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

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ABSTRACT

The Middle East and North Africa (MENA) region is a region of concern in regards to the global HIV epidemic as new infections in the region have tripled in the past decade. In March 2015, a call released through the American University of Beirut urged an expansion of research and policy focused on women and HIV in the MENA region. Through individual, semi-structured, qualitative interviews, we sought to understand barriers to HIV testing among women in Lebanon. Using purposive and snowball sampling strategies, key informants were recruited from a number of regions in Lebanon (N=21; 12 physicians, 9 NGO staff). Data was 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., societal-level barriers, structural-level barriers, interpersonal healthcare provider-level barriers, and intrapersonal-level barriers). Findings can be utilized to inform HIV-related education and sexual health interventions at multiple levels.

Key Words: HIV/AIDS, Women, HIV Testing, Healthcare, Qualitative
BACKGROUND

Research and reporting surrounding women’s sexual health in the Middle East and North Africa (MENA) is scarce (Azar et al., 2016). 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 (UNAIDS, 2014b).

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 (DeJong and Battistin, 2015). DeJong and Battistin (2015) stress that there is likely an under-detection of HIV infection among women in the region. Recent epidemiological literature focused on the MENA region highlights that the primary mode of transmission is heterosexual, but that the primary detection of newly reported HIV infections is centered only among men (Abbu-Raddad et al., 2010). The disproportionate detection of new cases between men and women, when the route of transmission is ostensibly the same, raises concern and requires further investigation.

The global burden of HIV among women is greater than 50% (UNAIDS, 2014c). 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 (UNAIDS, 2014a). The aforementioned studies
point to the fact that the low reported prevalence of HIV infection among women in Lebanon may, in fact, be due to underreporting and under-detection of incident HIV cases. 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 (Awad, 2009). 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, leaving women to go most of their lives without another HIV test.

The MENA region ranks next to last behind sub-Saharan Africa on the UN Development Program gender empowerment measure (HDR, 2015). 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 (Barbour and Salameh, 2009; Santina et al., 2013). 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 (DeJong et al., 2005; DeJong et al., 2007; El Kak, 2013). 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%) (Ghandour et al., 2014). 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.

RECRUITMENT AND SAMPLE

Key informants (KIs) were recruited from a number of regions in Lebanon to participate. 21 KIs participated in the study, twelve of whom are physicians, and nine of whom are staff (non-physicians) at STI/HIV Voluntary Testing and Counseling (VCT) centers and other non-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 purposive sampling strategy 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 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. The decision was made to interview KIs regarding women’s sexual health and HIV testing rather than interview women themselves due to: 1) feasibility; and 2) to better understand healthcare provider knowledge and attitudes that may affect women’s sexual healthcare experience.
DATA COLLECTION AND ANALYSIS

Individual, semi-structured qualitative interviews were conducted between May 2015 and July 2015 in Beirut, Lebanon and surrounding regions. 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 the final interview guide was pilot tested with five healthcare providers prior to data collection.

Participants were contacted via email initially, with a follow-up phone call if no email response was returned within three days. After a brief description of the study, potential participants who showed interest in participation were scheduled for an in-person interview. 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.

Data was analyzed utilizing a Grounded Theory inductive framework (Corbin and Strauss, 1998), and as themes emerged during the interview process, 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 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, usually a doctor’s office or NGO conference room at the place of work of the participant, for convenience. Approval for the study was granted by the Yale Human Subjects Committee and the American University of Beirut Institutional Review Board. Our analyses use pseudonyms for the presentation of data.

RESULTS

Demographics

The demographic characteristics of the sample are presented in Table 1. 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. OBGYN, 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 educated Lebanese people. The sample is predominately male (76.2%), reflecting restraints in employment among Lebanese women (Jamali et al., 2005). Average age of the key informants is 42.3 years (SD = 15.6).
Table 1. Demographic characteristics of key informants

<table>
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<th>Pseudonym</th>
<th>Age</th>
<th>Sex</th>
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Theoretical Framework

Themes emerged 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 (Baral et al., 2013). 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) (McLeroy et al., 1988). An adapted social-ecological model is utilized here to present the emergent themes surrounding barriers to HIV testing among women in Lebanon (see Figure 1): societal-level barriers, structural-level barriers, interpersonal healthcare provider-level barriers, and intrapersonal-level barriers.
1) **Societal-level barriers:**
   - Pre-marital sex as taboo
   - Emphasis placed on women’s virginity
   - Monitoring of women’s sexuality
   - “Dirty vs. Clean” phenomenon
   - HIV as a sexually transmitted disease

2) **Structural-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
   - Men’s health needs valued above women’s
   - Fear of losing patients

4) **Intrapersonal-level barriers:**
   - Fear of anonymity
   - Guilt/shame avoidance
Societal-level barriers

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

Societal-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 access and willingness to HIV testing, as well as access to affirmative sexual healthcare and sexual health education, which will be discussed in further detail below in structural-level barriers. A focus on virginity among young woman, 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 acting 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 through the lens of taboo in Lebanon, women’s experiences with sex and sexuality are particularly restrictive. One participant explained that women’s sexuality is supervised by society:

*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”, rather than “clean” women who do not engage in sex:

*Women are not perceived as sexual beings. If they engage in sex, they are always engaged passively. They’re not people who are going to demand sex, and offer sex, and require sex, and engage actively in sex. They’re just people who are going to be passive in sex. Usually this is why 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 societal-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:

*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

*When the guys come in for tests and you ask why and 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. I usually don’t think that they’re concerned about their health. They’re just disgusted.* – Cyla, NGO

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

*[Please 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
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 wraith punish him.”* – Dr. Lebbos, Infectious Disease

Due to the societal-level barriers to HIV testing for women, 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

**Structural-level barriers**

*It is very important to look critically at the numbers that National Aids Programs 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

Structural-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. A structural-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 societal 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 programs 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 reported that there is very little understanding of affirmative sexual health practices among their patients and clients, and specifically among women. In order to elucidate the lack of sexual health education and knowledge 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, people are left to ignore the disease 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 with your physician and that’s it.* – Dr. Makki, Infectious Disease

Financial issues surrounding reimbursement of HIV testing was also emphasized as a structural-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 Voluntary Testing and Counseling centers (VCT’s) 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

Even if a participant does pay for an HIV test, there is very little incentive to do so, based on the fact that numerous participants explained that one can be dropped from an insurance plan in Lebanon not only for being HIV positive, but also simply for seeking out an HIV test:

*Now medical labs at hospitals are sharing information with [who comes to get an HIV test] to 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. 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

Interpersonal healthcare provider-level barriers to HIV testing among women in Lebanon are those which are influenced by interpersonal 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 affirmative sexual healthcare. One participant from a sexual health NGO recounted one of her client’s traumatizing interactions with a 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 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 multiple times across interviews. Many participants highlighted that gynecologists often merely assume that if a woman is entering their doctor’s office, she must be married. In fact, 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 societal and structural taboos surrounding sex. A key informant who conducts sexual and reproductive healthcare trainings for future and current OBGYNs shared the uneasy response he often receives when training medical students, residents, and current healthcare providers on how to ask a female patient to take an HIV test:

*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

Feeling uncomfortable in administering an HIV test or speaking with patients regarding sexually transmitted diseases was a theme that emerged across numerous 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 women, especially pregnant women, are part of the institutional guidelines, a number of participants admitted that it is easier not to do the testing for fear of a negative reaction from 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 societal norms surrounding marriage and sex often led 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 that, “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, with limited access to sexual health education and knowledge, along with taboos surrounding sex, women do not argue with these explanations:

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

Lack of knowledge surrounding HIV among patients also translates into interpersonal healthcare provider interactions. 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:
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 in many healthcare institutions, misconceptions among women take precedent over affirmative sexual healthcare:

*It’s 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 is 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

**Individual-level barriers:**

_Sometimes [women] are worried because they feel that people will look at them strangely if they go and do 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

Intrapersonal-level barriers to HIV testing among women in Lebanon are behaviors on an individual-level that are influenced by knowledge, attitudes, and beliefs. 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 a theme 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 participant recounted a patient interaction in which the fear of anonymity surrounding an HIV test led a patient to call before coming to the hospital:

_Yesterday, I had one patient calling me and asking me specifically if I am free, and if I have no patients waiting in the waiting area. I told him yes, and I asked him, “why?” Because he saw two other patients that he already slept with._ – Dr. Khoury, Infectious Disease

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 women who do access an HIV test will often go to great lengths to conceal their identity or avoid interaction with people who may know who they are:

_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 are simply 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 it…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. 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:

*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 societal norms affect her clients:

*We have a lot of women coming in here, but we try to talk to them 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...it's like the practice of something, and then 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 seek out 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, along with the powerful societal norms surrounding sex, sexuality, and structural and healthcare provider interactions, instil shame and guilt in women and 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 among women in Lebanon work at multiple levels of an adapted social ecological model (societal-level barriers, structural-level barriers, interpersonal healthcare provider-level barriers, and intrapersonal-level barriers) to negatively influence uptake of HIV testing. Consistent with previous literature, our findings highlight that societal factors have considerable impact on HIV testing uptake (Obermeyer & Osborn, 2007). Sex and sexuality among women in Lebanon is imposed by conservative societal norms and beliefs (Azar et al., 2016). Societal 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 (Chesney & Smith, 1999; Fortenberry et al., 2002). Indeed, across interviews, stigmatizing societal norms surrounding HIV, due to its status as a sexually transmitted disease, acted as barriers to HIV testing among women.

A study investigating HIV-related knowledge among Arab university students in the United Arab Emirates 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 (Ganczak et al., 2007). Indeed, structural-level barriers to HIV testing among women in Lebanon emphasize that lack of sexual education programs greatly inhibit women’s awareness of the health benefits of accessing HIV testing. Financial barriers to HIV testing and discriminatory HIV-related insurance policies also emerged as structural-level barriers to women’s access of HIV testing in Lebanon. Participants highlighted the potential risk of being dropped from an insurance premium simply for seeking out an HIV test: coupled with the need to pay out-of-pocket to access an HIV test outside of a Voluntary Testing and Counseling (VCT) center, there
is limited incentive for women in Lebanon to access an HIV test unless they feel it is absolutely necessary.

Prior literature highlights 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 (Magnus et al., 2013). 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 (DeJong et al., 2005). The current study reinforces prior literature and shows 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 by administering HIV tests all serve as barriers to HIV testing among women in Lebanon.

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 high levels of shame, guilt, and disapproval of people living with HIV (Kalichman & Simbayi, 2003). There is limited investigation of intrapersonal barriers to sexual and reproductive healthcare among women in the Arab world. 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. Internalized stigma among people with HIV is associated with avoiding HIV-related healthcare and medication adherence (Lee et al., 2002; Rintamaki et al., 2006). 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.

CONCLUSION AND FUTURE DIRECTIONS

This study was the first of its kind to investigate barriers to HIV testing among women in Lebanon. Barriers to HIV testing described in this paper may contribute to the low uptake of HIV testing and the low detection of HIV cases, but research on these factors has been limited. 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 in the region. This research highlights the need for sexual health education for the general population in Lebanon, as well as for healthcare providers. 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. Interventions targeting barriers to HIV testing must be implemented at multiple levels in order to affect meaningful change at the population level.
REFERENCES


Rintamaki, L. S., Davis, T. C., Skripkauskas, S., Bennett, C. L., & Wolf, M. S. (2006). Social
stigma concerns and HIV medication adherence. *AIDS Patient Care & STDs, 20*(5), 359-368.
UNAIDS (2014a)
UNAIDS (2014b)
UNAIDS (2014c) Global Statistics