Addressing HIV Disparities Among Women Of Color In The Southern United States
As an increasing number of women in the United States become infected with HIV, particularly women of color, the changing epidemic is challenging established mechanisms for the delivery of primary medical care services. Advances in HIV treatments, and the resultant longer life expectancy for those living with the disease, means primary care providers must manage the chronic medical conditions of patients living with HIV in addition to providing HIV treatment. These developments, along with changes in the types and number of people living with HIV in the U.S., require a comprehensive, integrated approach to HIV primary medical care and treatment.

In 2006, an estimated 26% of new HIV infections were in females (up from 18% in 1994). Forty five percent of cases were in African-Americans, 35% in Whites, and 17% in Hispanics. Among women, 60% of new infections were reported in African-American women – despite the fact they make 12% of the US female population – 22% in White women and 16% in Hispanic women. The rate of HIV infection among African-American women was almost fifteen times higher than the rate for White females, and almost three times the rate for Hispanic females.

In 2007, 27% of AIDS clients were women (up from 7% in 1985). Sixty-six percent of these cases were among African-American women, 18% among White women, and 14% in Hispanic women. This trend among African-American women is most severe in the Southeastern United States (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Arkansas, Louisiana, New Mexico, Oklahoma, and Texas). Florida, Georgia, and Louisiana led the nation in HIV/AIDS diagnosis rates among female adults and adolescents in 2007.

### Biological Susceptibility

Women are more vulnerable to HIV infection due to prolonged mucosal exposure to semen containing HIV. Untreated sexually transmitted infections (STIs) and recurrent yeast infections also increase the biological susceptibility to HIV among women. Interpersonal power inequities in sexual and family relationships have been posited as an additional explanation for gender differences in HIV infection.

### Delay of HIV Testing and Late Initiation of Treatment

Diagnosis late in the progression of HIV disease frequently results in opportunistic infections and less robust immune system rebound once treatment has been initiated. Actual and perceived lack of power in sexual network patterns and family relationships also are thought to be factors contributing to women prioritizing the health concerns of others over their own, resulting in delayed testing, diagnosis, and care.

### Psycho-social Considerations

Substance abuse, mental illness, and physical and sexual abuse, disproportionately affect women of color and also lead to high risk behaviors and an increased chance of exposure to, and infection with, HIV.

### STIs

Chlamydia was the most reported infectious disease in the US in 2007, with more than half of all cases occurring in females aged 15-24. The rate of Chlamydia in Black females being almost eight times as high as in White females, and three times as high in Hispanic women. Due to the fact that Chlamydia can be asymptomatic in females, the diagnosis is often missed. Statistics are similar for gonorrhea, the second most reported infectious disease in the US in 2007. Southeastern states having the highest rate of gonorrhea in the nation, like Chlamydia, gonorrhea increases the likelihood of HIV transmission.

Cervical and anal human papilloma virus (HPV) infections are higher in women with HIV, as are abnormalities on Pap smears ranging from ASCUS (Atypical Squamous Cell of Undetermined Significance) to HSIL (High grade Squamous Intra-epithelial Lesion). Invasive cervical cancer or CIS (Carcinoma In Situ) is also more common in HIV positive women, particularly African-American and Hispanic women aged 20-34.
Missed Opportunities for Medical Documentation

Medical records that fail to document health issues unique to women with HIV, particularly sexual and reproductive health, miss an opportunity to remind providers of additional steps to take to ensure optimal health for female clients. HealthHIV’s clinical assessments at 20 clinics participating in a project supporting networks of HIV care in areas with high HIV prevalence and large minority populations, show routine gynecological examinations and diagnostic tests for STIs were rarely documented despite the fact it is widely known that concurrency of STIs with HIV increase HIV transmission.11

Sub-optimal Medical Care

Clinicians may not always be aware of adverse effects of certain ARVs during pregnancy, or drug-to-drug interactions between hormonal contraceptives and some ARVs that require dosage adjustments.12 Antiretroviral therapy (ART) adherence can be affected by the therapy’s perceived or actual adverse effects14, poor patient/provider relationship, inability to navigate the complexities of the health system, and fragmentation of care.

Domestic Violence and Gender Inequality

Manifestations of power disparities, including domestic violence, specific to women of color with HIV must be addressed. African-American women with abusive primary partners are less likely to use condoms and may experience abuse when requesting they be used. Evidence supports the conclusion that violence is also associated with HIV disclosure, with a number of HIV positive women reporting assaults within six months of disclosure. Adherence to antiretroviral medications may also be affected by threats of domestic violence15 as well as by competing family priorities such as childbearing and childrearing. Recent studies indicate women are frequently underrepresented in clinical trials of new classes of Antiretrovirals (ARVs) because of their ability to participate.16

Difficulties in achieving optimal care originate from a variety of sources including the prevailing socio-economic structure and from within the medical system.

Barriers to Effective Care Among Women

HealthHIV developed and field-tested “A Workshop to Develop Evidence Based Best Practices for Primary Medical Care of Minority Women with HIV in the Rural South.” The workshop was hosted in November 2009 by the Southeast Mississippi Rural Health Initiative, one of HealthHIV’s partners in a project to support networks of HIV care in areas with high HIV prevalence and large minority populations.

The workshop design was based on an organizational needs assessment at SeMRHI and addressed specific gaps in practice representative of other local health service delivery sites in the region. It focused on what has become a national public health imperative, particularly in the South - putting the unique needs of women of color, and especially those living with HIV, at the forefront of the healthcare agenda.

Five core interventions to reduce HIV in minority women were covered in the workplace:

- Aggressive STI screening
- Universal HIV testing according to CDC guidelines
- Effective dual protection (family planning and STI prevention)
- Optimal treatment of HIV, adherence, and retention in care
- Known barriers to access to HIV care and treatment

HealthHIV brought together faculty for the Women & HIV workshop, primarily African American women physicians and HIV Specialists who are consultants to HealthHIV. These clinicians provide comprehensive primary care and HIV treatment to minority women in high prevalence areas and have personal and professional experience confronting the challenges of providing such care to minority women on a daily basis. Several of the clinicians are care providers at HealthHIV partner organizations.

“Thanks to HealthHIV our community is now looking closer at the unique challenges faced by women living with HIV.”
- Hope Bradley, CEO Southeast Mississippi Rural Health Initiative

HealthHIV Addresses Women Living With HIV
Throughout the Southeastern United States, HIV incidence levels have grown alarmingly in women of color. Factors that make women of color more vulnerable to HIV infection and sub-optimal care are found at the socio-economic, health system, provider, and client levels. Additional emphasis within clinical and care coordination settings is needed when addressing HIV prevention and treatment among women. Organizations and providers can now identify barriers to care among their female clients, implement strategies to fill gaps, and reduce infection rates to improve health at the community and individual levels.

Based on experiences from the HealthHIV Women of Color and HIV workshop, HealthHIV recommends education for primary care clinicians and care coordination staff. The following topics may be included:

- The Need for an Approach in the Care & Treatment of Women of Color with HIV
- Integrating HIV into Primary Medical Care with Focus on Women of Color
- Primary Medical Care for HIV Positive Women – Comprehensive, Woman-Centered Treatment & Care, Initial Clinical Assessment of Women of Color with HIV Disease
- Strategies to Increase Access, Adherence, & Retention in Care for Women with HIV
- Reproductive Intentions, Contraception: Women of Color with HIV/AIDS
- STIs & HIV: A Missed Opportunity for HIV Prevention?
- Special Gynecologic Considerations in Women Living with HIV/AIDS
- Implementing the 2006 CDC HIV Testing Recommendations Locally: Are We Reaching Women of Color?
- Medical Case Management, Mental Health & Women of Color with HIV
- Unique Nutritional Considerations for Women of Color with HIV

For more information on HIV disparities among women of color in the Southern United States and HealthHIV’s response, email info@healthhiv.org

References

8. Gender bias in clinical trials of AIDS drugs. International Conference on AIDS.Int Conf AIDS. 2002 Jul 7-12; 1A: abstract no. WeFaB9964.