

# Health Equity, Social Justice, and HIV in Rhode Island: A Contemporary Challenge

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## ABSTRACT

From its beginning, HIV has primarily affected marginalized populations, such as injection drug users, gay, bisexual and other men who have sex with men (GBMSM), and minority racial and ethnic groups. HIV is a disease that, from the start, has been strongly influenced by issues related to social justice and health equity due to its intersection with behaviors among at-risk populations. While some of the risks associated with HIV have been successfully mitigated through social justice initiatives related to needle exchange programs and routine HIV testing of pregnant women, Rhode Island remains confronted with the health equity challenges of preventing HIV transmission and ensuring access to HIV care/treatment, especially for Black/African Americans, Hispanics, and GBMSM.

**KEYWORDS:** HIV, Social Justice, Health Equity, Rhode Island

## HIV IN A SOCIAL CONTEXT

In 1981, human immunodeficiency virus (HIV) was first identified in the United States among non-immunosuppressed injection drug users and gay men who were diagnosed with a rare form of pneumonia caused by *Pneumocystis jirovecii*. Prior to this time, *Pneumocystis* infections were only known to occur in people with compromised immune systems. Untreated, HIV leads to acquired immune deficiency syndrome (AIDS) and death. Since its emergence in 1981, the HIV/AIDS pandemic has had a major impact on morbidity and mortality across the world.

Even though HIV/AIDS is an infectious disease, it has had a remarkable impact on politics, education, the media, social movements, the entertainment industry, and professional sports in a manner unlike any other disease in modern history. Its societal impact has evolved in response to its shifting epidemiology, as well as advances in medicine and technology that have made HIV testing more accessible and new medications that are highly effective in managing – and most recently preventing – the disease

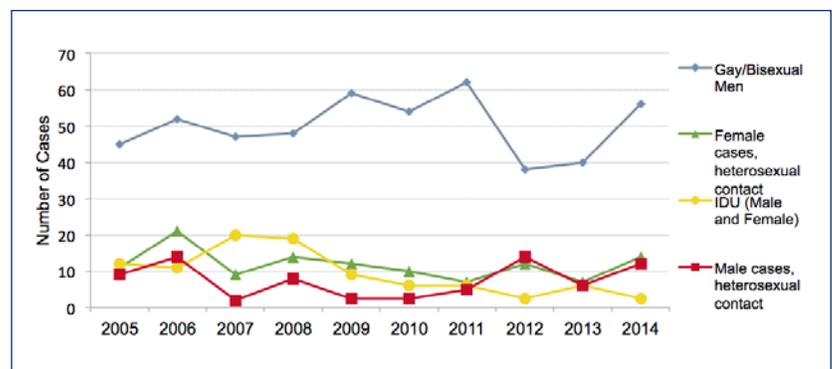
(pre-exposure prophylaxis or PrEP).

What makes HIV/AIDS historically stand apart from other diseases is its impact on a diverse subset of specific populations, including persons who inject drugs, gay, bisexual, and other men who have sex with men (GBMSM), minority racial and ethnic populations, children born to HIV-positive mothers, incarcerated populations, hemophiliacs, and foreign-born individuals from endemic countries. These groups have historically experienced societal marginalization, discrimination, and isolation that directly contributes to their disproportionate burden of HIV. (See Figure 1.)

Commenting on the HIV epidemic among African Americans, Dr. Jonathan Mermin, director of the CDC's Division on HIV/AIDS Prevention, stated that "there is nothing biological that has caused African Americans to have such a disproportionate rate of HIV infection. It's the social, it's the economic, and it's the epidemiological environment in which people live."<sup>1</sup>

As an outgrowth of the HIV epidemic, both nationally and internationally, many groups have mobilized social movements to advocate not only for affordable access to HIV treatment and care, but also for housing, employment, and education to help stem the incidence of HIV within their communities. Such groups include AIDS Coalition to Unleash Power (ACT UP), National Association for the Advancement of Colored People (NAACP), Black Church and HIV, and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Often framing their advocacy through a social justice lens, these groups frequently include a focus on improving conditions related to social determinants of health for the communities they represent.

Figure 1. Newly-Diagnosed Cases of HIV by Exposure Mode, Rhode Island, 2005–2014



## HIV AND SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are typically defined as a person's social environment, physical environment, and their access to health services.<sup>2</sup> These factors cannot be changed with differences in behavior, but can greatly affect the individual's environment, and their health outcomes. Some of the most salient social determinants of health include poverty, homelessness, unequal access to healthcare, incarceration, lack of education, stigma, homophobia, sexism and racism.

Socioeconomic status and HIV are closely linked. Socioeconomic status can affect HIV status, and vice versa. Individuals who have low socioeconomic resources are more likely to practice riskier behaviors, which may make them more susceptible to HIV. Some of these riskier behaviors may include earlier sexual debut and inconsistent condom use. It has been observed that the most substantial social determinants of health in relation to HIV/AIDS are education, employment, housing, income and insurance status. While all of these factors are significant predictors of HIV status, research indicates that education and housing status are the strongest predictors.<sup>3</sup> It has been demonstrated that those who experience unstable housing are more likely to have condomless sex, use drugs, and share syringes.

An HIV diagnosis may negatively impact someone's socioeconomic status by diminishing their capacity to work and earn income. The percentage of HIV-positive individuals who are unemployed is high compared to their seronegative counterparts. This is partially due to work responsibilities competing with healthcare needs, as well as difficulty in maintaining typical work hours due to fatigue.<sup>4</sup>

## HIV SUCCESSES IN RHODE ISLAND: HIV TESTING OF PREGNANT WOMEN AND NEEDLE EXCHANGE PROGRAMS

While many social determinants of health represent significant barriers toward reducing HIV risk, two public health interventions have proven successful as HIV prevention strategies in Rhode Island and in other jurisdictions across the nation: routine HIV testing of pregnant women and syringe exchange programs for injecting drug users.

In 1994 it was discovered that the administration of zidovudine (AZT) during pregnancy and childbirth reduced the chance of a child being born HIV positive to an infected mother by two-thirds. In 1999, the Institute of Medicine recommended "adoption of a national policy of universal HIV testing, with patient notification, as a routine component of prenatal care."<sup>5</sup>

In accordance with Rhode Island General Laws 23-6.3-3, enacted in 2009, HIV opt-out screening is incorporated into prenatal testing for all pregnant women as early and often as appropriate during each pregnancy.<sup>6</sup> Newborns are tested as soon as possible after delivery if the mother's HIV status is not documented (the mother's consent is not needed).

In Rhode Island, there has been only one case of mother-to-child transmission of HIV in the last five years.

Needle exchange programs, also known as "syringe services" programs, generally provide a full spectrum of services to individuals who inject drugs, including exchange of used syringes for clean ones, naloxone distribution, counseling, condoms, rapid HIV and hepatitis C testing, and referrals to mental health and social services. Since the inception of the needle exchange program in Rhode Island in 1994, there has been a precipitous drop in new cases of HIV identified among injecting drug users, with fewer than six cases reported annually from 2009–2014.

AIDS Care Ocean State (ACOS) operates Rhode Island's needle exchange program, which started as one fixed site in Providence in 1994. In 2002, ACOS expanded their services to include mobile sites in Woonsocket and Newport, then expanded their services to street outreach in 2008, and home delivery in 2012. In total, ACOS provides services through three fixed sites, a mobile/street-based exchange unit, and home delivery in five cities: Providence, Woonsocket, Newport, Pawtucket, and Central Falls.<sup>7</sup> Clean syringes can also be bought without prescription at retail pharmacies in Rhode Island.

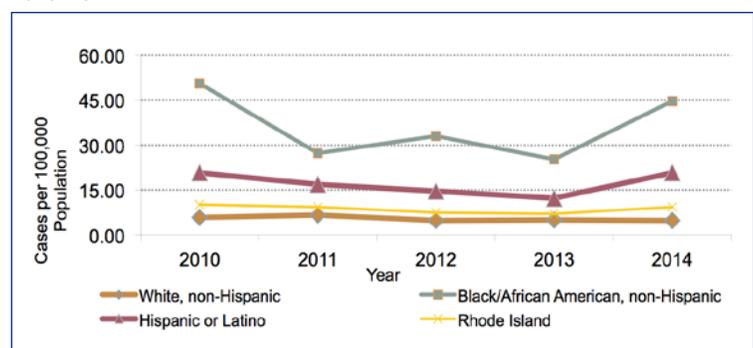
## HIV EPIDEMIOLOGY AND RACE/ETHNICITY

In a state with a population that is between 75% and 80% White, the rates of Black/African American males living with an HIV diagnosis is five times that of white males. Further, Black/African American females have rates that are 17 times that of their white counterparts. Black Americans represent only 12% of the United States population, but they account for 44% of individuals living with HIV.<sup>8</sup> In Rhode Island, the rate of HIV in the Black/African American population is roughly 10 times that of White, non-Hispanic individuals. The rate for Hispanic or Latino individuals is five times that of non-Hispanic Whites. (See Figure 2.)

## HIV EPIDEMIOLOGY AND SEXUAL ORIENTATION

According to the Centers for Disease Control and Prevention, GBMSM comprised 83% of new HIV diagnoses among

Figure 2. Rates of Newly-Diagnosed Cases of HIV by Race/Ethnicity, Rhode Island, 2010–2014



males age 13 and older in 2014. Furthermore, it is estimated in the United States that 15% of all GBMSM are HIV-infected.<sup>9</sup> A major barrier to testing and screening globally is that one-third of countries around the world criminalize same-sex conduct, thus restricting the rights of GBMSM and the lesbian/gay/transgender community. In these countries, GBMSM are less likely to access services, fearing prosecution.

The South (Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia) is home to 37% of the United States population, but more than 50% of newly-diagnosed HIV cases.<sup>10</sup> There are many contributing factors to this disproportionate epidemic in the South, including poverty, stigma, racism, and homophobia. Further contributing to these factors is “abstinence-only” education in schools, as well as limited Medicaid expansion by these Southern states.<sup>11</sup> Social stigma related to the GBMSM population is further exacerbated by race, as African American GBMSM are stigmatized not only because of sexual preference, but also due to race.<sup>12</sup>

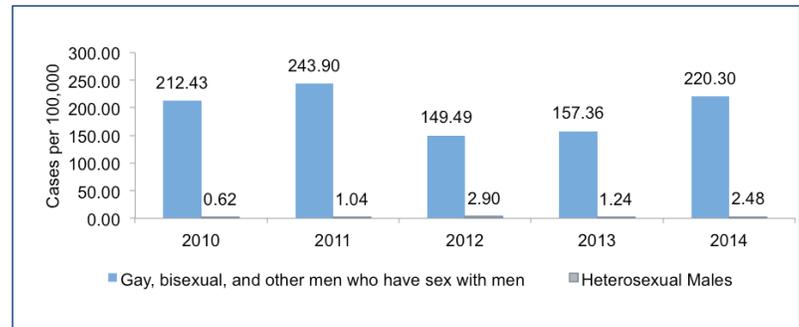
The rate of new HIV infections in 2014 in Rhode Island was 89 times higher in GBMSM than heterosexual men. While most of the cases of HIV among GBMSM in years past have been concentrated in men in ages 30–49, there has been a recent shift toward younger men (in their 20s). The majority of GBMSM diagnosed with HIV reside in Providence County. (See Figure 3.)

A recent advancement in addressing HIV prevention among GBMSM is PrEP. Taken once a day by HIV-negative individuals, PrEP can effectively prevent HIV infection. Studies suggest that PrEP is >90% effective in preventing HIV. Currently, The Miriam Hospital STD Clinic has prescribed PrEP to more than 200 patients and is taking referrals.

## ACHIEVING HEALTH EQUITY IN RHODE ISLAND

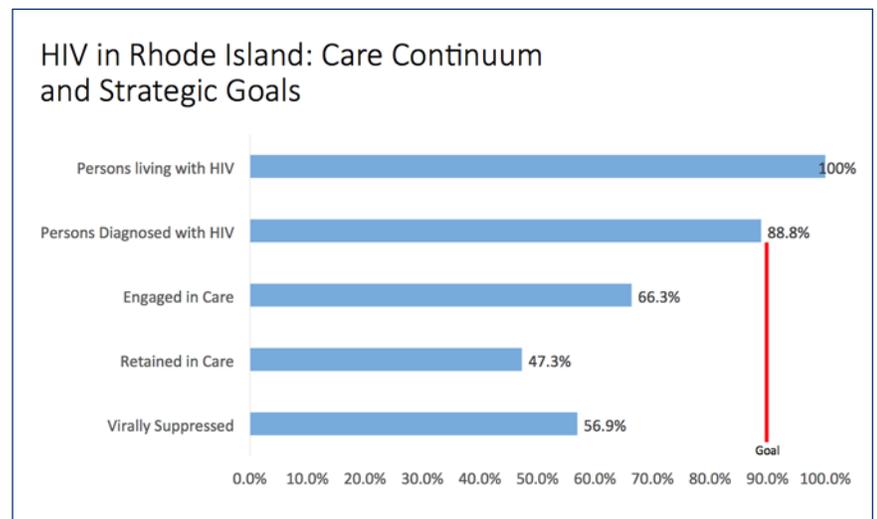
With the goal of scaling up HIV testing and treatment efforts and achieving health equity for individuals at-risk for – and impacted by – HIV, Rhode Island officially adopted the UNAIDS “90-90-90” initiative at the Rhode Island Statehouse *World AIDS Day* event in December 2015. The goals of this global initiative for the year 2020 include: 1) 90% of people living with HIV know their HIV status; 2) 90% of people who know their HIV-positive status access treatment; and 3) 90% of people in treatment have suppressed viral loads. Figure 4 illustrates Rhode Island’s progress towards these targets.

**Figure 3.** Rates of Newly-Diagnosed HIV among Males\* by Sexual Orientation, Rhode Island, 2010–2014



\*Denominator data to estimate the GBMSM population is derived from the Rhode Island Behavioral Risk Factor Surveillance System and Lieb et al., “Statewide Estimation of Racial/Ethnic Population of Men Who Have Sex with Men in the U.S.” *Public Health Reports* 126(2011): 60-72

**Figure 4.** Rhode Island’s Progress towards reaching set targets.



The cornerstone of Rhode Island’s 90-90-90 initiative is a commitment not only to address the medical needs of individuals at-risk for and living with HIV, but also their social and economic needs, including issues related to discrimination, housing, education, and employment. Accordingly, partnerships and planning groups have been formed that include social service agencies, AIDS service organizations, municipal governments, community-based organizations, and other state agencies.

While medical advances have led to tremendous successes in HIV prevention and care, Rhode Island’s current challenge is to combine these advancements with improvements in local environments and communities in which at-risk groups and people living with HIV live, grow, work, and learn. This comprehensive approach is intended to be a foundation on which Rhode Island hopes to be the first state in the nation to “get to zero.”

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