Black Women With HIV Are Less Likely to Receive Adequate Treatment During Pregnancy

Between 2004 and 2014, African-American women in South Carolina were less likely to receive guideline-based treatment.

September 20, 2021 By Heather Boerner

Despite federal guidelines that have not recommended single-drug therapy for pregnant people since the 1990s, a new analysis published in the Journal of Health Care for the Poor and Underserved found that, as late as 2014, Black women in South Carolina were still being prescribed HIV monotherapy.

“African-American women were also more likely to take monotherapy during pregnancy, a strategy that has not been recommended for the prevention of perinatal HIV transmission since the 1990s,” wrote Gweneth Lazenby, MD, associate professor of obstetrics and gynecology at the Medical University of South Carolina, and colleagues. “Our findings suggest that African-American women with HIV infection in South Carolina were less likely than others to receive guideline-based treatment for HIV during pregnancy.”

The Black maternal mortality crisis in the United States is well documented, and poor birth outcomes for Black women are higher than their white peers. What’s more, Black women living with HIV have also been found to receive less HIV care after childbirth. Previous research has already shown that women with HIV who have unintended pregnancies are more likely to have higher viral loads. Now, this new analysis suggests that women who don’t receive prenatal care during their pregnancies also have higher viral loads, and their infants experience worse outcomes.

Lazenby and colleagues previously published data on birth outcomes among rural women living with HIV that showed that rural status wasn’t associated with birth outcomes. But they wanted to look more deeply at another finding in that study: 14% of the women weren’t taking any antiretrovirals (ARVs) at all, let alone achieving viral suppression. So the researchers wanted to know why so many of these women weren’t receiving medication and whether three-drug combination antiretroviral therapy was associated with more preterm birth than monotherapy or dual therapy. The study spans the years 2004 to 2014, when combination treatment for HIV was just emerging.

The second question has become less relevant as three-drug ARV therapy is now the standard of care for almost everyone. Highly effective newer dual therapies, like Juluca (dolutegravir/rilpivirine), Dovato (dolutegravir/lamivudine) and injectable Cabenuva (cabotegravir/rilpivirine), have also emerged. Those medications have not been tested in pregnant people yet, though the Antiretroviral Pregnancy Registry does collect data on all the HIV regimens used during pregnancy.

The women included in the study come from South Carolina's Enhanced HIV/AIDS Reporting Surveillance System, a database that tracked all 643 women living with HIV who gave birth in the area from 2004 to 2014. Complete data on the women's care and delivery outcomes was available. The vast majority were Black (78%). At the time, 88% were taking some kind of ARV, but only half were on triple therapy. And while only 98 women took monotherapy and 79 women weren't taking any ARVs, Black women made up 85% of both groups. Meanwhile, Black women accounted for just 73% of those on modern combination ARV therapy.

The women had a median age of 38 when they gave birth, and they had been diagnosed with HIV for a median of three years.

The majority, 57%, gave birth via cesarean section—which used to be recommended to lower the risk of HIV transmission during delivery—and the median birth weight was 6.4 pounds. The women's median viral load was just 58—a level that data suggest is protective against mother-to-child transmission of the virus—and 41% had an undetectable viral load (defined as 40 copies or fewer). However, one in five women had a viral load of more than 1,000 copies at delivery—a level associated with a higher likelihood of transmitting HIV to infants.

To find out whether viral load and specific ARVs were associated with outcomes like preterm births, low birth weight and small infant size for gestational age, the researchers ran an analysis. There were six cases of HIV transmission in the group, accounting for less than 1% of all births. There were also 121 premature deliveries (accounting for 20% of the births), 35 (6%) very premature deliveries, 144 infants (23%) born at low birth, 24 (4%) born at very low birth weights and 13 (2%) infants born small for their gestational age.

However, when the researchers parsed the data according to ARV use, they didn't find that ARV types were associated with a greater likelihood of poor outcomes; those were associated with lack of any HIV treatment at all. Women not receiving HIV care were also eight times more likely not to be receiving routine care for their pregnancies either. And when women weren't in prenatal care, they were 90% more likely to transmit HIV to their infants.

Prenatal care was also associated with an 88% reduction in the risk of preterm birth and a 40% reduced risk of low-birth-weight babies. But it was not associated with reductions in very low birth weight, very preterm birth or small infant size for gestational age.

While the analysis showed no association between race and access to prenatal care, it did show that being Black was an independent risk factor for low birth weight babies.

“Although race was not associated with preterm delivery, we identified additional disparities in HIV care for African-American women,” Lazenby and colleagues said. “African-American women were more likely than others to report no ARV use, which in addition to conferring an increased risk of perinatal HIV transmission may increase the risk of preterm delivery.”

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