Black women continue to be disproportionately impacted by HIV, accounting for nearly 60% of new HIV infections in US women, despite making up less than 15% of the female population. Notably, although the rate of new infections among Black women has decreased over time, the decline has plateaued in recent years. Furthermore, the rates of sexually transmitted infections (STIs) are highest among Black women and are increasing. Black women who have a history of criminal justice system involvement, including those in community corrections (ie, probation, parole and other programs within the criminal justice system, but external to prisons and jails) are at particularly high risk. Development, evaluation, and scale-up of novel, evidenced-based interventions to reduce HIV and STI risk in this at-risk population are needed and are critical to ending HIV among women in the US.

In the study by Gilbert et al, the authors conducted a randomized clinical trial to test the effectiveness of Empowering African-American Women on the Road to Health (E-WORTH), a hybrid individual- and group-level, multisession, culturally tailored intervention vs a streamlined HIV testing control condition to decrease HIV and STI risk among Black women in community corrections. Drawing on empowerment theory and social cognitive theory, E-WORTH is designed to promote self-efficacy, sexual negotiation, and resilience in response to the structural drivers of HIV risk among women, including poverty, racism, discrimination, and gender inequity. In addition, E-WORTH sessions contain content to specifically address challenges facing women who use substances and women experiencing physical, sexual, and/or injurious intimate partner violence. The primary outcomes of the trial were incident STI infections and condom use during a 12-month postintervention follow-up period. Among 352 participants, most of whom had low income and reported recent drug use, sexual behavioral risk was high. Approximately 49% of women reported more than 1 sexual partner in the previous 90 days, and more than 30% of women had test results positive for gonorrhea, Chlamydia trachomatis, or Trichomoniasis at baseline. At the 12-month follow-up visit, E-WORTH participants were found to be 54% less likely to have chlamydia, gonorrhea, or trichomoniasis detected and reported 38% fewer condomless sex acts in the prior 90 days. Condom use with main partners also significantly increased during follow-up.

These findings by Gilbert et al provide support for the role of comprehensive, culturally tailored behavioral interventions that tackle the complex determinants of HIV and STI risk among Black women. Similar interventions developed more than 2 decades ago, such as Sisters Informing Sisters About Topics on AIDS and Sistering, Informing, Healing, Living, and Empowering, have also proven effective in increasing condom use and reducing STI incidence among Black women at high risk. Moreover, the use of racially and gender concordant (ie, Black women) facilitators is an effective strategy that is used by E-WORTH and these other interventions to mitigate mistrust and promote comradery. The addition of content that confronts dyadic issues, like intimate partner violence, was also found to be acceptable and helpful for the development of self-protective behaviors. Unlike previously established interventions, E-WORTH was designed to specifically address the unique needs of Black women involved in the criminal justice system. Therefore, the study by Gilbert et al fills an important gap in the current HIV and STI prevention toolbox for women.

Although E-WORTH and similar interventions have proven effective in decreasing HIV and STI risk among Black women, the focus of HIV prevention efforts in the US has dramatically shifted in
recent years. The Centers for Disease Control and Prevention promotes a “high-impact prevention” approach, which supports the implementation of interventions that are not only evidence-based, but are also deemed scalable, cost-effective, and have a high likelihood of population-level impact. Many of the interventions that were previously supported were not thought to reach most people who were most likely to acquire or transmit HIV and were not cost-effective. Furthermore, although group-level, community-based behavioral interventions can be cost effective, individual-level interventions that are brief, single session, and can be implemented during a routine clinical visit may be viewed as a preferred approach. Now that the E-WORTH intervention has been found to result in decreased STI incidence and increased condom use, further evaluation, outside of the context of a clinical trial, to assess feasibility of incorporation in community-based correctional settings, longer term impact, and cost-effectiveness is necessary.

Secondly, since 2012 when the Food and Drug Administration approved tenofovir disoproxil fumarate with emtricitabine for PrEP in men who have sex with men, transgender individuals, people who inject drugs, and cisgender women, biomedical prevention has become an increasingly important part of the HIV prevention landscape. Though PrEP is a highly effective means of preventing HIV acquisition by women, prescription by clinicians and uptake by Black women remain suboptimal. Barriers to use among Black women are numerous and include clinician-level factors (e.g., insufficient sexual risk screening, overt racism and discrimination, unconscious bias, and lack of familiarity or comfort with prescribing antiretroviral therapy), individual-level factors (e.g., discordance between self-perceived and actual risk, fear of adverse effects, lack of PrEP awareness, and medical mistrust), and structural factors (e.g., lack of access to health care and prescription cost). Interventions that address these and other barriers to PrEP uptake by women are under development and should be integrated with behavioral interventions, like E-WORTH, to provide women will all available HIV prevention options. Of note, PrEP education and access were not highlighted aspects of the E-WORTH intervention. Though HIV infection was not a primary outcome of this study, participants received HIV testing at baseline and at the 12-month follow-up. One new HIV infection was noted in a participant randomized to the E-WORTH intervention. Given the proven efficacy of PrEP in averting HIV infection, the incorporation of PrEP education and referral to knowledgeable and structurally competent clinicians must be considered in any HIV prevention intervention designed for Black women at high risk.

Lastly, most of the recent biomedical and nonbiomedical HIV prevention efforts in the US have focused on men who have sex with men and transgender women, groups who have the highest new HIV and STI diagnosis rates in this country, not cisgender women, despite their ongoing disease burden. It is time for renewed prioritization of Black women's HIV prevention needs. Novel, multimodal interventions that are structurally and culturally competent, feasible to implement, cost-effective, and provide Black women with PrEP knowledge and access to services are necessary if HIV among women in the US is ever going to be fully addressed.

ARTICLE INFORMATION
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REFERENCES


