Supporting Women of Color Living with HIV

Highlights from the Special Projects of National Significance (SPNS) Program

This fact sheet contains highlights from: *Project Women Empowered to Connect and Remain Engaged in Care (WE CARE)* at the Ruth M. Rothstein CORE Center (Chicago, IL) and *Guide to Healing: Enhancing Access for HIV+ Women in the Rural South* Intervention at the University of North Carolina at Chapel Hill.

Background

Women of color experience a disproportionate burden of HIV infection, and face significant barriers to accessing and remaining in HIV care. Black/African American women have the highest risk of HIV infection compared with women of other races/ethnicities.[1] While constituting only 14% of the female population, an estimated 60% of women diagnosed with HIV are Black.[2,3,4] Broadly, women of color often experience a variety of societal, psychosocial, and personal challenges that can dramatically reduce access to care and successful progression through the HIV care continuum. These factors can include: stigma, poverty, inadequate insurance, unstable housing or employment, mental health issues, substance use disorders, low health literacy, history of trauma, and gender inequality in relationships.[5,6] Interventions designed to specifically address the unique needs of women of color living with HIV, such as the two described in this guide, can improve HIV-related outcomes.

Unmet Needs

Among HIV-positive women of color, barriers to accessing and retaining HIV primary care include common psychosocial barriers such as gender inequality in relationships, including financial dependence on men; intimate partner violence; mental health issues; substance use disorder; distrust of the health care system; lack of social support; and stigma (both real and perceived).

Approximately 55 percent of women living with HIV/AIDS have experienced intimate partner violence.[7] A history of violence, trauma, and abuse has been shown to correlate with decreased medication adherence, decreased engagement in care,[8, 9, 10] and increased viral load as well as increased mental health issues/mental duress.[11, 12]

Project Women Empowered to Connect and Remain Engaged in Care (WE CARE)

Setting: Clinic setting in Chicago, Illinois

Target Population: Women of color newly diagnosed with HIV, new to care, or those struggling with retention in care

Theoretical Basis: Health Belief Model and Social Cognitive Theory

Intervention Objectives

The objectives of the *Project Women Empowered to Connect and Remain Engaged in Care (WE CARE)* intervention were to address individual-level barriers, especially stigma, and link and support women of color in Chicago who are newly diagnosed with HIV (or new to care), and those struggling with retention in care.

Key Considerations for Replication

- Sessions may be triggering for some participants; engaging mental health counselors can provide additional support
- To remain sensitive to participants who may have experienced trauma from men, identify facilitators who are women
- Meeting space should be confirmed for the full length of the intervention to support participants in feeling safe and comfortable to share
- The use of video clips are effective tools to foster discussion and demonstrate behaviors relevant to the group

Intervention Staff Requirements

To replicate the CORE Center's WE CARE intervention, the following positions and capacity are necessary.

- **Project Director or Coordinator**—The leader of all aspects of the project for reporting, planning, logistics, and protocols. This will be the go-to person who will synchronize and synergize efforts across the intervention. This person should be familiar with the policies and procedures of the setting, as well as have the trust and respect of staff and clients alike.
- **Facilitators/Group Staff**—Two to four part- or full-time staff during the actual group session are suggested for facilitation. If replicating on a smaller scale, this can be done with 2 part-time staff, particularly if using existing staff. *(Note: There is some intensive upfront work for planning and recruitment that staff must do before group sessions begin.)*
- **Advisory Board**—Needed to help select staff, movie clips, and provide feedback on the length and day of the group session. These should be a group of diverse staff, board members, and other stakeholders who can offer a variety of viewpoints.

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- **Mental Health Counselor**—This person could be in-house, through a partner agency, or with visiting hours immediately after group, so long as they provide easy access to mental health counseling.

Guide to Healing

Setting: Academic hospital-based setting in North Carolina

Target Population: Women of color

Theoretical Basis: Self-Determination Theory

Intervention Objectives

The *Guide to Healing: Enhancing Access for HIV+ Women in the Rural South (Guide to Healing)* Intervention was designed to link women of color to HIV primary care services within an academic infectious disease clinic, connect them to a Nurse Guide, and support development of autonomy and retention in care.

Key Considerations for Replication

- A primary goal of the intervention is to ensure that women feel safe and welcomed while managing their HIV; thus, all site staff should receive education on the intervention and the target population
- Engaging a variety of individuals and organizations (e.g., local health departments, emergency departments, case management agencies, disease intervention specialists) can foster rapid entry for newly diagnosis women
- Providing comprehensive support (e.g., parking vouchers, cell phones, access to rapid appointments, women's support groups) can further enhance linkage and retention efforts
- Clients in this intervention may be navigating the health care system for the first time; supportive case management can reduce intimidation and confusion about the process
- Conducting the initial contact and orientation by the Nurse Guide by phone (rather than in person and prior to the first medical visit) may be necessary so that clients do not have to arrange for two visits (each of which may be associated with time off work, need for childcare and transportation)
- Orientation materials should include information about the intervention, as well as basic resources on HIV, self-care, preparing for provider visits, HIV medication and refills, and prevention supplies

Intervention Staff and Participants

- **Program Manager**—responsible for day-to-day operations; coordinates the women's support group.
- **Nurse Guide** (registered nurse)—provides clinical, systems navigation, health education, and outreach/follow-up services to women in the intervention to engage and retain them in care and support their development of autonomy.

RESOURCES

This fact sheet is part of the ***Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond*** resources from the Integrating HIV Innovative Practices (IHIP) project.

- **SPNS Enhancing Access to and Retention in Quality HIV Care for Women of Color (WOC) Initiative: https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-women-color**
- **Chapter 5 in *Ahead of the Curve: Ryan White HIV/AIDS Program Progress Report:* https://hab.hrsa.gov/sites/default/files/hab/data/biennialreports/progressreport2012.pdf**
- **CDC's Healthy Relationships: A Small-group Level Intervention for Men and Women Living with HIV/AIDS: https://www.cdc.gov/hiv/research/interventionresearch/rep/packages/healthyrelationships.html**

- **Psychologist/Mental Health Counselor**—Provides mental health support services and conducts psychological support group sessions. **Ideally onsite, but services could be provided through a community partner, particularly if psychologist/counselor can come to clinic*

Notes

[1] CDC. HIV Among African Americans. Retrieved from: https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html.
[2] CDC. HIV Among Women. Retrieved from: https://www.cdc.gov/hiv/group/gender/women/index.html.
[3] Centers for Disease Control and Prevention. (2016). HIV Surveillance Report, Vol. 27. Retrieved from: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf.
[4] Centers for Disease Control and Prevention. (2016). HIV Among People Aged 50 and Over. Retrieved from: http://www.cdc.gov/hiv/risk/age/olderamericans/.
[5] HRSA/HAB. Enhancing access to quality HIV care for women of color: final report. 2008. Retrieved from: http://careacttarget.org/library/HIVcare/WOCFinalReport.pdf.
[6] CDC. Social determinants of health among adults with diagnosed HIV in 11 states, the District of Columbia and Puerto Rico, 2014. HIV Surveillance Supplemental Report 2016; 21. (No. 6). Retrieved from: www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-6.pdf.
[7] Machtinger EL, Wilson TC, Haberer JE, et al. Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS Behav*. 2012;16:2091–2100.
[8] Dae S, Cohen M, Weber K, et al. Abuse and resilience in relation to HAART medication adherence and HIV viral load among women with HIV in the United States. *AIDS Patient Care STDs*. 2014;28:136–143.
[9] Lopez EJ, Jones DL, Villar-Loubet OM, et al. Violence, coping, and consistent medication adherence in HIV-positive couples. *AIDS Educ Prevent*. 2010;22:61.
[10] Cohen MH, Cook JA, Grey D, et al. Medically eligible women who do not use HAART: the importance of abuse, drug use, and race. *Am J Public Health*. 2004;94:1147.
[11] Machtiner EL, Wilson TC, Haberer JE, et al. Psychological trauma and PTSD in HIV-positive women: a meta-analysis. *AIDS Behav*. 2012;16:2091–2100.
[12] Rose R, House AS, Stepleman LM. Intimate partner violence and its effects on the health of African American HIV-positive women. *Psycholog Trauma Theory Res Pract Policy*. 2010;2:311–317.