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Chapter 3

Ethnic Minorities and AIDS

Susan D. Cochran, Vickie M. Mays, and Vinson Roberts

WHO GETS AIDS?

Many people believe that AIDS affects only White gay men or IV drug abusers; they do not realize that AIDS has disproportionately affected ethnic minority communities, primarily Blacks and Hispanics. At present, 24 percent of reported AIDS cases have occurred among Blacks,[1] although Blacks constitute only 12 percent of the U.S. population[2] (see Table 3-1). It has been estimated that 1.0 to 1.4 percent of the Black population was infected with HIV as of January 1987.[3] In contrast, only 0.3 to 0.5 percent of the White population was estimated to be infected. Blacks are thus three times more likely than Whites to be infected with HIV. Hispanics are also at higher risk than Whites. Approximately 14 percent of reported AIDS cases occur among Hispanics, although they comprise only 6.3 percent of the U.S. population. Other ethnic minorities have been affected by AIDS, but not to the same devastating extent as Blacks and Hispanics. In total, these other groups, including Asian-Americans and Native Americans, constitute approximately 1.0 percent of AIDS cases and about 2.4 percent of the U.S. population.

Ethnic differences are even more pronounced among women affected by AIDS. While women represent only 7 percent of all AIDS cases, among women afflicted, Blacks account for 52 percent and Hispanics 19 percent as of October 5, 1987.

The CDC has calculated the chances of getting AIDS for several ethnic groups since 1981. As seen in Table 3-2, Blacks are at greatest risk for getting AIDS, followed by Hispanics, Whites, Asians, and Native Americans. Two cautionary points are relevant for ethnic minorities. First, while it is true that Blacks and Hispanics as communities are at higher risk for contracting the HIV virus, particular members within those communities are more at risk than others. Second, the present low number of cases among Asians and Native Americans should be viewed as an opportunity to provide appropriate AIDS health education

Table 3-1 Total Number of AIDS Cases by Risk Group and Gender for Each Ethnic/Race Group, United States, October 5, 1987

	Men				
	White	*Black*	*Hispanic*	*Other*	*Total*
Homosexual/Bisexual					
Homosexual	17,810 (72%)[a]	2,842 (32%)	2,283 (43%)	220 (59%)	23,155 (59%)
Bisexual	2,630 (11%)	1,221 (14%)	510 (10%)	62 (17%)	4,423 (11%)
Homosexual + intravenous (IV) drug user	1,597 (6%)	431 (5%)	250 (5%)	16 (4%)	2,294 (6%)
Bisexual + IV drug user	436 (2%)	269 (3%)	136 (2%)	3 (<1%)	844 (2%)
Exclusively Heterosexual					
IV drug user	1,012 (4%)	2,674 (31%)	1,739 (33%)	25 (7%)	5,450 (14%)
Heterosexual contact	74 (<1%)	680 (8%)	28 (<1%)	2 (<1%)	784 (2%)
Hemophiliac	324 (1%)	17 (<1%)	25 (<1%)	8 (2%)	374 (<1%)
Blood transfusion	454 (2%)	69 (<1%)	40 (<1%)	12 (3%)	575 (1%)
Other/unknown	393 (2%)	367 (4%)	180 (3%)	20 (5%)	960 (2%)
Children (under age 13)	74 (<1%)	157 (2%)	76 (1%)	3 (<1%)	310 (<1%)
Total male cases	24,804	8,727	5,267	371	39,169
	Women[b]				
	White	*Black*	*Hispanic*	*Other*	*Total*
IV drug user	323 (39%)	814 (49%)	284 (46%)	14 (44%)	1,435 (45%)
Heterosexual contact	192 (22%)	478 (29%)	200 (32%)	6 (19%)	876 (28%)
Hemophiliac	6 (<1%)	60 (4%)	23 (4%)	8 (25%)	314 (10%)
Blood transfusion	223 (25%)	3 (<1%)	0 (0%)	0 (0%)	9 (<1%)
Other/unknown	85 (10%)	145 (9%)	44 (7%)	2 (6%)	276 (9%)
Children (under age 13)	47 (5%)	160 (10%)	64 (10%)	2 (6%)	273 (8%)
Total female cases	876	1,660	615	32	3,183

[a]Percentages are percent in each risk group calculated for each gender separately.

[b]No information is available on sexual orientation of female cases, but the number of cases among homosexual women is known to be extremely low.

Source: Adapted from *Public Information Data Use Tape*, U.S. Centers for Disease Control, October 5, 1987.

Table 3-2 Number of AIDS Cases and Cumulative Incidence Rates by Ethnic Group and Race, United States, August 3, 1987

	White	*Black*	*Hispanic*	*Asian*[a]	*Native American*[a]
Total cases	24,012	9,699	5,508	232	38
Cumulative incidence per 100,000	168.3	520.7	454.5	66.3	27.1

[a]Asian and Native American data are estimated from an analysis of data compiled by the U.S. Centers for Disease Control in May 1987.

Source: U.S. Centers for Disease Control, August 1987.

services to these communities in order to prevent the development of new cases in these subpopulations.

WHY DO CERTAIN ETHNIC MINORITIES GET AIDS?

Although among Whites AIDS is most frequently a disease of gay and bisexual men, Blacks and Hispanics show more widely dispersed epidemiologic infection patterns. The presumed primary routes of infection for cases reported as of October 5, 1987 are given in Table 3-1. As the table shows, IV drug use is an important additional infection vector for Blacks and Hispanics. Many of the heterosexual transmission cases are from sexual contact with IV drug users.[4] Similarly, pediatric cases most often occur among offspring born to women who are IV drug users themselves or the sexual partner of a man who is.

Thus, for Blacks and Hispanics, AIDS is a disease strongly associated with the sociological realities of poverty. Approximately 45 percent of AIDS cases among Blacks and Hispanics occur in the urbanized Northeast, including New York City. In poor, urban ethnic minority communities, IV drug use is much more common,[5] as is the sharing of needles or "works" (drug paraphernalia), the primary route for HIV transmission.[6] In addition, simply living in this environment is more likely to result in contact with HIV-infected individuals who may be potential sexual partners.

Other factors in poor ethnic minority environments may also contribute to the spread of HIV. For example, commonly practiced birth control methods may facilitate transmission. It has been suggested that males in Mexico may more frequently utilize anal intercourse with a woman as a birth control measure or as a means of maintaining vaginal virginity.[7] Data from gay men's studies indicate that

receptive anal intercourse is the highest-risk sexual practice for contracting HIV infection.[8]

In both Black and Hispanic cultures there has always been a disdain for the use of condoms as a method of birth control.[9] While condoms may effectively fight the HIV virus, they are primarily associated with birth control. For some ethnic minorities, birth control is viewed as genocidal, depriving individuals as well as the community of the ethnic pride associated with parenthood.

Current risk reduction messages encourage condom use without consideration of their economic burden.[10] To suggest that a poor or ethnic woman living on a meager fixed income spend money on condoms, particularly when her partner is perhaps reluctant to use them, ignores the economic and social pressures in her life.

CARING FOR THE HIV-INFECTED INDIVIDUAL

Some special issues, including both medical and psychosocial concerns, arise in the care of ethnic minority clients with AIDS.

Medical Issues

First, there is evidence that Blacks and Hispanics are more likely to present with more severe acute opportunistic infections, necessitating more intensive medical and psychosocial care.[11] This is so because many of these individuals seek help late in the course of their illness or are IV drug users who were in poor health prior to HIV infection.[12]

Second, an increase in the incidence of tuberculosis infection has been noted among racial and ethnic minorities—a rate as high as six times greater than that among Whites.[13] Evidence suggests that much of the increase can be attributed to those individuals who are HIV-positive. Care should be taken to prevent transmission to adults or children who may be more vulnerable as a result of poor health status. In this regard, the prevention focus needs to encompass not only the PWA, but others in the social environment who may also be HIV-infected.

Third, educational, cultural, and language differences between health care providers and patients can hamper evaluation of the neurologic impairment seen in a significant percentage of AIDS patients.[14] The nurse must be especially sensitive to these differences before concluding that a client is neurologically impaired.

Psychosocial Issues

Cultural, ethnic, and racial barriers may create difficulties in communication that undermine the nurse-patient relationship. Some ethnic minorities, particularly

Hispanics and Asians, may find it culturally inconsistent to discuss or refer to specific body parts or sexual behaviors with a relative stranger, especially a woman. Equally true, nurses may refer to sexual behaviors and body parts in medical terms unfamiliar to some minorities. Cultural and ethnic barriers can compromise obtaining necessary information from clients as well as assurance that they understand risk reduction activities. For example, health educators have been encouraged by ethnic community AIDS workers to refer to condoms as "rubbers" or "protection." These language distinctions are important. Nursing personnel may find it helpful to discuss medical instructions for ethnic clients with a colleague of similar background to the clients' to ensure clear communication between nurse and client.

Other issues may be even more subtle. For example, among many Blacks a cultural norm is that one should behave more formally in the presence of non-Blacks to avoid the discriminations that occur unpredictably as a result of racist notions that Blacks are ignorant or poorly mannered. The need to maintain this formality in the hospital environment is underscored when family and significant others feel that hospital staff will perceive particular behaviors negatively, resulting in poor care for their loved one. This formality, however, is not always consistent with emotional needs or cultural norms for behavior when strangers are not present. For example, in a case related to us by one of our colleagues, a Black mother whose son was dying of AIDS in the hospital watched as he retreated in coma into a fetal position in the hours before his death. As a mother, she knew that what he needed (and what she needed also) was for her to crawl into bed with him and hold him as he died. But she was deterred by her fears that nursing personnel would not find this behavior acceptable and would reprimand her. To this day, she berates herself for sacrificing her son's dying needs in order to maintain their family's ethnic dignity in the face of the predominantly non-Black world of the hospital.

This conflict between maintaining formality and facing the reality of hospital life, with its frequent violations of personal or family privacy, does not always have to be so dramatic. Some Blacks may experience discomfort or embarrassment when White or Asian nursing staff perform the more intimate nursing behaviors, such as removing fungi from under toes or washing up after an episode of incontinence. The sociological realities of racism and interethnic group prejudices, translated into everyday life, mean that many Blacks do not normally have such intimate encounters with members from these groups. Culturally, Blacks, particularly from the lower socioeconomic groups, are proscripted to avoid these moments of vulnerability as a protection against possible discrimination. Some acknowledgment from the staff—a smile, a fragment of conversation—some attempt to lessen the sharp pain to the client's ethnic pride may be comforting. Indirectly, this may assist in diffusing any possible perceptions by the client's

family that nursing staff are not adequately caring for a particular patient out of perceived racist motivations.

Finally, in providing care for IV drug users, nurses need to realize that clients may, if the opportunity is present, steal drug-related paraphernalia, such as needles, to be resold on the streets. Precautions are recommended.

PSYCHOLOGICAL IMPACT ON PATIENTS, FAMILIES, AND SIGNIFICANT OTHERS

Little information has been published addressing the specific psychological needs of ethnic minority clients with AIDS. PWAs, irrespective of their ethnic status, may experience severe psychosocial disruptions, including, but not limited to, affective distress, loss of or severe strain on their systems of emotional and tangible support, and financial distress.[15] Ethnic minorities affected with AIDS differ from Whites in their family and friendship networks and in the role ethnic and cultural norms play in their health care behaviors.

As an example, homosexuality is viewed differently in ethnic minority cultures.[16] The gay ethnic minority man with AIDS may have chosen never to reveal or discuss his sexual orientation with his friends or family. In many instances such behavior has been well hidden by occasional heterosexual liaisons or is a known "secret" not talked about by his family and friendship network. It is important that nursing staff respect the possible role of this family secret in maintaining sources of social support.

For White gay men, the loss of family support can frequently be compensated for by support from the gay community, a primarily White social structure. For ethnic men, however, ethnic barriers in the gay community may inhibit the receipt of adequate and culturally relevant support. Thus maintenance of the family system may be even more critical. In settings with dedicated AIDS wards where PWAs and visitors are openly gay, the pressure may be for gay men to be "out." The individual from an ethnic minority, however, may suddenly become "closeted" while his family or friends are around. This behavior, should it occur, is understandable, given that cultural and racial identity of some gay ethnic minorities is even more fundamental to their self-image than their sexual orientation.[17] Emotional, familial, and economic ties may be to the ethnic community first and the gay community second. Since families may find it easier to accept drug abuse or prostitution as the source of their son's infection than sexual activities with another male, this may be the client's story line. Such a client would find it comforting to know that nursing staff will not openly or unintentionally reveal his guarded secret.

While hospital rules limiting immediate family to visitation in critical care units serve an important function for the nursing staff, they are sometimes problematic for ethnic minorities. As an example, an ethnic male chronic drug abuser separated from his wife but currently living with a companion may have very few emotional ties to his family of origin or to his wife. Where possible, nursing staff may lessen the conflicts that could occur by asking that only visitors *close* to the patient visit, as opposed to legally sanctioned individuals (i.e., married or blood relatives). This type of discrimination has been most salient for ethnic gay men whose lovers were unknown to family members or barred by hospital staff because of a nonkin status. Emotionally, the man may have been closer to his lover than his family, from whom he has been estranged because of his hidden gay status. Sensitivity on the part of nursing staff to the importance of extended family, gay family, or health care family (buddies) may prove to be a source of comfort for the client.

SUMMARY

1. Ethnic minorities, primarily Blacks and Hispanics, are disproportionately more likely to contract AIDS or an HIV infection than Whites.
2. Risk factors for HIV transmission in ethnic minority populations are more dispersed than among Whites. IV drug use and heterosexual sexual contact with infected individuals assume a more important role in HIV transmission than among Whites.
3. Care of ethnic minority PWAs requires a sensitivity to subtle, as well as obvious, ways in which cultural differences influence medical expression of HIV infection and psychosocial sequelae.

NOTES

1. U.S. Centers for Disease Control, *AIDS Weekly Surveillance Report, United States AIDS Activity*, October 5, 1987.

2. U.S. Department of Commerce, Bureau of the Census, *Characteristics of the Population. General Population Characteristics, Part 1* (Washington, D.C.: U.S. Government Printing Office, 1983).

3. V.M. Mays and S.D. Cochran, "Acquired Immunodeficiency Syndrome and Black Americans: Special Psychosocial Issues," *Public Health Reports* 102 (1987):226–31.

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5. L.E. Gary and G.L. Berry, "Predicting Attitudes Toward Substance Use in a Black Community: Implications for Prevention," *Community Mental Health Journal* 21 (1985):112–18.

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7. J.M. Carrier, "Sexual Behavior and the Spread of AIDS in Mexico," *Medical Anthropology* (in press).

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10. V.M. Mays and S.D. Cochran, "Interpretation of AIDS Risk and AIDS Risk Reduction Activities by Black and Hispanic Women," *American Psychologist* (in press).

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13. U.S. Centers for Disease Control, "Tuberculosis as Related to AIDS and HIV Infection Among Minorities" (Paper presented at the National Conference on AIDS in Minority Populations in the United States, Atlanta, Georgia, 1987).

14. Mays and Cochran, "Acquired Immunodeficiency Syndrome and Black Americans."

15. Ibid.

16. Ibid.

17. Carrier, "Sexual Behavior and the Spread of AIDS in Mexico"; Cochran and Mays, "Sources of Support in the Black Lesbian Community" (Paper presented at the meetings of the American Psychological Association, Washington, D.C., August 1986); Mays and Cochran, "Relationship Experiences and the Perception of Discrimination" (Paper presented at the meetings of the American Psychological Association, Washington, D.C., August 1986); J. Peterson and E. Andrews, "AIDS and Blacks: Gay Identity, Racial Poverty and Racial Discrimination" (Paper presented at the meetings of the American Psychological Association, Washington, D.C., August 1986); and L. Icard, "Black Gay Men and Conflicting Social Identities: Sexual Orientation versus Racial Identity," *Journal of Social Work and Human Sexuality* 4 (1986):83–93.

Chapter **4**

Substance Abuse in Persons with HIV Infection

Barbara G. Faltz, and Scott Madover

As the AIDS epidemic unfolds, an awareness of the connections between HIV infection and drug and alcohol abuse is emerging. The connections include:

- sexual transmission of HIV to partners of IV drug users
- neonatal transmission by infected mothers who are IV drug users or partners of IV drug users
- increased risk due to disinhibition under the influence of drugs or alcohol
- increased risk due to immunosuppression caused by drug or alcohol use
- inability to utilize resources (social, financial, or health) because of substance abuse.

ASSESSMENT

Substance abuse assessment for persons with HIV is an essential part of a psychosocial assessment. It includes an assessment of the amount, frequency of use, duration of use, and last use of all classifications of illicit drugs, mind-altering prescription medication, and alcohol. Assessment of the following factors is helpful in determining if a client has a substance abuse problem:

1. emotional, social, relationship, employment, legal, or other difficulties that can be linked to the use of alcohol or drugs
2. loss of control over the frequency or amount of alcohol or drug use
3. preoccupation with drug(s) of choice or alcohol
4. self-medication for anxiety or sadness
5. use of drugs or alcohol while alone
6. rapid initial intake of drugs or alcohol