efforts to prevent infection among minority women and to reach women who are infected with early prenatal care and preventive treatment" (CDC, Combating Complacency-HIV Prevention, Geneva '98). The Perinatal HIV Reduction and Education Demonstration Activity project sought to reach out to this population of women.

Between 1990 and 1991, 272 women (89 percent of whom were African-American), were recruited into the project. These women had either recently delivered with little or no prenatal care, defined as four or less prenatal clinic visits, or were enrolled in the Special Prenatal Clinic, a prenatal clinic designed specifically for women with a history of substance abuse (primarily crack or cocaine). They were considered at risk for HIV infection and unintended pregnancy because of a lack of consistent and correct usage of contraceptive methods; sexual behavior (their own or their partner's) which put them at risk of HIV and STD infection; drug using behavior; episodic health care, leaving them vulnerable to a host of undetected and untreated health problems; and, among the No Prenatal Care group, a lack of counseling and testing for HIV infection.

The project's research assistant administered a structured questionnaire to participants. This instrument was constructed in collaboration with the CDC. It was pilot tested with a sample group of women, and then tailored specifically for the target group of women, in order to obtain data about their socio-demographic backgrounds, health histories, pregnancy histories, drug use histories, HIV/AIDS knowledge, and knowledge and attitudes about contraceptives. They were given two-week postpartum appointments with the project's designated health care provider, the certified nurse midwife (CNM). At the postpartum visit, the CNM provided pregnancy planning counseling and HIV/AIDS education and counseling to the women.

The research assistant scheduled the two-week postpartum appointment with the woman, within 48 hours of her delivery. At this meeting, the research assistant gave each woman a special appointment slip with the name and telephone number of the midwife and two full-time project staff members to contact in case she could not keep her appointment; and the exact location, date and time of the appointment. This appointment slip, was larger than the traditional slip and contained key information about the patient's visit, such as the name of the midwife, which alerted clinic and hospital staff to the patient's arrival. Project staff instructed the woman to ask for the midwife by name, rather than simply state that she had a clinic appointment. These strategies, the special appointment slip and use of the midwife's name to gain entry, proved to be successful tools; both provided tangible ways of assisting the woman in navigating the hospital system. They helped to empower the woman to deal more effectively with the system by making her feel better equipped to overcome operational barriers. She also received a reminder in the mail and a telephone call from the research assistant (all with the participant's prior consent). Thus, reinforcement to keep the appointment was many-faceted.

Ideally, all project participants met the CNM before discharge from the OBS unit. However, due to the historical difficulty of recruiting midwives to a municipal hospital, the project was able to hire a midwife at only 20% effort. Twenty-three percent of the women met with the midwife prior to the first appointment. At this first meeting, the CNM met the woman and addressed her ensuing needs. Prior to the initial visit, the CNM telephoned those patients she had not met, as well as those she had met, and inquired about the woman's well-being; explained the



postpartum visit, addressed any concerns she may have had about this visit; and reinforced the appointment time, date and location.

The women were seen in the general clinic one afternoon per week. On the day of the clinic session the CNM handed the list of scheduled patients to the clinic's clerk to alert clinic staff to the arrival of patients participating in the project. This process enabled the CNM to make contact with the patients as soon as they arrived. The CNM reinforced the project's woman-focused message -- the clinic time was her time during which to discuss any concerns she may have had, whether they were physical or emotional. The CNM would then refer the woman for appropriate services, as needed. All participants who returned for the postpartum visit adopted a method of contraception (primarily condoms) at their first postpartum visit, fulfilling one of the project's primary objectives.

While both groups of project participants, the No Prenatal Care group and the Special Prenatal Care group, were given appointments with a designated health care provider, a higher rate of return for postpartum visits was evidenced among the Special Prenatal Care group (12% vs 74% respectively). This disparity was to be expected as the Special Prenatal Care group of women had been more closely integrated into the health care system, by virtue of their attendance at the Special Prenatal Clinic, than those in the No Prenatal Care group.

Prior to the initial meeting with the woman, the CNM assessed the woman's attitudes and level of knowledge about HIV/AIDS and contraception by reviewing the structured interviews which had been administered by the research assistant. The HIV knowledge and attitudes section of the questionnaire covered seven basic areas: the nature of the disease; how the disease is transmitted; how to prevent acquiring or transmitting the disease; available HIV tests; available treatments; perception of risk; and, sources of information about HIV. These women were reasonably knowledgeable about AIDS. Virtually all knew that pregnant women can give AIDS to their babies, that AIDS can be contracted through sexual intercourse with an infected partner from just one contact, and that AIDS can be transmitted via shared needle use. However, it is of concern that 17% thought that withdrawal was as effective in preventing the transmission of AIDS as was condom use. This item is of particular concern because of its direct implications for the transmission of HIV infection and the need to structure counseling sessions to address this misconception.

Included in the measures of the woman's knowledge and attitudes about contraception were her perceptions of the major advantages and disadvantages of using birth control, including suc issues as safety, cost, accessibility, and partner's attitudes toward family planning. Although 58% of this population brought with them no prior condom experience, 55% of the women, who returned to the midwife for postpartum care, selected condoms as their primary method of choice. While the women's desire to use condoms did exist, their behavior often contradicted

this intent. A prime opportunity exists for the health educator/provider to reduce this dissonance. At the time of the initial, and subsequent, postpartum visit, all women received HIV prevention education tailored to the woman's knowledge level, as determined by the woman's survey responses.

An opportunity also existed to correct any misinformation about condoms. While virtually all of the women said that it was important that a birth control method prevent venereal disease and AIDS, be safe, and that it effectively prevent pregnancy, when questioned about why they would not want to use condoms to keep from getting pregnant, many of the women felt that not only did condoms not protect against pregnancy, but in fact that they might be dangerous to one's health by remaining inside of them. To these women, the condom appeared to be an ineffective method of choice. These responses are valuable for structuring counseling sessions with the patient's health care provider, a time during which this misinformation can be corrected.

This high rate of return of the Special Prenatal Care group of women was most notably due to the frequency of the prenatal visit to the Special Prenatal Clinic, which served to link the woman to the healthcare system. Additionally, this innovative and distinguished clinic was known for providing care in a supportive and caring environment, created by healthcare providers and clinic staff who were responsive to the needs of this population of women. This, too, encouraged their return.

What have we learned about behavioral interventions?

The immediate needs of the target population must be addressed or else a behavioral intervention such as this could be doomed to failure. Women with a history of substance abuse or STDs/HIV have many of the same needs as women in the general population. Historically, women have had a host of priorities which supersede visiting family planning clinics and taking care of their own health. Some women in our target population may also have had additional needs that needed to be addressed - a need to replace a child who has been placed in foster care, and a need for self-esteem enhancement through childbearing. However, a majority of the women assessed initially (77%) responded that they were "not thinking about the possibility of getting pregnant" at the time of their last pregnancy, and 85% did not want another child. Self-esteem enhancement, or empowerment, is a vital element in a behavioral intervention such as ours. These issues can be addressed in the postpartum session and later discussions with the midwife.

We observed that those women who kept their appointments with the CNM, expressed immediate concerns, both physical and emotional. Our study demonstrated that when these needs are taken care of, the individual will be more receptive to HIV and pregnancy planning counseling. In order to address the woman's primary concerns, coordination with hospital-wide services is an important component.

While a majority of the women assessed initially (n=146) had used contraceptives before (56.8% had ever used condoms and 67.1% had ever used the pill), and expressed an interest in using them again (61.6% planned to use contraception to avoid pregnancy during the coming year), many had prior misinformation about the methods that they had used, as well as misconceptions or lack of information about those they had not used. A strong opportunity exists to provide correct contraceptive information to women who had expressed a desire to use contraceptives and to those who may have chosen not to use contraceptives due to lack of information or misinformation.

The intervention must be clear to all participants and potential participants. Project staff discovered, upon rescheduling patients who had missed their appointments, that a few women had feared that a pelvic exam was mandatory at their first visit, and therefore did not keep this appointment. And, initially some women felt that the project was only for women with AIDS. Staff members were retrained to highlight and clarify the features of the project. The research assistant enriched the project by calling it the "healthy mothers" project. Although HIV counseling was a strong component, the women now understood that the postpartum visit would serve as a place where their individual needs would be addressed, and the CNM was their designated health care provider. It is imperative that staff hired to carry out the interventions are knowledgeable about the target population, that staff's attitudes about the target population are assessed, and that appropriate training of this staff takes place.

What have we learned about encouraging traditionally underserved populations to use prevention services?

Prevention services for underserved populations should be flexible. Systems must change to accommodate the needs of those they wish to serve. Although having a CNM at only 20% effort allowed for only one afternoon clinic session per week, decreasing accessibility for many women, some women who could not keep their scheduled appointments walked in the following week, or at a later date. Walk-ins were always welcomed and seen. If underserved populations are to be encouraged to seek care, a protocol for walk-ins should exist.

Reinforcement to keep the appointment must be frequent. Our patients received multiple reminders encouraging them to keep their appointments: the call from the CNM, the mailed reminder, call from the RA and the special appointment slip with the name of the CNM, the location of the visit, and the names of two project staff she should call if she could not keep her appointment.

Prevention services should be multi-service oriented. Since traditionally underserved groups present with a legion of unmet needs, coordination with hospital-wide services is crucial. Women presenting to the midwife with medical complications were referred to the appropriate clinic and returned to her for follow-up. One patient suffering from physical abuse was referred to another project's case manager, who sought services for her at a shelter for battered women.

The intervention's message should be reinforced at each subsequent visit. Ideally, all who encounter the patient should emphasize this message. Due to the history of underserved communities seeking care in hospital emergency rooms, where traditionally continuity of care has been poor, each woman should receive personal assistance in navigating the system.

Conclusion

The design and implementation of this project enabled us to achieve success in getting participants, who had limited experience with the health care system, to return for care at higher rates than the general hospital population. We marketed the project in such a way that the target population perceived it as an endeavor which suited their needs. We designed a very simple, replicable model, which made the system more user-friendly, enabling the women to navigate the system more effectively. Our research analysis revealed that the highest rates of return were evidenced for those who were the most attuned to the system through the efforts of supportive, well-trained staff and flexible systems management. Although the number of staff members was quite small, the CNM at only 20% effort (providing care only one afternoon per week); the research assistant and project coordinator at 100% effort; and data evaluation staff at a maximum of 25% effort, the project was indeed workable.

Recommendations for providing services for at-risk underserved populations

- address individual's immediate concerns
- keep appointments flexible
- provide designated health care provider
- offer services in regular clinic
- structure the overall program so that it is responsive to participants' needs
- address public perceptions of the program
- develop staff training to support program's objectives
- utilize tangible project symbols
- coordinate program with other health and social services
- design multiple reinforcement mediums for delivery of the program's health care message
- tailor counseling sessions to the individual
- manipulate the system to overcome operational barriers, both concrete and perceived

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