HIV/AIDS among African American Women in the United States

DR. MICHAEL O. AKINTAYO
Adjunct Professor
General Human Services (Ph.D.), Masters in Administration (M.Sc.)
New York City Department of Health and Mental Hygiene, USA.
E-mail: Akintayomichael@hotmail.com
Tel: (646)-204-9282

FUNKE F. AKINTAYO
Ashford University
College of Health and Human Services
Clinton, IA, USA
Brookdale Hospital, Brooklyn, New York, USA.
Email: Funkeakintayo@aol.com
Tel: (718)-501-5195

Abstract:
This is an exploratory study about HIV/AIDS among African American women in the United States. The aim of this study is to increase our knowledge about the disease to identify how it is affecting the population of study (African American women). HIV dates back as far as 1981 when it was initially identified in West Africa by a group of scientists studying a type of chimpanzee and found out in the chimps a virus known as Simian Immunodeficiency Virus. This study provides measures to decrease risk behaviors associated with the disease among African American women utilizing existing literature to arrive at the conclusion that champions the need to build stronger relationships, families, and communities. Also, effective HIV prevention programs run by African American women and job training, counseling mental health services and family services should be provided to African American women affected by HIV/AIDS.

Keywords: *HIV/AIDS, African-American Women, Relationship, Risk Behavior*

1. Introduction

HIV is the Human Immunodeficiency Virus. It is the virus that can lead to acquired immune Deficiency Syndrome, or AIDS. The Center for Disease Control estimates that about 56,000 people in the United States contracted HIV in 2006. There are two types of HIV known as HIV-1 and HIV-2. In the United States, unless otherwise noted, the term "HIV" primarily refers to HIV-1. Both types of HIV damage a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial in helping the body fight diseases. Once infected with

HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. HIV-2 is less common in the United States but is more prominent in West Africa (Okigbo, 2002). People living with HIV may appear and feel healthy for several years. Even if they feel healthy, HIV is still affecting their bodies. All people with HIV should be seen on a regular basis by a health care provider experienced with treating HIV infection. Many people with HIV, including those who feel healthy, can benefit greatly from current medications used to treat HIV infection. These medications can limit or slow down the destruction of the immune system, improve the health of people living with HIV, and may reduce their ability to transmit HIV (Center for Disease Control, 2012).

AIDS and HIV infection disproportionately affect minority women in the United States. In 2008, AIDS incidence rate were 73 per 56,000 Black women, 32 per 56,000 among Hispanic women, and only 5 per 100,000 among White women. The death rate from AIDS for African American women is ten times the rate for White women and AIDS is a leading cause of death among Black women between the ages of 25 to 44 years (CDC, 2008). It is important to know that early in the AIDS epidemic, most women contracted HIV infection trough injecting drug use, sex work, or transfusions that were contaminated by HIV (Lawrence, Eldridge, Reitman, Little, Shelby & Brasfield).

2. Incidence and Prevalence Rates

In recent times, heterosexual transmission has become the most frequent mode of new HIV infections in women. Heterosexual transmission now accounts for 37% of the new cases of AIDS among women, but only 4% of new cases among men (CDC, 2008). Interesting enough, race and ethnicity are not the risk factors for HIV transmission, but do reflect social, economic, and cultural disparities that are associated with HIV transmission.

Minority women are at greater risk for HIV infection due to higher infection rates among racial and ethnic minorities in the U.S. and an increased concentration of HIV in urban inner city (Dicks, 1994). Also, many African American men report multiple risk factors and low rates of condom use (Peterson, Catania, Dolcini & Faigeles, 2007), heterosexual transmission of HIV to African American women is expected to continue increasing in future (Hobfoll, Jackson, Lavin, Britton, Shepherd, 1993).

3. Objective from Healthy People

It is believed that condom is the most effective way of preventing sexual transmission of HIV for sexually active women who are not in mutually faithful relationships with partners known to be uninfected. It is established that condoms reduce risk of HIV transmission during virginal intercourse by approximately 90% (Trussel, Sturgen, Strickler, Dominick, 1994) however, condom use among inner city African American women remains low (Kelly et al).

It is important to note that efforts to increase condom use among inner city African American women may be more effective when they attend to their social, economic, and cultural realities. Additionally, they need to focus on the nature of relationships between men and women in the African American community. This is true because lifelong monogamy among heterosexual couples is rear among the general population (Phinkerton & Abrahamson, 1993), as well as within the African American community.

In African American community in the United States, women also face formidable barriers in sustaining long term relationships and trying to adopt measures to prevent HIV infection. A typical example is that African American women are more likely to be poor and to live in inner-city areas with higher prevalence of HIV infection and injection drug use (Sobo, 1993). Many African American women perceive that they have little control over the sexual behavior of their partners and limited opportunity to introduce condoms into the relationship (Zierler, 1994).

4. Factors for Increase and Decrease Risks

One step toward decreasing risk is to increase self-protective behaviors among African American women. In order to do this, it is important that African American women understand the differences between women who do and do not use condoms. There is need to increase awareness and improve knowledge among African American women on how to adopt "safer sex" behaviors, including condom use, or increase intentions to use condoms (Shervington, 2007).

Additionally, African American women do not perceive themselves to be at high risk for HIV infection, even when high levels of objective risks are present. African American women are often in denial (Sobo, 1993). Research also shows that women's attitudes toward condom use suggests that many African American women appraise condoms negatively, perceiving condoms to be unromantic and detracting from sexual pleasure (kline, Kline & Oken, 1992).

Furthermore, attitudes of male partners also influence whether African American women are willing to use condom in sexual relationships (Quinn, 1993). Many women believe their partners dislike condoms and perceive condom-protected sex as less enjoyable, reducing the likelihood that women will attempt to introduce condom use into the relationships. This may also increase risks of HIV infection (Libbus, 2005). Another point is that African American women may be constrained by fears of anger, violence, or partner abandonment if they attempt to introduce condoms into the relationship (Shayne & Kaplan, 1995).

5. Clinical Data

Interestingly enough, one-third of all newly reported AIDS cases in the United States are associated with injection drug use, another 20% are related to transmission from drug users through sexual contact or birth and another 25% are among African American women and 35%

from Hispanics (CDC, 2007). Physical findings demonstrate that not only does needle sharing may lead to infection to other injection drug users; it also serves as one of the primary vectors of transmission into the heterosexual population (CDC, 2007). Other trends suggest that the rate of HIV among drug users or abusers is likely to increase.

African-American and Latino communities in the United States are being severally affected by HIV/AIDS and sexually transmitted infections according to available physical findings. Prior research evaluating high-risk behaviors among HIV-infected African Americans or Latinos has been conducted primarily among samples of drug users, men who have sex with men (MSM) or individuals who may not have been receiving regular clinical care (Kaichman, Rampa, & Cage, 2000).

Also, limited data exists concerning minority populations in treatment settings especially among those receiving ongoing HIV clinical care. Objective data suggest that high-risk sexual behaviors were frequently reported among HIV-infected men and women in HIV clinical care in a community with high HIV prevalence. In a recent study, among Latino minority, 76% of HIV infected participants reported being sexually active and 26% had multiple sexual partners (O'Brien, Richardson-Alston, Ayoub, 2003).

Furthermore, other factors in history that has been proven through research is the occurrence of unprotected sex after HIV diagnosis, exchanging sex for money and or drugs was associated with unprotected sex. It has also been established through research that women were less likely to use condoms with any partner during sexual encounter with unknown partners of HIV status (Wingood & Diclemente, 2000).

6. Laboratory Data

Furthermore, other factors that may increase HIV infection are based on laboratory diagnostic test data. Studies based on risk assessments among patients who expressed concern about HIV risk found that 73% of the encounters, the physicians did not elicit enough information to adequately characterize patient's HIV risk status. It is estimated that only two-thirds of all HIV-infected people in the United States know their serological status (Anonymous, 2000).

Untreated early HIV infection is also associated with many diseases including cardiovascular disease, kidney disease, liver disease, and cancer. Support services are also available to many people with HIV. These services can help people cope with their diagnosis, reduce risk behavior, and find needed services. AIDS is the late stage of HIV infection, when a person's immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer with HIV before they develop AIDS. This is because of strong combinations of medications that were introduced in the mid 1990s

7. Pathophysiology of the Risk Factors

The pathphysiology of the risk factors may lead to psychiatric problems. The psychiatric treatments for individuals with HIV infection follow the same principles as for any patient with a psychiatric diagnosis. It is important to help patients cope and deal with HIV illness and, when appropriate, with death and dying. There is also an ongoing need to determine whether new psychiatric symptoms have a medical basis that requires intervention (NYC, Department of Health, 2000).

Additionally, unique treatment issues with HIV patients include working with the patient on disclosure of HIV status. It is equally important to help families with dependent children arrange permanency planning and testing HIV-infected children who have developmental delays resulting from prenatal drug exposure or from HIV infection (Sobo, 2007). Also, one of the problems of the Acquired Immunodeficiency Syndrome (AIDS) is the long incubation during which CD4 T and B lymphocytes and monocytes and other agents are thought to be infected with HIV. The average interval between HIV infection of an adult through sexual intercourse or blood transfusion and development of clinical AIDS is 10 to 18 years (Laurence, 1990).

In 2006, African women accounted for 61% of newly HIV cases among women, but make us only 125 of US female population. The rate of HIV diagnoses for Black women is 15 times the rate for White women. Black women also have high rates of sexually transmitted diseases which can facilitate transmission of HIV (DeCarlo & Olga, 2009). Having STDs other than HIV, having unprotected vaginal and anal intercourse with an HIV positive person, and sharing injection drug equipment with an HIV positive person are the highest risk factors of HIV transmission for African women or anyone (DeCarlo & Olga, 2009).

Another risk is not knowing your partner's risks, such as injection drug use, having other current sex partners or unknown HIV status. In 2005, 80% of Black women were infected with HIV through heterosexual contact and 18% through injection drug use (Rose, Telfair, Raleigh, 2008). In addition, young women and teens are particularly affected. In 2004, HIV was the leading cause of death for black women aged 25-34 years. African American teenagers accounted for 69% of new AIDS cases among teens in 2006, but make up only 16% of US teenagers (Kaiser Family Foundation, 2008).

8. Clinical Nursing Intervention

The most certain way for persons to avoid sexually contracting HIV infection is by refraining from sex under any circumstance where a partner might be infected, whether this is achieved by abstinence or by having sex only in the context of a mutually-monoganous relationship with an uninfected partner. Also, consistent use of condom during intercourse or the adoption of other safer sex practices is widely encouraged among persons who are sexually active outside monogamous relationships with uninfected partners (Vicenzi, 1994). Also, group interventions are effective in producing risk reduction behavior change which focused heavily on skills

training practice or behavior rehearsal exercise in areas critical to successful behavior change enactment. The HIV risk reduction interventions described in group programs are of considerable intensity and duration but very effective (Peterson, Catania, Dolcini, & Faigeles, 2007).

9. Conclusion

Based on this paper, it is evident that African American community will continue to be severely affected by HIV unless prevention ad care efforts are combined with efforts to address the root causes of the disease. African American girls and women, teenagers need to be supported to build stronger relationships, families, and communities, and reduce their risk for HIV and other diseases. Finally, effective HIV prevention programs should be developed and run by African American women and provide job training, counseling mental health services and family services.

References

1. Center for Disease Control and Prevention, (2012), HIV/AIDS Statistics and Surveillance. Atlanta GA:http:www.cdc.gov/hiv/topics/survelliance/incidence.
2. Dicks, B.A. (1994). African American women and AIDS: A public health/social work challenge. In B. A. Dicks (Eds.). Social work in health care (pp.123-143). New York: Haworth.
3. Hobfoll, S.E., Jackson, A.P., Lavin, J., Britton, P.J. & Shepherd, J.B. (1993). Safer sex knowledge, behavior, and attitudes of inner-city women's Association, Health Psychology, 12, 481-488.
4. Kalichman, SS. C. Rompa, D., & Coley, B. (1996). Experimental component analysis of a behavioral HIV/AIDS intervention for inner city women. Journal of Consulting and Clinical Psychology, 64, 687-693.
5. Kline, A., Kline, E. & Oken, E. (1992). Minority women and sexual choice in the age of AIDS risk behavior knowledge: Scale development, validation, and norms. Journal of Behavior therapy and experimental Psychiatry, 20, 227-234.
6. Lawrence, J. S. et al. (1998). Factors influencing condom use among African American Women: Implications for risk reduction interventions. In American Journal of Community Psychology: 26, (1),
7. Libbus, K., (1995). Women's belief concerning condom acquisition and use. Public Health Nursing, 12, 341-347.21-37
8. Okigbo, C. (2002). The HIV/AIDS epidemic in African American communities: Lessons from UNAIDS and Africa. Journal of Black Studies, 32(6), 615-653.
9. Peterson, J.L., Catania, J.A., Dolcini, M.M., & Faigeles, B. (2007). Multiple sexual partners among blacks in high-risk Cities. Family Planning Perspectives, 27, 29-33.
10. Pinkerton, S.D., & Abrahamson, P.R. (1993). Evaluating the risks: A Bernoulli Process model of HIV infection and risk reduction. Evaluation Review, 17, 504-528.

11. Shervington, D.O. (2007). The acceptability of the female condom among low-income African American women. Journal of the National Medical Association, 58, 341-347
12. Shayne, V.T., & Kaplan, B.J. (1991). Double victims: Poor women and AIDS. Women and Health, 17, 1-6.
13. Sobo, E. J. (1993). Inner-city women and AIDS: The psychosocial benefits of unsafe sex. Culture, Medicine and Psychiatry, 17, 455-485.
14. Trussel, J., Strugen, K., Strickler, J., & Dominik, R., (1994). Comparative efficacy of the female condom and other barrier methods. Family Planning Perspectives, 26, 66-72.
15. Vincenzi, I. (1994). A longititudinal study of human immunodeficiency virus transmission by heterosexual partners. New England Journal of Medicine, 331, 341-346
16. Wingood, G. M. & DiClemente, R.J. (2000). HIV sexual risk reduction interventions for women, a review. Journal of Preventive Medicine, 12, 209-217.
17. Zierler, S. (1994). Editorial: Women, sex, and HIV. Epidemiology: 5, 565-567.