Factors Influencing HIV/AIDS in Women of Color

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SYNOPSIS

Objective: The author reviews selected findings on the behavioral risk factors for exposure to HIV among women of color and the social, psychological, and cultural factors that may be related to these risks and to the use of condoms. The potential value of empowerment models of AIDS intervention for women of color is examined.

Observations: The most common routes of exposure to HIV for women of color are intravenously injected drug use and prostitution related to drug use. A woman's risk for exposure to HIV is related to her ability to protect herself by negotiating a safe sexual relationship with a partner. Women who feel powerless in their relationships are less likely to protect themselves against HIV exposure. These perceptions of powerlessness are the result of a broad array of experiences that may include secondary status, exposure to violence, restricted economic opportunities, and experiences of racism and oppression.

Conclusions: Research on primary and secondary prevention of HIV infection in women of color must acknowledge and address the multiple determinants of health and risk behaviors in research paradigms and methodologies that assess women's risk in relationship to race, ethnicity, and socioeconomic factors.

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INTRODUCTION

The rate of HIV infection is increasing rapidly among women of color, particularly African American women and Latinas. Recent statistics indicate that among people with AIDS in the United States the proportion of women of color has increased dramatically and that women may constitute up to one-half of the AIDS cases in the future.[1,2] These statistics reinforce the importance of identifying factors that place women of color at risk for exposure to HIV.

This article presents findings on the behavioral risk factors for exposure to HIV among women of color in the United States. It reviews selected findings on the social, psychological, and cultural factors related to the behavioral risks for HIV infection and condom use in women. It then identifies factors that should guide research on HIV prevention for women of color, with particular emphasis on interventions that foster a sense of efficacy and empowerment regarding prevention of AIDS.

BEHAVIORAL RISK FACTORS FOR EXPOSURE TO HIV

The most common routes of exposure to HIV for women of color are intravenously injected drug use and prostitution related to drug use. Many drug-using women exchange sex for drugs or for money to purchase drugs.[3] One study found that 80% of women using crack cocaine reported exchanging sex for crack and 86% reported exchanging sex for money to buy crack cocaine.[4] A similar study reported that more than one-third of women using crack cocaine had more than 100 sexual partners in their lifetimes, and only 38% reported using condoms during vaginal sex with clients.[5] Women using crack cocaine were found to be significantly more likely than non-users to have had more than 20 sexual partners, to sell sex, and to have a sexually transmitted disease.[5] Seroprevalence studies of women using crack cocaine reveal high levels of HIV, and recent statistics indicate that 44% of all women with AIDS have a history of drug use.[6] Several studies have shown that HIV-positive status is directly related to a woman's involvement in prostitution and the use of crack cocaine.[6,7]

For women using intravenous (IV) drugs, the risk of exposure to HIV is significantly affected by drug use patterns, sexual behaviors, and personal relationships. Unlike women using crack cocaine, women using IV drugs are more likely to be involved in a monogamous relationship with a male IV drug user. These relationships may have considerable impact on the woman's drug use and risk for HIV infection. For example, Barnard found that women who obtained their needles from their male sexual partners were limited by the nature of the relationship in their ability to negotiate needle cleaning.[8] Women using IV drugs were more likely to share needles only with their partners, but male IV drug users were likely to share needles with many others, a practice that greatly increased the risk of HIV exposure for women using IV drugs.

SOCIAL, PSYCHOLOGICAL, AND CULTURAL FACTORS INFLUENCING BEHAVIORAL RISKS

There is increasing awareness of the broad array of social, psychological, and cultural factors that increase women's high-risk behaviors and exposure to HIV. Early research on HIV prevention focused almost exclusively on the impact of individual factors, such as perceived risk and knowledge of HIV prevention, on HIV risk behaviors. Recent research has focused on women's HIV risk in the context of broader social issues, such as gender relationships, power dynamics, socioeconomic factors, sex roles, and experiences related to race and ethnicity.[9] These studies are based on the recognition that a woman's ability and willingness to protect herself against AIDS, especially in the context of an intimate relationship, is directly related to her sense of empowerment and perceptions of efficacy in her personal life. In turn, a woman's sense of empowerment and efficacy is influenced by the nature of her interactions with the larger community and society. The impact of self-efficacy and empowerment on HIV risk in women of color may be particularly significant since they often face multiple burdens of racism, sexism, and poverty that may increase feelings of powerlessness and hopelessness.[10,11]

Growing evidence suggests that gender differences in power, efficacy, and socioeconomic status are related to gender differences in patterns of drug use that may increase exposure to HIV.[12] For example, women who use illegal drugs are more likely than men to use multiple drugs and use several drugs concurrently, report somewhat higher levels of drugs used but less money spent on drugs, live with a partner who is dependent on drugs, show symptoms of depression and isolation, and report more family and job pressures.[13-17]

Compared with women who report that they do not use illegal drugs, drug-using women are also more likely to be single, separated, or divorced; have less than a high school education; use alcohol and tobacco; and have fewer sources of social support.[14,16,18] Trauma, especially exposure to violence, may be a particularly important predictor of women's illegal drug use.

Pregnant victims of abuse are more likely to use alcohol, marijuana, and cocaine than nonvictims, and women who experience maternal battering report more alcohol and cocaine use than nonbattered women.[14] Women who abuse drugs are more likely to have histories of abuse and to be physically and sexually abused during the time of their drug use.[19]

These data strongly suggest that women drug users are more likely than men drug users to be socially isolated, depressed, and dependent on their partners. They also suggest that women who use drugs may initially engage in the social use of drugs as a means of coping with previous life traumas and high levels of stress. However, as they become more entrenched in the drug lifestyle, they become more alienated from the larger society and from their own communities. This reality reinforces their drug use. Unlike men, they may have limited options for social and economic support. As a result, they become further enmeshed in the drug lifestyle and dependent on sexual exchanges as a means of earning income. This creates a treacherous cycle of early trauma, social drug use, isolation, marginalization, increased drug use, and increased risk for exposure to HIV.[20,21]

This cycle is exacerbated for women of color who use drugs and whose statuses as women and ethnic minorities intersect to foster even greater drug dependence and involvement in the drug lifestyle. Several studies have documented ethnic differences in the initiation, addiction, and treatment phases of drug use for women. These studies indicate that women's initiation into drug use and their progression through the addiction cycle are significantly influenced by male partners.[22] In contrast, women partners do not generally influence the patterns of drug use by men. Other investigators have reported that male-female differences in drug use are more pronounced among ethnic minority women, particularly for Latinas in the United States. Anglin and colleagues have concluded that sex role conflicts, restricted job opportunities, and other marginal attributes affect all women, but their impact may be more severe for Latinas.[21]

The psychological and social factors influencing drug use in women of color and the nature of their relationship with their partners also influence decisions regarding condom use.[23] While many women who use drugs report that they recognize that condoms are useful for preventing HIV infection and other sexually transmitted diseases, they do not usually use them.[7] Fear of violence from their partners has been cited as a contributing factor.[24,25] The threat of violence is a reality for many women who use illegal drugs. Previous histories of violence and fear of further abuse are significant deterrents to negotiating safer sex.[24,26]

Role perceptions and interests may also influence the degree to which many drug-using women are likely to resist condom use. Low-income women who use drugs may seek the economic and emotional support of their male partners and may not be willing to risk losing that support.[26] Several investigators have reported that, especially for Latinas, the greatest obstacles to negotiating safer sex, including condom use, are social expectations that women will respect their men by playing a submissive role in the relationship and in sexual activities.[11,26]

Differences in perceived roles and power also influence the ability of prostitutes and drug-using women to negotiate safer sex. Longshore reported that perceived self-efficacy predicted sexual risk-taking by drug-using women.[27] Women with higher perceived efficacy in negotiating safer sex were less likely to engage in high-risk sexual behaviors. Cohen and colleagues found that negotiating condom use with a male client is a difficult problem that involves interpersonal power.[7] They concluded that the unequal power of women in relationships with men is the root cause of the refusal of drug-using women to use condoms: "The degraded, vulnerable, and impoverished condition of the 'crack whore' precludes being able to insist on using condoms or refusing to have relations with IV drug-using men."[7] Worth has argued that condom use requires a social assertion of power, control, and self-respect that most women find difficult to maintain on the street.[24] The lack of opportunity and structure in the lives of most women who use drugs also limits their concern for the medical and behavioral consequences of their sexual behavior.[24] Cohen concludes that "at this desperate and despondent point in their lives, some of these women may actually be committing a less direct form of suicide."[7]

The critical impact of social factors such as power differences, socioeconomic factors, sex roles, and fear of violence on a woman's ability or motivation to protect herself from HIV through condom use or other means has also been examined in women who do not use drugs. Quinn found that women who do not use drugs who are at greatest risk for HIV infection are those who are less educated, have the least sexual power (not sexually assertive), and have a history of abuse.[10] For Latinas, low perceived power in a relationship (less autonomy in sexual decision-making) was associated with less condom use and higher rates of partner abuse. Beadnell found that abused women were more likely than non-abused women to report traditional sex roles,

involvement with the sex trade, involvement with a risky partner, substance use, no condom use, and psychological distress.[28] These battered women also reported lower perceptions of control over safer sex, lower self-efficacy in sexual negotiation, lower self-esteem, and lower likelihood of participating in an HIV intervention.

These findings strongly suggest that power is a major factor underlying women's HIV risk-reduction practices. Women who feel powerless in their relationships are less likely to protect themselves against HIV exposure. These perceptions of powerlessness are the result of a broad array of experiences that may include secondary status, exposure to violence, restricted economic opportunities, and experiences of racism and oppression.[9-11,24-26] Exposure to violence is also a significant correlate of poor health behaviors and feelings of powerlessness.[29]

These conclusions are consistent with findings from a study of health promotion and risk behaviors among low-income African American and Latina women in Los Angeles.[29,30] Low-income women of color whose daily life experiences were characterized by high levels of violence, economic stress, and experiences of racism were more likely than women with low levels of these factors to experience psychological distress and were less likely to engage in health promotion behaviors of any kind. These women were depressed and alienated from both their own communities and the larger society. They felt powerless and hopeless and perceived that they had little control over their lives or health. As a result, they engaged in fewer self-protective behaviors and more risk behaviors.[29,30]

We have developed a theoretical model to explain relationships between social factors and poor health outcomes.[29] It describes the potential impact of factors such as exposure to racism or violence on priorities regarding health and motivation to improve health. It incorporates existing knowledge regarding the foundations for health-protective behaviors and empirical findings from several studies.[29,30]

The model suggests that a sense of stability and trust in the future are critical preconditions for engaging in healthy behaviors. It posits that healthy behaviors are related to people's perceptions that they can control their health and life outcomes.[29] Experiences that reinforce a sense of powerlessness and hopelessness tend to be expressed as feelings of powerlessness and hopelessness regarding health. According to Rainwater, to protect one's health is to behave as if one has control over one's life and outcomes.[31] In the absence of control over one's life, taking care of one's health has no meaning.

Life experiences that reinforce a sense of inferiority, powerlessness, and hopelessness severely limit the degree to which certain preconditions for healthy behaviors can be met. Experiences of violence and oppression related to one's gender or ethnicity can significantly and negatively influence one's perceptions of well-being and one's ability to influence future outcomes. These issues may be particularly important for minorities, whose sense of efficacy and control often derive from the nature of their social experiences and the larger social structure in which they live.[10,11] For women of color, life experiences that result in feelings of alienation, powerlessness, and hopelessness may increase feelings of marginalization, affect perceptions of control over life, and decrease motivation to influence future personal and health outcomes. Such perceptions may significantly increase the likelihood of engaging in risk behaviors, such as failure to use condoms.

DISCUSSION

Women's risk behaviors are associated with a complex array of individual, psychosocial, and environmental factors and conditions. Future research on primary and secondary prevention of HIV infection in women of color must acknowledge and address the multiple determinants of health and risk behaviors. Researchers will need to develop paradigms and methodologies that assess women's risk in relationship to race, ethnicity, and socioeconomic factors.

The findings on factors related to HIV risk in women of color are consistent with an ecological conceptualization of risk behaviors and suggest an ecological approach to future research on HIV risk in women of color. An ecological approach focuses on the environmental, cultural, and social correlates of health and risk behaviors while acknowledging the individual factors that also contribute significantly to health and risk behaviors.[32,33] In an ecological framework, effective health promotion programs must identify and address the social, cultural, psychological, and economic factors that influence health and risk behaviors in women as well as the cultural and community factors that maintain health and risk behaviors.[32]

Amaro and Raj have recommended the development of theoretical models to guide research that examines the individual, cognitive, and behavioral factors that increase HIV risk in women of color.[9] These models would stress the importance of examining critical factors within the context of the larger social dynamics of oppression, racism, and sexism. An

example would be a model that focuses on self-efficacy as an immediate predictor of HIV risk behaviors while investigating how contextual factors, such as experiences of racism, exposure to violence, or sex role expectations, may influence immediate predictors, such as self-efficacy.[9]

Although limited, the success of health intervention programs that focus on social and cultural factors influencing AIDS risk in women of color supports an ecological approach to AIDS prevention. Programs that have been developed with ethnic identity as a central theme have been successful in changing attitudes regarding condom use by women of color.[34] This approach, which focuses on health as both an individual and a group responsibility, seems promising and is currently available.

Ethnic identity and empowerment programs often include discussions of women's roles and status in their society, the repercussions of discrimination and oppression, women's relationships and patterns of social support, and religion and spirituality.[26,34] In particular, women are encouraged to discuss the ways in which they may draw on their strengths as members of ethnic groups to decrease their risk of AIDS. Women are also encouraged to examine the circumstances of their communities and identify the forces that encourage high-risk sexual behaviors and exposure to HIV. These factors may include the economic, political, and social factors that place women at risk for substance abuse and exposure to HIV. The primary focus of these interventions is to help participants avoid self-blame while building a sense of personal responsibility to change individual health habits and unhealthy social conditions. Culturally important concepts are used to motivate women's behavior. Although the specific focuses of programs vary, the interventions generate group discussion about how race, class, and gender affect the risk of contracting HIV and how community strengths and social institutions (church, kin networks) can become forces to help people avoid the risks. In the process, women may become more aware of the factors influencing their behavior and develop strengths to overcome the barriers to and advocate for their own economic, educational, health, and other needs.

Conclusion

Risks for AIDS must be understood and addressed in the context of women's lives. Preventing HIV exposure among women of color may demand the development of programs that address the gender, class, and ethnic issues that increase women's risks. The increasing rates of AIDS among women of color reflect our failure to view women's risks separately from men's risks and to analyze the unique forces that affect women's lives. Gender roles and relations, reproductive issues, and social conditions that place women in dependent relationships and secondary status relative to men limit women's abilities to recognize the risk they face and to make changes in their lives and relationships to decrease that risk.[11,24-26] The lack of economic, social, cultural, sexual, and technological options leads vulnerable women to concentrate on addressing the more immediate risks in their lives, such as poverty, homelessness, and financial support rather than health and safety. These factors form the foundation for the increasing rates of AIDS. Until these issues are addressed, many women will continue to be at risk for AIDS and to make choices that do not reduce their risk.

Emphasizing the importance of relationships between social position and experiences in a society and health outcomes is not new. In the field of public health, secondary status and oppression have often been seen as markers for poor health outcomes. AIDS activist Jonathan Mann concludes that a patriarchal society in which women experience secondary status relative to men is one of the most significant predictors of poor health outcomes.[35] He, as well as others, has also stated that inequality in status and power is one of the most fundamental causes of diseases such as AIDS.[35,36] Regardless of how it enters a country, AIDS will always settle among the groups that are most oppressed—those who are discriminated against, marginalized, stigmatized, and excluded from society.[35] As Christensen notes, "HIV infection tends to worsen already existing forms of inequality and oppression based on gender, race, and ethnicity."[36]

These conclusions suggest that, at its core, prevention of AIDS is a human rights issue that is tied to other human rights, such as the right to dignity, respect, and freedom from oppression and sexism. If we are to be successful in eradicating this disease, we must generate useful data and use them to identify and address the critical social and cultural issues that significantly impact the lives of women of color and their risk for AIDS.

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