



CHANGING THE CONVERSATION:  
TAKING A SOCIAL DETERMINANTS OF HEALTH APPROACH TO  
ADDRESSING HIV/AIDS AMONG WOMEN OF COLOR

*Prepared for a Grantmakers In Health Strategy Session*

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## INTRODUCTION

For the past decade, HIV/AIDS-related conditions have been the leading cause of death for African-American women ages 25-34 years in the United States (CDC 1999). In the District of Columbia, black women make up 90 percent of women living HIV/AIDS (District of Columbia Department of Health 2009).

Despite HIV/AIDS prevention programs specifically designed either to increase African-American women's access to screenings and treatments, or to change their skills, knowledge, and behavior, HIV/AIDS rates continue to rise. This is because many of these programs do not take into account the historic and contemporary socioeconomic conditions that continue to adversely affect black women's life options and choices and, most importantly, the public policies and structures that shape them.

The following paper was written in conjunction with a Grantmakers In Health (GIH) strategy session on this topic, sponsored by the Consumer Health Foundation. The foundation, which has a longtime commitment to HIV/AIDS prevention in the Washington, DC metropolitan area, believes strongly that true prevention requires new paradigms, strategies, and interventions that focus on the broad social, economic, and community factors that put African-American women disproportionately at risk for HIV/AIDS. These broader factors are the social determinants of health.

The purpose of the strategy session was to understand HIV/AIDS prevention among women of color through a social determinants lens and to explore the possibilities that this approach opens up. Because of the crisis in the District of Columbia, African-American women were the focus of much of the discussion, but issues facing Latinas were addressed as well.<sup>1</sup>

The goals of the meeting were to:

- assist the Consumer Health Foundation in identifying next steps for its HIV/AIDS prevention work in the Washington, DC metropolitan area;
- stimulate thinking among providers, advocates, and funders about developing new program and funding ideas for a holistic range of initiatives, both short-term and long-term, that incorporate socioeconomic factors and ultimately have the potential to shape personal behavior;
- stimulate thinking among funders working in areas highly affected by HIV/AIDS—especially southern states—about what they can do in order to meet the needs of African-American women and Latinas; and
- help create new alliances among funders.

This version of the paper incorporates main points raised during the meeting discussion.

### HIV/AIDS in the District of Columbia

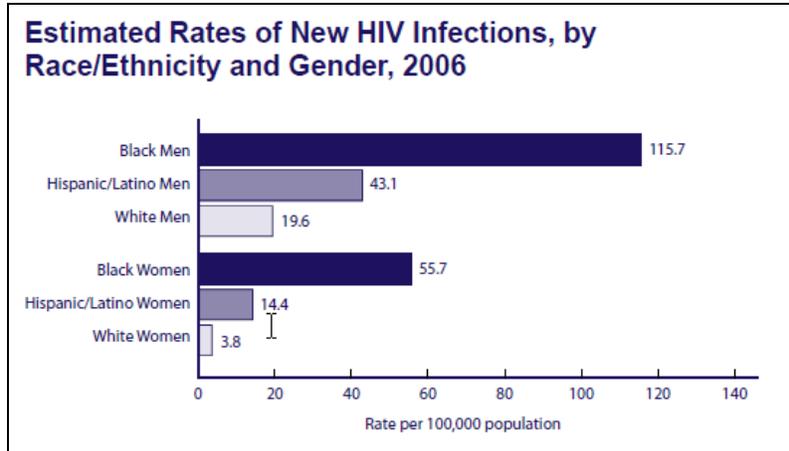
Washington, DC, has the highest per capita rate of HIV/AIDS in the United States (District of Columbia Department of Health 2009). Compared to the rest of the country where there are 14 AIDS cases for every 100,000 people, there are 128.4 cases per 100,000 in the District—almost a 10-fold difference. As was widely reported earlier this year, at least 3 percent of District residents have HIV or AIDS, a total that far surpasses the 1 percent threshold that constitutes a “generalized and severe” epidemic (Vargas and Pears 2009). And as unacceptably high as that statistic is, these figures only measure the cases that are known. The true number of residents currently infected and living with HIV is undoubtedly higher (Vargas and Fears 2009).

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<sup>1</sup> Note: the terms African American/black and Hispanic/Latino(a) are used interchangeably.

Since the beginning of the HIV/AIDS epidemic, racial and ethnic minorities have been disproportionately affected. Now, communities of color account for 65 percent of new HIV infections in the United States and constitute the majority of people living with AIDS. As Chart 1 illustrates, infection rates for black men and women are dramatically higher than other racial/ethnic groups.

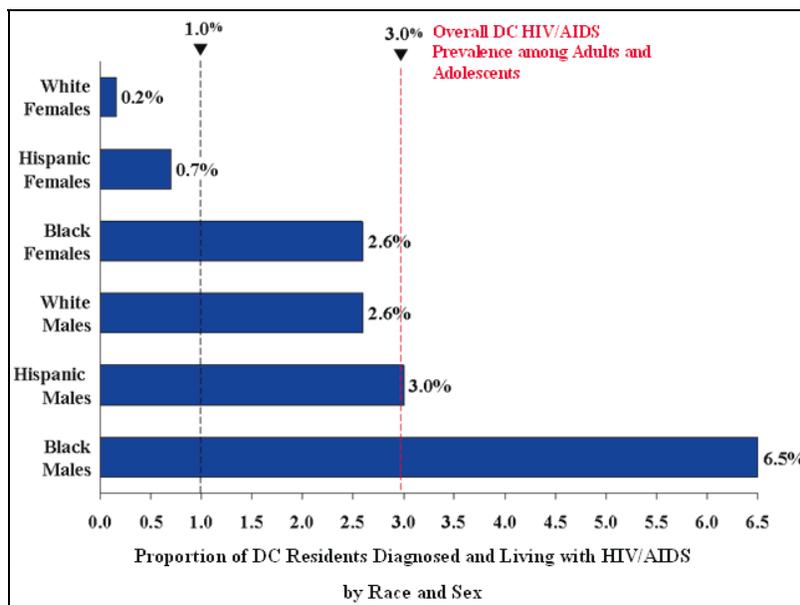
**Chart 1: Estimated Rates of New HIV Infections, by Race/Ethnicity and Gender, 2006**



**Source: CDC 2008**

In the District of Columbia, the HIV/AIDS epidemic has had a devastating impact on the African-American community. As of 2007, nearly 7 percent of black men and almost 3 percent of black women were living with AIDS (Chart 2), compared to about 3 percent for white men and less than 1 percent for white women. Overall, the District has the highest rate of new AIDS cases among women in the United States (The Henry J. Kaiser Family Foundation 2009).

**Chart 2: Proportion of DC Residents Diagnosed and Living with HIV/AIDS by Race and Sex, 2007**



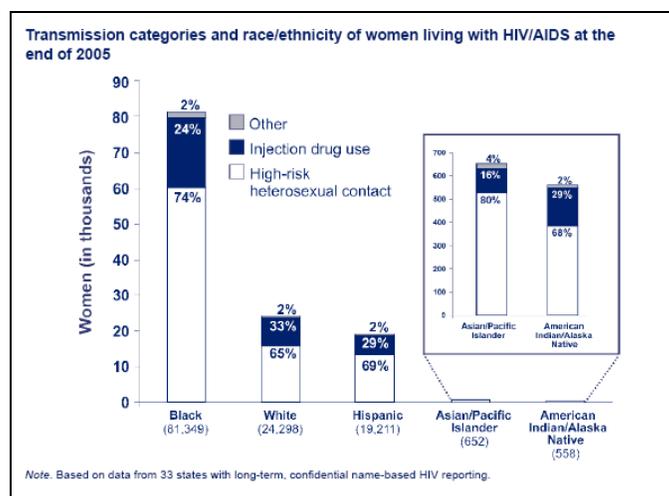
**Source: District of Columbia Department of Public Health 2009**

## HIV/AIDS and African-American Women

Among African Americans, heterosexual contact is the leading exposure category, accounting for nearly half of all newly diagnosed cases in 2007 and leading to the steady rise in infection rates among women (CDC 2009). In 2006 the HIV incidence rate for black women in the United States was 55.7 per 100,000, in comparison to 14.4 among Latinas and 3.8 among white women. In the District of Columbia, the number of women living with AIDS has climbed by more than 76 percent over the past 6 years. Black females now comprise about 90 percent of women living with HIV/AIDS in Washington.

Initially, injection drug use was the leading cause for HIV infection among women. Now, most infections are the result of “high-risk” heterosexual contact (Chart 3). For African-American women, about three-quarters of infections are transmitted heterosexually. In the District, the rate is 58 percent, followed by injection drug use (27 percent).

**Chart 3: Transmission Categories by Race/Ethnicity, 2005**

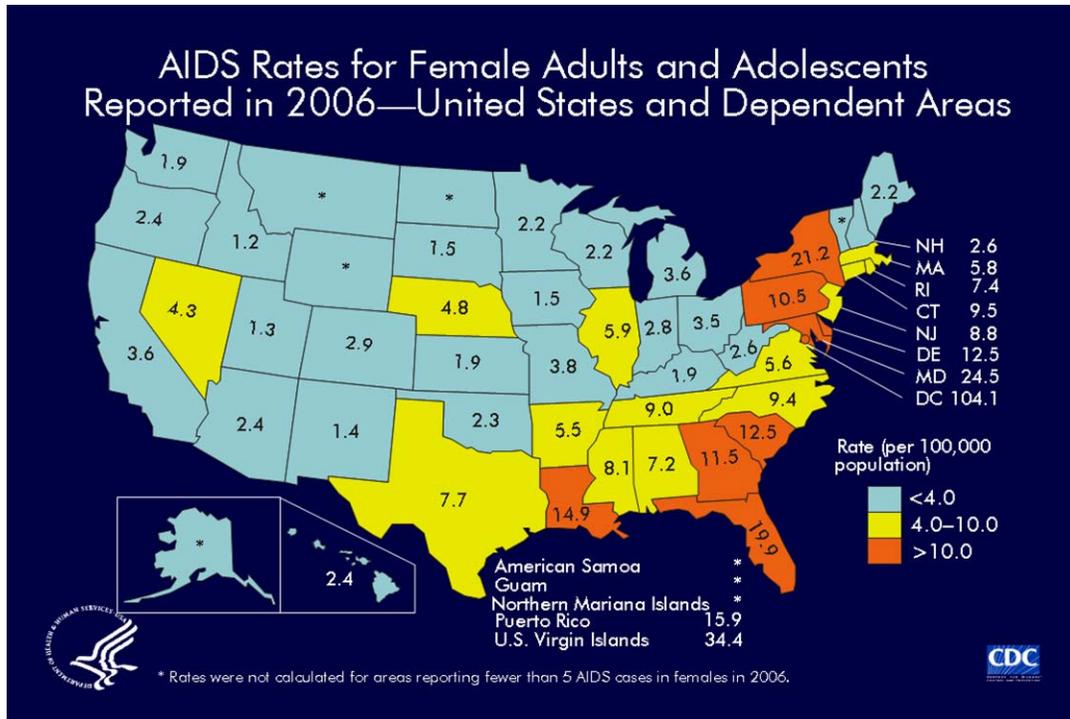


Source: CDC 2008

Chart 4 maps AIDS rates for U.S. women, showing that the areas with the highest rates of AIDS are also those with large African-American populations, such as parts of the Northeast; Washington, DC; and the South, which has been hit particularly hard. As the poorest part of the country with the lowest rankings of population health, the South has the highest number of adults and adolescents living with and dying from AIDS (FCAA 2008a). In 2004 the AIDS death rate per 100,000 among southern black women ages 25 to 44 was 23.1 compared to 1.3 for white women—a 20-fold difference. In some parts of the South, women—mostly black—comprise over 30 percent of the HIV-positive population. In some rural counties, this figure is closer to 50 percent (Southern AIDS Coalition 2008).

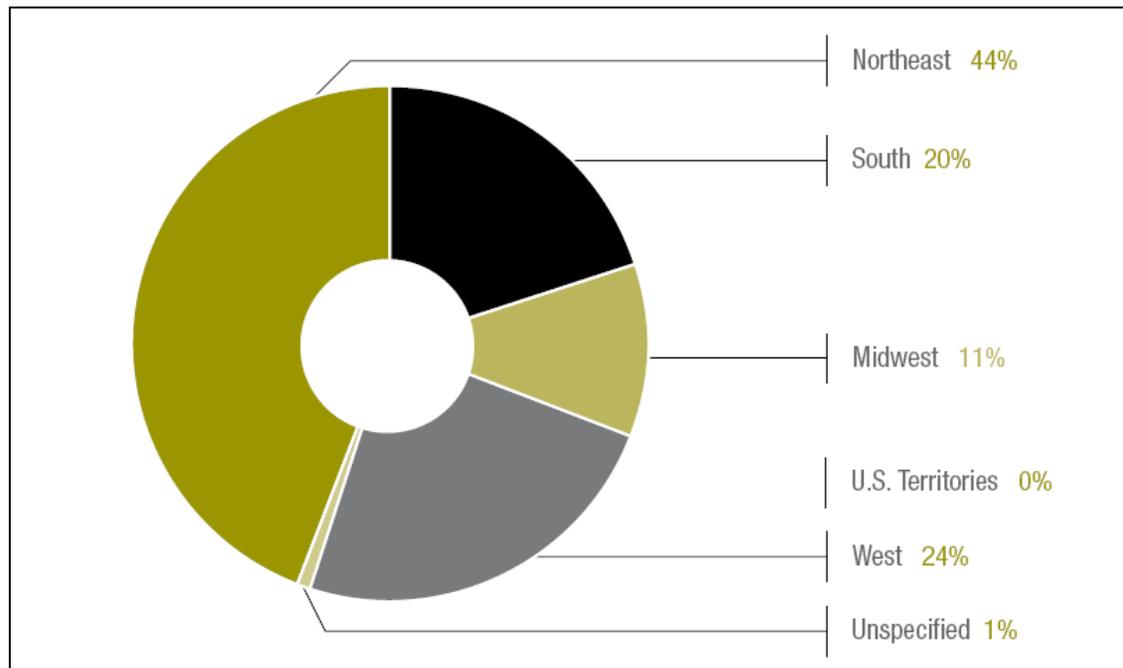
The lack of philanthropic investment in the South (Chart 5) makes the needs of those communities a natural extension of our discussion of HIV/AIDS in the District of Columbia. Although southern states—Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina—saw a 33 percent increase in the number of people living with AIDS from 2001 to 2005, in 2007 only 20 percent of U.S. philanthropic commitments for HIV/AIDS went to the South (FCAA 2008b).

Chart 4: Location of AIDS Cases among Women, 2006



Source: CDC 2008

Chart 5: Regional Distribution of Domestic U.S. HIV/AIDS Philanthropic Funding in 2007



Source: FCAA 2008b

## HIV/AIDS and Latinas

HIV/AIDS among Latinas should not be overlooked simply because it is less prevalent than among African-American women. In fact, the rate of HIV infection is seven times higher in Latinas than in white women—and rising. Because of infrequent HIV testing, Latinas are often diagnosed during a very late stage of infection and therefore develop AIDS sooner after an HIV diagnosis than white women. Consequently, AIDS has become a major cause of death. In 2004 it was the fifth leading cause of death for Hispanic women 35-44 years of age. Latinas are 4.3 times more likely than non-Hispanic white women to die from HIV/AIDS (CDC 2008; Office of Minority Health 2009).

In the District of Columbia, the rate of HIV infection for Latinas is nearly four times higher than that for white women (Chart 1). The high proportion of Hispanic men in the District who are living with HIV/AIDS (3 percent) adds to their risk for infection (Chart 2).

Among Latinas, the most common methods of HIV transmission are high-risk heterosexual contact and injection drug use (Chart 3). Latinas confront several potential obstacles when it comes to HIV prevention, testing, counseling, and seeking treatment once infected, including embarrassment, fear of rejection and stigma, partner's objection to testing, and lack of access to financial resources and health insurance coverage (National Latino AIDS Awareness Day 2009).

The challenges of preventing HIV/AIDS are similar for Latinas and African-American women because they share many of the social and economic factors that place them at higher risk for infection and disease.

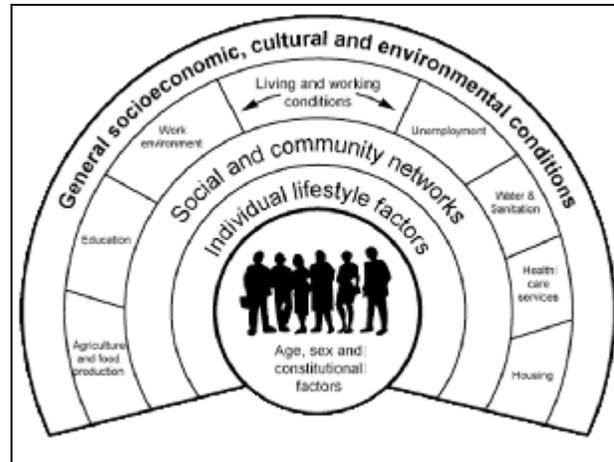
## The Social Determinants of Health Approach to Illness and Health

The conventional approach to disease prevention has primarily focused on programs designed to change people's behavior. For example, we know that eating a diet low in sugar, salt, and saturated fats, plus regular exercise can lower our risk for diabetes. But focusing solely on diet and exercise without addressing the context of people's real lives, such as what foods are available, socioeconomic status, the psychosocial impact of multiple stressors, the resources needed to effectively mitigate that stress, and others, will yield only limited results at best.

What puts people at risk for or protects them against disease is the environment in which they are born, grow, live, and work. These conditions shape their options and choices, and therefore, their behaviors (Chart 6). These social conditions, which include educational attainment, job security and stability, income and wealth, housing/neighborhood environment, social inclusion, and health care, are called the social determinants of health. In addition, these factors are created and maintained by policies, systems, and structures that benefit some groups and disadvantage others, resulting in differences in health and social outcomes among these groups.

Consequently, using a social determinants framework gives us a more comprehensive understanding of the reasons why communities of color continue to experience disproportionately higher rates of disease and death. Poverty, income and wealth inequality, poor quality of life, racism, sexism, and low socioeconomic status are the major risk factors for ill health and "health disparities." The unequal distribution of power, income, goods, and services that produce socioeconomic conditions (such as polluted environments, inadequate housing, lack of educational and employment opportunities, and unsafe working conditions) combine in inextricable ways that damage the physical and mental health and well-being of communities of color. Furthermore, these systematic, avoidable disadvantages are interconnected, cumulative, and intergenerational, inhibiting a person's capacity to participate fully in society, and threatening the social and economic health of that individual, her community, and our nation as a whole.

Chart 6: The Social Determinants of Health



Source: Dahlgren and Whitehead 1991

### Social Determinants of Health and HIV/AIDS among Women of Color

Given that social inequity is a major risk factor for disease, understanding the socioeconomic context within which African-American women grow, live, and work, and the root causes of those conditions, is essential for developing effective and sustainable interventions.

Undergirding the socioeconomic inequity that shapes the context of African-American women's lives is structural racism, in both its legacy and contemporary forms. There are now over 100 studies that link racism to worse health. Whether it takes the form of overt discrimination or structural disadvantage, race continues to influence how people are treated, the resources and jobs that are available, where they are likely to live, how they perceive the world and their place in it, environmental exposures, and the opportunity to reach full potential (California Newsreel 2009).

In addition to structural racism, gender inequities and sexism are critical factors that also shape the experiences and conditions of black women's lives in the United States. Black women stand at the intersection of race and gender.

While there are unequivocal inequities between men and women, there are also documented inequities among women. A key finding of The Henry J. Kaiser Family Foundation's 2009 report *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level* is:

Women of color fared worse than white women across a broad range of measures in almost every state, and in some states these disparities were quite stark. Of particular interest, black women experienced consistently higher rates of health problems. At the same time they also had the highest screening rates of all racial and ethnic groups.

The importance of this finding is inescapable. Can a social determinants framework provide a more comprehensive understanding of why communities of color, and black women in particular, experience high rates of disease and death? Comparing women of color to white women, the Kaiser report found inequities across critical social indicators. These indicators underscore the inequities in disease and wellness and strongly suggest that different approaches to prevention are required.

- **Poverty:** Women of color lived in poverty at more than twice the rate of white women (25.8 percent vs. 11 percent). Women in southern states, such as Mississippi, Louisiana, and Alabama, had higher poverty rates than women in any other region of the country.

- **Median Household Income:** Nationally, the median income for women was \$45,000 and ranged from a low of \$24,000 for American Indian and Alaska Native women; to \$26,681 for black women; \$27,748 for Hispanic women; \$52,669 for Asian-American, Native Hawaiian, and other Pacific Islander women; and \$54,536 for white women.
- **Gender Wage Gap:** Nationally, the gender wage gap between women and men was 69.2 percent. The disparity differed significantly by race and ethnicity. Hispanic and American Indian and Alaska Native women earned 50.9 and 56.5 cents, respectively, compared to 61.1 cents for black women; 73.3 cents for white women; and 77.4 cents for Asian American, Native Hawaiian, and other Pacific Islander women. There was a disparity in the wage gap between White women and women of color in most states.
- **Education:** More than 12 percent of nonelderly adult women lacked a high school diploma. Nearly 15 percent of black women and nearly 36 percent of Hispanic women had not completed high school, compared to 7.3 percent white women.
- **Women in Female-Headed Households with Children:** Forty-five percent of African-American women and 32.9 percent of American Indian and Alaska Native women lived in a female-headed household, while fewer Asian-American, Native Hawaiian, and other Pacific Islander women (9.2 percent), and white women (17.4 percent) lived in this household arrangement.
- **Residential Segregation:** African Americans tended to live in the most segregated neighborhoods, followed by Asian Americans, Native Hawaiians, and other Pacific Islanders, and Latinos.

Like structural racism, gender inequities and sexism create significant crosswinds that limit opportunities for black women. As delineated in the Kaiser report, black women are likely to be less wealthy; have less education; and live in segregated communities with underfunded schools, insufficient services, poor transportation and housing, and higher levels of exposure to toxic and environmental hazards. Such socioeconomic conditions can strongly influence psychosocial well-being and personal behavior especially if access to the resources needed to effectively cope with or mitigate/eliminate these types of stressors is unavailable or unattainable.

Within the context of HIV/AIDS prevention among African-American women, these socioeconomic factors combine to affect their health outcomes and well-being. When dealing with the stress of trying to meet pressing and oftentimes competing priorities, such as housing, food, transportation, and childcare, how do African-American women cope and what resources are available to negotiate the multiple facets of their lives? Does HIV/AIDS prevention that solely focuses on increasing screenings and/or changing African-American women's skills, knowledge, and behavior have the broad, long-term, and sustained impact needed to effectively reduce, much less eliminate, rates of HIV/AIDS within communities of color?

## INSIGHTS FROM THE DISCUSSION

GIH has found strategic, invitational meetings to be an excellent way of drawing grantmakers, advocates, researchers, policy experts, and service providers into a constructive, forward-looking discussion that encourages them to work across institutions and sectors. This strategy session was an opportunity for organizations and people who work on different aspects of HIV/AIDS treatment and prevention to review the issues together and to clarify an action agenda for addressing HIV/AIDS among women of color. The lively discussion was informed by presentations from Gail Christopher of the W.K. Kellogg Foundation, Carol Hogue of Emory University, Camara Jones of the Centers for Disease Control and

Prevention (CDC), Lauren LeRoy of GIH, Diane Lewis of the Consumer Health Foundation, Margaret O’Byron of the Consumer Health Foundation, Cynthia Prather of the CDC, and David Williams of Harvard University. Key insights from the meeting are briefly summarized below.

### ***Why Are the Social Determinants of Health Important?***

- The social determinants of health are the context of individual behavior. They affect the extent to which individuals have the resources they need to achieve their aspirations, satisfy their needs, and cope with their environment. We have to address this context—education, incarceration policies, what’s happening in the jails, and what happens when people get out—if we want to change people’s behavior. Public health traditionally focuses on individual behavior. But we have to ask the “why” question: why are some people doing some things more than other people?

### ***How Is Racism Related to the Social Determinants of Health?***

- Racism is a system of power, of structuring opportunity and assigning value based on the social interpretation of people’s appearance that unfairly advantages and disadvantages individuals and communities. Residential segregation based on race determines the quality of schooling in communities, access to fresh fruits and vegetables, the quality of available medical care, and access to employment. Through all these factors, it negatively affects health.

### ***Are the Social Determinants the Same for all People of Color?***

- Hispanic and African-American communities are affected by different systems of power, but women’s health may reflect the impact in similar ways. For many Latinas, immigration is an important system of power that affects their social and economic circumstances. For example, because of their immigration status, women may be considered criminals or may be subject to exploitation as workers. In addition, immigrant women are vulnerable to abuse in their communities of origin, during the process of coming to the United States, and in their destination communities on arriving here. Prejudice and discrimination on the basis of socioeconomic class—classism—also shapes Latinas’ lives, both in their home countries and in the United States.

### ***What Can Foundations Do to Address the Social Determinants of Health?***

- It is fundamental to understand that to bring about the conditions needed for health, the grantmaking focus should be on both communities and individuals, not either/or. In addition, by ending siloed funding, foundations can make it easier for community organizations not only to adopt a social determinants approach, but also to work collaboratively with other organizations that are addressing the factors that put people at risk.
- Frontline community organizations often tackle multiple factors related to people’s health. For example, they may help HIV-positive women find housing and employment, in addition to providing medical services. By putting more money into frontline groups, especially for capacity building, technical assistance, and training, foundations will strengthen existing resources that are taking a social determinants approach to community health issues.
- When economic conditions improve, health improves as well. The evidence for this is the post-Civil Rights period from 1968 to 1978, when black communities’ economic growth was mirrored in improved health. After 1978, with economic decline, African Americans’ health declined. By creating communities of economic opportunity for people of color, foundations can also improve health.
- It is not always obvious how a specific grantmaking priority connects with broader upstream issues. By asking, “Could racism or poverty be operating here?” a foundation can begin to dig deeper and thus identify social and economic factors that are the root causes of community health problems.

### ***What Can Foundations Do to Improve Prevention of HIV/AIDS among Women of Color?***

- Undervaluing people is one of the byproducts of systems of power. By investing in programs that communicate people's value, foundations can strengthen prevention by tapping into important, but perhaps previously overlooked, community voices and perspectives. Valuing people (for example, women with HIV) can be done by inviting them to the table, taking their viewpoints seriously, and acknowledging their contributions.
- It is vitally important to find ways to translate social determinants into messages that help people understand the implications of their personal decisions. For example, unprotected sex in Washington, DC, is very different from unprotected sex in a low-prevalence community, but the average person does not know that. Foundations have an important role to play in helping people understand why they and their communities may be at more risk for illness and disease than other communities.
- There is a need for more services that are directed specifically to women. Currently there is an emphasis on services for children that may ignore the needs of their mothers or female guardians. Services for children must also address the people they go home to. Foundations can be aware of the need to balance an emphasis on children with a concern for mothers and other women. They can also make certain that organizations that claim to serve women are actually using their funding for this purpose. Specific services needed by women with HIV/AIDS are programs for incarcerated women leaving jail, for women with HIV as storytellers, and programs to support domestic violence prevention among HIV-positive women.

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