THE EPIDEMIC OF HIV AMONG AFRICAN AMERICAN WOMEN

Brittany Thomas
Faculty Mentor: Dr. Ricky Green

ABSTRACT

HIV has reached epidemic proportions in African Americans. Specifically, most women living with HIV are black, and HIV/AIDS is the leading cause of death for black women aged 24-34. Previous research attributes this high incidence to the lack of HIV testing, racial disparities in health care and socioeconomic status, and multiple sexual partners. Even after such research, and the application of existing results, HIV seroprevalence in African American women is still increasing. Thus, the present research aims to uncover other social or economic factors that may be contributing to the high incidence of HIV among black women.

Since the early 1980s, the United States has participated in large-scale national research efforts to identify, understand, treat, and eradicate HIV/AIDS (Beatty et al. 2004). African American men and women are the most at risk group for HIV and AIDS in the nation (Fauci 2009). Although this group is only 12% of the population in the United States, African Americans account for 46% of those living with HIV in this country (CDC 2004). AIDS is the leading cause of death among black women aged 25-34 (Heron et al. 2007) with the reality being that one in every 30 African American women will be diagnosed with HIV in some point in her life (Hall et al. 2008). In 2006, women represented 35% of new HIV infections among African Americans, more than any other race. There are a number of risk factors that contribute to the increasing incidence of HIV in the black community, including a higher prevalence of sexually transmitted diseases (STDs), related stigma, and socioeconomic factors that all help to maintain the burden of HIV in the African American community. This research aims to discuss why the rates of HIV infection among African American women are so high, and to suggest other possible areas that should be researched further in order to decrease the number of new infections. Corollary to the main research question, the researcher will be looking at what is causing the rate of infection to be 15 times as high for black women compared to white women, and four times as high compared to Hispanic women. Research continues to focus on the stated risk factors, but it still has not had enough of an impact to significantly decrease the number of black women getting infected. For the
purpose of this research the terms “African American” and “black” are used interchangeably.

Although there are different ways to contract HIV, sexual contact is the primary mode of transmission (UNAIDS 2002). Sexual transmission of HIV requires unprotected sexual contact and sexual intercourse between HIV serodiscordant partners, in which one partner is HIV positive and the other is HIV negative (Miller et al. 2009). Since 1996, more AIDS cases have occurred among African Americans than any other U.S. racial/ethnic population (CDC 2003), which means they are experiencing HIV at a much higher rate. HIV was the leading cause of death for African Americans ages 25-44 in 2000, compared to it being the fifth leading cause of death for whites and the fourth for Latinos in this age group (CDC 2002). In 2001, the AIDS case rate among African American adults and adolescents was almost 10 times higher than among whites, 76.3 per 100,000 compared to 7.9 (CDC). Specifically, African American women account for 66% of all HIV/AIDS cases among women reported in 2005 (CDC). Research continues to focus on high-risk minority women and men who have sex with other men (Alleyne 2008) while ignoring black women as a separate risk group. More black women are contracting HIV than any other racial or ethnic group in the United States, and among those women living with HIV, black women account for the highest percentage. In 2006, the rate of new infections in black women was 15 times higher than white women per 100,000 women (CDC 2008). HIV primarily affects homosexual men but the CDC reports high-risk heterosexual contact as the source for 80% of newly diagnosed infections of women in 2006. Unprotected sex between infected men plays a role in the increasing number of infected black women (Payne 2008; Gomez et al. 1996). Heterosexual contact and injection drug use were the primary modes of HIV transmission for African American women, but over the last 20 years, more women have become infected through heterosexual contact than through injection drug use (Hader et al. 2001).

METHODS

The present research aims to examine socio-cultural indicators that contribute to the high incidence of HIV infection in African American women. The population for this study is being limited to African American women currently living in the United States. Data for the present research may include other ethnicities of African people that currently live in the United States, but who may not have been born in the United States. The current research only requires African American women who self-identify as “black” or “African American,” since there are those who may be of mixed race and
may choose to identify with other ethnicities. Research also tends to treat blacks in America as one whole group even though there are different ethnic groups within the African American community.

The researcher examined epidemiological and sociological studies to determine which indicators, if any, directly affect the high rate of HIV infection in black women. Indicators can be socio-cultural, socioeconomic, or psychosocial. Various data on the number of African American women with HIV is analyzed to determine a relationship between HIV infection and a specific indicator or group of indicators. Journal articles, experiments and studies on African American women with HIV were reviewed in order to find common risk indicators and behaviors. The researcher looked for adequate research methods and designs that included African American women in their population samples. Those studies that did not have a significant representation of black women were not used.

**LITERATURE REVIEW**

Zierler and Krieger (1997) found structural factors such as racism, poverty, and inadequate access to health care to be the causes of existing and new HIV infections in the African American community. They also discussed how those factors increased rates of infection among women of color. Another study, one of the first public health articles to focus on the experiences of women with HIV, was done by Anastos and Marte in 1989. They wrote about how a woman’s social status and geographic location affects her risk for HIV, maybe more than drug abuse and sexual practices. According to the authors, poor women of color are at a greater disadvantage because “poverty and lack of resources and opportunity keep them in areas of high HIV seroprevalence” (Anastos and Marte 1989, 10). For years, women in the United States faced inequalities in the workplace and now social inequalities are affecting their exposure to HIV/AIDS. Zierler and Krieger (1997) examined the epidemiology of HIV and AIDS among women in the United States linking inequalities of class, race/ethnicity, gender and sexuality with the distribution rate of HIV infection. This study was monumental in prompting public health researchers and epidemiologists to integrate data on women’s social, economic and political conditions into HIV surveillance statistics. It is because of these four categories that women are becoming more at risk for the virus. During the period from 1984-1995, AIDS cases among women rose from 6% to 19%. Statistics show the majority of women living with AIDS in the United States were poor women of color with 75% being non-Hispanic black or Hispanic women (CDC 1996). The death rate due to HIV among black women was nine times higher than white women.
in 1994, and black women accounted for 54.7% of women with AIDS and had the highest number of new infections in 1995 (CDC 1996). With rates of infection increasing since the onset of HIV in the early 1980s, research was essential in this vulnerable population of African American women.

Zierler and Krieger go on to describe how social and economic policies under the Reagan administration forced millions of women out of their jobs and into poverty (Plotnick 1993), most of these women being African American or Hispanic. The “War on Drugs” campaign during the 1980s did not help the number of women of color living in poor neighborhoods where illegal drug trafficking took place, increasing their risk to HIV infection due to injection drug use by them or their sexual partners (Lillie-Blanton 1993; Lusane 1991; NIDA 1991; U.S. DHHS 1985). The researchers also discussed the effects of racism and gender inequalities in relation to sex, violence and drugs as reasons for the increased burden of HIV in populations or color. These studies observed the social surrounding and societal inequalities of black women that place them at a high risk to HIV. This factor still does not provide a conclusion for the increasing number of HIV cases among black women. HIV intervention programs have not been used in a way that speaks to black women specifically. More emphasis on structural intervention is needed to help combat these social inequalities of race and gender among women of color. Zierler and Krieger’s study set out to find out what accounts for the distribution of HIV cases among women in the United States, but it was not specific to African American women. When most African American women are contracting HIV through heterosexual contact, a more explicit study on this type of transmission would benefit the African American population. More research is needed in determining the risk factor for those women who contract HIV from a male sexual partner. In 2007, the CDC published a table reporting HIV cases for female adults and adolescents by transmission and race/ethnicity (CDC 2007, Table 24). Out of the 8,119 black/African American women who became infected in 2007, 44% contracted HIV through heterosexual contact. Under that category is a sub-category of “sex with HIV-infected person, risk factor not specified.” Of the 3,561 women, 3,054 belong to this sub-category. Another 45% of the total number of infected women are in the “Other/Risk factor not reported or identified” category (CDC 2007, Table 24). Research needs to uncover the risk factors of those not reported in the CDC data.

Underrepresentation of African American Women in Epidemiological Studies

In 2004, women accounted for nearly half of all people living with HIV worldwide (UNAIDS) and rates among women in the United States have
steadily increased, accounting for 29% of all newly reported HIV diagnoses (CDC 2002). Research has shown that intervention strategies that appeal to the cultural sensitivity of at-risk populations produce greater reduction in high-risk behaviors (DiClemente and Wingood 1995; J. Jemmott, L. Jemmott and Fong 1992). Another researcher, Kelley states, “...we need not only to change the behavior of individuals but also change social networks and communities…” (1999). If researchers are to provide suggestions on how to decrease the epidemic of HIV in the United States, more focus needs to be placed on those populations with the most infections, in this case African American women. Rates of new infections are increasing among blacks while rates in other ethnic groups are decreasing. Marin et al. (1995) reviewed 41 studies published from 1986 to 1995 and found that only four were adequately designed and showed substantial behavior change. Out of those four studies, only one focused on high-risk women. Women are at a higher risk for HIV infection around the world due, in part, to inequalities in society.

HIV Testing Among African American Women
In a study that examined the prevalence of HIV testing among sexually active black women in the U.S. and the associated social, behavioral, and health care factors, researchers Nearns, Baldwin, and Clayton (2009) found only 28.8% of the women sampled reported having had HIV testing between 2001 and 2002. These results are said to be consistent with previous research by Anderson et al. (2005) who found that only 29.9% of non-Hispanic, black women were tested for HIV during the previous year, and went on to conclude that HIV testing is more common among African Americans and other high-risk populations. However, with a sample size of only 5,226, 29.9% does not constitute “more common” among the general African American population. With HIV rates being disproportionately high among black women, a sample with only 12% being African American does not adequately represent the target risk population, and therefore cannot provide significant results. In addition to Anderson’s study, Brown et al. (2007) examined HIV testing, high-risk behaviors and condom use among an ethnically diverse sample of women and found that black women were three times more likely than white women to report having an HIV test in the past year. Returning to the study by Nearns et al. (2009), 55.3% reported a ratio of income to poverty less than 200%, but 83.8% had more than a high school education, 72.8% had continuous health insurance within the past year, 78.1% had a Pap test in the past year, and 79.7% had not engaged in HIV risk behaviors in the past year. Also, 81.7% had a monogamous male partner in the past year. Persons with increased risk for HIV, drug use or risky sexual behavior had higher reported testing during their lifetime. Nearns et al. found few associations between HIV testing in the past year and socioeconomic
status, or SES, among this group of non-Hispanic black women. These findings suggest black women have similar rates of HIV testing regardless of SES, contrary to previous research (Anderson et al. 2005; Brown et al. 2007; Ostermann et al. 2007). Both Brown et al. and Anderson et al. reported that black women were more likely to get an HIV test, but Nearns et al. does not confirm this conclusion. The CDC also reports that many at-risk black women are not being tested for HIV (CDC 2006).

African American Women and Their Sexual Experiences

Some of the research focuses on the cultural and social structures that influence sexual practice (Bolton 1992; Carrillo 1999; Parker 2001), because structural, political, and economic factors shape sexual experience (Singer et al. 1990; Farmer 1992; Schoepf 1991). As a result, this information tells us more than studying women's individual sexual behaviors and related factors. Research that looks at each race separately to determine cultural and social settings that regulate sexual interaction also provides much needed information that is unique to each population (Parker 2001).

Heterosexual contact has become the primary cause of HIV infection among women in the United States (Gatali and Archibald 2004; Fullilove et al. 1990; Frasca 2003; Miller et al. 2007; Gomez and Marin, 1996). As the primary method of HIV infection shifted from injection drug use to heterosexual contact, researchers Wingood, DiClimente and Hunter-Gamble (1993) were able to predict the possibility of HIV affecting African American women at a much higher toll in the future. These researchers were able to identify African American women as an understudied population at increased risk for infection (Wingood and DiClemente 1998). In a study that examined partner influences of non-condom use among African American women, Wingood and DiClemente found women whose sexual partners did not use condoms, were four times as likely to believe negotiating condom use implied an unfaithful partner, and were three times as likely to have a partner who resisted condom use (Wingood and DiClemente 1998). With a sample size of 128 women from the Bayview-Hunters Point neighborhood in the San Francisco Bay Area, where 84% of the community is African American and 24% live below the poverty line, Wingood and DiClemente assessed behaviors such as sexual behavior, substance use, condom use, and sexual self-control. Results concluded that 45% of these sexually active African American women did not use condoms under the belief that asking their partner to do so would “imply infidelity or may compromise the stability in the sexual relationship” (Wingood and DiClemente 1998, 47). Such patterns of sexual behavior are important in determining how women choose their sexual partners.
To better understand how social class, education and drug use effect sexuality, Fullilove et al. also carried out a study on 28 black women and teenage girls in the Bayview-Hunters Point neighborhood in the San Francisco Bay Area (1990). With the notion that AIDS education is not culture specific, the researchers have noted that an increase in cocaine use, a decline in the economic status of the black community, and an increase in STD infection in black adults and adolescents all contribute to the spread of HIV in urban communities (Fullilove et al. 1990). Using questions such as “How do black couples negotiate meeting potential sexual partners and initiate sexual relations?” helped the researchers initiate conversations about sexual behavior.

African American Women and Condom Use

Women who are in long-term heterosexual relationships may be at greater risk to contract HIV because condom use is limited. In a study that examined 423 sexually active African American women, results concluded that women in exclusive relationships reported less commitment to using condoms (St. Lawrence et al. 1998). This finding suggests that being in a committed relationship with someone known to be uninfected lowers the desire for condom use. If women are trying to get pregnant, using condoms would be unreasonable (Weeks 1995). In addition to this reason, there are a number of different reasons why women do not use condoms. If women feel they are in a committed relationship they likely would have no reason to think that their partner is having outside sexual partners. As a result, condom use becomes less of a priority in such relationships despite the risk for infection.

Other than the lack of condom use, high rates of HIV infection in African American men creates a greater risk for African American women to contract HIV/AIDS (McNair and Prather 2004). African American women are among those least likely to date outside their race (Staples 1981), so they are more likely to have sexual contact with African American men, making this social factor a contributor to the increasing number of women being infected with HIV (CDC 2003). If men are not disclosing their sexual orientation and having unprotected sex with these women, the men are presenting a greater risk for women to become infected. African American women are said to use condoms inconsistently, increasing their chances of contracting sexually transmitted infections. According to existing research, African American women in relationships may be afraid to negotiate condom use with their partners because it is not ‘romantic’ or implies infidelity. A questionnaire completed by 393 low-income, sexually active African American, Hispanic and white women who attended family planning and STD clinics was used to determine how relationship dynamics and ethnicity affect condom use among
low-income women (Soler et al. 2000). The data comes from the social and health service center these women attended in 1994 and 1995, and shows that black and Hispanic women reported higher levels of consistent condom use compared to white women. A large percentage (90-95%) of African American and white women said they were comfortable talking to their partners about using condoms with only 76% of Hispanic women agreeing. A multivariate analysis of the data showed evidence of African American and Hispanic women being more likely to be consistent condom users than white women.

RESULTS
For the past 20 years, there has been documented success of prevention strategies targeting behavioral risk education (Soler et al. 2000), and reports of a decline in the number of annual new HIV infections from 150,000 to 40,000. These findings offer evidence that prevention efforts work (Wolitski et al. 2003), but these efforts have not worked to help decrease the rates of HIV infection within African American communities. Wolitski et al. found that, while rates of HIV infection among African Americans are increasing, rates among white Americans are decreasing (2003). Essentially, these prevention efforts are not reaching the black community as effectively as they are elsewhere. There is a need for more culturally appropriate efforts that are specific to the values and cultural norms in the black community. Strategies should be focused on approaches intended for African Americans (Smith et al. 2000). HIV preventions strategies and programs are not appealing to the cultural differences in these two populations. Studies have shown ‘culturally tailored’ interventions produce reduction in high-risk behaviors (DiClemente and Wingood 1995), supporting the need for changes in the “social networks and communities” that African American women participate and live in, according to Kelley (1999).

Black women are dying at rates higher than any other race or ethnicity due to HIV infection and AIDS. Too many studies that focus on HIV-infected women suggest that African American women are less educated, drug and alcohol users/abusers who cannot negotiate condom use with their male partners. If race was a major risk factor for HIV infection, then anyone who was African American would be at high risk for HIV. Anyone who was poor, used/abused drugs or alcohol, or had a minimal education would also exhibit high rates of infection similar to that of African Americans. Under this suggestion, all races/ethnicities would experience high rates of HIV infections, because African Americans are not the only race that uses/abuses drugs or alcohol, etc. As HIV-infected women tend to be of minority race,
specifically African American, research needs to determine what other risk factors besides drug/alcohol use, education and geographic setting contribute to the rising number of black women infected with HIV each year. As one of the leading causes of death in the African American community, it is pertinent to society to resolve this issue. Research has come very far since HIV/AIDS first introduced themselves to the lives of African American women in the United States.

CONCLUSION

Prevention efforts aimed to reduce at-risk behavior shaped by social, cultural and economic forces not under the individual’s control will not decrease the number of black women infected with HIV. A more in-depth study of HIV-positive African American women is needed to further determine what can be done to decrease the number of infected women. The researcher’s future goal is to decrease the number of newly infected African American women in the United States, along with other scholars already focused on this plan. Hopefully this plan will lead to answers on how to stop the progression of HIV infection in the African American population. However, while the pursuit of this goal could lead to an answer, the present research is only the beginning, an argument for the question not an answer. Scholars, the HIV/AIDS community, and those infected by HIV/AIDS must continue to ask the question: Have we really found the reason for such high rates of HIV infection in African American women? Before any answer can be reached, further examination of the cultural norms should be analyzed from the perspective of the African American population. Questions should be developed from a black cultural standpoint and not from a European standpoint, since that populace within the black value system determines behavior. Answers to these questions will be rooted in the black value system and be more effective in changing negative behavior patterns among African American women.

Future research areas should identify the reasons why some African American women view condom use in a negative way, and how research can design and implement intervention programs that respond to the political and economic limitation society has placed upon the black community. Apparently sexuality is openly discussed in the black community through music, literature and community settings such as barbershops and beauty salons. It is through this open dialogue that researchers can aim to incorporate discussion about HIV/AIDS as a way to ultimately “develop effective AIDS prevention for black women” (Fullilove et al. 1990, 50). As this idea to develop open discussions about sexual behavior and how it affects a woman’s ability to choose sexual...
partners and negotiate condom use is a creative way to get black women talking about HIV/AIDS, it is also important to help black women assess their partners’ risk factors for HIV/AIDS before engaging in sexual activities. In order to fully determine why black women are overrepresented in the number of new HIV infections each year, research must uncover the category of risk factor not yet identified. The risk factor of the male partners needs to be assessed so that researcher can start developing culturally appropriate prevention programs that address black women’s ability to establish safer sex practices.
REFERENCES


