Drug-Using Women and HIV Access to Care and Treatment Issues

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INTRODUCTION

In *Women at Risk: Issues in the Primary Prevention of AIDS* (Weissman & Brown, 1995), we discussed the complex issues that surround risk reduction and prevention efforts aimed at drug-using women. Despite these efforts and despite the fact that heterosexual transmission now accounts for more new AIDS cases among women than injection drug use (CDC, 1995), the majority of women living with HIV disease in this country are either active or recovering drug users.

The challenges facing these women in obtaining adequate and appropriate care and their providers in giving it are formidable indeed. Until recently there have been no large-scale studies of the natural history of HIV infection in women. Specific treatment protocols for drug-using women need to grow out of the study of the natural history of infection in these women. They also need to take into account the many underlying and sometimes long-standing health issues with which these women frequently present.

For drug-using women with HIV there are multiple barriers to access: educational, cultural, economic, psychological, physical, and social. Most of the women have family responsibilities; and many have children or partners/spouses who are also infected with HIV, or may be ill. Many have lost children or partners—to HIV, to violence, to drug abuse, to foster care, and to the criminal justice system. In addition to the psychological access barriers these losses may engender, they tend only to increase these women’s distrust of both systems and care regimens. Many women with HIV are homeless or living in makeshift arrangements with family and friends. Without a stable living situation, receiving

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regular care is nearly impossible, and not a first priority. Many of these women are poor at diagnosis and, like others living with HIV, become considerably poorer as their illness progresses. While many are Medicaid eligible, many others are not. Many have undocumented status; others have health insurance that may pay for medical care, but not for mental health or substance abuse services.

The same psychosocial realities that impinge on drug-using women’s ability to engage in preventive interventions and to change risk behaviors affect their ability to access and use the medical and other services they need to receive optimal care for their HIV disease. These include: a significant likelihood of sexual, other physical, or psychological abuse (both current and past); significant feelings of powerlessness, psychological distress, and depression; a lack of consistent social supports and related systems and resources; and a lack of available, appropriate, and accessible drug treatment.

However, for women living with both HIV and drug abuse, there are additional institutional and psychosocial factors that affect their ability to effectively cope with and utilize service systems, particularly those not designed for their needs. First, many of the psychosocial factors noted above may be exacerbated simply by virtue of a diagnosis of HIV infection; these include especially denial/fatalism, depression, lack of supports, stigma, and poverty.

Second, the primary delivery system for services for drug abusers with HIV is likely to have been designed with men’s needs in mind, since there are approximately three men for every woman living with HIV disease and drug abuse. The largest group of individuals living with HIV have been men who have sex with men, and the overall HIV care delivery system is often oriented toward this population.

Third, it has been well documented that drug users as a group have difficulty accessing care for HIV-related illness. A number of studies have compared health care access and utilization for persons living with HIV who do versus do not have histories as injection drug users (IDUs). IDUs with HIV disease have significantly less access to and lower utilization of zidovudine (AZT) therapy than their non-IDU counterparts (Stein et al., 1991; Moore, Hidalgo, Sugland & Chaisson, 1991; Crystal, 1992). Fleishman, Hsia, and Hellinger (1994), Mor, Fleishman, Dresser, and Piette (1992), Seage, Landers, Lamb, and Epstein (1990), and Seage, Hertz, Stone, and Epstein (1993) have found that current and former IDUs reported significantly fewer outpatient visits, more emergency room visits, more inpatient hospital admissions, and lengthier hospital stays than other persons with HIV. This pattern of care utilization has been related to drug users’ lack of stable housing and informal support systems, as well as their difficulties in accessing community-based services, particularly early in the course of HIV disease (Drucker et al., 1991; Solomon, Frank, Vlahov, & Astemborski, 1991; Bennett, Pascal, & Cvitanic, 1992).

Less information has been available on drug-using women’s access to and utilization of HIV-related medical care, but considerable evidence exists that, at