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REVIEW ON HIV AMONG WOMEN IN NURSING PERSPECTIVE

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ABSTRACT

The article review was to identify, discuss, explore, critically analyze and evaluate the scenario of Human ImmunodeficiencyVirus (HIV) among women in nursing perspective taking into account global perspective. The current aim is to reduce the number of HIV globally, especially among women. Acquired immune deficiency syndrome (AIDS) is considered as a disease state of hopelessness and imminent death. HIV and AIDS status demotivate the women emotionally in physical, social, and emotional perspectives. HIV-positive women portray of AIDS is deeply discrediting; with physical failure, moral failure, and social ostracism.

Keywords: HIV, Women, Nursing

RESEARCH QUESTION

HIV is a global issue, with a variety of perceptions among communities regarding patient diagnosed with HIV. Scott (2010) explores the meanings associated with AIDS among HIV-positive women. The study result showed that understanding of disease knowledge can enhance the need of adherence, and individualized patient care. However, men and women have been reported to be differing in their concerns about the implications of HIV infection. As men were more concerned about individual needs, such as resuming and initiating sexual relationships (Solomon *et al.,* 2008). Currently, widowed, divorced and those never married were significantly more likely to have a diagnosed with HIV/AIDS than married women (Sareen, Pagura & Grant, 2009). Besides that, women with higher education were significantly less affected than women who did not complete high school. Besides that, women in the higher household income groups were significantly less likely to be affected than those in the lowest household income group (Sareen, Pagura & Grant, 2009).

Women who were 20 to 24 years old were more likely to be infected compared with those aged between 15–19 years. Therefore, women aged 20–24 years were significantly more likely to be infected with HIV compared with women aged 15–19 years. However, older women might be at increased risk because they were reported having sex more frequently than younger women and were in a longer duration relationship than younger women. The factors that increase the risk of HIV infection included not completing high school, older age, higher HIV prevalence. Education can significantly reduce young women's vulnerability to HIV infection (Pettifor *et al.,* 2008).

Furthermore, the relationship between self-perceptions of risk and prior sexual risk behaviors among women in abusive relationships affect women's current posttraumatic stress severity (Cole, Logan & Shannon, 2008). Whereby, number of sexual partners and illicit drug use were associated with women's self-perceived risk of HIV. Women with HIV-positive were facing social barriers in adhering to antiretroviral therapy and medication adherence due to the absence of love, care, and support from husband and family in providing emotional support. Emotional support and often instrumental support were most desired and wanted (Edwards, 2010).

Moreover, urban and semi-urban women population in Uganda aged between 30 to 34, does not believe in the reliability of the HIV test, whereby, women refuse to attend antenatal care (Dahl *et al.,*

2008). However, Bevier (1995) noted women at a sexually transmitted disease clinic who reported same-sex contact had more HIV risk behaviors and were more often HIV seropositive than women who had sex only with men. Among these individuals heterosexual contact and injection drug use were the most likely sources of HIV. Currently, in Malaysia HIV epidemic is largely driven by intravenous drug use, then heterosexual transmission is accountable for an increasing number of new infections. Therefore, in 2006 the government launched a five-year strategic plan to tackle HIV, which includes, drug substitution therapy and needle exchange programs for drug users.

Overall, there are three main HIV transmission routes in Oceania, namely unprotected paid sex (contributed to a high HIV prevalence among sex workers), injecting drug use (most common HIV transmission route) and homosexual transmission (a prominent feature of many countries' epidemics). Mother to child transmission is also a significant HIV transmission route in Oceania and worldwide. The development also plays an important role in rural Malawi, women who live further from health clinics, major roads, and major cities are less probable to be infected. For men, HIV status is strongly related with migration patterns in specific areas. (Feldacker, Emch & Ennett, 2010).

Critically Analyze the Issue

In order to critically analyze the scenario of HIV among women worldwide, we need to look from all perspectives. Generally, HIV will spread through intravenous drug users, sexual activity and mother to fetus during pregnancy. The spreading of HIV globally was due to migration scenario, which refer to migration patterns in specific areas (Feldacker, Emch & Ennett, 2010). Study in rural South Africa noted that women who experienced intimate partner violence and higher gender inequity in relationships, had increased incidence of HIV infection (Jewkes *et al.,* 2010). Women scored significantly lower than men in psychosocial well-being among individuals living with HIV/AIDS. Whereby, women were more likely to be asymptomatic than men (Solomon *et al.,* 2008).

Regular drug use, criminal justice involvement and risky sexual partnerships were the main contributing factor for HIV infection. The low-intensity criminal justice involvement may serve as a marker for HIV risk among drug involved women. Whereby, the criminal justice involvement may increase the likelihood of HIV infection among drug-involved women by contributing to multiple sexual partnerships (Epperson *et al.,* 2010).

Currently, sex behavior among men (including men having sex with men), multiple women sex partners, visiting sex workers, having sex after consumption of alcohol and lack of circumcision, were significantly associated with a higher risk of HIV. The highest HIV rate was among women who are working as sex workers (Dandona *et al.,* 2010). Therefore, this indicates that women in New York City were more likely to acquire HIV through heterosexual contact and intravenous drug use (Bevier *et al.,* 1995). Solomon *et al.,* (2008) stated that more than 40% of new HIV infections globally occur among women, via heterosexual transmission. In additional, penile-anal transmission was more risky than penile vaginal transmission among men who have sex with men (Powers *et al.,* 2008).

Moreover, socioeconomic factors were associated with an increase in risk of HIV infection among impoverished women, particularly poverty, food insecurity, and partner's occupation are associated with HIV-positive status among women in rural Haiti (Fawzi *et al.,* 2010). Besides that, unemployment, lack of access to health care, stigma, and lack of prevention approaches are to be blamed (El-Bassel *et al.,* 2009). Therefore, significantly higher risk of HIV among unskilled women laborers were noted. Furthermore, a history of having had a blood transfusion and tattooing was also significantly associated with having HIV (Dandona *et al.,* 2010).

HIV as a Global Issue

HIV is a global issue because it involves all countries with respect to the magnitude of problems. Women who choose to terminate a pregnancy in order to appease their partners may experience significant resentment and these feelings may have a negative impact on their intimate relationships (Craft *et al.,* 2007). Most pregnant women were facing this problem. This results in high rate of depression among

HIV-positive pregnant women in Thailand because of low self-esteem (Ross, Sawatphanit & Zeller, 2009). Whereby, emotional support from family and friends was negatively associated with the progression of the disease. Therefore, gender emerged as a strong predictor of risk perception, with females' risk perceptions from both main and casual sexual partners constitute higher weight than that of males (Mehrotra *et al.,* 2009).

Interventions in Globally

Factors such as cultural beliefs, social norms, gender roles and power imbalances among women should be considered in prevention of HIV (El-Bassel *et al.,* 2009). Therefore, the rates of test acceptance increased with the duration of time of suffering while the intervention programs had been running. The importance of this program is an excess of anti retrovirus therapy among HIV infected women (Dahl *et al.,* 2008). Whereby, perinatal HIV transmission has been dramatically reduced in recent years because HIV-positive women were identified during pregnancy, providing timely interventions that decrease perinatal HIV infection (Criniti, Aaron & Levine, 2009).

Universal HIV testing, early in pregnancy and second HIV test during the third trimester to identify women who may have HIV were important. Whereby, it reduces the transmission of HIV to the fetus. Therefore, HIV re-screening in the third trimester of pregnancy with rapid HIV testing technology was highly accepted in an urban prenatal clinic (Criniti, Aaron & Levine, 2009). However, women who refuse third-trimester re-screening should be offered testing in the delivery. Furthermore, continuing to provide risk reduction messages during the prenatal period is important, because our results indicate that risk behaviors continue beyond that.

Moreover, the population attributes also show the importance of effectively addressing the HIV epidemic through programs and interventions (Jewkes *et al.,* 2010). Malawi healthcare slows down the spread of HIV because of successful variation in interventions and policies (Feldacker, Emch & Ennett, 2010). Programs and policies that improve the economic and social status of women may have an impact on reducing the risk of HIV infection.Whereby, economic independence, offer greater capacity against the risk of HIV infection (Fawzi *et al.,* 2010).

IMPLICATION FOR NURSING

Pregnant women with HIV during antenatal check up need to be monitored more frequently and improve their nutritional status in order to increase birth weight viaan increase in caloric intake. As result there was slight differences in pregnancy outcomes between HIV-infected and HIV-uninfected women in Lusaka, Zambia (Banda *et al.,* 2007). It is because the body mass index was associated with a linear increase in infant birth weight regardless of maternal HIV status. Moreover, the nurse should monitor and assess for suicidal tendencies among HIV women. Cooperman & Simoni (2005) found suicidal tendencies was high (78%) with reported suicidal thoughts (since their HIV diagnosis) and 26% of the women in this sample reported a suicide attempt since diagnosis. Moreover, working women with HIV may have to deal with issues of disclosure, discrimination in the workplace, and worry about caring for HIV-positive children, taking medications, becoming ill or missing from work. Therefore, motherhood was a significant predictor of suicidal tendencies and suicide attempts.

Besides that, the nurse should monitor and do an assessment of neuro-cognitive changes and provide proper anti retroviral therapy. Whereby, Maki & Martin-Thormeyer (2009) found a significantly higher prevalence of neurocognitive impairment among HIV positive women compared to HIV− controls regardless of symptom status and with or without an AIDS diagnosis. The risk of neuropsychological impairment was increased among HIV+ women not on antiretroviral therapy. Nurse, should have adequate knowledge about HIV and give proper health education. The stress was an important factor for HIV-positive women in child bearing age. Consequently the must receive quick and accurate information about pregnancy and neonatal HIV transmission (Craft *et al.,* 2007). Therefore, the paramount need of pregnant women is to be tested for HIV and it is essential to provide them with information on neonatal transmission of HIV.

Women with drug users and recent criminal justice

involvement represent a group in greater need of targeted HIV prevention services. The overlapping risk factors of drug use, psychological distress, and criminal justice involvement present a complex challenge in addressing treatment and HIV prevention needs for drug-involved women. Furthermore, an access to drug treatment among the affected populations must be expanded and understood as a potential protective factor against the spread of HIV (Epperson *et al.,* 2010).

However, among African American, women were less likely to report compliance issues with Highly Active Antiretroviral Therapy (HAART regimens) (Cook *et al.,* 2002). In nursing implication, an emergency department, could include HIV screening, testing, prevention efforts for women with drug involvement and overlapping risk factors (Epperson *et al.,* 2010). For women with HIV, housing and employment support may help to reduce not only HIV risk but criminal recidivism as well.

Furthermore, the specific prevention strategies, including psycho education and skills-building activities are essential to allow these women to cope with HIV (El-Bassel *et al.,* 2009). The combining of single-gender groups, couple sessions with both the woman and her partner may be an effective preventive strategy to increase sexual decision-making power and to negotiate sexuality and risk reduction. However, among young black women were twice as likely as their white counterparts to use condoms consistently (Teitelman *et al.,* 2008).

Furthermore, HIV prevention strategies should include media campaigns and community- based programs that involve social networks and local organizations (El-Bassel *et al.,* 2009). In which, multilevel HIV prevention strategies are needed to deal with co-occurring risk factors; social, economic, and gender inequalities; and social norms related to sexuality and HIV risks. Among women who cannot yet depart from a harmful relationships must have protection options available to boost their chances of remaining uninfected with HIV until they can leave (Gollub, 1999). As a result, women who report sex abuse were at higher risk for HIV infection (Bevier *et al.,* 1995).

Clinicians who work with women with HIV need to be aware of these potential limitations and help their patients' to assess their needs for supplemental services such as physical and occupational therapy (McDonnell *et al.,* 2000). On the other hand, it would also be beneficial to examine the role that positive emotion in the lives of women living with HIV, as it appears that women's experience of negative emotions could be eradicated by the experience of positive emotions.

Nurses must assess the presence of partner abuse among both adolescents and young women seeking reproductive health services and provide appropriate supportive services (Teitelman *et al.,* 2008). Besides that, for those with a history of substance abuse and history of partner abuse, needs to be attended to in order to reduce further possible negative psychological and physical consequences.The nurse should be involved in providing safety planning, reproductive health counseling, and referral to hotline and community agencies that specialize in partner abuse intervention and prevention.

In addition to the direct benefit of reducing HSV2-related morbidity, high efficacy HSV2 vaccines could have a substantial impact on population-level HIV incidence, and lower efficacy vaccines could still have a useful impact on HIV if given at high coverage. Vaccines inducing lifelong protection would be easier to implement, because vaccination could be integrated into existing childhood vaccination schedules. For this a therapeutic vaccination therapy is required. Bosch *et al.,* (2010) found in their study, that compared to a group of patients that had tolerated and responded to treatment with concurrent antiretroviral therapy and IL-2, in a previous study, patients newly exposed to IL-2 after initial ART achieved similar CD4 T-cell numbers after 72 weeks.

According to Mallory, Harris & Stampley (2009) suggestions for practice are related to stereotypical views in treatment in a clinical setting. Those interventions that help women achieve higher self-esteem, greater emotional and economic independence are important in improving women's ability to negotiate protective sex practices. Besides that, a clear influence of the community environment in shaping HIV related stigma among young people were noted in the three African countries (Stephenson, 2009). Less supportive attitudes toward those with HIV held by

both young and older people may be the product of exposure to a shared environment; these include lack of HIV services/education programs to marginalized sub-groups disproportionately affected by HIV (Stephenson, 2009). Additionally, young people with high level of knowledge of transmission routes for HIV, concurrently had more supportive attitudes toward those with HIV. Lastly, prevention of HIV among women is intimately associated with the need for social and cultural change and to the promotion of women's empowerment. In the specific context of pregnancy and HIV, some strategies for the prevention of vertical transmission include HIV screening for all women in reproductive age and improvement of psychosocial assessment of social support networks (Pereira & Canavarro, 2009).

RECOMMENDATION

The following are behavioral strategies to reduce HIV transmission. According to Coates, Richter, & Caceres (2008) expanded theoretical and methodological approaches are essential. The limited benefit of behavioral strategies derives from the present dominance of some theoretical approaches is no helping to bring about behavioral changes.The limitations of knowledge from randomized trials testing the efficacy of interventions in individuals and small groups is still noteable. Secondly, it is necessary to understand and stimulate ground-up approaches. Behavioral strategies are needed to mobilize prevention activities and programs. Such efforts inevitably should involve building social and behavioural science capacity, particularly in resource-poor and hyperepidemic settings. Third is integrating behavioral, biomedical, and structural HIV prevention strategies with HIV treatment. HIV prevention with the exception of a prophylactic vaccine does not constitute an effective behavior modification. Fourth, treatment for HIV has extended life in resource-rich countries. Prevention with positive outcomes becomes more achievable as individuals living with HIV/AIDS are encouraged to learn their serostatus and access to treatment (Coates, Richter & Caceres, 2008).

Other than that, encouraging HIV women to use condom during sexual intercourse will help to reduce the number of transmissions. The greater condom usage was related to higher levels of risk perception as it has been hypothesized that people who perceive higher risk of unprotected sex would use condoms more consistently (Mehrotra *et al.,* 2009). Furthermore, an emphasis on prevention of mother to child transmission of HIV (based on short course prophylaxis) such as the three-part regimen Zidovudine and the single dose Nevirapine in labor (Chama, Gashau & Oguche, 2007) was essential. Current therapeutic interventions focus on early initiation of aggressive combination antiretroviral regimens to maximally suppress viral replication, preserve immune function and reduce the development of resistance. The only available HAART regimen was a combination of Nevirapine 200 mg twice daily, Stavudine 40 mg twice daily and Lamivudine 150 mg twice daily, all in tablet form and manufactured by Ranbaxy in India (Chama, Gashau & Oguche, 2007).

To develop and enhance existing prevention interventions at the macrosystem level it is necessary to promote media campaigns designed to increase HIV-related knowledge, encourage routine HIV testing, and promote condom use. Moreover, community based prevention interventions involve networks and local organizations. Outreach efforts have been found to be effective in changing social and community norms for safer sexual relations and reducing HIV. Specific prevention strategies should include psycho-education and skills-building activities to allow women to cope with the consequences of trauma and substance abuse. Ecosystem risk factors such as poverty, unemployment, lack of access to health care, stigma, and lack of culturally preventive approaches in health care systems may lead to the spread of the disease.Therefore expanding the access to effective HIV prevention is essential to eradicate HIV(El-Bassel *et al.,* 2009).

CONCLUSION

HIV is a serious global issue which, caused by sexual activities, drug users whichis is also transmitted from mother to fetus leading to the ever increasing number of HIV infection worldwide. Therefore, each country should work synergistically to reduce the number of HIV globally via the World Health organization. The fundamental behavioural change that is required to reduce HIV transmission

necessitates radical commitment. Prevention strategies will never be useful if they are not put into practice completely, with suitable resources and standards, and with a outlook toward sustainability. It is to be noted that only focusing on sexual risks will never significantly help in the prevention of this disease.

REFERENCES

Banda, Y., Chapman, V., Goldenberg, R. L., Chi, B. H., Vermund, S. H., & Stringer, J. S. A. (2007). Influence of body mass index on pregnancy outcomes among HIV-infected and HIV-uninfected Zambian women. *Tropical Medicine and International Health*,12 (7), pp 856-861.

Bevier, P. J., Chiasson, M. A., Heffeman, R. T. & Castro, K. G. (1995). Women at a Sexually Transmitted Disease Clinic Who Reported Same-Sex Contact: Their HIV Seroprevalence and Risk Behaviors. *American Journal of Public Health*, 85(10), pp1366-1371.

Bosch, R. J., Pollard, R. B., Landay, A., Aga, E., Fox, L. & Mitsuyasu. R. (2010). Continuing or adding IL-2 in patients treated with antiretroviral therapy (ACTG Protocol A5051, a rollover trial of ACTG Protocol A328). *AIDS Research and Therapy*, 7(1), pp 30.

Chama, C., Gashau, W. & Oguche, S. (2007). The value of highly active antiretroviral therapy in the prevention of mother-to-child transmission of HIV. *Journal of Obstetrics and Gynaecology*, 27(2), pp134-137.

Coates, T. J., Richter, L. & Caceres, C. (2008). Behavioural strategies to reduce HIV transmission: how to make them work better. *Lancet*, 372 (9639), pp 669-684.

Cole, J., Logan, T. K. & Shannon, L. (2008). Self-Perceived Risk of HIV Among Women with Protective Orders against Male Partners. *Health & Social Work*, 33(4), pp 287-298.

Cooperman, N. A. & Simoni, J. M. (2005). Suicidal Ideation and Attempted Suicide Among Women Living With HIV/AIDS. *Journal of Behavioral Medicine*, 28(2), pp-149-156.

Cook, J. A., Cohen, M. H., Grey, D., Kirstein, L., Burke, J., Anastos, K., Palacio, H., Richardson, J. Wilson, T. E. & Young, M. (2002). Use of Highly Active Antiretroviral Therapy in a Cohort of HIV-Seropositive Women. *American Journal of Public Health*, 92(1), pp-82-87.

Craft, S. M., Delaney, R. O., Bautista, D. T & Serovich, J. M. (2007). Pregnancy Decisions Among Women with HIV. *AIDS Behaviors*, 11(6), pp 927-935.

Criniti, S. M., Aaron, E. & Levine, A. B. (2009). Using the Rapid HIV Test to Rescreen Women in the Third Trimester of Pregnancy. *Journal of Midwifery & Women's Health*, 54(6), pp 492-496.

Dahl, V., Mellhammar, L,. Bajunirwe, F. & Bjorkman, P. (2008). Acceptance of HIV testing among women attending antenatal care in south-western Uganda: risk factors and reasons for test refusal. *AIDS care*, 20(6), pp 746-752.

Dandona, L., Dandona, R., Kumar, G. A., Reddy, G. B., Ameer, M. A., Ahmed, G. M., Ramgopal, S. P., Akbar, M., Sudha, T. & Lakshmi, V. (2010). Risk factors associated with HIV in a population-based study in Andhra Pradesh state of India. *International Journal of Epidemiology*, 37(6), pp 1274-1286.

Edwards, L. V. (2010). Perceived Social Support and HIV/AIDS Medication Adherence Among African American Women. *Qualitative Health Research*, 16(5), pp 679-691.

El-Bassel, N., Caldeira, N. A., Ruglass, L. M. & Gilbert, L. (2009). Addressing the unique needs of African American women in HIV prevention. *American Journal of Public Health*, 99(6), pp 996-101.

Epperson, M. W., Khan, M. R., Miller, D. P., Perron, B. E., El-Bassel, N. & Gilbert, L. (2010). Assessing criminal justice involvement as an indicator of human immunodeficiency virus risk among women in methadone treatment. *Journal of Substance Abuse Treatment*, 38(4), pp 375-383.

Fawzi, S. M. C., Lambert, W., Boehm, F., Finkelstein,J. L., Singler, J. M., Le´ andre, F ., Nevil, P., Bertrand, D. Claude, M. S., Bertrand, J., Louissaint, M., Jeannis, L., Farmer, P. E., Yang, A. T. & Mukherjee, J. S. (2010). Economic Risk Factors for HIV Infection Among Women in Rural Haiti: Implications for HIV Prevention Policies and Programs in Resource-Poor Settings. *Journal Of Women's Health*, 19(5), pp 885-892.

Feldacker, C., Emch, M. & Ennett, S. (2010). The who and where of HIV in rural Malawi; Exploring the effects of person and place on individual HIV status. *Health & Place*, 16(5), pp 996-1006.

Gollub, E. L. (1999). Human Rights Is a US Problem, Too: The Case of Women and HIV. *American Journal of Public Health*, 89(10), pp 1479-1482.

Jewkes, R. K., Dunkle, K., Nduna, M. & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet*, 376(9734), pp 41-48.

Jewkes, R., Dunkle, K., Nduna, M., Levin, J., Jama, N., Khuzwayo, N., Koss, M., Puren, A. & Duvvury, N. (2006). Factors associated with HIV sero-status in young rural South African women: connections between intimate partner violence and HIV. *International Journal of Epidemiology*, 35(6), pp 1461-1468.

Maki, P. M. & Martin-Thormeyer, E. (2009). HIV-Cognition and Women. *Neuropsychology Review*, 19(2), pp 204-214.

Mallory, C., Harris, G. & Stampley, C. (2009). Midlife African-American women's protective and risky practices related to HIV. *Journal of Advanced Nursing*, 65(6), pp 1248-1258.

McDonnell, K. A., Gielen, A. C, Wu, A. W, O'Campo, P. & Faden, R. (2000). Measuring health related quality of life among women living with HIV. *Quality of Life Research*, 9(8), pp 931-940.

Mehrotra, P., Noar, S. M., Zimmerman, R. S. & Palmgreen, P. (2009). Demographic and Personality factors as predictors of HIV/STD partner-specific risk perceptions: Implications for interventions. *AIDS Education and Prevention*, 21(1), pp 39-54.

Pereira, M. & Canavarro, M. C. (2009). Relational contexts in adjustment to pregnancy of HIV –positive women: relationships, social support and personal adjustment. *AIDS Care*, 21(3), pp 301-308.

Pettifor, A. E., Levandowski, B. A., MacPhail, C., Padian, N. S., Cohen, M. S. & Rees, H. V. (2008). Keep them in school: the importance of education as a protective factor against HIV infection among young South Africa women. *International Journal of Epidemiology*, 37(6), pp 1266-1273.

Powers, K.A., Poole, C., Pettifor, A.E. & Cohen, M.S. (2008). Rethinking the heterosexual infectivity of HIV-1: a systematic review and meta-analysis. *Lancet Infection Disease,* 8 (9), pp 553-563

Ross, R., Sawatphanit, W. & Zeller, R. (2009). Depressive Symptoms Among HIV-Positive Pregnant Women in Thailand. *Journal of Nursing Scholarship*, 41(4), pp-344-350.

Sareen, J., Pagura, J. & Grant, B. (2009). Is Intimate partner violence associated with HIV infection among women

in the United States? *General Hospital Psychiatry*, 31(3), pp 274-278.

Scott, A. (2009). Illness meanings of AIDS among women with HIV: Merging Immunology and life experience. *Qualitative Health Research*, 19(4), pp 454-465.

Solomon, S., Venkatesh, K. K., Brown, L., Verma, P., Cecelia, A. J., Daly, C., Mahendra, V. S. Cheng, N., Kumarasamy, N. & Mayer, K. H. (2008). Gender-related differences in Quality of Life Domains of persons living with HIV/AIDS in South India in the era prior to greater access to antiretroviral therapy. *AIDS Patient Care and STDs*, 22(12), pp 999-1005.

Stephenson, R. (2009). Community factors shaping HIV-related stigma among young people in three African countries. *AIDS Care*, 21(4), pp 403-410.

Teitelman, A. M., Ratcliffe, S. J., Dichter, M. E. & Sullivan, C. M. (2008). Recent and Past Intimate Partner Abuse and HIV Risk Young Women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37(2), pp 219-227.