BLACK WOMEN'S HEALTH IMPERATIVE

Improving Outcomes for Black Women and Girls Living with HIV

Policy Priorities to Advance Prevention, Treatment, and Support

OUR POSITION

The human immunodeficiency virus (HIV) epidemic has been a public health issue for Black women and girls for decades.[1] Persistent disparities in transmission, treatment, and outcomes are driven by preventable gaps in prevention, access to care, and support services – not personal failures. **The Black Women's Health Imperative (BWHI) calls for bold, strategic investments in prevention, access to treatment, and integrated care systems to reduce new HIV cases among Black women and girls, and ensure that those living with HIV can lead longer, healthier lives with the support they deserve.**

ABOUT HIV

HIV is a virus that attacks the body's immune system and increases vulnerability to other infections and diseases.[2] It is primarily acquired through contact with certain bodily fluids from a person with HIV, including blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk.[3] The most common modes of transmission are condomless sex and blood-to-blood contact, including through injection drug use.[4] Once an individual acquires HIV, they have it for life.[5] Without treatment, HIV can lead to acquired immunodeficiency syndrome (AIDS).[6] However, antiretroviral therapy (ART) treatment taken consistently as prescribed can reduce the amount of HIV in the blood to Undetectable levels, make the virus untransmittable through sex, and allow people with HIV to live long and healthy lives.[7]

HIV AMONG BLACK WOMEN

Black women have been disproportionately affected by HIV since the beginning of the HIV epidemic.[8] In 2022, Black women accounted for 50% of all new HIV diagnoses among women – a rate 10 times higher than among White women and three times higher than among Latinas.[9] Black women also represent the largest group of women living with HIV.[10] The rate of AIDS among Black women is 18 times higher than the rate in White women.[11] Black transgender women also face alarming disparities, making up nearly 50% of all new diagnoses among transgender women in 2019.[12]

These disparities are driven by multiple, overlapping factors, including limited access to health care and testing, higher rates of poverty, greater HIV-related stigma, and residence in communities with higher prevalence of HIV and sexually transmitted infections (STIs).[13,14] They are not influenced by differences in high-risk behavior. In fact, Black women are no more likely to have condomless sex, multiple sexual partners, or use more drugs than women of other races.[15]

Despite these disturbing statistics, there has been some progress. From 2010 to 2022, the rate of new HIV diagnoses among Black women declined by 39%.[16] However, this progress

has slowed, as this number decreased by only 1% from 2018 to 2022.[17] These trends show that HIV prevention strategies have had some positive effect, but further targeted, sustained efforts are needed to aptly address the persistent gap facing Black women.

BWHI's policy approach to addressing HIV among Black women has focused on four key areas: (1) combatting stigma; (2) preventing future transmissions; (3) improving access to comprehensive treatment; and (4) providing essential support, beyond medical treatment, that focus on the wellbeing of Black women living with HIV and AIDS.[18] These priority areas are integrated into the policy solutions outlined below.

INCREASE PrEP ACCESS AND AWARENESS

Preexposure prophylaxis (PrEP) is a highly effective medication for preventing HIV that can reduce the risk of sexually acquired HIV by up to 99%.[19] Yet, despite the disproportionately high rates of HIV among Black women and adolescent girls, awareness and uptake of PrEP among Black women and adolescent girls is critically low.[20] Less than 20% of Black women are aware of PrEP, and just 1% have been prescribed it.[21] While there is limited data on PrEP uptake among Black transgender women, one study shows that only 18% of Black and Latinx transgender women aware of PrEP had ever taken it.[22] This gap can be attributed to both provider-side and patient-side barriers. Providers may lack training or feel uncomfortable initiating conversations about PrEP, while Black women and adolescent girls may have concerns about cost, confidentiality (especially while on a parent's insurance), mistrust or curiosity about the novelty of PrEP, limited understanding of PrEP's relevance to their lives, or stigma tied to accusations of promiscuity or infidelity.[23] Ensuring that both providers and patients are educated about PrEP, and that PrEP is affordable and appropriately prescribed, will be critical to reducing HIV transmission rates among Black women and adolescent girls.

POLICY RECOMMENDATIONS

- **Pass the PrEP Access and Coverage Act** to require private and public health insurance programs to cover HIV prevention drugs like PrEP without cost-sharing or preauthorization, and invest in outreach to high-risk populations.
- **Protect the U.S. Preventative Services Task Force's authority to require coverage of recommended preventive services** like PrEP across private insurance and Medicaid expansion plans.

ADDRESS THE CONNECTION BETWEEN HIV AND INTIMATE PARTNER VIOLENCE (IPV)

Intimate partner violence (IPV) is often both a risk factor for HIV transmission and a barrier to care. Women living with HIV are more likely to experience IPV, and women exposed to violent relationships are four times more likely to contract STIs, including HIV.[24] IPV can limit a woman's ability to access healthcare, like HIV testing, treatment, and prevention, due to controlling behavior from a violent partner, financial dependency, lack of privacy, and feelings of shame.[25] It also makes it more difficult to negotiate condom use or safely decline sex.[26] Fear of being accused of promiscuity or infidelity can also lead to violence following requests for the violent partner to get tested for STIs or discuss HIV prevention.

PrEP can be lifesaving for women at risk of IPV-related HIV exposure. However, research shows that women experiencing severe psychological IPV are more likely to be embarrassed

to initiate a PrEP discussion with a healthcare provider or domestic violence advocate.[27] Women who experience physical IPV and IPV-specific medical mistrust are also less likely to accept a PrEP recommendation from a domestic violence advocate.[28]

Four in ten Black women experience physical violence from an intimate partner at some point in their lives.[29] Over half of all transgender and non-binary people, including transgender Black women, experience IPV.[30] Coupled with disproportionately high HIV rates and low PrEP awareness and uptake, this data underscores the urgent need for research and interventions that address the intersection of IPV and HIV among Black cisgender and transgender women.

POLICY RECOMMENDATIONS

- **Increase Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and National Institutes of Health (NIH) funding for research and community-based interventions** to improve access to HIV prevention and treatment for women experiencing IPV.
- **Expand IPV risk screening and safety planning** within HIV clinics.

INVEST IN INTEGRATED CARE SYSTEMS

Effective HIV care requires more than just medication, especially for Black women living with HIV.[31] Integrated care systems that combine HIV treatment with wraparound services like mental health support, substance use treatment, housing assistance, and food security can improve health outcomes and long-term retention in care.[32] When integrated care is affordable, accessible, sustained, and grounded in trusted community partnerships, it addresses the unique challenges Black women face, especially those complicated by HIV stigma, discrimination, and systemic barriers to care.[33] These programs go beyond supporting medical needs by also improving overall wellbeing, enabling Black women to live healthier lives on their own terms.

Although federal HIV funding has grown over time, intentional, targeted investments are still required to close disparities and maximize impact for Black women.[34,35] This would include creating disparities-focused funding opportunities specifically designed for high-vulnerability groups like Black women; increased funding for the Ryan White HIV/AIDS Program, which offers exemplary models of integrated care; strengthening the 340B Drug Pricing Program, which keeps HIV medications affordable; and expansion of housing and community programs that care for the whole person.[36,37]

POLICY RECOMMENDATIONS

- **Increase funding within the existing HIV care infrastructure**, including the Ryan White HIV/AIDS Program, 340B Drug Pricing Program, and community-based services.
- **Utilize Medicaid waivers and state-level reimbursement mechanisms** to fund innovative care models that expand coverage for essential wraparound services.

END HIV CRIMINALIZATION LAWS

Thirty-two states still have laws that criminalize HIV by imposing criminal penalties for alleged or perceived exposure, nondisclosure, or transmission.[38] These laws apply even when there is no intent to harm, no actual transmission, or the person is virally suppressed.[39] Most of these laws were enacted during the early HIV epidemic, when little was understood about the virus.[40] Today, we know better: these laws do not prevent transmission, but instead drive stigma and fear, discourage testing and early prevention, and compromise patient-provider trust.[41]

Black people are more likely to be arrested and convicted of HIV-related offenses, and Black women face some of the most harmful enforcement.[42,43] These laws can be used as tools of control against women in abusive relationships, can complicate custody battles and pregnancies, and are used to overtarget sex workers.[44] For Black trans women specifically, HIV criminalization reinforces harmful stereotypes and transphobia, and deepens profiling, stigma, and criminalization.[45]

The goal should be ending HIV and not punishing people, especially Black women, for living with it. That will not happen until these outdated laws are repealed.

POLICY RECOMMENDATIONS

- **Repeal state-level HIV criminalization laws** to align with current medical science and ensure they do not punish people for their HIV status.
- **Reintroduce and pass the Repeal Existing Policies that Encourage and Allow Legal (REPEAL) HIV Discrimination Act**, which would mandate a federal review of laws that criminalize HIV, develop best practices for reform, and track states' progress in modernizing or repealing the laws.

Endnotes

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