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Progress Towards Achieving National Goals for Improved Quality-of-Life among Cis-gender Black Women with HIV

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Summary:

Data from the CDC's Medical Monitoring Project indicate that the United States is on track to meet 1 of 5 National HIV/AIDS Strategy (NHAS) Quality of Life goals among cisgender Black women, specifically, hunger/food insecurity. Substantial work needs to be done to improve self-rated health and to decrease unmet need for mental health services. Enhanced and coordinated action are necessary to reach all Quality of Life goals in this NHAS priority population.

Keywords

HIV; quality of life; women; Black or African American; social determinants of health

Some Black/African American women (hereafter referred to as Black women) in the United States experience high rates of HIV and face challenges to optimal health due to social and structural determinants of health like homelessness and poverty.^[1, 2] Social and structural determinants of health place Black women at higher risk for adverse HIV treatment outcomes. For example, only 62% of Black women are estimated to have achieved sustained viral suppression (compared with 70% of white women)^[2] and Black women are more likely to die prematurely due to HIV compared to both men and women of any race or ethnicity.^[3] Recognizing this inequity, the National HIV/AIDS Strategy (NHAS) 2022–2025 identified cis-gender Black women as a priority population for HIV prevention and treatment efforts.

An effective way to reduce health inequities is a comprehensive approach that addresses the whole person and not solely their medical needs.^[4] While innovations in HIV treatment have resulted in longer life expectancy for people with HIV,^[5] their quality of life is equally important. In 2022, five indicators focused on Quality of Life (QOL) from the Centers for

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Disease Control and Prevention's (CDC) Medical Monitoring Project (MMP) were added to the NHAS with specific goals to achieve for each indicator by 2025.^[6] We evaluated whether existing trends in these indicators are sufficient to meet NHAS goals for cis-gender Black women with HIV (CgBWH), with the understanding that estimates for 2020 and 2021 may have been affected by the COVID-19 pandemic.

We used data from the 2017–2021 cycles of the Medical Monitoring Project, an annual probability sample of U.S. adults with diagnosed HIV.^[7] Among 2,917 CgBWH, we calculated annual weighted percentages and 95% confidence intervals (CIs) for QOL indicators from baseline (2017 or 2018, depending on the indicator, see Figure for definitions) to 2021. For each indicator, we calculated the following: 1) the estimated annual percent change (EAPC) and associated test for significance ($p < 0.05$) based on trends from baseline to 2021; 2) projected annual estimates for 2022–2024 to meet NHAS 2025 goals, assuming linear relationships between indicator 2021 values and NHAS goals; and 3) the EAPC needed from 2021 to 2025 to meet NHAS 2025 goals (i.e., the change needed each year to meet the goals). We compared the EAPCs and CIs calculated from baseline to 2021 (#1) with that for 2021–2025 (#3) for each indicator to determine whether existing rates of change are sufficient to meet NHAS goals.

Trends for QOL indicators are presented in the Figure. The EAPC from baseline to 2021 indicates that three indicators—unemployment (EAPC: -3.0% , $p < .001$), hunger/food insecurity (EAPC: -13.4% , $p < .001$), and unstable housing/homelessness (EAPC: -6.8% , $p < .001$)—improved significantly. However, there was no significant change for unmet need for mental health services (EAPC: -0.2% , $p < 0.45$), and self-rated good or better health significantly worsened (EAPC: -3.2% , $p < .001$). The EAPC for 2021 to 2025 needed to reach the NHAS goal for hunger/food insecurity is well above the upper CI of the 'baseline to 2021 EAPC' (-6.2 compared with EAPC CI: $-13.7, -13.0$), suggesting the U.S. is on track to meet this goal. However, the EAPCs needed to reach goals for unmet need for mental health services, unemployment, and unstable housing/homelessness are appreciably below the lower bounds of the CIs of the baseline to 2021 EAPCs, indicating that goals may only be met if progress substantially accelerates (-18.5% compared with EAPC CI: $-0.8, 0.3$; -12.7% compared with EAPC CI: $-3.4, -2.6$; -13.4% compared with EAPC CI: $-7.3, -6.3$; respectively). Moreover, the EAPC needed to meet goals for good or better self-rated health would require a reversal of the current trend and substantial improvement (12.5 compared with EAPC CI: $-3.5, -2.9$).

Comparisons of baseline-2021 and 2021–2025 EAPCs demonstrate that if existing trends continue, the United States will likely meet the NHAS goal for decreasing hunger/food insecurity among CgBWH. Continuation of national initiatives that can address these needs among CgBWH is crucial. These include the Community Food Projects Competitive Grant Program (CFPCGP),^[8] the Gus Schumacher Nutrition Incentive Program (GusNIP),^[9] and the Expanded Food and Nutrition Education Program (EFNEP)^[10] sponsored by the National Institute of Food and Agriculture (NIFA) at the U.S. Department of Agriculture. Governmental and non-governmental COVID-related food assistance programs may also have contributed to recent declines in hunger/food insecurity among CgBWH; as these are

scaled back, continued monitoring of hunger/food insecurity will be important if NHAS goals are to be met in this area.

Alternatively, while we saw significant decreases in unemployment and unstable housing/homelessness from baseline to 2021, the EAPCs needed to reach NHAS goals for these indicators require more rapid improvement than that achieved thus far. Housing-related COVID assistance programs such as the federal eviction moratorium may have contributed to recent declines in unstable housing/homelessness among CgBWH. Ensuring these gains are not lost as these initiatives end is of utmost importance. The Department of Housing and Urban Development's Housing Opportunities for People with AIDS (HOPWA) Program is the only federal housing program specifically for people with HIV and provides crucial assistance to CgBWH to address their housing needs. However, a recent analysis^[11] found that housing assistance funds may not be adequate to address local needs. Ensuring that CgBWH continue to receive high quality housing assistance is crucial for accelerating progress towards NHAS housing goals.

To meet the NHAS goals for CgBWH, organizations at the local, community and national level will need to significantly impact factors like persistent low, stagnant, and declining wages that perpetuate the racial wage gap and the affordable housing crisis. Initiatives such as the Government Alliance on Race and Equity (GARE)^[12] highlight the importance of prioritizing issues of race, equity and implicit bias, in policy and in practice, within governmental agencies, educational institutions, and provider organizations. However, more is needed if we are to reach the NHAS QOL goals for CgBWH. In particular, we found the magnitude of change needed to reach goals for self-rated good or better health and unmet needs for mental health services is substantial and will require enhanced and coordinated action to achieve. Strategies that may increase self-rated health and reduce unmet needs for mental health services among CgBWH include treating comorbidities—particularly among older CgBWH, enhanced screening and treatment for mental health disorders, and the development, adaptation, and scale-up of effective interventions to increase viral suppression (see The CDC Compendium of Effective Interventions^[13]). In conclusion, we urge a national call-to-action on behalf of CgBWH to improve their health and QOL, and equitably achieve NHAS goals.

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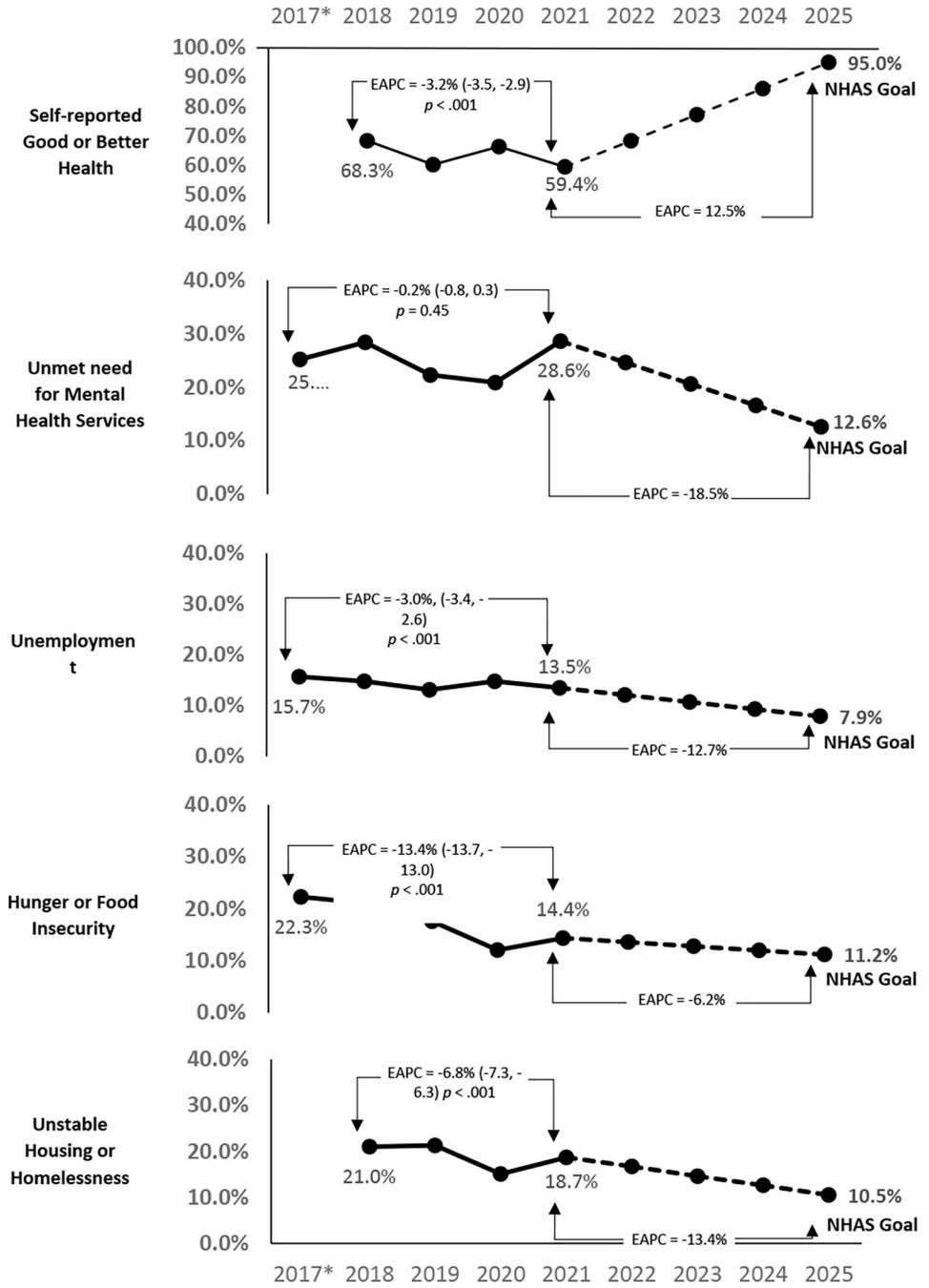


Figure: Trends in National HIV/AIDS Strategy (NHAS) quality of life indicators among cisgender Black women with HIV and estimated annual percent change needed to achieve NHAS 2025 goals (N=2,917).

Note: EAPC, estimated annual percent change; EAPC is a measure of relative annual percent change that was calculated using Poisson regression models.

*Data collection for self-reported good or better health and homelessness/unstable housing began in 2018.

^a Good or better self-rated health defined as rating one’s health as good, very good, or excellent (as opposed to poor or fair) at the time of interview

^b Unmet need for mental health services defined as needing, but not receiving, services from a mental health professional among those who indicated needing mental health services (i.e., receiving or needing but not receiving) during the past 12 months

^c Unemployed persons included those who reported being unemployed at the time of the interview, and did not include persons who were unable to work

^d Hunger/food insecurity defined as going without food due to lack of money during the past 12 months

^e Unstable housing or homelessness defined as experiencing unstable housing (i.e., moving in with others due to financial issues, moving two or more times, or being evicted at any time) or homelessness (living on the street, in a shelter, in a single-room–occupancy hotel, or in a car at any time) during the past 12 months