
AFRICAN AMERICAN WOMEN AND HIV RISK: EXPLORING THE EFFECTS OF GENDER AND SOCIAL DYNAMICS ON BEHAVIOR

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African American women and men continue to be disproportionately infected with sexually transmitted diseases (STDs), including the human immunodeficiency virus (HIV), the virus that is a precursor to acquired immunodeficiency syndrome (AIDS) (CDC, 2000; 1998). Although African Americans represent only 12% of the U.S. population, they comprise 37% of the total AIDS cases in the U.S. (CDC, 2000). According to the Centers for Disease Control and Prevention (2000), women are increasingly becoming infected with HIV, accounting for 28% of HIV infection cases. Alarming, African American women and adolescents are particularly at risk, accounting for 68% of women infected with HIV through June 2000. The annual AIDS case rates for African American women are 16 times that of White women (National Center for Health Statistics, 1997). The two largest exposure categories for women are heterosexual contact followed by injection drug use.

Given the escalating rates of HIV infection among African American women, it is imperative to look at the behaviors that place these women at risk for HIV. Moreover, it is important to situate African American women's experiences within broader societal and relationship contexts. This paper will address African American women's HIV risk, paying particular attention to the gender and social dynamics (particularly class and youth) that affect these women. Within this scope, we will examine the interplay of race, gender, age, and class, by examining the extant literature related to adolescent girls and college-aged women, low-income women, women who are drug users, and women who have sex with women (WSW).

Gender and Societal Dynamics

Negotiating for Condom Use. Condom use and the reduction of multiple sexual partners are often recommended as effective strategies for STD and sexually-transmitted HIV prevention (Taylor, 1995). However, these strategies alone are not sufficient for preventing the transmission of disease because many individuals use condoms inconsistently (Desiderato & Crawford, 1995; Dolcini, Coates, Catania, Kegeles & Hauck, 1995; Freimuth, Hammond, Edgar, McDonald & Fink, 1992; Mays & Cochran, 1993; Sobo, 1993). Wingood and colleagues proposed that "engaging in safer sex is not merely a question of proper condom use; rather, it involves issues of

trust, sexual negotiation, power, sexual self-efficacy, and gender roles” (Wingood, Hunter-Gamble & DiClemente, 1993, p. 202). The issues that Wingood et al. (1993) address are important to consider when examining women’s risk of heterosexual exposure to HIV because heterosexual relationships involve simultaneous and complex interplays of power, perceived trust, and gender expectations.

Frequently, individuals may determine that they have accurately judged their partner’s health status and thus assess that it is safe to have unprotected sex (Afifi, 1999; Kline, Kline & Oken, 1992). Women may not want to risk losing a steady relationship and imply mistrust of their partners if they feel that they have already determined that the person is “safe” (Afifi, 1999). Given the low rates of consistent condom use, the need for alternative strategies (e.g., sexual communication) is also important, especially in circumstances in which condom use may not be an effective strategy to ward off disease, such as when STDs are transmitted through skin-to-skin contact (e.g., herpes). Sexual communication between intimate partners might be one alternative strategy to consider because, if used in conjunction with other proactive measures, individuals may be able to protect themselves from disease by making more informed decisions about the people with whom they become sexually involved. Without communication of vital information about their partners’ sexual past and present behavior, women will not have an accurate appraisal of their risk (Campbell, 1995).

Socialization and Concepts of Femininity and Masculinity. Socialization and societal messages play important roles in how women and men view sexuality and their roles in intimate relationships (Campbell, 1995; Fullilove, Fullilove, Haynes & Gross, 1990; Holland, Ramazanoglu, Scott, Sharpe & Thompson, 1990; Mane, Gupta & Weiss, 1994; Taylor, 1995; Weeks, Grier, Radda & McKinley, 1999; Wingood et al., 1993; Wyatt & Riederle, 1994). From early childhood through adulthood, women and men receive mainstream and personal messages about appropriate sexual and gender role behavior and what it means to be feminine and masculine. Historically, it has been expected that women will have little sexual knowledge and experience and that men will have more knowledge and experience (Taylor, 1995; Wyatt & Riederle, 1994). These polar messages convey that men are supposed to be dominant and women should be submissive (Holland et al., 1990; Taylor, 1995; Wingood et al., 1993) in romantic relationships. Often, women fulfill these expectations even though such “traditional” relationships are implicitly unequal.

Such messages can also contribute to an environment in which it is awkward or unacceptable for a woman to question her partner’s sexual behavior or history. If a woman seeks to protect her sexual health by negotiating for condom use in the relationship, then she may be viewed as stepping outside her “traditional” role (Taylor, 1995). Holland and colleagues (1990) stated that, “it is difficult for young women to insist on safe sexual practices, when they do not expect to assert their own

needs in sexual encounters” (p. 340). That is, women who desire to use condoms in sexual encounters may feel that their partners’ wishes, which may include condomless sex, are more important than their own wants, which may be to protect their health (Wyatt, 1997).

Because of the socially constructed notions of femininity and masculinity described above, some African American women may also struggle with the fear of being labeled ‘whores’ (or tainted) as opposed to ‘madonnas’ (or pure) (Fullilove et al., 1990; Wyatt & Riederle, 1994). Thus, women may be reluctant to carry condoms because it suggests the absence of innocence, which could result in women not being deemed desirable partners (Mane et al., 1994; Taylor, 1995; Worth, 1989; Wyatt & Riederle, 1994). Because African American women have consistently been stereotyped as promiscuous and sexually available, this stigma may have additional impact on African American women. The concepts of “femininity” and “masculinity” are complex when considering the cases of African American women and men. Historically, African American women have not always fit into the traditional notions of femininity described above, nor have African American men fit the mainstream notions of masculinity. Indeed, in a study investigating psychological femininity and masculinity and sex role attitudes, Binion (1990) found that African American women in her study were most likely to identify as “androgynous” (having high levels of both masculine and feminine traits) and least likely to identify as “feminine.” However, views about female roles differed by educational level, with college graduates holding more liberal views than women with less education. Other researchers have found that some African American women are afraid to exhibit traits associated with masculinity (e.g., assertiveness) in romantic relationships for fear that they will be viewed negatively by their male partners (Fullilove et al., 1990; Weeks et al., 1999). Women’s fear of not being considered “feminine enough” may result in them relinquishing control over their health and leaving their health and their fate in their male partners’ hands. It will be important for researchers to further investigate the links between African American women’s sexual identities, their sexual behaviors, and their willingness to communicate with partners about HIV risk.

Issues of Power in Intimate Relationships. In addition to being cognizant of the impact of gendered behavioral norms on romantic relationships, it is important to understand broader structural, societal factors that contribute to the decisions that women make. African American women’s behavior in intimate relationships has been linked to the lack of eligible and available heterosexual African American males in relation to the number of heterosexual single females, referred to as the sex-ratio imbalance (Kline et al., 1992; Miller, Burns & Rothspan, 1995). According to Guttentag and Secord’s (1983) sex-ratio imbalance theory (as cited in Miller et al., 1995), when there is an overabundance of women in certain communities (e.g., African American communities), women may perceive less power in their relationships,

giving men disproportional relationship power. Frequently, women in relationships with men in such communities accept activities such as ‘man sharing’ and/or not using condoms because they do not want to risk losing the relationship by challenging men about these issues. By not questioning aspects of the relationship about which they might disagree, these women place the status of the relationship above their own basic needs (i.e., health and safety).

It is important to note that not all women refrain from exerting power or control in their intimate relationships with male partners (Kline et al., 1992; Wingood et al., 1993). Kline et al. (1992) conducted a focus group study with African American and Latina women and found that the participants did not fit the gender role characteristic of minority women, which is to sacrifice their own personal needs for the sake of their male partners and be dependent on those men. In fact, the women in that study reported that they were willing to end unsatisfying relationships with men; they did not place the relationship above their own needs and well-being. This result may be a function of the degree of equality that already exists between women and men in some communities. For example, historically, African American women and men have had a somewhat balanced relationship, partially because of the societal barriers that have blocked African American men’s ability to fulfill the mainstream breadwinner role and to achieve economic success (Harris, Torres & Allender, 1994). Additionally, African American women often financially contribute to the household, which affords them some degree of influence in relationship decisions.

Differences in HIV Risk among Subgroups of African American Women

Adolescent Girls and College-Aged Women. The interaction of ethnicity and adolescence creates unique HIV risk factors for young African American women. Incidence rates in this group are disproportionately rising: African American women ages 16-21 have HIV prevalence rates seven times higher than Caucasian women and eight times higher than Latina women in the same age group (Solomon, Flynn, Schuman, Schoenbaum, Moore, Holmberg & Graham, 1998). Adolescent African American and Latina females are more likely to be sexually active than White females, to have had multiple sex partners, and to have had an STD (Longshore, Annon & Anglin, 1998). Yet, most sexually experienced youth do not consider themselves seriously at risk for any STD, including HIV (Health Resources and Services Administration, 1999b). Risk of contracting HIV is most acute among young minority women who are poor and undereducated. Poverty and poor academic achievement are associated with drug use and early sexual activity, which dramatically increase the threat of HIV transmission (Health Resources and Services Administration, 1999b). Factors such as socioeconomic status, lack of sexual education, less education, cultural, religious and gender socialization may also place African American adolescents and young women at disproportionately high risk for HIV.

In general, the literature suggests that behavioral differences alone do not appear to account for the magnitude of differences in rates by race/ethnicity (Kramer, Aral & Curran, 1980; Sonenstein et al., 1989; Forrest & Singh, 1990; Ku, Sonenstein & Pleck, 1993). Ethnic group differences in rates of STDs may be attributed to nonbehavioral factors such as geographic segregation (Potterat, Rothenberg, Woodhouse, Muth, Pratts & Fogle, 1985; Aral, Soskoline, Joesoef & O'Reilly, 1991) and the pattern of sexual partner networks (Ellen, Kohn, Bolan, Shiboski & Krieger, 1995). Further, community prevalence rates have been correlated with access to and use of health services related to STD (Anderson, 1992). These factors may function to maintain a higher prevalence of infection in African American adolescents' sexual networks.

Low-Income Women. Like other groups of African American women, low-income women's decisions to be assertive in their relationships may be linked to a host of socioeconomic and political factors including poverty, racism, and classism (Kline et al., 1992; Weeks et al., 1999). These factors are often competing ones, and women who are confronted with various socioeconomic and political adversities may construct a hierarchy of these issues according to the impact that they have on their lives. When women are struggling with issues such as poverty, homelessness, and other obstacles, practicing safer sex may be low on their list of priorities (St. Lawrence, Eldridge, Reitman, Little, Shelby & Brasfield, 1998; Weeks et al., 1999). That is, the need to protect against a possible future threat (e.g., HIV) may not seem as pressing an issue as immediate threats (e.g., poverty). Additionally, some researchers have found that low-income women may be motivated to practice safer sex due to economic dependence on their male partners. In contrast, however, Margillo and Imahori (1998) found that the low-income, African American women in their study did not practice consistent safer sex primarily because of difficulty negotiating safer sex with their male partners. These women were more concerned about implying mistrust of their partners and threatening the intimacy of the relationship than they were about threatening their economic survival.

Further, women of color have higher incidences of co-morbidity, which reflect problems of poverty, racism, disenfranchisement from social institutions, and lack of access to health care. Co-morbidity compromises individuals' lives, and therefore may compromise women's ability to make decisions (e.g., sex and health), respond to prevention messages, access health services and comply with treatment regimens (Health Resources and Services Administration, 1999a).

Women Who are Drug Users. Women who are injection drug users face many of the same challenges as low-income women because they often reside in low-income communities. For example, women who inject drugs and who engage in risky sexual behavior may give their risky behaviors low priority, placing HIV risk below other

risks (McNair & Roberts, 1997). Women who use illicit drugs through other routes of administration have an increased risk of contracting HIV as well. For example, active cocaine users report more sex partners than do heroin injectors and non-substance abusers. Number of sex partners has been shown to predict a lower rate of condom use, more STDs, greater frequency of sex-for-pay, exchanging sex for drugs and having sex with injection drug users (as discussed in Health Resources and Services Administration, 1999a). Further, the use of both injected and non-injected illicit substances leads to lower health care utilization, including prevention (Health Resources and Services Administration, 1998b).

Additionally, drug use increases the risk of physical and sexual violence, as well as associated sexual HIV risks. For example, the presence of physical abuse in an intimate relationship often prevents women from asking their partners to use condoms (El-Bassel, Gilbert, Rajah, Foleno & Frye, 2000). Further, while female condoms are an option for women who perceive a great need to enhance their ability to protect themselves from HIV and other STD infections, Witte, Wada, El-Bassel, Gilbert and Wallace (2000) found that among women who exchange sex for money and drugs on the streets of New York City, physical or sexual abuse by a commercial partner decreased the probability of female condom use (Witte et al., 2000).

Women Who Have Sex with Women (WSW). Very little research has been conducted on the HIV risk posed to women who have sex with women (WSW). The sexual transmission of HIV between WSW is rare (CDC, 2000b), but not impossible because women's bodily fluids (e.g., vaginal secretions and menstrual blood) could carry the virus. The Centers for Disease Control and Prevention (2000b) report that it is difficult to isolate the exposure category for WSW with AIDS because this group often engages in other high-risk behaviors such as injection drug use and unprotected sex with gay and bisexual men. Young, Friedman, Case, Asencio and Clatts (2000) provided a review of the literature on injection drug users who identify as WSW. Compared to non-WSW injection drug users, WSW injection drug users have higher rates of HIV infection and risk behaviors. It is important to investigate HIV risk among WSW who do not inject drugs, rather than assume that their risk is negligible. However, it may be difficult to recruit WSW for studies of sexual behavior because of the social stigma attached to non-heterosexual behavior, especially in the African American community.

Conclusion

In order to effectively stem the spread of HIV among African American women, prevention and intervention programs must specifically address the unique needs faced by those at high risk for HIV infection. African American women often face not only the trauma of addressing their HIV status, but other factors such as unique gender and

social dynamics as well as health complications such as substance abuse and poor nutrition. Further, tertiary complications such as poverty, disenfranchisement from social institutions, lack of transportation, and lack of daycare inhibit the effectiveness of available services. Understanding the interaction of multiple variables such as cultural and gender socialization, perceptions of susceptibility to HIV, socioeconomic status and education, and health care status is critical to improving prevention and intervention as well as informing the social service, legislative and health care communities.

Research increasingly reveals that effective intervention and care programs are culturally appropriate and incorporate the values and beliefs of the population served (Health Resources and Services Administration, 1999b). Service provision must also overcome economic and transportation issues as well as address the discrimination and alienation that keep individuals from seeking care. Only by overcoming the multiple barriers that hamper the ability of African American women to make healthy decisions about their lives will the spread of HIV decline and the effects of the epidemic be reduced among this population of women.

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