LATINAS AND HIV IN NYC: AN OVERVIEW[1]

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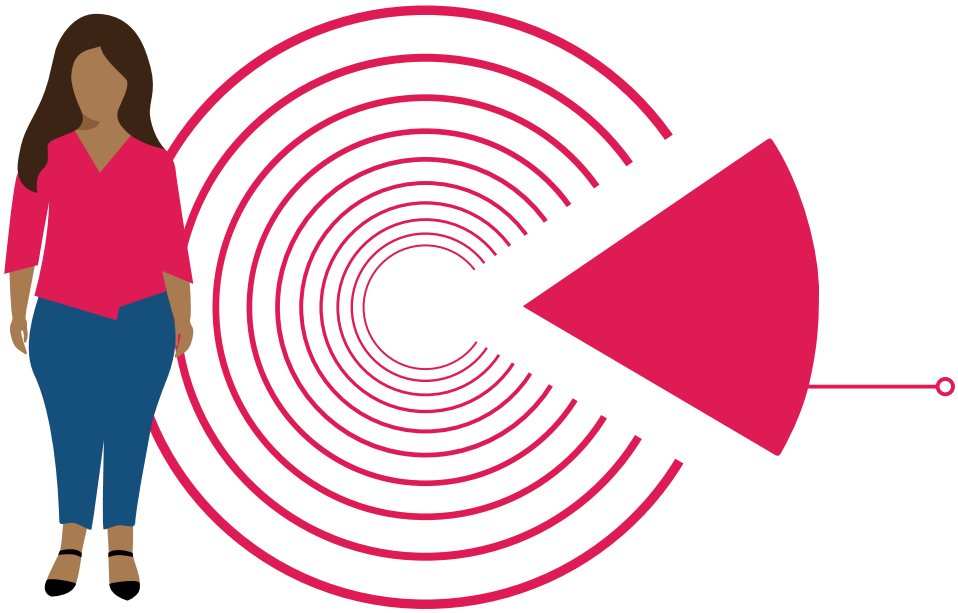


THERE WERE 143 HIV DIAGNOSES AMONG LATINAS IN NYC IN 2015

18%
of these Latinas were also diagnosed with AIDS

The rate[2] of reported HIV diagnoses in New York City (NYC) in 2015 among Latinos was 36.3, more than twice the rate of whites (15.0), 4 times that of Asians/Pacific Islanders (9.3), and second only to the highest rate in the city among African-Americans (54.5).[3] According to **mid-year 2016** surveillance data – there were 413 diagnoses of HIV among Latinos, and of these, almost 19% (n=77) were among Latinas.[4]

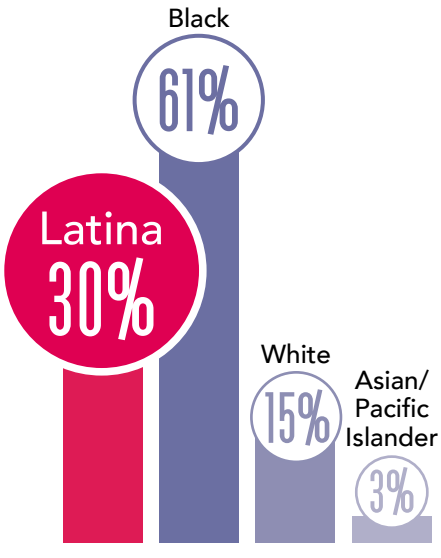
The New York City Department of Health and Mental Hygiene recently highlighted the needs of African American and Latina women in relation to HIV prevention, asking providers to consider offering PrEP to those at increased risk (i.e. STIs, IPV, residence in high-incidence area, partner of person living with HIV (PLWH) with detectable or unknown viral load, engaging in sex in exchange for money/goods, etc.) It is important to contextualize recommendations and understand HIV among women of color in NYC, **of both trans and non-trans experience**. This brief focuses on Latinas and HIV in NYC, highlighting the most recent epidemiological data publicly available, and discusses recommendations for HIV prevention and treatment, as well as principled approaches to providing culturally-responsive and equitable sexual health education and care.

The Numbers

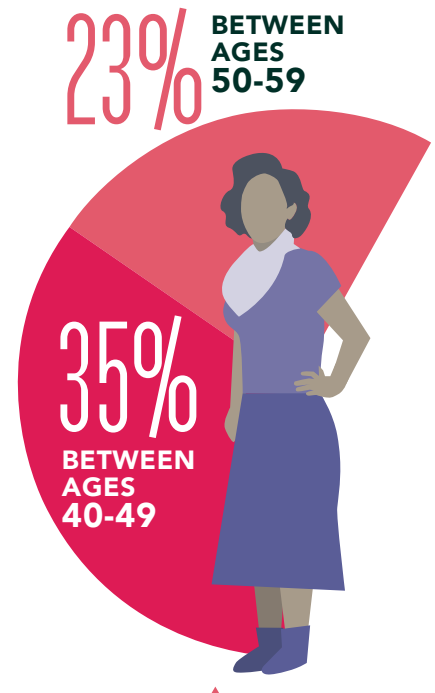
There were a total of 482 diagnoses of HIV among women[5] in New York City in 2015[3]; of these almost 20% (n=94) were concurrent with AIDS diagnoses (meaning that both HIV and AIDS were diagnosed at the same time). Concurrent diagnosis is an indicator of late testing and a predictor of poorer health outcomes. Almost 30% (n=143) of the HIV diagnoses were among Latinas (compared to 61% among African American women and 6% white women). Almost 28% (n=26) of the concurrent HIV/AIDS diagnoses were among Latinas in 2015. This comprised 18% of the total number of HIV diagnoses among Latinas in 2015.

Risk

Among Latinas diagnosed with HIV in NYC in 2015 – the majority were between the ages of 20 years and 59 years, and those with concurrent AIDS diagnoses between the ages of 40 years and 59 years. Specifically, 35% of concurrent HIV/AIDS diagnoses among Latinas were within the age range of 40-49 years, and an additional 23% among between the ages of 50 and 59 years[3]. This indicates that Latinas are at highest-risk for HIV throughout most



PERCENTAGES OF THE (482) CASES OF HIV DIAGNOSES IN 2015 AMONG WOMEN (INCLUDING TRANSGENDER WOMEN) IN NYC



CONCURRENT HIV/AIDS DIAGNOSES AMONG LATINAS BY AGE RANGE

Older Latinas have a higher risk of receiving a simultaneous HIV/AIDS diagnosis

of the reproductive life-span and may be unaware of their status for a considerable amount of time before testing and being diagnosed with HIV and AIDS. Furthermore, Latinas continue to be at high risk as they age past their reproductive years and may consider themselves to be less "at risk."

Seventy-eight percent of total diagnoses among Latinas were linked to sexual contact[6]; and unknown status increases risk of sexual transmission to others. Over ¼th (26.5%) of the HIV diagnoses among women linked to heterosexual risk in NYC in 2015 were Latina.[7]

Among individuals of transgender experience, there were a total of 41 diagnoses of HIV – and all 41 (100%) were among women. Latinas of transgender experience were at highest risk – 61% (n=25) of the diagnoses were among Latinas, followed by Black women (37%, n=15) and 75% of concurrent HIV/AIDS diagnoses were among Latinas.[8] This is a trend that has been noted from 2011 through 2015, with transgender Latinas experiencing the highest number of newly diagnosed HIV, followed by Black transgender women, comprising 92% of the diagnoses among transgender women between 2011 and 2015.[9] In New York City, Black and Latina transgender women are amongst the most vulnerable to HIV infection. Transgender women are disproportionately at risk for HIV and are in urgent need of prevention, treatment, and general healthcare services. The primary exposure to HIV among transgender women stems from the high transmission probability via penetrative sexual intercourse without use of a condom or pre-exposure prophylaxis (PrEP). Transgender women have been identified as "men who have sex with men" (MSM), and as such, their vulnerabilities to HIV have been lost and largely under researched. In the few instances where epidemiological data for transgender women have been obtained, results have reflected disproportionate risk for and burden of HIV infection.

Injection Substance Use

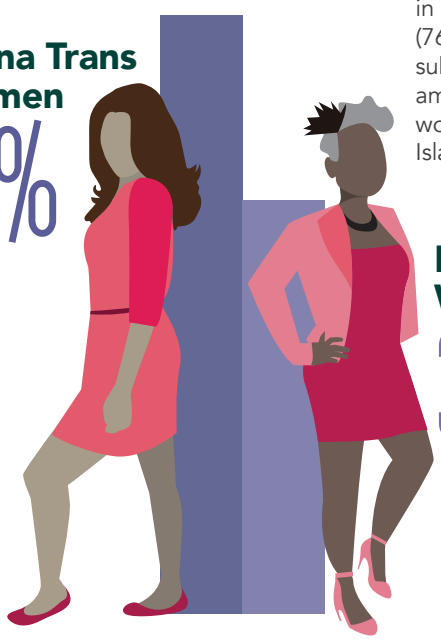
There were 16 diagnoses of HIV in 2015 among women linked to injection drug use (IDU) history, and of these 37.5% (n=6) were among Latinas, and 50% of the concurrent HIV/AIDS diagnoses were among Latinas.[10]

Social and Structural Determinants

It is important to note the role of place in HIV and how it disproportionately affects community members, and inequitably determines health outcomes. This can be seen in place of residence, as well as place of birth. For Latinas diagnosed with HIV in 2015, almost 48% resided in the Bronx and an additional 18% in Brooklyn. These boroughs were also the ones with the highest number of concurrent HIV and AIDS diagnoses among Latinas in 2015. Both boroughs, but particularly The Bronx, hold some of the highest poverty rates in the nation. For Latinas diagnosed with HIV in NYC in 2015, half (49.7%, n=71) lived in very high poverty (>=30% below FPL) according area-based poverty levels.

Almost 100% of the HIV diagnoses among women in the Bronx in 2015 were among women of color (52% Black and 45% Latina), and the majority (83%) of the diagnoses were linked to sexual transmission risk (compared to 1% injection substance use risk and 16% "unknown" risk). Similarly, almost 100% of the HIV diagnoses among women in Brooklyn in 2015 were among women of color (78% Black and 18% Latina), and the majority (76%) of the diagnoses were linked to sexual transmission risk (compared to 2% injection substance use risk and 22% "unknown" risk.) Thirty-one percent of the HIV diagnoses among women in Manhattan in 2015 were Latina, 21% of the HIV diagnoses among women in Queens were Latina, and 12.5% of the HIV diagnoses among women in Staten Island were Latina.

Latina Trans Women
61%



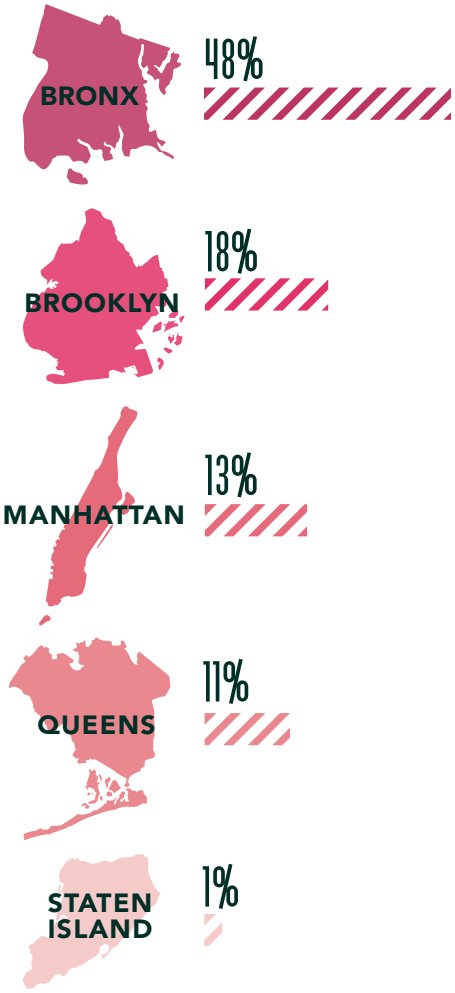
Black Trans Women
37%

LATINAS OF TRANS EXPERIENCE WERE AT HIGHER RISK FOR HIV INFECTION COMPARED TO BLACK WOMEN OF TRANS EXPERIENCE

Where is the epidemic? Who does it affect?

DISTRIBUTION BY BOROUGH* OF HIV DIAGNOSES AMONG LATINAS (INCLUDES TRANSGENDER WOMEN)

*Remaining 9% were from outside of NYC or unknown residency



HIV Diagnoses Among Foreign-Born Individuals

It has been firmly established that immigration status has a strong association with HIV risk. Although we cannot make inferences using the following data for Latinas alone, it is important to understand inequities in HIV outcomes by place of birth. Note – not all countries of the Caribbean, South America, and/or Central America are Spanish-speaking, and individuals born in these countries do not necessarily identify as "Latino/a" in the United States.

Among all new HIV diagnoses in females in 2015, 34% were foreign-born.[11]

The majority (63%) reported being born in the western hemisphere: i.e. the Caribbean (not including Puerto Rico and the US Virgin Islands), South America and Central America (including Mexico).[i]

- Caribbean – 40%
- Africa – 28%
- South America – 14%
- Central America – 9%
- Asia – 4%
- Europe – 3%
- Other – 2%

Note: the data presented below represents both males and females of transgender experience, although data support that the majority of HIV diagnoses are among women.

Among transgender individuals diagnosed with HIV in NYC between 2011-2015, 21% (n=48) were born outside of the US (including Puerto Rico (PR) and United States Virgin Islands (USVI).[12] The majority (98%) reported being born in the western hemisphere, with over half indicating they were born in a Central American country or Mexico.

- 55% born in Mexico and Central America[i]
- 24% in the Caribbean
- 18% in South America
- 2% Asia

3 IN 4

Transgender women who received a concurrent HIV/ AIDS diagnosis were Latinas

Histories of trauma

Trauma is also an established risk factor for HIV. A study of characteristics of women of transgender experience[12] diagnosed with HIV in NYC between 2011 and 2015 found 49% had at least one of the characteristics identified as an increased risk predictor, including sexual abuse:[ii]

- History of substance use (32%)
- History of incarceration (25%)
- History of commercial sex work (10%)
- History of homelessness (7%)
- History of sexual abuse (3%)

Given the sensitive nature of disclosure, it is highly likely that the documented percentages represent conservative estimates.

27%

of the HIV diagnoses among women linked to heterosexual risk in NYC in 2015 were Latina

37%

of the 16 diagnoses of HIV in 2015 among women linked to IDU (injection drug use) were among Latinas

50%

of Latinas diagnosed with HIV in 2015 in NYC lived in high poverty

Conclusions

The data available indicates that Latinas in NYC experience unmet needs leaving them increasingly vulnerable to HIV, and that current prevention strategies may not be effectively addressing the realities of their lives. Latinas at highest risk experience striking inequities in social and structural determinants of health throughout the life course. The intersectionality of high poverty, and limited power and privilege in society due to racism, xenophobia, misogyny, and transphobia, among others, leaves Latinas in NYC vulnerable, particularly those living in high-incidence boroughs and neighborhoods. Sexual contact poses the highest risk of transmission among Latinas[13] on average – but this is mediated by both macro-level factors as well as individual-level behaviors. Often, the two interact and manifest in relationship dynamics between sexual partners. For example, women may find themselves in coercive relationships with limited ability to exert prevention methods, but outweigh risk in relation to other priorities, such as basic survival needs. This likelihood increases for disenfranchised women of color, including women of transgender experience, women concerned about their immigration status, and women living in high-poverty areas with little opportunity for quality employment.

It is important to remain conscientious and principled in our approaches to marketing, educational efforts, outreach, and provision of PrEP to Latinas, as well as other women of color, women of both trans and non-trans experience, and other disenfranchised women in New York City. It is vital to understand the nuances and importance of sexual and reproductive health (SRH) and justice in Latina communities and in the lives of women of color in general. Acknowledgement of the historical events that led to mistrust of medical authorities and establishments in our communities, including forced sterilization, non-informed and non-consensual interventions aimed to exert sexual and reproductive control, and the withholding of lifesaving care to study the natural progression of morbidity, is critical if we are to be effective in our public health strategies, goals and outcomes.[14]

Finally, it is important to contextualize the role and limitations of routine HIV testing and SRH care – given the threats to accessible and affordable quality health care, particularly SRH services and providers that represent the ONLY sources of care available to Latinas.

Note: Sexual risk is included in this brief, but warrants further centering, exploration, and understanding of risks for transgender women. The majority of the data included in this brief has been recently released by the New York City Department of Health and Mental Hygiene (NYCDOHMH) - inclusive of women of both trans and non-trans experience.

Recommendations

❶ PROVIDERS:

Acknowledge, understand and respect their lived experiences, and their concerns. Center Latinas' lives when offering the full range of prevention and treatment methods to Latinas, regardless of status to effectively provide culturally-responsive SRH care leading to the reduction of HIV disparities and eradication of health inequities across NYC.

❷ HEALTH POLICY MAKERS:

Address social determinants such as quality employment and education, including comprehensive medically accurate sexual health education in your efforts to eliminate disproportionate levels of poverty, underemployment, and insurance coverage. Collaborate with key stakeholders. Policy Reduce and eliminate legal barriers related to immigration status and criminalization laws that leave individuals vulnerable to infection or increased viral load.

❸ RESEARCHERS:

Document and build evidence to understand the causal pathways between trauma and abuse and poor sexual health outcomes among vulnerable women of color in NYC including adverse childhood experiences (ACES), intimate partner violence (IPV), violence, mental health, and substance use disorders. Forge partnerships with community based organizations (CBOs) including faith-based organizations (FBOs), that have established trust in the community to collaboratively develop effective interventions, health promotion messaging, and awareness campaigns that resonate for constituents.

❹ FUNDERS AND FUNDING STREAMS:

Further allocate resources to assess and document risk for transgender women and men – related not only to sexual risk, but injection use related to hormones, as well as risk posed by exploitation, coercion, and both social and structural determinants of health.

❺ EVERYONE:

Work to increase the availability, accessibility, and acceptability of HIV education, prevention, and treatment via advocacy and awareness campaigns. Promote adherence and principled approaches to health-seeking behaviors and health equity.

References

1. Latinas – defined as individuals, regardless of sex/gender assigned at birth that identify as female and Latino/Hispanic.
2. Rate – defined as diagnoses per 100,000 population. Diagnoses include diagnoses of HIV without AIDS and HIV concurrent with AIDS. Rates calculated using the intercensal 2015 NYC population. As defined by New York City HIV/AIDS Annual Surveillance Statistics 2015; HIV Epidemiology and Field Services Program, NYC DOHMH.
3. New York City HIV/AIDS Annual Surveillance Statistics 2015: See https://www1.nyc.gov/assets/doh/downloads/pdf/ah/surveillance2015-table-all.pdf
4. HIV Surveillance Mid-Year Report NYC 2016 See https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-mid-year-report-2016.pdf).
5. Ages 13 years and older
6. Sexual contact includes "heterosexual contact" and "transgender people with sexual contact" transmission risk categories specified by the HIV Epidemiology and Field Services Program, NYC DOHMH. See Table 1.3.4 of New York City HIV/AIDS Annual Surveillance Statistics 2015.
7. See Table 1.6.6. New York City HIV/AIDS Annual Surveillance Statistics 2015.
8. See Table 1.6.7. New York City HIV/AIDS Annual Surveillance Statistics 2015.
9. See https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-in-transgender-persons.pdf.
10. See Table 1.6. 3 of New York City HIV/AIDS Annual Surveillance Statistics 2015.
11. See https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-aids-in-females.pdf
12. http://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-in-transgender-persons.pdf
13. See also HIV Risk and Prevalence among Heterosexuals at Increased Risk for HIV in New York City (2013 National HIV Behavioral Surveillance Study) https://www1.nyc.gov/assets/doh/downloads/pdf/dires/nhbshet-2013.pdf
14. See "LARC Statement of Principles" – SisterSong and National Women's Health Network. http://bit.ly/2crsyQi.

i. Note - Mexico is defined as part of Central America in the NYCDOHMH data, and presented as aggregate.

ii. Note - the study did not disaggregate by race and ethnicity.

LATINO COMMISSION ON AIDS

HISPANIC HEALTH NETWORK

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