Organizing to Survive
THE HIV/AIDS CRISIS AMONG FLORIDA’S WOMEN

“The greatness of a community is most accurately measured by the compassionate actions of its members.”
-CORETTA SCOTT KING

FLORIDA DEPARTMENT OF HEALTH
The HIV/AIDS epidemic in the U.S. and Florida impacts all racial/ethnic groups of women in unacceptable ways. HIV/AIDS has reached crisis proportions among minority women and black women, in particular. Compared with white women, all groups of minority women have significantly greater AIDS case rates, but the black-white disparity is widest by far. The epidemic presents a unique set of challenges to the community, public health workers, and providers of HIV prevention and care.

In the U.S. in 2006, the AIDS case rate per 100,000 population was 40.4 for black women, 9.5 for Hispanic women, 2.4 for Asian/Pacific Islander, American Indian, and multi-racial women (“other” women), and 1.9 for white women. In Florida, 2006, the AIDS case rate per 100,000 population was 89.4 for black women, 14.6 for Hispanic women, 11.5 for “other” women, and 5.1 for white women. For 15 consecutive years HIV/AIDS has been the leading cause of death among black women aged 25-44 years in Florida.

This report seeks to mobilize women to confront and overcome their vulnerability to HIV/AIDS. To achieve this broad aim, an analysis of Florida’s HIV/AIDS data among women by race/ethnicity is presented, together with a realistic set of recommendations. The goal is to stimulate the development and implementation of community action plans to prevent the further spread of HIV/AIDS among women living in Florida.

“You gain strength, courage and confidence by every experience in which you really stop to look fear in the face.”

–Eleanor Roosevelt
The objectives of this report are to:

- Raise awareness about the magnitude of HIV/AIDS among women in Florida’s communities.
- Strengthen women’s ability to take charge and control of their sexual health.
- Connect women to HIV/AIDS resources.
- Offer tools to enable women to educate others about HIV/AIDS and HIV prevention where they live, work, play, learn, and worship.
- Inform women about mother-to-child transmission of HIV.
- Increase the capacity of women to build effective responses to the HIV/AIDS epidemic in local communities.

REPORTING

HIV Cases: By Florida statute, confirmed positive HIV tests must be reported to the Florida Department of Health by every laboratory, as well as by all persons who diagnose or treat a person with HIV (since July 1997).

AIDS Cases: All persons who diagnose or treat an AIDS case must report it to the Florida Department of Health (since 1983).

Approximately 90% of all diagnosed HIV cases and AIDS cases are reported.

PLWHA: Person living with HIV/AIDS at a given time (reported case).

Through 2006, there were 81,832 PLWHAs in Florida. Women account for 31% (25,365) of the total PLWHAs.
The Findings

Table 1. PLWHA Rates Among Women Aged 13+ Years, by Race/Ethnicity, 22 Counties, Florida, Through 2006*

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<th>Hispanic Women</th>
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PLWHA = person living with HIV/AIDS (reported case).
*Top 22 counties are shown (those with greater than 150 total PLWHAs among women).

Table 1. The PLWHA rate is a measure of the impact of HIV/AIDS on each group. Expressed as a “one-in” statement, the rate equals the number of people in the population divided by the number of PLWHAs in the same population. Rates can be directly compared with each other, regardless of how many people are in the group. This table shows the PLWHA rates among women by race/ethnicity for the top-ranked 22 counties in the state having a total of at least 150 adult female PLWHA cases through 2006 (aged 13+ years). The data exclude women of other race/ethnicity, due to small numbers of cases in most counties. The counties are ranked from the highest rate (greatest impact) to the lowest rate (least impact).

The PLWHA rates in Table 1 reveal dramatic disparities. For example, in Miami-Dade County, through 2006, 1 in every 43 black women was living with HIV/AIDS, compared with 1 in 470 Hispanic women and 1 in 482 white women. The rate among black women in this county is 11 times greater.
than the rate among white or Hispanic women. In all 22 counties, the PLWHA rate among black women is at least 8 times greater than the rate among white women. In 16 of the 22 counties, the PLWHA rate among Hispanic women is at least twice as great as that among white women. Minority women in Florida’s counties – and black women in particular – are at increased risk for HIV/AIDS. (See Appendix 1 for a map of Florida showing all 67 counties and their central cities.)

**FIGURE 1**

**PLWHAs, by Sex and Race/Ethnicity**
**Florida, Through December 2006**

![Pie charts showing PLWHA rates by sex and race/ethnicity.](chart.png)

*Other includes Asian/Pacific Islanders, American Indians, and multi-racial persons.

**Figure 1.** This figure is one way to illustrate the racial/ethnic disparities and to compare the situation among men and women, statewide. In comparing these racial/ethnic trends in HIV/AIDS cases, it should be noted that in 2006, Florida’s total adult (13+ years) population (15.5 million, out of a total population of 18.4 million) was 63% white, 16% black, 19% Hispanic, and 2% other. The group most disproportionately impacted by HIV/AIDS is black women, accounting for 70% of the female PLWHAs, but only about 16% of the female population.

“You must learn to say no when something is not right for you.”

-Leontyne Price
Figure 2. The disparities can also be shown by converting the raw numbers of PLWHAs to rates per 100,000 population. These rates are equal to the number of PLWA cases divided by the population in each group and multiplied by 100,000. Statewide, the highest HIV/AIDS rate is among black males (1,681.2 per 100,000 population), followed by black women (1,177.7 per 100,000 population). However, the greatest racial/ethnic disparities are among women, not men:

The PLWHA rate among black women is 17 times greater than the rate among white women, and 7 times greater than the rate among Hispanic women.

The PLWHA rate among black men is only 5 times greater than the rate among white men and 3 times greater than the rate among Hispanic men.

HIV/AIDS CASES AMONG WOMEN, BY RACE/ETHNICITY AND RISK FACTOR

Among all women, high-risk heterosexual contact is the most likely way that HIV transmission occurs, followed by injection drug use (IDU). However, the risk profile among white women living with HIV/AIDS through 2006 differs from the risk profile of their minority counterparts:

- Among 4,059 white female PLWHAs, 66% acquired HIV through heterosexual contact, while 31% acquired it through IDU, and 3% through other routes of transmission.

- Among 17,745 black female PLWHAs, the corresponding percentages were 85% via heterosexual contact, 12% via IDU, and 3% via other routes. This pattern is considerably different from that among white females.

- Among 3,202 Hispanic female PLWHAs, the corresponding percentages were 83% via heterosexual contact, 14% via IDU, and 3% via other routes. This pattern is similar to the risk profile among black females.
Figure 3. HIV/AIDS Cases and HIV/AIDS Deaths Among Women
By Race/Ethnicity and Year, Florida 1999 - 2006

Figure 3. HIV/AIDS Cases and HIV/AIDS Deaths: During 1999-2006, newly diagnosed HIV/AIDS cases among black women greatly exceeded those among white or Hispanic women. Yet, HIV/AIDS cases steadily declined 50% among black women, while those among white and Hispanic women remained mostly level. The decline among black women could reflect possible success of primary HIV prevention efforts or possible declines in HIV testing, or both. Data presented in Figure 6, however, show that HIV testing among black women has in fact been increasing, which suggests primary HIV prevention has been working for this population. Nonetheless, deaths among HIV/AIDS cases increased 21% among black women during 1999-2006, while those among white and Hispanic women remained level. As previously mentioned, for 15 consecutive years HIV/AIDS has been the leading cause of death among black women aged 25-44 years in Florida. The death trends among black women may reflect decreased access to or acceptance of diagnosis and care.

There is a pressing need to emphasize early and routine HIV testing, other prevention efforts, and care and treatment. Because the numbers of newly diagnosed HIV/AIDS cases in each group in each year (incidence) exceed the numbers of HIV/AIDS deaths by year, the numbers of PLWHAs (prevalence) are constantly increasing during this period, and will continue to do so for several more years, at least.
Figure 4. Adolescents aged 13-19 years are a key group that warrants special attention for HIV/AIDS prevention. Of 3,571 young female PLWHAs reported through 2006, 75% were black, 14% white, 10% Hispanic, and 1% of other race/ethnicity.

“According to a recent report from the Centers for Disease Control and Prevention, one in four female adolescents in the U.S. is infected with at least one sexually transmitted disease (STD). Given the relationship between HIV and STD’s, it is more important than ever that we focus our education and prevention efforts on this vulnerable population.”

-Marlene LaLota, MPH, HIV Prevention Program Administrator, Bureau of HIV/AIDS
Figure 5. The HIV/AIDS epidemic among women is reflected in the HIV/AIDS cases among children less than 13 years of age. Similar racial/ethnic disparities impact both groups. Almost all (95%) of pediatric cases reflect HIV transmission from mothers to newborns. Mother-to-child transmission of HIV is greatly reduced by providing the HIV-infected pregnant woman and the newborn with appropriate antiretroviral therapy.

*HIV/AIDS Cases and population include children less than 13 years of age only.
Figure 6. During 1999-2006, HIV testing in publicly funded counseling and testing sites increased 146% among Hispanic women and increased 89% among black women, but decreased 10% among white women. The marked increase in the number of HIV tests among Hispanic women could be related to social marketing and a media campaign promoting testing that was aimed at the Hispanic community, particularly in South Florida. Hispanic men had a similar increase in HIV testing (117%) during 1999-2006. The trend in testing among black women suggests that their decrease in newly diagnosed HIV/AIDS cases (see Figure 3) was not due to decreased HIV testing. Thus, the trend in HIV/AIDS cases among black women may mean real decreases in HIV transmission and AIDS diagnoses.

“I am my own woman.”

-Evita Perone
Recommendations

I. For the Individual

What YOU can do.

- Become educated about HIV/AIDS. Reading this report is just one step. Learn the facts about transmitting and preventing HIV.

- Get tested for HIV and know your status.

- Encourage your partners to get tested for HIV and know their status.

- Encourage your family, friends, co-workers, church members to get tested and get involved with HIV prevention.

- Use condoms if you are unaware of your partner’s HIV status. Make this a priority and refuse unsafe sex as an option. If you are negative, this is a necessary step to remain negative.

- Seek treatment if you are HIV positive.

II. For the Community at Large

HIV/AIDS trends should be monitored closely to help guide ways to increase the effective use of statewide and local resources for HIV prevention and to evaluate progress. Vulnerable communities can be mobilized in response to the release of compelling HIV/AIDS data. Periodically, the data should be clearly interpreted and widely disseminated. However, discussion of HIV/AIDS trends and their impact on various communities of women and men may inadvertently contribute to a sense of HIV/AIDS stigma. HIV/AIDS stigma can lead to fear of discrimination and denial. Stigma can have a negative effect on acknowledging HIV risk, as well as seeking HIV testing and treatment. The Florida Department of Health, Bureau of HIV/AIDS and its partners are fully committed to seeking ways to reduce stigma, while raising awareness about HIV/AIDS and providing ample opportunities for HIV testing, prevention, care, and treatment. Please share your ideas on our blog at: www.wemakethechange.com.

HIV/AIDS disparities are determined by many underlying factors other than a person’s race/ethnicity. The amount of HIV already established in the community is one such factor, because the more HIV that is present the greater the chance that even a few unprotected sexual encounters or sharing of injection drug equipment can result in transmission. Late diagnosis of HIV or AIDS is another underlying factor, resulting in less opportunity to take advantage of life-saving medications and more opportunity to unknowingly spread the virus. Regardless of race/ethnicity, increased risk for HIV and AIDS can also be related to poverty, unemployment, discrimination, racism, lack of health insurance, homelessness, and other social and economic factors.
• Recognize and discuss underlying factors that contribute to HIV/AIDS trends to help reduce stigma.

• The public health benefits of releasing scientifically sound data should outweigh the risk of possibly causing people to feel stigmatized.

• Develop strategies to normalize HIV testing, education and prevention through widespread education, media campaigns, and social marketing.

• Media campaigns should emphasize the benefits of HIV prevention and early intervention, as well as provide information on where women can go to access related services.

• Educate community leaders, elected officials, the faith community, the media, and others on the impact of HIV on women, particularly minority women.

III. For the Provider

Based on the differences in women’s and men’s anatomy, women are more likely than men to acquire HIV from unprotected heterosexual intercourse. Untreated sexually transmitted diseases (STDs) also put women at increased risk for being infected with HIV.

• Comprehensive sexual health education should be a part of every school curriculum in Florida. Work with elected officials, community leaders, school board members, and others to develop and implement curricula appropriate for the local community.

• Educate women and girls that abstinence is the best way to prevent HIV, but also provide education on all prevention measures, including monogamy and correct, consistent use of condoms.

• Ensure that education on STDs is readily available to women and girls. Work with schools, clinics, local physicians, and others to ensure that STDs are promptly diagnosed and treated.

Women may feel a lack of control and/or power in their relationships with men. They may be afraid to say no to sex or reluctant to insist on condom use. Domestic violence and sexual coercion are complex issues for many women in Florida. Survivors of domestic violence, sexual violence and, especially, childhood sexual molestation often have not had the opportunity to develop refusal or negotiation skills.

• Increase the availability and accessibility of behavioral interventions that provide women with skills to negotiate safer sex and improve women’s confidence in dealing with culture, power, and gender issues. Latex condoms should be readily available to women and education on how to use them properly should be part of prevention interventions.

• Advocate for development and improvement of women-controlled HIV prevention methods, such as microbicides and female condoms.
• Increase partnerships with local domestic violence and sexual violence service providers to work together to educate and counsel women with domestic violence or sexual violence issues. HIV/AIDS counseling and testing is available in many domestic violence and sexual violence programs in Florida.

Women are caregivers. They are often too busy taking care of other family members – children, parents, partners – to take care of themselves. Women tend to put everyone else in their lives first. They often test late in the course of their HIV disease.

• Look for creative ways to make HIV testing accessible for busy women. Testing should be available at places frequented by women, such as hair salons, Laundromats, community centers, churches, and social clubs. Providing on-site childcare, transportation vouchers, and other incentives can increase test acceptance. Confidentiality concerns should be fully addressed so that women are comfortable with testing and reporting procedures.

• Women tend to have many interactions with the health care system. Providers should routinely offer HIV and STD testing to sexually active women, regardless of marital status. This will enable more women to view testing as an acceptable and normal part of health care.

• Overall, pregnant women tend to accept HIV testing during pregnancy and will also accept treatment for HIV while pregnant, at least for the sake of reducing the chance of their newborn being HIV-infected, if not for themselves. However, all too often they will neglect their own care after delivery. Intensive case management should be provided during pregnancy and following birth to ensure that both mother and child have access to and remain in care.

• Ensure a continuum of family-centered services for women and children. Families affected by HIV will need a variety of medical, psychosocial, and support services.

Substance abuse and co-occurring mental health issues play a large role in the transmission of HIV to women. Women are at increased risk through injecting drugs, having sex while high on drugs or alcohol, and exchanging sex for money or other items. Women addicted to drugs may turn to prostitution to support their habit.

• Increase partnerships between substance abuse, mental health, and HIV/AIDS providers. Advocate decision makers to increase the priority placed on substance abuse treatment. Provide education, prevention and testing to substance abusers in and out of treatment. Where possible, service providers should coordinate delivery of treatment and ancillary services. Encourage cross-training for HIV prevention, substance abuse, and mental health issues.
• Form collaborative workgroups among county health departments, consumers, university-based researchers, and social service agencies to address co-occurring health conditions.

Women who have been incarcerated often have been convicted of crimes associated with HIV risk behaviors, such as injection drug use and prostitution.

• Develop, implement, and support prevention and pre-release planning programs in jails and prisons. Ensure that HIV testing is available upon request during incarceration and upon release. Education and behavioral interventions should be available to all inmates.

Men sometimes engage in behaviors while in jail or prison that they would not engage in on the outside. This situational sex, which often includes unprotected sex with other men, can put female partners at risk once they are released. This underscores the need for women to negotiate safer sex and condom usage.

• Develop, implement, and support prevention and pre-release planning programs in jails and prisons. Ensure that HIV testing is available upon request during incarceration and upon release. Education and behavioral interventions should be available to all inmates.

• Whether or not men experience jail, prison, or sex with other men, they should be informed about the benefits of safer sex and condom usage. Men and women share the responsibility for taking measures to protect their own health and prevent the transmission of HIV and other STDs.

"Perhaps the single most important preventive measure is for people to know their own HIV status. If they are uninfected, this knowledge helps them take measures to continue to protect themselves; if they are infected, this information helps them to protect their partners and seek care and treatment for themselves."
- Tom Liberti, Bureau of HIV/AIDS
ACKNOWLEDGMENTS

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A copy of the report can be found on the Bureau of HIV/AIDS website at: http://www.doh.state.fl.us/disease_ctrl/aids.
For testing locations near you, visit http://www.doh.state.fl.us/disease_ctrl/aids/testing/testing.html or text your zip code to 46264.