Women, Mental Health & HIV Treatment Engagement

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Women of color, particularly those impacted by poverty are at heightened risk for HIV infection both locally and globally.

- Black and Latino women represent 27% of all women in the U.S. but they account for 80% of HIV new infections among women

- African-American women have an HIV prevalence rate nearly four times that of white women

Low income HIV+ women of color demonstrate a high need for medical services, but evidence low treatment adherence.

Of the 1.1 million Americans living with HIV, only 25 percent are virally suppressed.
Previous research has focused on people of color overall. Very little gender specific research has been conducted.
Taking a Closer Look

Women of Color
People of Color
HIV
Background

Low-income females are at heightened risk for HIV infection.

Many of the unique barriers to care for women of color meet at the intersection of poverty and HIV.

Women living in poverty are concentrated in areas with high rates of HIV infection.

The environmental consequences of living in low-resourced, high stress communities present perpetual challenges.

Poverty-impacted women with HIV are at higher risk of mental health challenges.
HIV is often comorbid with diabetes, hypertension, or other conditions.

Complex treatment regiments present another barrier to treatment adherence.

Managing household and parenting responsibilities may have been overburdened by side effects.

Complex regiments became difficult to incorporate into daily routines.

Symptoms often attributed to depression (fatigue and difficulty concentrating) may actually stem from medication side effects.
Factors Impacting Adherence

- Family
- Stigma
- Community Support
- Transportation
- Mental Health
- Relationship with Provider
HIV+ women of color frequently choose to discontinue care, jeopardizing their long-term health and survival.

An important influence on healthcare use for poverty impacted women may be explained by childrearing demands, particularly within single parent homes.

Many are the primary caregivers in their families, often placing the needs of their children before their own.

(Mellins and Ehrhardt, 1994; Cunningham et al., 1995; Cunningham et al., 1998, Mellins et al., 2003; Mor et al., 1992)
Trauma has been increasingly associated with the high prevalence and poor outcomes of HIV in this population.

HIV-positive women are disproportionately affected by sexual and physical trauma in both childhood and adulthood.

Experiencing Childhood Sexual Abuse (a form of Violence Against Women) is associated with risk-taking behavior later in life, increasing an individual’s lifetime risk of contracting HIV.

Women living in poverty are more likely to experience violence and trauma.

(www.who.int/gender/violence/vawandhiv/en/; Matchinger et al., 2012a; Matchinger et al., 2012b; Boarts et al., 2009; Mugavero et al., 2009)
Mothers with HIV are at an even greater risk of developing depression.

Depressive symptoms may result from family and financial stressors competing with maternal healthcare needs. This can impede parental functioning, have detrimental effects on children, and increase non-adherence to medical treatment.

(Lovejoy et al., 2000; Nicholson, Sweeney, and Geller, 1998; Crnic and Low, 2002; Gonzalez, 2012; Israelski et al., 2007; Cruess et al., 2003)
Poverty and associated distress are some of the primary drivers of the longstanding disparity in accessing HIV related care.

Low-income women are particularly vulnerable to underuse services.

(Holstad et al., 2011; Sandelowski, Lambe, and Barroso, 2004)
There are specific and unique barriers mitigating healthcare use for poverty-impacted women of color.

The integration of health and behavioral healthcare services may offer HIV+ women of color opportunities to address their complex needs.

Understanding barriers to adherence is crucial in creating new services to help decrease the disparity in healthcare use facing this population.
Thank you!

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