The Influence of the Caregiving Relationship on HIV Positive African American Women’s Level of Disease Control

Sanda McFadden, RN

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Abstract

According to CDC statistics, African American women are one of the fastest growing population groups to contract HIV. These women face health disparities, social stigmas, fear of disclosure and the majority lack a trusted support system. As healthcare providers we have a responsibility to assess what influences the client’s healthcare decisions. Mutual trust is needed to encourage and set the stage for adherence to the plan of care. The purpose of this research was to evaluate the relationship between the healthcare provider and HIV positive African American women, and how it influences her health care decisions.

The sample consisted of 15 African American women, from rural Georgia, 18 years old or older, HIV positive and being cared for at local HIV clinics. The study involved using the Sowell Relationship with Primary Health Care Provider Scale, (1992), demographic data, and viral load laboratory data to determine the level of disease control.

The results of the study indicated that the type of relationship did not have an influence on the women’s viral load. Thirteen women said they had a good relationship with their PHCP (nurse) and out of the thirteen, five had a decrease in their viral load number, three had an increase in viral load, and five remained the same.

Purpose

The purpose of this research will be to evaluate the relationship between the healthcare provider and HIV positive African American women, as it influences health care decisions.

Literature Review

One of the fastest growing population groups to contract HIV is that of African American women. “Southern women, and particularly African American women, comprise a disproportionate number of newly reported HIV/AIDS cases” (Misener, & Sowell, 1998). “From 1999 through 2003, the annual number of estimated AIDS diagnoses increased 15% among women and increased only 1% among men” (CDC, 2004). Statistics show that African American women hold the highest percentage of diagnosed cases of AIDS of any female population. The percentage of women diagnosed with AIDS by race/ethnicity in 2003 was Asian/Pacific Islander 1%, American Indian/Alaska Native <1%, White 15%, Hispanic 16%, and African American 67% (CDC, 2004). “In 2001, HIV infection was the leading cause of death for African American women aged 25-34 years and was among the four leading causes of death for African American women aged 20-24 and 35-44 years” (CDC, 2004). With this high percentage of diagnosed AIDS cases among African American women, it is imperative for healthcare providers to assess what influences the client’s healthcare decisions and medication adherence.
Even with the advancement of medical technology in the area HIV medications, adherence to medical regimen continues to be an issue related to disease control. The relationship between the healthcare provider and client has been sited as a barrier to medication adherence. Mutual trust is needed to encourage and set the stage for adherence to the plan of care. Misener, & Sowell (1998) implemented a focus group. They reported that:

Many women said their interactions with and perceptions of health care professionals influenced their willingness to take antiretrovirals. These women most often said their health care providers take a comprehensive approach to their care and include them in decisions about treatment. In contrast, the largest number of women in the focus groups reported a lack of trust in health care professionals. These women said care providers know little about treating HIV infection and prescribed medications because they did not know what else to do (Misener, & Sowell, 1998).

Mutual trust breaks down barriers, but it is also important to the clients to know that their healthcare provider is treating them on an individual basis, listening to what they are trying to communicate, and providing an individualized plan of care. “Patients seek sympathy. They want respect and regard for personal dignity. They seek interest in them as persons. They want to express and have the details of their health problems heard” (Peplau, 1997).

The literature supports the importance of a study to evaluate the relationship between healthcare provider and the HIV positive African American women. This population of women faces health disparities, stigmas, fear of disclosure, and the majority lack a trusted support system. As healthcare providers we have a responsibility to assess what influences the client’s healthcare decisions, and put forth an effort to break down those barriers.

**Theoretical Framework**

The theoretical framework for this study was based on Peplau’s Theory of Interpersonal Relationships. Peplau states, “Interpersonal competencies of nurses are key to assisting patients in the work necessary for regaining health and well-being” (Peplau, 1997). This is an excellent framework for this study, because we are researching the influence of the healthcare provider’s relationship with the client and the influence on the client’s health care decisions.

**Model of Design**

**Relationship with Healthcare Provider**

1. What is the relationship between healthcare provider and client?
2. Does a positive or negative relationship between the healthcare provider and the HIV client have an effect on the client’s disease control?

**Study Setting, Design, and Sampling Procedure**
This research was conducted in rural Georgia. The sample consisted of 15 African American women, 18 years old or older, HIV positive, and in care at local HIV clinics. This was a convenient sample taken as clients came into the clinic for their appointments. A Descriptive, Correlational design was used.

**Instrument, Data-Collection, Analysis of Data, and Ethical Considerations**

The instruments used in this study were the Relationship with Primary Healthcare Provider Scale (RPHCPS) developed by Sowell and Associates (1992). The RPHCPS is a 12-item Likert scale and can be found in Appendix A, and a demographic tool was used. Viral load laboratory counts for the past year were collected for each client. Client confidentiality was kept by assigning a number from the Table of Random Numbers, and a signed informed consent was required from each subject. The consent form explained the purpose of the study, participation was voluntary, and each subject would be assigned a number that would be kept confidential.

**Results**

The results of the study indicated that the type of relationship did not have an influence on the women’s viral load. An improved disease level would be a viral load that has decreased in number. Out of thirty subjects, three refused to sign the consent form, two were too ill to participate, ten were no-shows to their clinic appointment, and fifteen completed the survey. Out of the fifteen completed surveys, thirteen women said they had a good relationship with their PHCP (nurse) and out of the thirteen, five had a decrease in their viral load number, three had an increase in viral load, and five remained the same. The two negative relationships, one had a decrease in viral load, and one remained the same.

Out of the twelve survey questions, two questions indicated that there was a need for educating the PHCP (nurse) and client in the area of confidentiality. Twenty percent of the subjects agreed with question 2 “I worry about my PHCP keeping information about me confidential”, and question 5, “there are some things I don’t feel comfortable telling my PHCP”.
Conclusion

The results of this survey emphasize the need to continue researching what influences the clients’ disease level. Even with the advancement of medical technology in the area HIV medications, adherence to medical regimen continues to be an issue related to disease control. As healthcare providers we have a responsibility to assess what influences the client’s healthcare decisions, and put forth an effort to break down those barriers. Further research is needed to determine the influence of other possible indicators that affect the client’s level of disease control such as, family and community support, side effects of taking the antiretroviral medications, and disclosure issues.

References


McFadden

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Appendix A

RELATIONSHIP WITH PRIMARY HEALTH CARE PROVIDER

These next questions are about your primary health care provider. Your primary health care provider is the person you go to for most of your care. Tell me whether you strongly disagree, disagree, agree or strongly agree with each of these statements.

Who is your primary Health Care provider?
1. Doctor  2. Nurse  3. Other(state one)_________________

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>1. My primary health care provider (PHCP) always tells me the truth.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>2. I worry about my PCHP keeping information about me confidential.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>3. My PCHP tries to give me the best care and treatment available.</td>
<td>1</td>
<td>2</td>
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<td>4. I can trust my PCHP to explain my treatment so that I can understand.</td>
<td>1</td>
<td>2</td>
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<td>5. There are some things I don’t feel comfortable telling my PHCP.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<td>6.</td>
<td>I take my PHCP’s advice about treating symptoms of my HIV.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>7.</td>
<td>My PHCP is likely to report me to the Department of Family Services or other authorities if I’m not careful about what I tell him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>8.</td>
<td>My PCHP gives me accurate information about my health care treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>9.</td>
<td>Sometimes I think my PCHP doesn’t tell me everything about my health.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>10.</td>
<td>I trust what my PHCP tells me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>11.</td>
<td>I can talk to my PHCP about anything that concerns me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>12.</td>
<td>My PHCP Trusts me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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