



DOI: 10.5859/nairjpms.2024.10.04.1

## COMPREHENSIVE ANALYSES OF THEORETICAL FOUNDATION OF HEALTH BEHAVIOR IN AIDS/HIV DIAGNOSES DATA STATISTICS IN UNITED STATES OF AMERICA (USA)

1<sup>st</sup> DR. PARK E. ATATAH

*1<sup>st</sup> (Ph.D.) Public Health Services & Criminal Justice, Assistant Professor, Prairie View A&M University, Prairie View, TX, USA*

*School of Public Allied and Health (SPA) Division of Public Health & Health Research Coordinator*

*Email: [peatatah@yahoo.com](mailto:peatatah@yahoo.com) or [peatatah@pvamu.edu](mailto:peatatah@pvamu.edu)*

### ABSTRACT

*The quantitative research study investigated the correlations/relationships between races/ethnicities and testing positive for AIDS/HIV diagnoses in the US between 2017 and 2021. This study used “**Social Construction of Ideology of Reality Theory**” as a lens of analyses of the secondary data collected between 2017 and 2017. This research study used “**Non-Experimental Descriptive Statistics**” quantitative methodology to analyze the collected data. The study found that of almost 37, 000 data that were collected and analyzed, Black/African Americans accounted for 40% positive tests for AIDS/HIV in the US, 29% of Hispanics/Latinos, 25% of whites, 3% of multiracial, 2% of Asians, 1% of American Indians/Alaska Natives and less than (< 1%) of Hawaiians/Other Pacific Islanders also tested positive for AIDS/HIV in the US. Secondly, among about 30,000 of men data analyzed in the US between 2017 and 2021, Blacks/African American men tested positive for AIDS/HIV at a ratio of 37%, Hispanics/Latinos men at a ratio of 29%, white men at a ratio of 26%, Multiracial men at a ratio of 3%, Asians men at a ratio of 2%, American Indians/Native Alaska men at a ratio of 1% and less than (< 1%) of Hawaiians/Other Pacific Islanders men also tested positive for AIDS/HIV in the US. Furthermore, among about 6700 of women data analyzed in the US between 2017 and 2021, Blacks/African American women tested positive for AIDS/HIV at a ratio of 53%, Hispanics/Latinos women at a ratio of 19%, white women at a ratio of 23%, Multiracial women at a ratio of 3%, Asians women at a ratio of 1%, American Indians/Native Alaska women at a ratio of 1%, and less than (< 1%) of Hawaiians/Other Pacific Islanders women also tested positive for AIDS/HIV in the US. **This comprehensive research study serves as reality effects and as a warning about the systematic and symmetric increases of AIDS/HIV diagnoses in the US, Africa, and beyond, and it also serves as positive social changes’ applications for the US, Africa, and possibly beyond.***

**KEYWORDS:** AIDS/HIV, Diagnoses, US, Africans, Ethnicities, Blacks/African Americans, Hispanics/Latinos, Whites, Multiracial, Asians, American Indians/Alaska Native Americans, Hawaiians/Other Pacific Islanders, Corruptions, Leaderships

## INTRODUCTION

The America health care system consist of patients from different cultures. Every culture have systems of health beliefs that explain what causes illness, different ways illness can be treated, and who should be involved in the process. Patients response and reaction to health information provided, depends on whether they are of any cultural importance to them (Hyder & Morrow, 2005). They also defined culture as beliefs, ideas, meanings, and values that are shared socially learned; but, not genetically transmitted patterns of behavior that guide group of people and it changes with lived experiences. This research study investigated by analyzing the theoretical foundation of healthcare behavior effects' data statistics in America in the most recent emerging increases in AIDS/HIV diagnoses in the US between 2017 and 2021.

### Background and Significance of Identified Population Health Issues

The identified population health issue is human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The background and significance of HIV/AIDS was discussed below.

## BACKGROUND OF STUDY

HIV is a virus that spread through body fluids which affects particular cells of the immune system, called CD4 cells, or T cells. Eventually, HIV progresses and destroys so many of these cells in a way that the body cannot fight off infections and disease. HIV infection eventually leads to AIDS when the body can no longer fight off infections and disease. Research studies acknowledged that a type of chimpanzee in West Africa is the origin of HIV infection in humans. Research alleged that the chimpanzee version of the immunodeficiency virus is called simian immunodeficiency virus (SIV) was likely transmitted to humans and mutated into HIV when chimpanzees were hunted by human for meat whereby they came into contact with their infected blood. Some other studies speculate that HIV might have jumped from apes to humans as far back as the late 1800s. Above all, for more than decades, the virus gradually spread through Africa and subsequently into other parts of the world. HIV has existed in the United States since at least the mid- to late 1970s (Centre for Disease Control and Prevention CDC, 2015).

## SIGNIFICANCE OF THE STUDY

HIV is more or less universally fatal because it ultimately overwhelms the immune system. Thus, HIV eventually results in acquired immunodeficiency syndrome (AIDS). HIV infection has three different stages (Acute infection, clinical latency & AIDS stages). The virus can be spread at any point of the stages. The treatment of HIV with retroviral medication helps people at all stages of the disease. Treatment with retroviral medications can slow or prevent progression of the virus from one stage to the next (CDC, 2015).

According to Hyder and Morrow (2005), HIV/AIDS have social and economic consequences. The social consequences of HIV/AIDS is that the infection occur before 25 years of age and about half of the infected patients die before 35 years making their children orphans especially in the developing countries of Africa where treatment with retroviral medication is scarce and expensive. HIV infection affects young people at their very productive years. As it progresses, they are too weak and sick to work and eventually die. The consequences of HIV infection

on the economy eventually lead to political instability. More resources is allocated for research studies, treatment with retroviral medications and education for the prevention from private entities, national and international bodies such as World Health Organization (WHO).

### **A Comprehensive Description of Ecological Model and its use in the Analysis of HIV/AIDS and Subsequent Health related Interventions**

The Institute of Medicine (IOM) rightly defined ecological model as a health model that highlights the influences and relationships among numerous factors (or determinants) that affects health (IOM, 2003). National Cancer Institute (NCI, 2005), stated that people's interactions with their physical and social-cultural environments are highlighted by ecologic model. It further stated that there are 2 concepts of ecological model that helps to identify intervention points when it comes to health promotion. The 2 concepts that it identified are behavior which affects and also affected by multiple levels of influences. The second concept is individual behaviour which is shapes and shaped by the social environment.

According to NCI (2005), the first concept of the ecological model consists of 5 various levels of influences. The 5 various levels of influences are intrapersonal or individual factors, interpersonal factors, institutional or organizational factors, community factors and public policy factors. According to NCI (2005), the first level of influence for health-related behaviour is the intrapersonal or individual factors. Intrapersonal or individual level is defined as the characteristics of individual such as knowledge, attitude, beliefs and personality traits that influence behaviour (NCI, 2005). The second level of influence for health-related behaviour is the interpersonal factors. These are "interpersonal processes and primary groups, including family, friends and peers that provide social identity, support, and role definition" (NCI, 2005, p. 11).

### **Analysis of influencing Health factors at the Individual, Interpersonal, Organizational, Community and Public Policy Levels**

At the individual level, the women of Sub-Sahara Africa indulge in commercial sex for favours to enable them to care for their families. The men indulge in sex with multiple partners as they believe that having sex regularly is important to health. Some of the men have sex with prostitutes because of migration to the urban areas where they are working without their wives around. All these factors aid in the transmission of HIV infection (Hyder & Morrow, 2003).

At the interpersonal level, there is believed that AIDS is "slim disease" as a result of the muscle wasting that result from the infection. Also the men, who sleep with prostitutes contact HIV infection, go back home to their wives and get them infected. Therefore, plump women are considered not having HIV infection and safe to have sex with. HIV infection is also considered as a "Whiteman's disease" and cannot infect black people. Having HIV is considered as a shame and many people do not seek to be tested or seek treatment because they do not want other people to know. There is believed that having sex with a virgin cures HIV infection and women also get circumcision with infected instrument. This makes men with HIV to sleep with virgin, thereby infecting young girls (Hyder & Morrow, 2003).

At the organizational level, men migrate to the urban areas where they are working without their wives. This increased the numbers of sex partners as these men sleeps with multiple women, contact HIV and later go home to

their wives, sleep with them and get them infected. Shortage of sexually transmitted disease clinics prevent the people from seeking for testing and treatment of HIV when considering the influencing health factor at the community level. Hyder and Morrow (2003), summed that there are not a lot of available sexually transmitted clinics to go for HIV testing and treatment in the Sub-Sahara Africa.

Since several young people in the Sub-Sahara Africa were affected by HIV, the economy and political stability is greatly threatened as those affected become too weak to work and then eventually die. There is also the burden of AIDS-related cost of workers medical care on the economy. There are no available policies that enforce mandatory HIV testing and no policies to protect rape victims such as those virgin that get infected by men with HIV or women raped during war. Interferences in women's core beliefs, in association with complication by the cultural taboos around sexuality, make disclosures and support seeking for the acts of violence committed against them nearly impossible (Hagen, & Yohani, 2010).

### **Identification of one (1) Health Promotion/Disease Prevention Intervention for each of the levels of Intervention with supporting rationale**

World Health Organization (WHO), (2015) defined Health promotion as the process of empowering people to take control of and to improve, their health. Health promotion extends further than individual focus but towards an extensive range of social and environmental interventions. For health promotion to be achieved, health professionals must develop cultural competence awareness. Therefore, cultural competence is defined as a set of similar behaviours, attitudes, and policies that come together in a system, agency or among professionals and empower that system, agency or those professions to work efficiently in cross-cultural situations (National Institute of Health, 2015).

#### **Health Promotion/Disease Prevention at the Individual Level**

It is very important to promote awareness of HIV through health education. Just like the definition of health promotion rightly stated, providing education to the individual patients about the different made of HIV transmission, importance of prevention through abstinence, having one sex partner (avoiding multiple sex partners), use of condoms and importance of seeking early professional help such as HIV testing and use of retroviral medications (Kalichman & Simbayi, 2003).The rationale for providing health education is that awareness empowers individuals and people tend to comply with treatment regimen when they know what to do.

#### **Health Promotion/Disease Prevention at the Interpersonal Level**

In order to make a particular group of people to respect, listen and adhere to a practitioner's advice, it is important for them to know that the practitioner also have respect and share some of their beliefs and ideas. However, when those beliefs and ideas are dangerous to the people and others around them, then it is the practitioner's position to discourage them. To achieve this, it is important to establish clinics at work places with practitioner available to provide education about the positive effects of HIV testing and treatment. This will also decrease the negative perceptions of testing services. The rationale for the above is that stigmatizing beliefs about AIDS and their

associated fears of discrimination can influence decisions to seek HIV testing and HIV treatment services (Kalichman & Simbayi, 2003).

### **Health Promotion/disease Prevention at the Organizational Level**

At the organizational level, employers should be encouraged to provide relocation benefits to employees. This will enable the men migrating to the urban area for work to relocate with their families. There should be occupational health clinics where employees and their families can have access to HIV testing, treatments and counselling. The rationale of the above benefit to employees is that it will lessen the financial burden of relocating their families close to where they work and also decrease the incidence of having multiple sex partners.

### **Health Promotion/disease Prevention at the Community Level**

Investments should be made to build multiple sexually transmitted clinics in both the urban and rural areas. Voluntary HIV antibody counselling and testing (VCT) should be encouraged. Practitioners should be encouraged to serve and work in these clinics. Benefits such as student loan repayment, relocation, and retention benefits should be provided to encourage practitioners to work in these clinics. The rationale is that research studies conducted in developed and developing countries revealed that VCT can reduce high risk sexual practices, thus able to decrease rates of sexually transmitted infections (Kalichman & Simbayi, 2003).

### **Health Promotion/disease Prevention at the Public Policy Level**

There should be development of policy to provide psychological interventions with focusing primarily on culturally sensitive counselling with war rape victims. Guidelines and policies for prevention and response to sexual and gender based violence against war victims to be enacted. This will enable prosecution of the offenders instead of the offended (Hagen, & Yohani, 2010). The government should promote activities such as aggressive public education for HIV testing, treatment and condom promotion campaigns. There should be mobilization of nongovernmental organization (Hyder & Morrow, 2003). The rationale for this intervention is that rape is more common when there are no repercussions to the actions, and hateful attitudes of these men towards women that they rape (Hagen, & Yohani, 2010). They asserted that "...Aggressive public education and condom promotion campaigns promote the public awareness" (Hyder & Morrow, 2003, p. 60).

### **Application of Socioecological Model to a Population that I have served as an advanced Practice Nurse**

Anno, (2004) stated in the study reviewing the United States (US) prison that though much have been done to improve the health systems in the prison, the focus still remains on addressing acute physical and mental needs and not in addressing the other aspects of the prisoners' health and well-being. Tuberculosis (TB) is one of the prevalent diseases in the prison.

Also, using the socio-ecological model to analyze an individual with tuberculosis in the prison is significant. At the individual level, the TB infection might have been due to the inmate being homeless due to drug addiction prior to imprisonment. Intervention is to take comprehensive health history and administer Mantoux tuberculin skin test



which is a test to check if a person has been infected with TB bacteria or chest X-ray on individuals with allergy to the skin test.

At the interpersonal level, the prison employees might have forgotten to administer the TB skin test not knowing the inmate has active TB. The intervention to this is to isolate any inmate with TB until initiation of anti TB drugs is started. At the organizational level, it is difficult to find a separate room for isolation due to overcrowding of the prison or Anti TB drugs is not readily available. Thus this inmate remains with others thereby infecting them. The interventions are to provide N95 mask for the patient to wear at all times, transfer patient to the hospital for isolation and anti TB drugs. At the public policy level, the inmate may not have had insurance while he was homeless, or the prison or no policy covering the screening and management of TB. The intervention is to develop policy and practice that will improve the health of prisoners (Anno, 2004).

## THEORETICAL FRAMEWORK

As previously pinpointed by Atatah and Kisavi-Atatah (2016);

This study used Social Construction of Ideology Reality Theory as a lens of analyses which stipulated that errors thinking, faulty errors, gossips, false perceptions, assumptions, and presumptions lead to the creation of ineffective, inefficient, and in proficient public social policies (Berger & Luckman, 1966)...In fact, it appears that this falls under the theoretical and practical definition of social construction of the ideology of reality theory. The premises of this theory argued that issues such as stimulations play significant roles in the initiation, development, and the implementation of public policy. (p. 78)

Hence, “**Social Construction of Ideology of Reality Theory**” was selected over others as a lens of data statistical analyses in this quantitative research study.

## DESIGN OF THE STUDY

### Methodology

This study reviewed, selected, and used Non-Experimental research study “Descriptive Statistics” as the most effective and the most appropriate methodology as to protect and assist participants’ integrities and privacies. The primary purpose was to compare and investigate the correlations/relationships between individual races and testing for AIDS/HIV diagnoses in the US between 2017 and 2021. This quantitative research study used “descriptive statistics” methodology also to compare and investigate if any accesses to treatments’ availabilities or lack of accesses to treatments’ availabilities have any correlations/relations/ships for testing positive for AIDS/HIV diagnoses in the US between 2017 and 2021 based on the secondary data collected, classifications, and analyzed in this research study (see Creswell, 2009; Frankfort-Nachmias& Nachmias, 2000; Frankfort-Nachmias& Nachmias, 2008 for more details).

## Hypotheses of the Study

This study hypothesized two major hypotheses which were;

### Alternative Hypothesis 1:*H1*

There were significant correlations/relationships between races and positive diagnoses for AIDS/HIV in the US.

### Null Hypothesis 1:*Ho1*

There were insignificant correlations/relationships between races and positive diagnoses for AIDS/HIV in the US.

### Alternative Hypothesis 2:*H2*

There were significant correlations/relationships between accessibilities to treatments' availabilities or lack of accesses to treatments' availabilities and testing positive for AIDS/HIV positive diagnoses in the US.

### Null Hypothesis 2:*Ho2*

There were insignificant correlations/relationships between accessibilities to treatments availabilities or lack of accesses to treatments' availabilities and testing positive for AIDS/HIV positive diagnoses in the US.

## Data Collections and Classifications

AIDS/HIV secondary data statistics between 2017 and 2021 were collected from Center of Disease Control and Preventions (CDC, 2017-2021) in 2024 and were fed into SPSS 27 version and analyzed.

## Results and Findings of the Study

**Table 1. Statistical Data Cases of All AIDS/HIV in the US between 2017 & 2021**

		Statistics		
		AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021	AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021	AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021
N	Valid	45	39	15
	Missing	0	6	30
Mean		2.5333	2.6923	3.0667
Std. Error of Mean		.23484	.26016	.48272

Median	2.0000	2.0000	3.0000
Mode	1.00	1.00	1.00 <sup>a</sup>
Std. Deviation	1.57538	1.62471	1.86956
Variance	2.482	2.640	3.495
Skewness	1.049	.917	.722
Std. Error of Skewness	.354	.378	.580
Kurtosis	.574	.167	-.131
Std. Error of Kurtosis	.695	.741	1.121
Range	6.00	6.00	6.00
Minimum	1.00	1.00	1.00
Maximum	7.00	7.00	7.00
Sum	114.00	105.00	46.00

a. Multiple modes exist. The smallest value is shown

**Table 1.** Showed the summation of 114, 105, and 45 for the overall HIV/AIDS cases in the US, cases in men, and cases in women between 2017 & 2021 respectively and the standard deviations of 1.58, 1.6, & 1.9 respectively (see table 1 above for more details).

**Table 2. AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021**

**AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Blacks/African Americans In Thousands	15	33.3	33.3	33.3
Hispanics/Latinos In Thousands	10	22.2	22.2	55.6
White In Thousands	11	24.4	24.4	80.0
Multiracial In Thousands	3	6.7	6.7	86.7
Asians In Thousands	3	6.7	6.7	93.3
Native Indians/Alaska Native In Thousands	2	4.4	4.4	97.8
Native Hawaiians&Other Pacific Islanders In Thousands	1	2.2	2.2	100.0
Total	45	100.0	100.0	



**Table 2.** Showed the cumulative frequencies’ percentages of all AIDS/HIV cases in the US of 100% with no missing data statistics (see table 2 above for more details).

**Table 3. AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021**

**AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Blacks/African Americans Men In Thousands	11	24.4	28.2	28.2
	Hispanics/Latinos Men In Thousands	10	22.2	25.6	53.8
	White Men In Thousands	8	17.8	20.5	74.4
	Multi-Racial Men In Thousands	4	8.9	10.3	84.6
	Asian Men In Thousands	3	6.7	7.7	92.3
	American Indians/Alaska Native	2	4.4	5.1	97.4
	Native Hawaiians& Other Pacific Islanders	1	2.2	2.6	100.0
	Total	39	86.7	100.0	

**Table 3.** Showed the cumulative frequencies’ percentages of all AIDS/HIV cases in the US in men of 100% with no missing data statistics (see table 3 above for more details).

**Table 4. AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021**

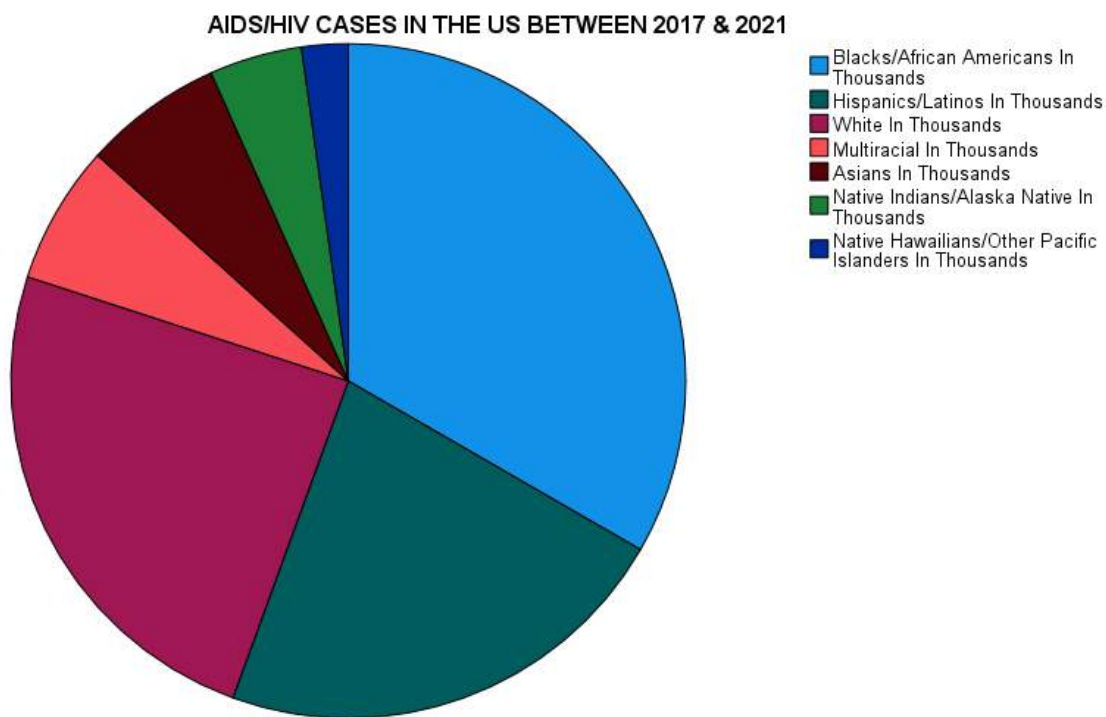
**AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Black/African American Women	4	8.9	26.7	26.7
	White Women	2	4.4	13.3	40.0
	Hispanic/Latinos	4	8.9	26.7	66.7
	Multiracial	2	4.4	13.3	80.0
	Asian	1	2.2	6.7	86.7

American Indian/Alaska Native	1	2.2	6.7	93.3
Native Hawaiians & Other Pacific Islander	1	2.2	6.7	100.0
Total	15	33.3	100.0	

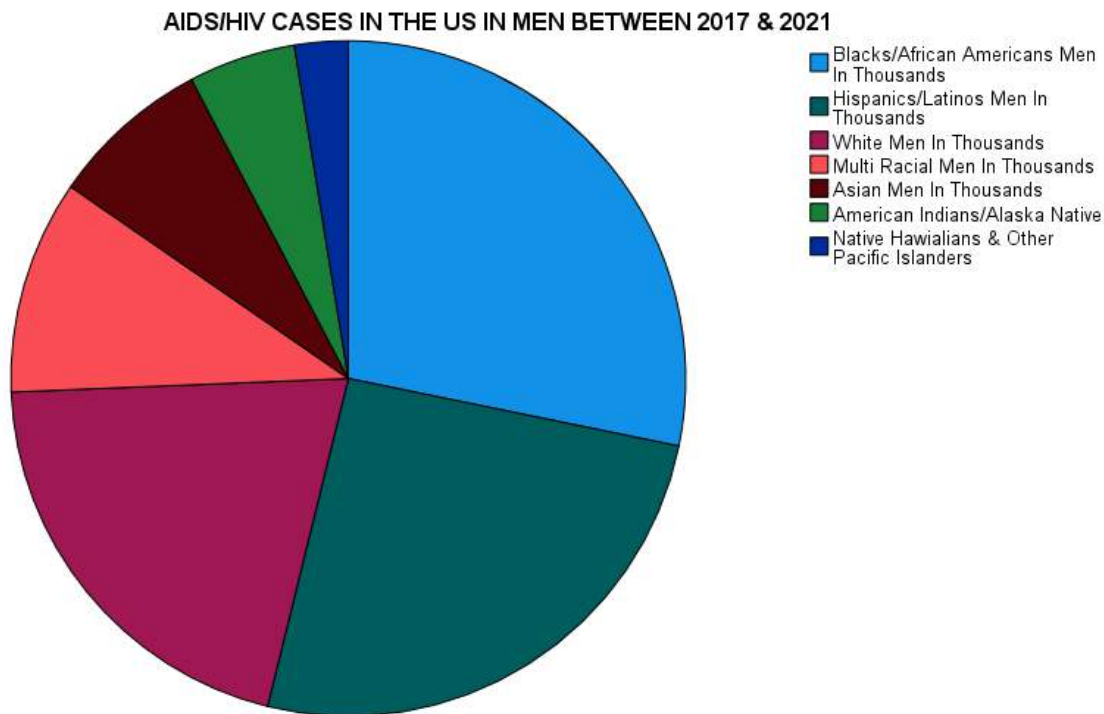
**Table 4.** Showed the cumulative frequencies’ percentages of all AIDS/HIV cases in the US in women of 100% with no missing data statistics (see table 4 above for more details).

**Figure 1. AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021 IN COLOR CODED PIE CHART**



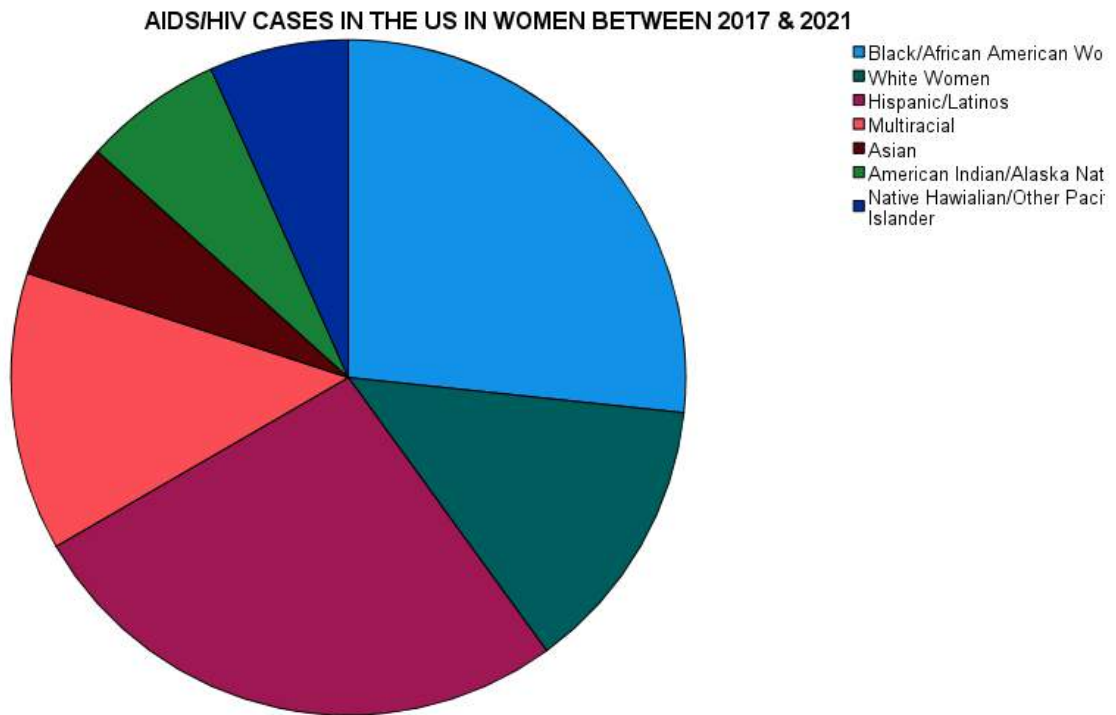
**Figure 1.** Showed the color coded pie chart of all AIDS/HIV cases in the US between 2017 and 2021; Blacks/African Americans took the lead, followed by Hispanics/Latinos, and Whites to the third position (see figure 1 above for more details).

**Figure 2. AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021 IN COLOR CODED PIE CHART**



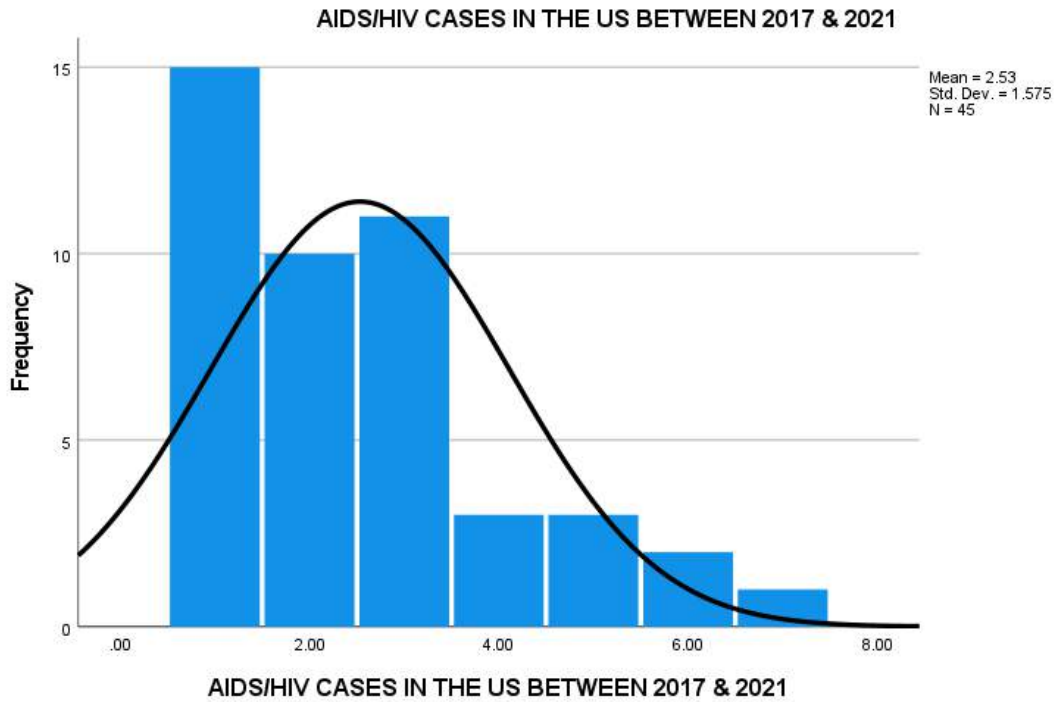
**Figure 2.** Showed the color coded pie chart of all AIDS/HIV cases in the US in men between 2017 and 2021; Blacks/African Americans took the lead, followed by Hispanics/Latinos, and White men took the third position (see figure 2 above for more details).

**Figure 3. AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021 IN COLOR CODED PIE CHART**



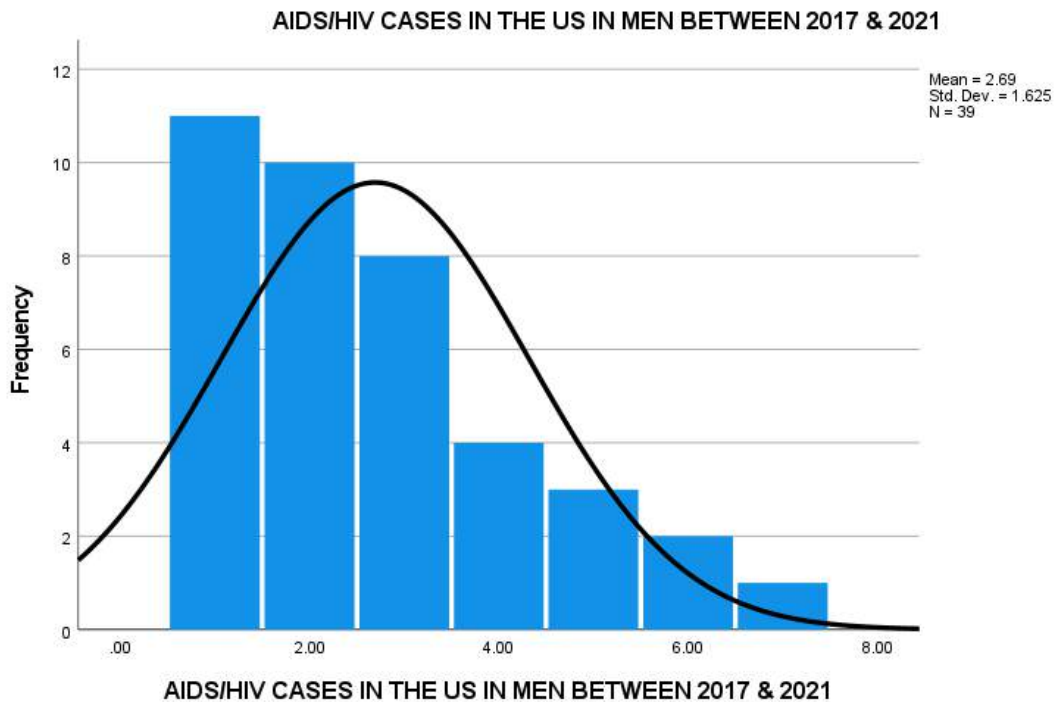
**Figure 3.** Showed the color coded pie chart of all AIDS/HIV cases in the US in women between 2017 and 2021; Blacks/African American women took the lead, followed by white women, and Hispanics/Latinos, took the third position (see figure 3 above for more details).

**Figure 4. AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021**



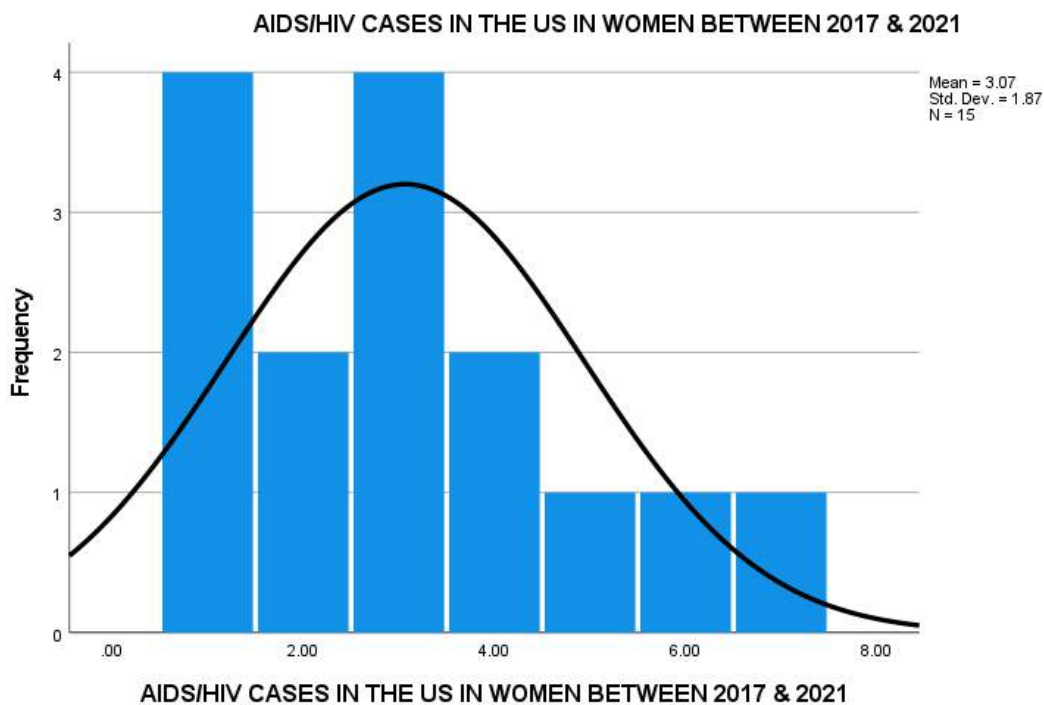
**Figure 4.** Showed all AIDS/HIV cases in the US between 2017 and 2021 with a mean of 2.5, Std. Dev of 1.6 and N of 45, with no missing numbers (see figure 4 above for more details).

**Figure 5. AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021**



**Figure 5.** Showed all AIDS/HIV cases in the US in men between 2017 and 2021 with a mean of 2.7, Std. Dev of 1.7 and N of 39, with no missing numbers (see figure 5 above for more details).

**Figure 6. AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021**



**Figure 6.** Showed all AIDS/HIV cases in the US in women between 2017 and 2021 with a mean of 3.1, Std. Dev of 1.9 and N of 15, with no missing numbers (see figure 6 above for more details).

**Figure 7. Barriers Associated with Health Care Continue Drive of Disparities in AIDS/HIV Diagnoses**



Figure 7. Barriers Associated with AIDS/HIV Diagnoses

Racism, HIV stigma, discrimination, homophobia, poverty, and other barriers to health care continue to drive disparities in HIV diagnoses.



**Figure 7.** Showed some of the barriers associated with AIDS/HIV diagnoses; data obtained from CDC in 2024 which included racism, HIV stigmas, discrimination, poverties from 2017 to 2021 (see figure 7 above for more details, CDC, 2024).

Figure 8. The Statistical Data of AIDS/HIV Trends by Race and Ethnicities

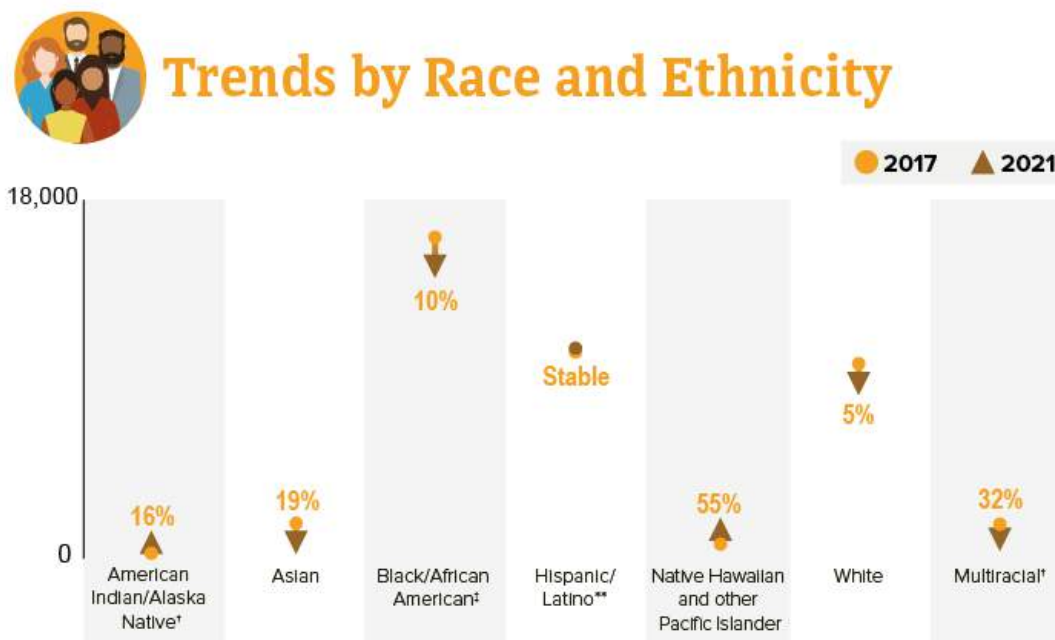


Figure 8. Showed the statistical data of AIDS/HIV trends’ increases or decreases by race and ethnicities in the US between 2017 and 2021; data obtained from CDC in 2024 (see figure 8 for more details, CDC, 2024).

Table 5. One-Sample Statistics

	One-Sample Statistics			
	N	Mean	Std. Deviation	Std. Error Mean
AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021	45	2.5333	1.57538	.23484
AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021	39	2.6923	1.62471	.26016
AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021	15	3.0667	1.86956	.48272

Table 5. Showed of a one-sample statistics with a Std. Deviations of 1.6, 1.6, and 1.9 and N of 45, 39, and 15 (see table 5 above for more details).

**Table 6. One-Sample Test**

One-Sample Test						
Test Value = 0						
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021	10.787	44	.000	2.53333	2.0600	3.0066
AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021	10.349	38	.000	2.69231	2.1656	3.2190
AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021	6.353	14	.000	3.06667	2.0313	4.1020

**Table 6.** Showed one-sample test with a Sig. (2-Tailed) of .000 of all AIDS/HIV cases in the US between 2017 and 2021, .000 for men, and .000 for women the same time... The analyzed data indicated that there was a 100% correlations/relationships between the AIDS/HIV and in all tested cases in the US between 2017 and 2021 in all tested Americans, in all tested men and in all tested women in the US (see table 6 above for more details).

**Table 7. One Sample Effect Sizes**  
**One-Sample Effect Sizes**

		Standardizer <sup>a</sup>	Point Estimate	95% Confidence Interval	
				Lower	Upper
AIDS/HIV CASES IN THE US BETWEEN 2017 & 2021	Cohen's d	1.57538	1.608	1.159	2.048
	Hedges' correction	1.60288	1.580	1.140	2.013
AIDS/HIV CASES IN THE US IN MEN BETWEEN 2017 & 2021	Cohen's d	1.62471	1.657	1.166	2.138
	Hedges' correction	1.65768	1.624	1.143	2.096
AIDS/HIV CASES IN THE US IN WOMEN BETWEEN 2017 & 2021	Cohen's d	1.86956	1.640	.842	2.414
	Hedges' correction	1.97776	1.551	.796	2.282

a. The denominator used in estimating the effect sizes.

Cohen's d uses the sample standard deviation.

Hedges' correction uses the sample standard deviation, plus a correction factor.

**Table 7.** Showed the One Effect Sizes of all AIDS/HIV cases in the US between 2017 and 2021 with a 1.6, 1.6, 1.6 and 1.7 and 1.7 and 2.0 corrections requests between Hedges and Cohen's (see table 7 above for more details).

### **Interpretations of the Results and Findings of the Research Study**

The study found that there were significant AIDS/HIV cases' increases in the US between 2017 and 2021; for instance, while it had been sold years that due to healthcare applications' treatments of AIDS/HIV in the US while make impossible to detect the virus, many Americans are still testing positive for AIDS/HIV infections.

- 1. The question now becomes is it possible for invisible AIDS/HIV negative individual test to physically transmit AIDS/HIV to innocent persons during sexual encounters?**
- 2. When and how AIDS/HIV invisibilities due to previously well documented tests' scores become visibilities transmissions of AIDS/HIV's abilities, due to overwhelmingly presumed non-transferable assumptions, before getting physical involve in sexual activities?**

For example between 2017 and 2021 of almost 37, 000 data that were analyzed, Black/African Americans accounted for 40% positive for AIDS/HIV in the US, 29% of Hispanics/Latinos, 25% of whites, 3% of multiracial, 2% of Asians, 1% of American Indians/Alaska Natives and less than (< 1%) of Hawaiians/Other Pacific Islanders also tested positive for AIDS/HIV in the US. Secondly, among about 30,000 of men data analyzed in the US between 2017 and 2021, Blacks/African American men tested positive for AIDS/HIV at a ratio of 37%, Hispanics/Latinos men at a ratio of 29%, white men at a ratio of 26%, Multiracial men at a ratio of 3%, Asians men at a ratio of 2%, American Indians/Native Alaska men at a ratio of 1% and less than (< 1%) of Hawaiians/Other Pacific Islanders men also tested positive for AIDS/HIV in the US. Furthermore, among about 6700 of women data analyzed in the US between 2017 and 2021, Blacks/African American women tested positive for AIDS/HIV at a ratio of 53%, Hispanics/Latinos women at a ratio of 19%, white women at a ratio of 23%, Multiracial women at a ratio of 3%, Asians women at a ratio of 1%, American Indians/Native Alaska women at a ratio of 1%, and less than (< 1%) of Hawaiians/Other Pacific Islanders women also tested positive for AIDS/HIV in the US. It should be noted that this research could not answer alternation hypothesis 2 because there no data statistics available to be analyze about the roles accessibilities treatments or availabilities lack of accessibilities to treatment availabilities play in testing positive during AIDS/HIV diagnoses in the US. Finally, it should be noted that all of the founded reports of these AIDS/HIVS tests reports superseded the actual populations' races classifications in the US; reference tables 1 to 7 and figures 1 to 8 for pinpointed details.

- 3. The secondary question 1: remains how many people were actually tested due to opened clients' accessibilities to AIDS/HIV tests or due to closed clients' accessibilities to AIDS/HIV tests did they actually tested, as to obtain these critical AIDS/HIV data statistics between 2017 and 2021?**

4. **The secondary question 2: remains what roles did COVID-19 pandemic played in the limited secondary data statistical tests between 2019 and 2021?**
5. **The secondary question 3: remains were/are we operating with a false unproven presumed assumptions or fantasies that AIDS/HIV is no longer a pandemic in the US and in other countries, worldwide?**

These are some critical research unanswered questions that need to be investigated, addressed, and answered in the follow-up research studies that question the efficacies or inefficacies of the US healthcare applications in the control of current AIDS/HIV increases in the United States of America in 2024 and beyond in other countries worldwide.

## CONCLUSION AND DISCUSSIONS

In conclusion, HIV/AIDS infection has a lot of consequences. HIV infection is not considered an individual or community problem; but instead, it is considered as a national and international burden. Above all, if the problem of the AIDS epidemic in Africa is not controlled, it will eventually affect many parts of the world. Furthermore, as people migrate from different parts of the world, they form relationships which assist in the transmission of HIV. It is imperative therefore, for the problem of HIV to be addressed both nationally and internationally. In the final analysis, it is highly recommended that theoretical foundation of health behaviour needs to be holistically implemented across the board, as to achieve unequivocal success when dealing with the United States health care delivery system.

From a general standpoint, Blacks/African Americans and Hispanics/Latinos their populations' threshold of the US overall population; for example, Blacks/African Americans account for almost 14% and Hispanics/Latinos account for almost 15% of the US population, yet the analyzed data statistics showed that they both accounted for 40% and 29% respectively as compared to White at 25% which was way below their US populations' threshold. All the others in the analyzed data statistics were either within their US's populations' threshold, and in some cases they were way below their populations' thresholds' counts. The question now becomes were they (**Black/African Americans & Hispanics/Latinos**) more sexually reckless in their Theoretical Foundation's Behaviours than others in the US overall population? **This question could not be answered because CDC did not show us where, when, and how they collected these critical data statistics.** The second research question analyzed was does races play any roles in being diagnosed positive for AIDS/HIV in the US? **This question can be easily answered based on the data statistics collected and analyzed in this research study because it showed various racial inconsistent indifferences in the results and findings of this research study.** Practically, testing positive for AIDS/HIV has been on the increase way before COVID-19 pandemic in the US and worldwide. It appears that people all over the world no longer see testing positive for AIDS/HIV infections as "DEAD SENTENCE"; however, the marginal propensities for them to become detrimental are still there, if one is diagnosed with the disease; not to mention the pains and sufferings one has to go through in life.

Furthermore, unconfirmed data statistics had showed that AIDS/HIV positive diagnoses have been on the increase in places like South Southern Africa like South Africa, East Africa like Kenya, West Africa like Ghana and Nigeria, in places like Cameroon, Niger, North Africa countries, Northern Africa like Libya, Egypt, Tunisia, Sudan, Central Africa countries, and in other Africa countries, just to mention a few in Africa. However, in the most recent

debate in the US congress, there has been a drive not to support any African countries with AIDS/HIV treatments or with any assistance from the US. The opposition politic parties argued that they have been supporting and assisting all African countries since the discovery of AIDS/HIV EPIDEMIC in early 1980s and there should be no need for doing it today after almost 40 years of commitments with our limited resources of \$25 billion dollars annually. Absolutely correct with the opposing viewpoints about continued supports for African countries about how to tackle AIDS/HIV in their own geographical entities.

It should be noted that majority of African leaders in the west, east, central, south-souths, north, mid, and all over Africa seize foreign public resources as their self-ownerships; almost 1 trillion plus dollars annually are prevented from getting into the HANDS of the **INNOCENT SUFFERING AFRICANS**. This study reminds us about an **“AGED JAPANIZE SAYING”** that **“If you give a man who came to your house door’s front and beg you for some fishes to eat for the first time, GIVE IT TO HIM; and if he comes back the second time, please, give it to him joyfully, but if he comes the THIRD TIME for more free fishers to eat, TAKE HIM TO THE NEAREST RIVERS OR WATERS AND TEACH HIM HOW TO CATCH FISHES FROM THE RIVERS/WATERS AND HE WILL NO LONGER BE YOUR CREATED SELFMAD PROBLEMS ANYMORE.”** Africans’ **LEADERSHIPS** need to learn how to **FISH** for **THEMSELVES** and stop being **NUISANNCES’ PROBLEMS** to the rest of the western world; **they are more financially privileged than in the “REAL AFRICANS”in the MOTHERLAND; this research study knows the truth.** However, in summation new generations Africans’ leaderships are now tackling the **BULLS** by holding their **HORNS** tightly; they are now demanding that the internal mineral resources should benefit their peoples and they are no longer waiting for what the Western World leaderships consider as **“HANDOUTS”** such as assumed treatments, accessibilities, and assistances like **AIDS/HIV’s**efficacies in their **MOTHERLAND AFRICA**. They believed they can do better for themselves; without any external evasive foreign directives instructional stipulated and pinpointed compliances. While these critical unproven assumptions are believable for today, it should be noted that **“only will tell us if their unproven assumptions are possible, workable, and obtainable in the near or far future to come”**; no doubt, **“TIME WILL TIME”**about the future psychological prognoses of **AFRICA THE MOTHERLAND.”**

## ACKNOWLEDGEMENTS

This study wants to give a special thanks to the **PVAMU the Division of Research & Innovation (R&I)** in response to the **Faculty and Staffs of the-Research & Innovation for Scholarly Excellence (RISE)** for their continued supports of such research studies. Also, this research study wants to thank **PVAMU School of Public & Allied Health the Division of Public Health & Health and Division of Public Allied** faculty members and staffs for their continued supports for all researches studies’ obligations and commitments.

## CONFLICT OF INTERESTS

This study shares no conflict of interests.

## REFERENCES



1. Anno, B. J. (2004). Prison health services: An overview. *Journal of correctional health care*, 10, 287-301.
2. Atatah, P.E., Kisavi-Atatah, C. W. and Branch-Vital, A. (2016) Classification: The Analyses of the Psychometric Performances' Effects on the Special Needs Offenders Program. *Open Journal of Social Sciences*, 4, 198-216. <http://dx.doi.org/10.4236/jss.2016.45024>
3. Berger, P.L. and Luckmann, T. (1966) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Doubleday & Company, New York.
4. Center for Disease Control and Prevention, (CDC, 2015). About HIV/AIDS. Retrieved from <http://www.cdc.gov/hiv/basics/whatishiv.html>. Center for Disease Control and Prevention. (CDC, 2024). HIV in the United States by Race and Ethnicity: HIV Diagnosis. Available at <https://www.cdc.gov/hiv/group/raciaethnic/other-races/diagnoses.html>
5. Frankfort-Nachmias, C. and Nachmias, D. (2000). *Research Methods in the Social Sciences*. 6th Edition, Wadsworth, New York.
6. Frankfort-Nachmias, C. and Nachmias, D. (2008). *Research Methods in the Social Sciences*. 7th Edition, Worth, New York.
7. Hagen, K. T. & Yohani, S. C. (2010). The nature and psychosocial consequences of war rape for individuals and communities. *International journal of psychological studies*, 2 (2).
8. Hyder, A. A., & Morrow, R. H. (2005). Culture, behavior and health. Retrieved from <http://www.jblearning.com/samples/0763729671/chapter 02.pdf>.
9. Institute of Medicine. (2003). Who will keep the public healthy? Educating public health professionals for the 21<sup>st</sup> century. Retrieved from <http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/eco-model/Transcript-Ecological-Model.pdf>.
10. Kalichman, S. C., & Simbayi, L. C. (2003). HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa. Retrieved from <http://sti.bmj.com/content/79/6/442.full>.
11. National Cancer Institute. (2005). Theory at a glance: A guide for health promotion practice. Retrieved from <http://www.sneb.org/2014/Theory%20at%20a%20Glance.pdf>.
12. National Institute of Health. (2015). Cultural competency. What is cultural competency? Retrieved from <http://www.nih.gov/clearcommunication/culturalcompetency.htm>.
13. World Health Organization, (2015). Health promotion. Retrieved from [http://www.who.int/topics/health\\_promotion/en](http://www.who.int/topics/health_promotion/en)