Then and Now: Historical Landscape of HIV Prevention and Treatment Inequities Among Latinas

Hortensia Amaro, PhD, and Guillermo Prado, PhD

ABOUT THE AUTHORS

Hortensia Amaro is with the Robert Stempel College of Public Health and Social Work and the Herbert Wertheim College of Medicine, Florida International University, Miami. Guillermo Prado is with the School of Nursing and Public Health Studies, University of Miami, Miami, FL.

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Scientific advances in HIV/AIDS prevention and treatment have transformed AIDS from a death sentence to a preventable and manageable chronic disease. Yet, progress has not equitably benefited Latinos. Even at the beginning of the epidemic, inequities in HIV/AIDS incidence, survival, and death among Latinos were evident.[1] Among Latinas, from 1988 to 1991, the AIDS case rate was 7.5 times higher than that of their non-Latina White counterparts (https://bit.ly/3gSSeXT). Early research and prevention largely ignored women except for their roles as vectors or vessels of disease transmission.[2] This heightened stigmatization of women living with HIV led to vigorous calls for a gender-focused understanding of HIV risk, including the effects of social determinants of health and HIV vulnerability.[3,4] Simultaneously, the lack of attention to HIV/AIDS among Latinos by government agencies, funders, and the research community left Latino community organizations working on HIV prevention without sufficient support or funding.[1,5]

Not until the 1999 calls to action by the Latino and Black congressional caucuses was there the first major federal effort to develop an integrated community-based HIV and substance abuse prevention program to address these dual crises in Latino and Black communities: the Minority AIDS Initiative (https://bit.ly/3aUpkmw). And it was not until 2014 that the Centers for Disease Control and Prevention reported that Latinos were disproportionately affected by HIV, with rates three times those of non-Hispanic Whites, and called for efforts to improve HIV-related care (https://bit.ly/3nE2iFy).

FORTY YEARS OF UNHEEDED EVIDENCE

Inequities in timely HIV testing and access to competent HIV/AIDS prevention, care, and treatment of Latinos persist today.[6–8] In 2018, HIV diagnosis among Latino adults was 16.4 per 100 000 compared to 4.8 per 100 000 for non-Latino Whites. Latina adolescents and adults continue to be disproportionately affected. For example, the HIV incidence rate for Latinas is 4.9 per 100 000 compared with 1.6 per 100 000 for non-Latino White females (https://bit.ly/3eOHk2D). These inequities coupled with Latino invisibility in the larger HIV/AIDS scientific literature and public discourse are astounding given that Latinos are the largest minority group in the United States—from 6.4% in 1980 to 18.5% in 2019 and 29% projected by 2050 (https://pewrsr.ch/3vzj8YU). Despite the diversity of the US-based Latino population, throughout US history and contemporary times, Latinos have been subjected to anti-immigrant and anti-Latino policies (https://bit.ly/3ufzghN) and racism (https://pewrsr.ch/3nKuBlQ), including in health care (https://bit.ly/3xGMUg2). Yet, inadequate public health attention to Latino HIV inequities and related social determinants of health and HIV vulnerability, including racism, xenophobia, and discrimination, continue to render Latinos invisible. Contributing to this invisibility in public health, including HIV prevention, is the prevailing focus on Black–White inequities, history of injustice, and civil rights struggles, referred to as the Black–White binary paradigm of race in the United States.[9,10] It leads to an incomplete understanding (https://bit.ly/3eeDzEN) of the role of inequities and racism in health and HIV vulnerability and care among other racialized groups (i.e., Latinos, Native Americans/Alaska Natives, Asian Americans) and renders invisible their histories and how racism affects groups and their

health because it does not fit in the prevailing paradigm.

GESTALT AND CONSEQUENCES OF INVISIBILITY

The context of longstanding Latino health inequities and the history of discrimination has shaped access to and receipt of HIV prevention. For example, delivery of preexposure prophylaxis (PrEP) to Latinos lags significantly behind delivery to non-Latino Whites, and there are no systematic behavioral interventions scaled to prevent HIV among Latinos. Specifically, of the 1.1 million adults who were PrEP eligible in 2015, approximately 26% were Latinos and 28% were non-Latino Whites. Yet, PrEP use was 13% among Latinos and 69% among non-Latino Whites (https://bit.ly/3vzjoak).

This is a significant gap and is partially explained by structural factors such as lack of health insurance (https://bit.ly/3eJFyjk)—which is highest among Latinos (29.7% vs 7.5% among non-Latino Whites)—and barriers to HIV care across patient, clinic, provider, health system, and community levels (https://bit.ly/3eMI4Fu). These structural barriers must be addressed by improving health insurance access and implementing strategic and evidence-based, culturally efficacious behavioral and community-level interventions to increase access to and uptake of PrEP (https://bit.ly/33ahjFK).

This is especially needed for at-risk Latinas, for whom stigma, acculturation challenges, discrimination, social rejection, and substance use may be barriers to PrEP uptake (https://bit.ly/3vFoj9w). Other prevention approaches, including behavioral, family, and social network (peer) interventions, have demonstrated efficacy in HIV prevention by increasing condom use and decreasing sexual activity while under the influence of drugs or alcohol, but they have not been taken to scale. Interventions that engage parents as agents of change, such as Familias Unidas,[11] have been found to reduce HIV risk behaviors for both female and male youths.

Similarly, interventions such as Cuídate! (https://bit.ly/3t7oyZu), keepin' it R.E.A.L. (https://bit.ly/2SbrS95), and Families Talking Together (https://bit.ly/3ta5N7H) have also proven efficacious in preventing and reducing sexual risk behaviors and substance use in Latinos. The number and quality of evidence-based interventions for adult Latinas are more limited owing to lack of or limited inclusion of Latinas in samples and analyses establishing efficacy in Latinas and a glaring absence of studies on HIV prevention focused on Latina drug users.[12–15]

A 2015 review of randomized clinical trials on HIV prevention interventions that focused on women who use alcohol and other drugs showed that, from the 1990s to 2015, only one of 23 focused on US Latinas (https://bit.ly/33c8J9r). Yet, some studies designed to be culturally tailored have demonstrated efficacy in sexual risk behavior change among sexually active adult Latinas (e.g., Amigas [https://bit.ly/3uhsfx5], SEPA [https://bit.ly/3nLjokL], VOICES [https://bit.ly/3gVumCU]). Despite the availability of efficacious interventions for Latina adolescents and adults, the lack of dissemination at the population level or scaled-up implementation in community or clinical contexts has stymied efforts to reduce HIV disparities in Latinas.

Furthermore, there is a need to develop and scale-up scientifically proven HIV prevention interventions for specific subgroups of Latinos, such as sexual minorities and Latina transgender females (https://bit.ly/2PIQwgt) and US Latinas who use drugs (https://bit.ly/3xJK4qy), as there are no evidence-based behavioral HIV preventive interventions specifically shown to be efficacious in these groups. More interventions at all levels, but particularly at the community, macro, and structural levels (e.g., to address gender-based power differentials, systemic discrimination, and racism), must be developed and evaluated. Understanding downstream and upstream factors impeding the adoption of evidence-based preventive interventions is critical to their dissemination. Easily scalable eHealth (https://bit.ly/3ecJREF) interventions have proven to be efficacious in Latinos and may reduce some barriers (e.g., level of resources needed) to widespread dissemination. Funding these interventions via reimbursement through insurance and public health program funding is essential to sustaining them and their impact on eliminating HIV/AIDS inequities among Latinos.

Finally, another critical tool in HIV prevention is access to and engagement in efficacious treatment of substance use disorders (SUDs). Again, data indicate that Latinas are among the most underserved and severely uninsured (https://bit.ly/3xAvfqm) in need of SUD treatment in the United States. Latinas have lower access to SUD treatment, including opioid treatment (https://bit.ly/3eNjPqT); receive lower quality of care; and drop out of treatment at higher rates than do non-Latinas.

Key features of SUD treatment programs ([https://bit.ly/3nIXLlm]; e.g., cultural competence, counselor's Spanish-language proficiency [https://bit.ly/2RgudiE]), availability of Spanish-language treatment-related material) are associated with reduced wait time to SUD treatment entry and greater treatment engagement among Latinas. Access to and utilization of treatment is hampered by a host of multilevel factors, including

limited health insurance coverage, sufficient availability of providers and programs (https://bit.ly/3nN1A8O), underrepresentation of Latinos in the workforce (https://bit.ly/3eS5F7G), social stigma, individual and community-level lack of understanding of SUD treatment, and services that do not meet the needs of Latinas. Additionally, significant inequities in access to care and HIV treatment outcomes persist (https://bit.ly/3gXmuAI).

Specifically, compared with non-Latino Whites living with HIV, Latinos have lower rates of care initiation (61%), retention in care (49%), and viral suppression (53%). Rates among non-Latino Whites living with HIV are 70%, 52%, and 63%, respectively. Much more progress has to be made to provide access to HIV care and improve viral suppression among Latinos (https://bit.ly/3z5ICzu).

CORRECTING THE COURSE

Despite significant scientific advances in HIV prevention and treatment, little progress has been made in reducing HIV inequities in Latinos (https://bit.ly/3ecPSBu). These disparities continue to disproportionally lead to the death of Latinos from what is now a preventable and manageable chronic disease. This is unacceptable and requires a call to action for policy, science, and public health programming dedicated to eliminating HIV inequities among Latinos.

At the policy level, we need initiatives to reduce stigma and racism against Latino populations, including immigrants; adequate reimbursement for comprehensive and quality SUD treatment; and insurance coverage that provides equitable access to HIV prevention and treatment, including SUD treatment.

At the scientific level, we must invest more aggressively in funding to evaluate and disseminate behavioral interventions at all levels—from individual to community. We must champion for greater inclusivity of Latinos in federally funded studies and call on journal editors and reviewers to evaluate whether sample sizes of Latinos included in studies are sufficient to draw conclusions for this population separately and, if so, require that such analyses be conducted and reported.

At a population level, we must change the anti-Latino sentiment of public discourse and collectively push for an equitable agenda and life for Latinos free of HIV. The public health community must examine how it has contributed to the invisibility of Latino HIV inequities and courageously take action to correct course. AJPH

CORRESPONDENCE

Correspondence should be sent to Hortensia Amaro, Herbert Wertheim College of Medicine and Robert Stempel College of Public Health and Social Work, 11200 SW 8th St, AHC4 Room 419, Miami, FL 33199 (e-mail: hamaro@fiu.edu). Reprints can be ordered at http://www.ajph.org by clicking the “Reprints” link.

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CONFLICTS OF INTEREST

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