



HIV and STI testing among Indigenous women and women who inject drugs

? Questions

What programs and services have been shown to be effective in increasing HIV and STI testing among Indigenous women and women who inject drugs?

🔑 Key take-home messages

- Rates of HIV and other sexually transmitted and bloodborne infections are high among Indigenous women and women who inject drugs (1-3).
- For women who use drugs, centres that provide treatment, services and programs for people with substance use issues have been identified as good sites for HIV and HCV testing and counselling to take place (2).
- Among Indigenous women, there is evidence to support using clinical reminders to promote chlamydia testing (4).
- “Ideal” HIV testing environments for Indigenous women should promote confidentiality, be harm reduction-focused and include Elders throughout the testing process (5).

! The issue and why it's important

People living with HIV who are unaware of their serostatus are at greater risk of acquiring opportunistic infections and transmitting HIV to others (1). Testing for HIV and other STIs helps ensure that people receive the care they need and reduces the risk of onward transmission (6).

Rates of HIV and other sexually transmitted and bloodborne infections are high among both Indigenous women and women who inject drugs. Among people who inject drugs, the prevalence of HIV is estimated to be 25%, while HCV prevalence is as high as 98% (2). HIV rates among Indigenous people in Ontario are 1.7 times that of the general Ontario population (3). Regionally, Indigenous people in Toronto and Central West Ontario are nearly four times more likely to have HIV than those in other parts of the province

References

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3. The Ontario HIV Treatment Network (OHTN). The Current State of the HIV Epidemic among Indigenous People in Ontario. <http://63.135.124.232/wp-content/uploads/2014/09/Indigenous-Report-2014Final.pdf>. Toronto, ON; 2014.
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(3). Although HIV prevalence is higher among Indigenous and non-Indigenous men, women account for one-quarter of new diagnoses among Indigenous people, compared to one-sixth of new diagnoses among non-Indigenous people (3).

Indigenous women and women who inject drugs are not mutually exclusive categories. The Cedar Project—a prospective cohort study of young Indigenous people in Vancouver and Prince George—found that, of 605 participants, 55% were using injection drugs and women were twice as likely to inject as men (7).

What we found

HIV and STI testing among women who inject drugs

Researchers have noted that the stigma facing women who inject drugs is worse than the stigma facing men (8), and that women who inject drugs face many barriers to HIV services, including police harassment, judgmental health care personnel and fear of losing their children (8). It is critical that health care providers be trained to provide tests in a supportive, culturally safe and nonjudgmental manner (8).

A 2008 U.S. study sought to determine the barriers to and facilitators of testing for HIV and HCV among women who inject drugs (2). The researchers interviewed 20 women at a short-term drug treatment centre in Rhode Island and discovered the following:

- Drug use often took priority over health care issues. When using drugs, participants were less likely to test or receive results.
- There was a low level of disease-specific knowledge, especially around HCV. Many participants identified themselves as being at low risk for HIV and HCV, even though they shared needles.
- Many women did not understand HCV test results or treatment options.
- Stigma was a problem for many women. Women said they would prefer to test at a site where staff were knowledgeable about addiction; the treatment centre was identified as a place where women felt comfortable receiving medical attention.
- Transportation was identified as a problem for both accessing testing and receiving results.
- Many women were depressed and fearful of testing positive for HIV and/or HCV.

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The researchers found that women wanted to protect themselves and promote their health, and this was a motivating factor that could encourage them to test (2). The researchers noted that substance use treatment centres present a good site for offering comprehensive HIV and HCV counselling, testing and education (2), and that vaccinations could be offered in community-based settings such as methadone clinics or needle exchange programs (2).

A 2015 U.S. study found that substance use treatment clinics were the most frequently identified location of injection drug users' most recent HIV test (6). Of 1,224 male and female participants in the study, 33% had tested at a treatment facility within the past 12 months (6). The authors noted that testing at substance use treatment centres has the potential to identify new cases of HIV (6).

A 2008 Canadian study sought to assess the uptake of STI urine screening in a weekly women's program in Vancouver's Downtown East Side (9). Compared to other clinics and programs in the area serving people who inject drugs, this three-hour community clinic-based program offered more general services, such as food, health care and social activities. One hundred and twenty-six women (40% of whom were injection drug users) were recruited and invited to test for chlamydia and gonorrhoea (9). Ninety-six women agreed to be tested. The authors found a low prevalence of chlamydia and gonorrhoea (2% and 0% respectively), possibly because this population has many clinics available to it. However, the authors concluded that the program could still be used to improve women's knowledge and awareness of STIs (9).

Another approach to increasing HIV and STI testing among women who inject drugs was the WORKS intervention (Women's Options for Risk Reduction through Knowledge of Self) (10). The intervention was developed and implemented by the California State Office of AIDS and four community-based organizations. Intervention participants were recruited at needle exchange sites, a methadone centre, homeless shelters, an LGBT community centre and a women's jail. Two community-based agencies took turns hosting

monthly workshops; one provided onsite STI counselling and testing every other week and the county health department provided HIV testing and pre- and post-test counselling. Women's-only needle exchange services were also provided at workshops whenever possible. Participants received grocery store gift cards for being tested, for returning for STI and HIV test results, and for attending each of the four educational workshops (10).

Over the course of three years, the WORKS intervention engaged 562 participants – 68% of whom were current or former injection drug users. HIV and STI testing rates were high and participants gave positive feedback about the project. The authors noted that—going forward—rapid HIV and/or STI tests would ensure that a higher proportion of women receive results (10).

HIV and STI testing among Indigenous women

Indigenous women are epidemiologically and socioeconomically more vulnerable to HIV than non-Indigenous women, since they are more likely to experience social drivers of HIV, such as poverty, substance use and intimate partner violence (5). There is also evidence that Indigenous women may not be taking advantage of early HIV testing. A 2003 study showed that 75% of HIV tests among Indigenous women were administered late in the development of the infection, compared to 43% of tests among non-Indigenous women (5).

A 2008 U.S. study noted that STIs continue to impose a disparate health burden on American Indian and Alaskan Native people, with chlamydia rates five times higher than those of Caucasians (4). The study authors used medical record review to identify missed opportunities for chlamydia screening among American Indian women. The goal was to identify all patients of a large Indian Health Service facility who were eligible for screening but who had not been screened in the past 12 months.

Results showed that, of 4,940 eligible women, 38% had been screened. Two hundred and fourteen unscreened women were selected for further study; analyses showed that 34% of this subgroup

were sexually active but unscreened. The authors concluded that clinical reminders could greatly assist health care providers in identifying and screening eligible patients; a clinical reminder linked to a urine test would have referred 74% of eligible women to screening (4). The authors also found that many women who had been screened had been tested as part of prenatal visits, gynecological exams or family planning visits, and that automated reminders linked to these types of visits could improve screening (4).

A 2006 Edmonton study sought to explore how Indigenous women perceived HIV counselling and testing (5). The authors interviewed seven Indigenous women and held a focus group with six other Indigenous women. Participants identified several barriers to testing (e.g., a lack of anonymity in the testing situation, fear of testing positive, past negative experiences with testing and concerns about the potential involvement of child welfare agencies). Participants also identified the following as aspects of an ideal testing situation:

- the adoption of a harm reduction approach that takes a value-neutral stance to HIV risk behaviour and focuses on the future instead of the past
- the provision of choice prior to and during the testing situation, including choice regarding the tester (gender, ethnicity and age), the presence of a support person, and the option of participating in traditional Indigenous practices (e.g., smudging)
- the sequencing of testing so that the tester begins by providing information and giving women the chance to ask questions. Only then would the tester ask questions and complete paperwork.
- a physical environment that fosters anonymity, ideally in a multipurpose building offering various services. Several women supported the idea of an Indigenous women's health centre attached to an existing Indigenous agency where women already had relationships with staff.

- a team approach that sees the tester working in concert with either an Elder or an Indigenous service provider (5).

Most participants in the study preferred an Indigenous tester as they would have a better understanding of the women's experiences; however, having an Indigenous tester raised concerns about confidentiality, especially in small communities. Ideally, the tester would be someone who was not known to the women and not connected to the women's communities (5).



What We Did

We searched Medline using a combination of the following: [text terms (Injecting drug use* or Injection drug use* or people who inject drugs or IDU* or intravenous drug use* or Indigenous or Aboriginal or Native American* or First Nation* or Metis or Inuit or native Canadian* or American Indian) or MeSH terms (Substance Abuse, Intravenous or Needle-Exchange Programs or Needle Sharing or Indians, North American)] AND [text terms (HIV or Hepatitis C or Sexually Transmitted or Sexually Transmitted or sexual health) or MeSH terms (Sexually Transmitted Diseases or Sexually Transmitted Infections)] AND [text terms (women or female* adj5 inject* or female* adj5 drug*) or MeSH term Women] AND [text terms (test* or diagnos*)] . The search was conducted on January 29, 2016 and articles were limited to those published since 2005 in English. The search yielded 428 references from which 10 studies were included. Study sample sizes ranged from 13 to 4,940 participants. Only studies conducted in high-income countries were included. Reference lists of identified studies were also reviewed.

Factors That May Impact Local Applicability

All studies cited in this review were conducted in the United States or Canada. There are likely no factors that would affect local applicability.

Rapid Response: Evidence into Action

The OHTN Rapid Response Service offers quick access to research evidence to help inform decision making, service delivery and advocacy. In response to a question from the field, the Rapid Response Team reviews the scientific and grey literature, consults with experts, and prepares a brief fact sheet summarizing the current evidence and its implications for policy and practice.

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