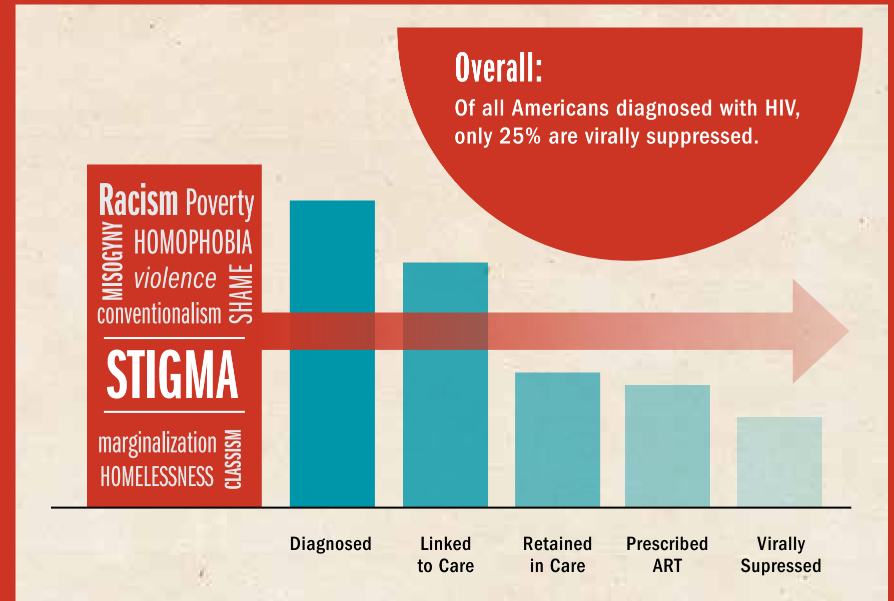
A Blueprint for Improving HIV/STD Prevention and Care Outcomes for Black & Latino Gay Men

NASTAD™
NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

NCSD
National Coalition of STD Directors
Promoting Sexual Health Through STD Prevention

THE BAR BEFORE THE BARS



Stigma and other social determinants influence the HIV care continuum before a diagnosis is even made.

ADDRESSING STIGMA

BACKGROUND

Stigma and epidemics of sexually transmitted diseases (STDs), notably HIV, have long been intertwined in the United States and countries around the globe. Stigma refers to the social devaluation of people who are different, whether due to conditions that do not affect the majority of a population (e.g., homosexuality, HIV/AIDS, mental illness), or more ordinary conditions that affect many or all in a population (e.g., demographic features tied to age, race/ethnicity, gender). Stigma, in its varying forms, serves to fuel the propagation of STDs, notably within marginalized and stigmatized communities.

> “Disentangling stigma from HIV risk, infection, and treatment is one of the greatest public health challenges of the 21st century.[2,16]”

Governments and non-government entities[2] have called for interventions to reduce stigma and its impacts on risk for HIV/STDs and uptake of prevention and treatment for HIV. In the summer of 2010, the White House released the National HIV/AIDS Strategy (NHAS). In response to the NHAS, the U.S. Centers for Disease Control and Prevention (CDC) made significant changes to its plan for providing funding to state and local health departments for HIV programs and services. A key component of this change was a focus on High Impact Prevention (HIP). HIP encourages health departments to implement programs and other scalable interventions that have demonstrated the potential to reduce new HIV infections in the most impacted populations in order to yield a greater impact on the HIV epidemic[6].

The release of the NHAS and changes to the way health departments are funded for HIV prevention represent unique opportunities for public health leaders, HIV/AIDS and sexual health practitioners, and community stakeholders to reassess and evaluate public health efforts to reduce HIV infection. Specifically, efforts to prevent and treat HIV/STDs among Black and Latino gay men and other men who have sex with men (MSM)—populations that are most significantly impacted by HIV/AIDS in the U.S.—must be critically evaluated.

In reflecting on past successes and failures, we must acknowledge that stigma is a central challenge that remains inadequately addressed in attempts to promote sexual health and reduce HIV/STDs among Black and Latino gay men/MSM. The National Alliance of State and Territorial AIDS Directors (NASTAD) and the National Coalition of STD Directors (NCSD) have been engaged in a multi-pronged effort to reduce stigma in public health practice and promote access to HIV and STD prevention and treatment among gay men/MSM. The actions facilitate the implementation of the NHAS and the achievement of the goals of HIP, as well as respond to important gaps in the NHAS and CDC's revised prevention strategy.

The complex role stigma plays in poor sexual health outcomes among gay men/MSM – and the resulting disproportionate rates of HIV and STDs among the population – are largely overlooked in the NHAS. Throughout the NHAS, only stigma surrounding HIV (and not specifically targeting/affecting gay men/MSM) is addressed. Likewise, the prevention programs prioritized in the CDC funding strategy are primarily focused on strategies such as HIV testing and condom distribution, but not necessarily the personal-, community-, and institution-level factors that reduce uptake of these interventions.

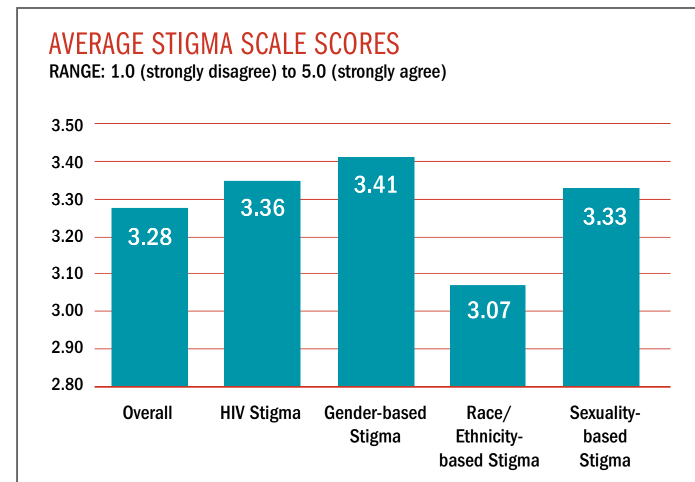


Figure 1. Average scores on stigma scale and sub-scales based on survey conducted by NASTAD and NCSD.

> “Research has shown that in order to effectively respond to the HIV and STD epidemics affecting Black and Latino gay men/MSM, stigma tied to homosexuality, race, and gender nonconformity must be addressed.[11, 15, 18, 33]”

The recent advances made in HIV prevention, including the use of antiretroviral therapies as pre-exposure prophylaxis (PrEP) and treatment as prevention, will fail to put a significant dent in the epidemic affecting Black and Latino gay men/MSM without robust, multi-level interventions to reduce stigma across a variety of domains.

NASTAD and NCSD have partnered to engage in activities aimed at (a) understanding stigma within public health practice, (b) arming health departments and communities with the information and resources they need to effectively combat stigma, and (c) increasing comprehensive access to unfettered HIV and STD prevention and treatment services that respects gay men/MSM from diverse backgrounds.

As a part of these efforts, NASTAD and NCSD have advanced three key activities:

- » First, the organizations conducted a stigma survey to explore perceptions of institution-level stigma impacting Black and Latino gay men/MSM.
- » Second, two “Optimal Care Checklists” were developed with the goals of (1) providing Black and Latino gay men/MSM with comprehensive sexual health information and (2) educating health care providers on the unique sexual health needs of Black and Latino gay men/MSM.
- » Third, a stigma toolkit was developed in an effort to provide tools that health departments and communities across the U.S. can use to engage in stigma reduction efforts and improve health outcomes among Black and Latino gay men/MSM.

THE STIGMA SURVEY

The stigma survey was designed and implemented in an attempt to explore how community- and institution-level stigma within public health practice negatively affect HIV- and STD-related outcomes. The survey,

which was completed by more than 1,300 health department and community-based organization (CBO) staff, health providers, and community members representing 54 different U.S. states and territories, showed high levels of perceived community-level and institutional stigma targeting Black and Latino gay men/MSM (see Figure 1). Higher levels of gender-, HIV-, and sexuality-based stigma were reported compared to levels of race/ethnicity-based stigma. Also, perceptions of institutional stigma varied by geographic region and state, race/ethnicity, gender, sexual orientation, and occupation.

Subsequent analyses showed that state polices related to HIV criminalization, immigration, and LGBT rights were shown to be related to HIV incidence and prevalence, as well as state-level perceptions of community/institutional stigma. Findings showed that states with HIV criminalization policies had higher HIV incidence and prevalence than states without criminalization policies. Also, states with employee non-discrimination policies focused on sexual orientation and/or gender, those with a hate crimes law, and those allowing for same-sex marriage or civil unions showed lower average levels of stigma across several domains. NASTAD and NCSD have been disseminating findings from the stigma survey and using the data to provide technical assistance (TA) to health departments and CBOs.

OPTIMAL CARE CHECKLISTS

Two interrelated factors that help explain HIV and STD disparities affecting Black and Latino gay men/MSM are access to health care and institutionalized stigma in health care settings[20]. The stigma survey showed that Black/African-American and sexual minority participants expressed higher levels of race-, sexual orientation-, gender, and HIV status-based institutionalized stigma compared to White and heterosexual participants, respectively. With the implementation of the Affordable Care Act (ACA), the country has an unprecedented opportunity to ensure that populations that have previously lacked access to routine medical care, such as lower income and minority individuals, receive such care.

In order to capitalize on the opportunity the ACA will provide, we must make efforts to reduce stigma in health care settings and improve Black and Latino gay men's experiences receiving health care.

In response to the need to address stigma within health care settings and empower Black and Latino gay men/MSM with the knowledge they need to have about sexual health, NASTAD and NCSD developed patient and provider "Optimal Care Checklists" (OCCs). The checklists are meant to be guides for Black and Latino gay men/MSM to use when seeking and engaging in health care and for providers who treat Black and Latino gay men/MSM.

The OCCs were developed via a series of activities, including:

- A review of research literature to identify barriers to sexual health care among gay men/MSM.
- One-on-one consultations with providers who treat patients who are Black and Latino and/or gay men/MSM.
- A national Blue Ribbon Panel of clinicians and sexual health experts to discuss best practices and provider needs.

The patient-focused OCC informs Black and Latino gay men/MSM about how to choose a doctor and effectively communicate needs, provides information on sexual health and HIV/STD prevention, symptoms, and treatment, and includes information on hepatitis A and B vaccinations and PrEP. The provider-focused OCC educates health care providers on the role of stigma in contributing to poor health outcomes among gay men/MSM, explains the need for providing patient-centered care, taking a detailed sexual history, and conducting MSM-specific health screenings. Together, the OCCs are resources for patients and providers, and the health departments that support them.

THE STIGMA TOOLKIT

The stigma survey and OCCs represent NASTAD's and NCSD's attempts to describe stigma targeting Black and Latino gay men/MSM as it influences public health practice, and to reduce the impact of stigma on the provision and uptake of clinical care. These activities are only the start of robust and progressive steps that must be taken to reduce stigma and mitigate its effects on HIV and STD vulnerability among Black and Latino gay men/MSM.

Stigma-focused interventions must be implemented by health departments and the communities that they serve in order to improve health outcomes and reduce disparities. This Stigma Toolkit represents a primer that health departments, communities, and advocacy organizations can use to develop and implement novel approaches to addressing stigma and its impacts on prevention efforts targeting Black and Latino gay men/MSM. It is designed to stimulate conversations about approaches to reduce stigma in public health practice. It also describes innovations in community-level, institutional, and structural interventions to reduce stigma. These efforts will enhance opportunities to reduce disparities in HIV and STD diagnoses affecting Black and Latino gay men/MSM, and realize the goals of the NHAS and HIP.

WHY BLACK AND LATINO GAY MEN/MSM?

Black and Latino men's increased vulnerability to HIV is exemplified by national epidemiological data. The CDC indicates that in 2009, men accounted for the majority

(77%) of new HIV diagnoses in the United States. Within this group, Black and Latino men were disproportionately impacted[28]. That same year, HIV incidence among Black and Latino men was six and a half and two and a half times greater, respectively, than it was among White men.

In some U.S. cities, HIV prevalence among men of color rivals prevalence in countries with generalized HIV epidemics[10]. Likewise, Black and Latino men account for a disproportionate number of STD diagnoses in the U.S.[22]. Notably, throughout the last decade there have been outbreaks of syphilis and gonorrhea[7, 29, 31], two STDs that enhance the transmission of HIV and fuel the epidemic.

The continuing HIV crisis among Black and Latino MSM suggests that public health interventions are greatly needed in order to control the epidemic in these groups. However, there are very few HIV prevention interventions tailored to the unique needs of Black and Latino MSM. For example, of the 74 interventions currently included in the CDC's Compendium of Evidence-Based HIV Behavioral Interventions, the primary source of HIV/AIDS interventions used by community-based organizations (CBOs), only one was specifically developed for Black MSM (i.e., Many Men, Many Voices) while two have been adapted for use with Black and/or Latino MSM (i.e., MPowerment, Popular Opinion Leader (POL)).

Though other interventions targeting Black and Latino MSM, such as *dUp!*, *Hermanos de Luna y Sol*, and *SOMOS*, are being disseminated, there are still too few programs that are culturally sensitive to the unique prevention and treatment needs of Black and Latino MSM. Moreover, existing interventions do not focus on the many barriers at the community, institutional, and structural levels that increase risk in this population[9, 33].

This oversight must be addressed in order to reduce disparities[22]. The critical factor that influences and perpetuates barriers at each level is stigma.

DEFINING AND CONCEPTUALIZING STIGMA

Stigma encompasses a wide-ranging and complex assortment of attitudes and behaviors. It refers to personal experiences, interactions and stereotyping experiences among marginalized and non-marginalized groups, and broader social and cultural factors including power relations, community values, and historical practices[31].

There have been several different and useful conceptualizations of stigma put forth over the last several decades. Erving Goffman[13], one of the pioneers of stigma research and theory, noted that:

> “[Stigma is] an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one.”

Thus, stigma is understood as devaluing a person or group of people based on the way society views a particular attribute or characteristic. Individuals who are stigmatized have higher levels of stress due to both the anticipation of negative treatment by non-marginalized/non-stigmatized individuals, and the internalization of stigma. This stress has direct and indirect impacts on the health of stigmatized individuals.
Recently, stigma has been increasingly acknowledged as a critical process for maintaining systems of power and dominant societal norms. As Parker & Aggleton[25] note:

> “Stigma plays a key role in producing and reproducing relations of power and control. It causes some groups to be devalued and others to feel that they are superior in some way. Ultimately, therefore, stigma is linked to the workings of social inequality and to properly understand issues of stigmatization and discrimination, whether in relation to HIV and AIDS or any other issue, requires us to think more broadly about how some individuals and groups come to be socially excluded, and about the forces that create and reinforce social exclusion in different settings.”

Previous understandings of stigma were limited to thinking of stigma in terms of individual-level and inter-group processes. The recent shift takes a more systemic approach that incorporates social, economic, political and cultural forces tied to power and privilege. Thus, while our focus on the prejudicial beliefs, stereotypes, and discriminatory actions of individuals and groups is important when examining stigma and its effects on health, we must also describe and intervene upon systems of power and social processes that aim to legitimize and reinforce social hierarchies and inequities. These inequities are a driving factor in explaining HIV and STD disparities affecting Black and Latino gay men/MSM.

Camara Jones[17], a well-known family physician and epidemiologist whose work has aimed to describe the effects of racism on health, has a frequently referred to metaphor that helps to explain the complex process by which stigma becomes institutionalized and a part of dominant social forces. The work, which uses the story of a gardener that finds differential outcomes in flowers planted in two different flower boxes, helps to simplify the explanation of a complex process.

Upon moving into a new house, the gardener finds two flower boxes, one empty and one with existing soil. She adds new soil to the empty flower box, adding seeds for red flowers, her favorite. She uses the existing soil to plants seeds for pink flowers, which she does not like as much. The gardener notices that the red flowers quickly sprout and flourish, while the pink flowers were slow to sprout and did not appear to be strong.

As seasons pass, the flowers in the boxes repeatedly go to seed, dropping their progeny into the soil in which they are planted. Over time, the gardener sees the red flowers thrive while the pink ones struggle; she sees this as an endorsement of her preference for red flowers. The red flowers simply do better than pink ones and thus should be preferred. Others may see the flowers and the differences in how they grow over time and come to the same conclusion.

This story highlights how stigma perpetuates from inequality – in this case, fertile soil for the red flowers and poor soil for the pink flowers. This feature is easy to overlook, particularly as you see the different flowers develop over time. The difference in how well the flowers thrive is mistakenly attributed to innate characteristics of the flowers, instead of the different soils in which they are planted, which do not offer the same opportunities for growth, though they may appear to look the same. In this way, the differential outcomes of the flowers serve to support the gardener's preference for red flowers, just as pervasive stigma related to race, sexual orientation, gender, and HIV status serves to support societal beliefs and practices that keep non-marginalized groups dominant to those who are marginalized.

Figure 2. Bronfenbrenner's (1995) Ecological Model

STIGMA AND THE ECOLOGICAL FRAMEWORK

The dominant frameworks used to explore stigma highlight the importance of conceptualizing stigma as a phenomenon that exists and is practiced at multiple levels, including individual, group, and institutional levels. Examining stigma through an ecological framework may facilitate understanding the social forces that perpetuate stigma and targets for intervention.

The ecological model, developed by Uri Bronfenbrenner[3, 4, 5] is a frequently used method to examine the varying degrees of social influence in human development. As Figure 2 shows, human development is influenced by overlapping and concentric social factors at various levels. These levels include parents and peers (i.e., microsystem influences), neighborhoods and mass media (i.e., exosystem influences), and laws, culture and history (i.e., macrosystem influences). At each of these levels, and across time periods, stigma may exist and be enacted in such a way to exacerbate race/ethnicity-, gender-, sexual orientation-, and class-based disparities in HIV and STDs.

The ecological model exemplifies the way that stigma can take many forms and can be understood as layered—or stemming from a multitude of sources and attached to different personal characteristics and/or behaviors—within the lives of gay men/MSM. It is affected by powerful historical, political, and cultural factors in the U.S.

In order to effectively reduce stigma targeted toward Black and Latino gay men/MSM, and improve sexual health outcomes in this population, we must develop interventions and approaches to reduce stigma as it exists within multiple levels of influence.

TYPES OF STIGMA IMPACTING BLACK AND LATINO GAY MEN/MSM

Community- and institutional-level stigma has a profound impact on the health of Black and Latino gay men/MSM. In this toolkit, we focus on four interrelated types of stigma:

1. Stigma related to HIV/AIDS (i.e., community-level and/or institutional attitudes or practices that devalue or discriminate against people living with or affected by HIV)
2. Stigma related to same-sex sexuality/homophobia (i.e., community-level and/or institutional attitudes or practices that devalue or discriminate against people who engage in same-sex sexual behavior)
3. Stigma tied to gender performance/femininity (i.e., community-level and/or institutional attitudes or practices that devalue or discriminate against effeminate men, transgender women, and other gender queer individuals)
4. Race/ethnicity-related stigma/racism (i.e., community-level and/or institutional attitudes or practices that devalue or oddslot discriminate against persons from minority racial, ethnic, and immigrant groups).

These types of stigma affect Black and Latino gay men/MSM via multiple spheres, including individual (i.e., through internalization of stigma), group/community (i.e., through experiences of prejudice and discrimination), and institutional (i.e., through exclusionary policies and programs, systematic discrimination, and norms that perpetuate social hierarchies). The impacts of these types of stigma may vary from level to level, and over the life course.

In the stigma toolkit, we aim to provide information and recommendations for health departments and communities that are comprehensive and account for the complexities of stigma in its varied forms. As noted in the introduction, solving the problem of stigma and its effects on HIV and STDs is one of the most difficult challenges of the century. While no one document can solve this problem, we endeavor to use it to facilitate stigma-reduction actions at multiple levels and within various contexts in order to achieve the structural changes necessary to reduce the impact of HIV and STDs on Black and Latino gay men/MSM.

THINGS TO CONSIDER
WHEN IMPLEMENTING THESE RECOMMENDATIONS

CONSIDERATION

Have you engaged both internal and external partners who might assist in implementing these recommendations? If so who?

Has your AIDS/STD Director/supervisor signed off?

IMPLEMENTATION

Do you have a plan for diffusing these recommendations among staff?

Have you considered concrete ways to gauge whether these recommendations are decreasing stigma for your health department?

FOLLOW-UP

Do you have a 6-month and annual benchmark to assess effectiveness of the recommendations?

List three possible evaluation benchmarks.

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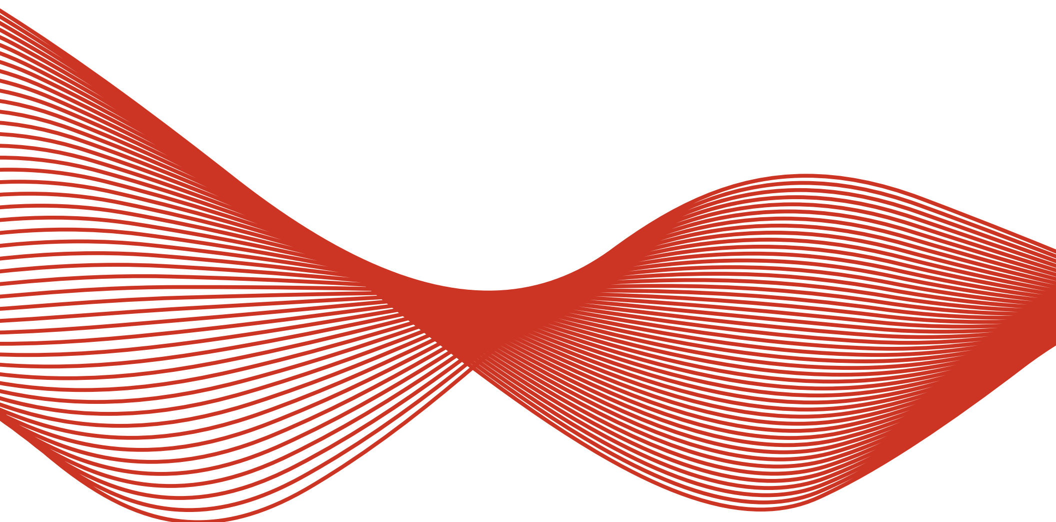

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NASTAD represents the nation's chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis health care, prevention, education and support service programs funded by state and federal governments. As the only national organization with a constituency that provides frontline STD programs and services, NCSD works toward the development of systemic change and promotion of national awareness in the policies that govern STDs.

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BACKGROUND

After more than three decades of the HIV epidemic, there is little evidence that HIV prevention efforts have been effective in decreasing rates of HIV infection among Black and Latino gay men and other men who have sex with men (MSM) in the U.S. Indeed, seroprevalence data show that, since 2006, HIV incidence has increased among Black and Latino gay men/MSM, notably those aged 13 to 24 years[28]. Investments in tools that can be used to prevent HIV transmission and acquisition across populations, such as condom dissemination programs, behavioral interventions, post-exposure prophylaxis (PEP), and pre-exposure prophylaxis (PrEP), have not paid off for Black and Latino gay men/MSM.

The goal of this component is to provide summaries of how stigma impedes the implementation of prevention programs, and, most importantly, offer recommendations and action steps for addressing stigma in HIV prevention programs implemented by health departments and their community partners.

1. BEHAVIORAL INTERVENTIONS

Since the beginning of the HIV epidemic, behavioral interventions have been a critical component of the public health response to reducing HIV incidence and prevalence. Behavioral interventions have targeted a variety of HIV-related health behaviors, including promoting condom use and promoting social norms around safer sex, among others.

Public health practitioners and researchers have noted the dearth of culturally-tailored behavioral interventions for Black and Latino gay men/MSM. For example, a recently conducted review of behavioral interventions for Black MSM identified only eight studies conducted to test the efficacy of interventions for Black MSM21. The limited number of behavioral interventions targeting Black and Latino gay men/MSM has direct implications on the level of exposure these men have to appropriate interventions that can otherwise improve health outcomes.

Institutional and community-level stigma have impeded the development of potentially effective, culturally-tailored HIV testing and prevention interventions for Black and Latino gay men/MSM. Institutional stigma contributes to the lack of practitioners and researchers with the knowledge needed to develop behavioral interventions, and limits public health's focus on the rapid development, testing, and dissemination of behavioral interventions designed for diverse groups of Black and Latino gay men/MSM.

2. PEP & PREP

For years medical personnel and those with accidental exposures to HIV have used post-exposure prophylaxis (PEP) as a resource to prevent HIV infection. With data showing its efficacy in preventing infection after accidental exposure, PEP has been offered to those with non-occupational exposures since just before 2000. It is now available from private providers, emergency rooms, and HIV/sexual health clinics to all who need it. Pre-exposure prophylaxis (PrEP), or use of antiretroviral drugs (currently, Truvada) prior to exposure to HIV in order to prevent infection, came to the forefront as a prevention strategy for gay men after the iPrEX trial demonstrated a 44% reduction in the incidence of HIV among gay men who used PrEP8. Demonstration trials (i.e., HPTN 073, Project PrEPARE) are currently underway to explore the feasibility and acceptability of using PrEP to prevent HIV among HIV-negative Black gay men/MSM.

While feasibility and acceptability data are still pending, insights from community-based organizations and clinics let us know that PEP and PrEP appear to have had limited uptake by Black and Latino gay men/MSM, two at-risk populations that could greatly benefit from it. Just as in the development of behavioral interventions, community-level stigma targeting Black and Latino gay men/MSM impedes the implementation of potentially effective PEP and PrEP programs. Likewise, stigma exacerbates disparities in accessing health care, and, given that PEP and PrEP tend to be administered in health care settings, limits access to these HIV prevention interventions.

3. HOME HIV TESTING

Another important HIV prevention tool that has not been explored for feasibility and acceptability, but is available for use by the public is home HIV testing. In 2012, the Food and Drug Administration (FDA) approved use of an over-the-counter HIV test designed by OraSure. The home HIV test is marketed as a way to reach those who will not get an HIV test, and help to reduce the relatively large number of people in the U.S. who are unaware of their HIV status, potentially due to stigma around HIV testing. Moreover, while many individuals seek treatment once learning of their HIV status, Black and Latino gay men/MSM may avoid or delay treatment due to stigma related to being HIV-positive. Thus, it seems clear that for home HIV testing to be truly effective in preventing new HIV infections, stigma associated with being HIV-positive must be explored and addressed.

RECOMMENDED STEPS
FOR REMOVING *STIGMA* FROM PUBLIC HEALTH PRACTICE

In order to enhance the potential for behavioral interventions, PEP and PrEP, and home HIV testing to successfully address and reduce HIV risk among Black and Latino gay men/MSM, there are several steps that can be taken:

ROUTINIZE HIV AND OTHER STD TESTING (IN PUBLIC AND PRIVATE SETTINGS).

Testing is central to prevention-focused behavioral interventions and is usually a marker to decide whether PEP/PrEP is an option based on an individual circumstance.

- Health departments and providers should increase public education for home testing.
- In conjunction with the National HIV/AIDS Strategy (NHAS) imperative to reduce stigma, stakeholders (e.g., CDC and health departments and communities) should consider the efficacy of approaches and/or messages to remove stigma not just from initial testing events, but from life-long repeat testing.
- The public health community should encourage regular testing for Black and Latino gay men/MSM (every 3-6 months, if necessary), based on risk.

ASSESS CURRENT INDICATORS AND INTEGRATE TESTING.

We should not let imperfect data stop us from determining whether our efforts are impacting progress. In addition, any increase in testing must be accompanied by home-grown community-level stigma reduction efforts that empower Black and Latino gay men/MSM to routinize testing.

Federal agencies, health departments, community based organizations and private physicians should analyze key testing indicators among Black and Latino gay men/MSM. For example, how many new Black and Latino gay men/MSM need to be tested in order to identify new cases that can be linked into care? What are the best ways to integrate HIV/STD testing into non-medical settings? These are just a few of the questions that need to be addressed with regard to accelerating goals of the NHAS.

INCREASE LEARNING AND SKILL-BUILDING OPPORTUNITIES TO ENSURE BLACK AND LATINO GAY MEN/MSM RECEIVE OPTIMAL CARE.

As HIV prevention interventions, including behavior change programs and adherence interventions, become more routinely implemented in medical settings and/or medical care homes, it is important that those working within these settings are well-equipped to deliver HIV prevention services to Black and Latino gay men/MSM.

- Talk to the men that you are serving and ask them what they need and how you can assist them in meeting shared goals.
- Robust, comprehensive sexuality and health curricula need to be integrated into medical student/provider training programs.
- The implementation of these curricula need to be mandated as a part of medical training, and specific attention should be paid to those disproportionately affected by negative sexual health outcomes, namely Black and Latino gay men/MSM.

CREATE AN ENVIRONMENT OF ACCEPTANCE.

Healthcare providers need to obtain continuing education in delivering culturally appropriate interventions and understanding the concept of "cultural humility."

Cultural humility is a concept that builds upon the idea of cultural competency. Cultural humility suggests that, in order to be effective in delivering care, providers need to possess a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations. Cultural humility is an important characteristic that all health care providers, health educators and counselors, and patient navigators that work with Black and Latino gay men/MSM should possess.

FOCUS STIGMA-REDUCTION EFFORTS AND BEHAVIORAL INTERVENTIONS TO INTERRUPT HIV/STD ACQUISITION.

Addressing stigma that impedes prevention can have a profound impact on the HIV care continuum, which must be addressed to see reductions in new infections.

As we determine how to allocate resources and the best ways to address the epidemic among Black and Latino gay men/MSM, prevention should be at the forefront of our minds.

BACKGROUND

Screening for HIV and STDs (that can facilitate the transmission of HIV and exacerbate poor health outcomes) is a hallmark of HIV prevention. Without access to testing for the diagnosis of HIV and other STDs, prevention and treatment programs cannot work effectively. Community-level and institutional stigma can keep Black and Latino gay men/MSM from getting tested for HIV, and from asking medical providers about additional tests to diagnose STDs for which they may be at risk (e.g., syphilis, gonorrhea, and HPV/anal cancer).

Placing STD testing and HIV testing into separate silos within the national and local public health systems may enhance stigma that Black and Latino gay men/MSM experience around HIV testing by encouraging them to believe that HIV is different from other STDs, or that other STDs are unimportant (or at least not as important relative to HIV) for their health. Given what we know about the interplay between HIV and STDs in promoting poor HIV-related health outcomes, it is essential to remove these separated screenings from their current siloes and couple them as one combined sexual health promotion intervention.

This component of the blueprint focuses on routine HIV and STD screening in clinic and community settings. Our goal is to provide a summary of the ways stigma impedes the implementation and uptake of HIV and STD screening, and, most importantly, offer recommendations and action steps for addressing stigma in HIV and STD screening activities implemented by health departments and their community partners.

HIV AND STD SCREENING

HIV and STD screening are critical activities in the fight against HIV. While HIV testing and diagnosis aligns squarely with the HIV treatment continuum, the role of screening in the HIV care continuum is less clear (in that it is not explicitly mentioned). For Black and Latino gay men/MSM, STD screening is perhaps just as profound for the continuum as HIV testing. This is because these men are far more likely to have an STD compared to the general population[22]. Since 2002, there have been outbreaks of syphilis and gonorrhea that have been documented among gay men/MSM throughout the country[7, 29, 32]. These two STDs have a particular impact on HIV, as they facilitate both the acquisition of HIV (by those who are HIV-negative), and the transmission of HIV (by those who are HIV-positive) to uninfected others. Moreover, STDs such as syphilis and gonorrhea also increase viral shedding and impede the effectiveness of antiretroviral treatments, making viral suppression – the critical "endpoint" of the treatment continuum – much more difficult.

Syphilis and gonorrhea are only two of several STDs that disproportionately affect Black and Latino gay men/MSM. The CDC recommends that gay men/MSM who are sexually active be tested for the following STDs on an annual basis: HIV (at least annually), syphilis, hepatitis B and C, chlamydia and gonorrhea of the rectum, chlamydia and gonorrhea of the penis (urethra), and gonorrhea of the throat.

Tests for some of these STDs can be invasive (e.g., involving anal or urethra swabs), and require both providers to be comfortable asking and hearing about sensitive sexual health information, and patients to be comfortable requesting STD testing and disclosing behaviors which are often stigmatized (e.g., engaging in receptive oral and/or anal intercourse). Research suggests that neither behavior from providers or Black and Latino gay/MSM patients occurs as regularly as needed.

For example, one study of 197 sexually active Black MSM in Massachusetts found that 33% had not tested for HIV in the last two years, and 60% had not tested for STDs in the same timeframe[24]. Community-level and institutional stigmas are at play in reducing patient-provider discussion surrounding sexual health. Without addressing the underlying issues that keep providers from having frank discussions with their gay/MSM patients and that keep Black and Latino gay men/MSM from accessing health care and disclosing sexual behaviors, improved outcomes as they relate to the treatment continuum will not improve for this population.

The **CDC recommends** that gay men/MSM who are sexually active be tested for the following STDs on an annual basis:

- HIV (at least annually)
- syphilis
- hepatitis B and C
- chlamydia and gonorrhea of the rectum
- chlamydia and gonorrhea of the penis (urethra)
- gonorrhea of the throat

RECOMMENDED STEPS
FOR REMOVING *STIGMA* FROM PUBLIC HEALTH PRACTICE

In order to harness the great potential for HIV and STD screening to reduce HIV incidence among Black and Latino gay men/MSM, there are several steps that can be taken:

- [ ] **IMPLEMENT STRATEGIES TO INTEGRATE HIV TESTING AND STD SCREENING.**

When Black and Latino gay men/MSM are offered HIV testing, they should also be offered an STD screen.

Integrating HIV and STD testing will require actions on the parts of state and local health departments, as well as within public and private health clinics and medical practices. While bureaucracies and policies must be considered in this process, coupling HIV and STD testing is critically important in terms of improving outcomes across the HIV treatment continuum, but also for de-stigmatizing and normalizing HIV and STD screening behaviors.

- [ ] **OFFER SEXUAL HEALTH VACCINATIONS FOR BLACK AND LATINO GAY MEN/MSM.**

Vaccinations such as HPV and hepatitis A and B need to be targeted as pivotal areas for physicians and health providers, as well as Black and Latino gay/MSM patients, to address.

Health providers and clinicians should offer these potentially life-saving vaccinations to all of their gay/MSM patients. Health department policies and medical provider trainings can facilitate the exchange of information regarding why these vaccinations are critically important for Black and Latino gay men/MSM.

- [ ] **EXAMINE EFFORTS TO BREAKDOWN "HIV TESTING AND STD SCREENING" STIGMA.**

State and local health departments must engage in community-level stigma reduction efforts that specifically address Black and Latino gay men/MSM's negative perceptions of HIV and STD screening.

These efforts should focus on reducing the discomfort in having frank discussions about sexuality, behaviors that place one at risk for various STDs, and testing/treatment actions to take if a possible exposure occurs. Testing for HIV and other STDs needs to be considered as "routine" as any test for a chronic disease or condition (such as high blood pressure, diabetes, and cancer).

- [ ] **PHYSICIANS, NURSES AND KEY STAKEHOLDERS WORKING WITH BLACK AND LATINO GAY MEN/MSM, AND BLACK AND LATINO GAY MEN/MSM THEMSELVES, SHOULD SEEK THE KNOWLEDGE AND TOOLS TO EDUCATE THEMSELVES AROUND HIV AND STD PREVENTION.**

Stigma around HIV and sexuality serves as a barrier for Black and Latino gay men/MSM to equip themselves with knowledge about STDs and available treatments and feel empowered to have honest and open discussions with their health care providers about their sexual behaviors.

NASTAD and the National Coalition of STD Directors (NSCD) have developed Optimal Care Checklists (OCCs) for patients and providers that can facilitate these actions and reduce the stigma around testing for STDs and protecting one's sexual health. Multi-pronged, iterative approaches, including social marketing campaigns that demystify sexual health and promote "knowing your body" are paramount.

Addressing stigma that hinders routine HIV and STD screening can have a profound impact on the health outcomes of Black and Latino gay men/MSM. Focused, multi-level interventions aimed at reducing stigma around HIV and STD testing, and improving access to and utilization of STD screening (that includes HIV), can potentially improve treatment outcomes at many points across the HIV care continuum.

BACKGROUND

Two recent major advances in HIV research and intervention have highlighted the importance of linkages to and retention in care. First, in 2011, Dr. Edward Gardner and colleagues published work exploring the spectrum of engagement in HIV care in the U.S., ranging from HIV testing and diagnosis, to linkage and engagement in care, receipt of antiretroviral therapy, and, finally, achievement of viral suppression. In this work it was estimated that of all HIV-infected individuals in the U.S., only 19% were virally suppressed (i.e., had an undetectable HIV load)[12]. It should be noted that, because Gardner analyzed the estimated proportion of those virally suppressed out of all HIV infected individuals in the U.S. (including those unaware of their infection/not diagnosed as HIV-positive), his estimate is lower than the CDC's estimate of 25% virally suppressed. The CDC based their estimate off the number of HIV diagnosed individuals in the U.S.

Gardner's model has become the standard in terms of understanding the complexities and various meanings of "engagement in care." It has also highlighted the inadequacies of current approaches to linkages to and retention in care by highlighting the drastic drops in the number of individuals engaged in care.

A second key advance was a six-year, global research trial conducted by the HIV Prevention Trials Network (i.e., HPTN 052) that showed the effectiveness of consistent adherence to antiretroviral treatment (ART) in: (1) improving health outcomes among HIV-positive individuals, and (2) significantly reducing their ability to transmit the virus to uninfected partners[8]. The work highlights the importance of people living with HIV to be actively engaged in care, which is necessary for the continuous receipt of ART and monitoring its effects on viral load and other health outcomes.

This component of the blueprint focuses on linkages to and retention in care among Black and Latino gay men/MSM. The goal is to provide a summary of the ways stigma thwarts efforts to link and retain HIV-positive Black and Latino gay men/MSM, and, most importantly, offer recommendations and action steps for addressing stigma in linkage and retention activities implemented by health departments and their community partners.

LINKAGE TO AND RETENTION IN CARE

It is essential to improve linkages to and retention in care among HIV-positive Black and Latino gay men/MSM. In 2013, Dr. H. Irene Hall and colleagues published results from a comprehensive analysis looking at the HIV care continuum within specific demographic groups[14]. The analysis demonstrated that Blacks and Latinos are markedly less likely to be engaged in care across the spectrum. Racial and ethnic minorities who are HIV-positive are less likely to have ongoing care and be virally suppressed. Moreover, there have been several studies documenting HIV-positive Black and Latino gay men's reduced engagement in care compared to HIV-positive White gay men/MSM.

When comparing HIV-positive Black and Latino MSM to other HIV-positive MSM, it is clear that there are glaring differences in HIV care access. Black and Latino MSM are less likely to have access to health insurance, attend clinical visits to receive treatment, and have access to ART[19, 22]. Other work has shown similar disparities affecting HIV-positive Latino MSM, notably those who are under the age of 24.

Both institutional and community-level stigma strongly influence the existence and persistence of these disparities in linkage to and retention in care. Stigma related to HIV prevents Black and Latino gay men/MSM who are HIV-positive from disclosing their status to providers and accessing treatment facilities and resources that may be available to them. Fear of being seen at an HIV treatment/sexual health clinic prevents these men from setting up and consistently attending medical appointments to receive treatment. Many treatment facilities, including those catering to lower-income and racial/ethnic minority HIV-positive individuals, have ostracized Black and Latino gay men/MSM due in large part to institutional stigma and structural homophobia. These treatment facilities are often perceived to be unwelcoming toward racial/ethnic minority patients.

Similarly, HIV care providers are often unaware of the unique health and treatment needs of HIV-positive Black and Latino gay men/MSM, and are perceived as uncaring and not focused on treating the whole person. The lack of culturally appropriate care provided at health clinics and from providers exacerbates disparities in linkages to and retention in care. Thus, it is clear that in order to redress these disparities, structural and community-level interventions are needed to reduce stigma in public health practice.

> "Black and Latino MSM are less likely to have access to health insurance, attend clinical visits to receive treatment, and have access to ART.

RECOMMENDED STEPS
FOR REMOVING *STIGMA* FROM PUBLIC HEALTH PRACTICE

In order to improve engagement in care among Black and Latino gay men/MSM and improve linkage to care and retention in care, there are several steps that can be taken:

- [ ] **EXPAND ACCREDITED, CONTINUING EDUCATION OPPORTUNITIES FOR MEDICAL PROVIDERS SERVING BLACK AND LATINO GAY MEN/MSM.**

A critical action step is improving provider education and competence in providing culturally appropriate and holistic HIV care to Black and Latino gay men/MSM.

Currently, most medical providers do not receive consistent, continuing education training on the unique health concerns and issues affecting racial/ethnic minorities and lesbian, gay, bisexual and transgender (LGBT) persons. Medical schools and continuing education programs rarely include courses on LGBT and minority health. This oversight has meant that providers working with patients who are Black and Latino gay men have to learn about these populations on the job, if they learn about them at all. Greater efforts must be made to change the way healthcare providers are educated and to make training on racial/ethnic minority and LGBT health a mandatory component of medical education.

- [ ] **IMPROVE ACCESS TO MENTAL HEALTH SERVICES FOR BLACK AND LATINO GAY MEN/MSM TO INCREASE THEIR ABILITY TO STAY ENGAGED IN CARE OVER TIME.**

HIV testing and treatment clinics should integrate mental health counseling both at the time of diagnosis and in the months following, as newly diagnosed Black and Latino gay men/MSM are linked to care and begin to make decisions with their health providers about their course of treatment.

Similarly, mental health treatment should be accessible to HIV-positive Black and Latino gay men/MSM who are actively engaged in care and may need resources to stay engaged, especially as they are likely to experience high levels of stigma within their communities and have personal difficulties maintaining their treatment regimens.

- [ ] **INCREASE ACCESS TO SUBSTANCE USE TREATMENT FOR BLACK AND LATINO GAY MEN/MSM TO FACILITATE LINKAGES AND RETENTION IN CARE.**

Clinics that work with HIV-positive Black and Latino gay men/MSM must integrate substance use treatment services (along with mental health counseling, as previously noted) into HIV care.

- [ ] **CONSIDER WAYS TO IMPROVE THE EXPERIENCES THAT BLACK AND LATINO GAY MEN/MSM HAVE WHEN RECEIVING HIV TREATMENT.**

Healthcare providers should go beyond provider training to focusing on institutional settings.

From the clinic receptionist to the medical director, all staff at HIV and sexual health clinics must be mindful of the needs of Black and Latino gay men/MSM and respectful of these men's experiences and cultures. Including health care materials that feature gay men of color, hiring staff who are Black and Latino, and creating comfortable spaces in which men can speak with their providers are all strategies that can improve the healthcare experiences of HIV-positive Black and Latino gay men/MSM.

Addressing institutional and community-level stigma that intensifies the persistence of racial/ethnic group disparities in linkages to and retention in care is critical in order to see reductions in new HIV infections among Black and Latino gay men/MSM in the U.S. Structural interventions that seek to improve access to and utilization of culturally-appropriate HIV treatment services, enhance medical provider education and motivate Black and Latino gay men/MSM to stay engaged in HIV care can potentially increase treatment outcomes across the treatment cascade and reduce HIV incidence and AIDS mortality in this population.

BACKGROUND

Treatment adherence has become one of the most important topics in HIV prevention and treatment programming, clinical practice, and research. This is due to a landmark six-year, global research trial conducted by the HIV Prevention Trials Network. The trial, called HPTN 052, showed that early treatment and consistent adherence to antiretroviral treatment (ART) among HIV-positive individuals reduced transmission of HIV to uninfected sex partners by 96%[8]. This work, which the journal *Science* named its 2011 Breakthrough of the Year, gave rise to the current "Treatment as Prevention" era. HPTN 052 demonstrated the critical importance of treatment adherence in managing our current epidemic in the U.S. and promoting reduction in future incidence.

This final component focuses on treatment adherence among Black and Latino gay men/MSM. This part of the blueprint provides a summary of the ways stigma impedes treatment adherence among HIV-positive Black and Latino gay men/MSM, and, most importantly, offers recommendations and action steps that can be implemented by health departments and their community partners.

TREATMENT ADHERENCE

Treatment adherence—which involves consistent, as-scheduled, daily use of ART—is critically important to improving health outcomes and reducing new infections among Black and Latino gay men/MSM.

Adherence to ART leads to viral suppression and decreased morbidity and mortality in people living with HIV. However, research has shown that adherence is a challenge for most HIV-positive individuals, as ART medications need to be taken consistently and correctly (90-95% of prescribed doses) for adequate viral suppression to occur. Maintaining 95% adherence to prescribed doses equates to missing no more than three doses of a twice-daily HIV medication over the course of a 30-day period.

In one study, between 57% and 77% of HIV-positive individuals failed to meet the high standard of ART adherence[27, 30]. For HIV-positive Black and Latino gay men/MSM, rates of treatment adherence are much lower than they are for other groups. Of note, research suggests that HIV-positive Black MSM are half as likely to be adherent to ART than White MSM.

Reasons for non-adherence include:

- Forgetting to take the medication.
- Changes in a daily routine.
- Feeling depressed or overwhelmed.
- Dealing with side effects[1].

Key barriers to treatment adherence among HIV-positive Black and Latino gay men/MSM include institutional and community-level stigma. Stigma that men experience within their families and social networks, neighborhoods, jobs, health care institutions, and other institutional settings (e.g., churches, prisons and detention facilities, etc.) could strongly influence treatment adherence disparities affecting Black and Latino gay men/MSM. Stigma around HIV and homosexuality creates contexts in which these men feel that they have to hide their medication and their use of it. This means they may have fewer, less reliably occurring, and consistent daily occasions to take medications, compared to other populations.

Unstable living situations, joblessness, incarceration experiences and other traumatic life experiences—each of which Black and Latino gay men/MSM experience at greater rates than other MSM—exacerbates struggles with daily adherence. Both community-level and institutional stigma are internalized among many Black and Latino gay men/MSM, and through direct and indirect ways influence men's desires to take ART and their abilities to consistently adhere to treatment. The stigma that Black and Latino gay men/MSM experience must be addressed in order to improve health outcomes.

> In one study, between **57% & 77%** of HIV-positive individuals failed to meet the high standard of ART adherence.

RECOMMENDED STEPS
FOR REMOVING *STIGMA* FROM PUBLIC HEALTH PRACTICE

In order to improve treatment adherence among Black and Latino gay men/MSM there are several steps that can be taken by health departments and the communities they serve:

DEVELOP EFFORTS TO REDUCE STIGMA AROUND HIV AND HOMOPHOBIA, IN BLACK AND LATINO COMMUNITIES ACROSS THE U.S.

Anti-stigma campaigns need to be developed, and those in existence need to be evaluated, and, if shown effective, taken to scale.

Additionally, greater alliances among public health departments, community-based organizations, and private sector companies need to be developed. These alliances can help to create norm changes within and across community and institutional settings. The CDC's Act Against AIDS Leadership Initiative, a partnership between CDC and leading national organizations representing the populations hardest hit by HIV, including Blacks, Latinos, and gay men/MSM, needs to be replicated on the state and local levels.

Similarly, efforts such as Kaiser Family Foundation's Speak Out initiative, which involves young gay men telling their own stories and experiences about HIV/AIDS, need to be leveraged. These alliances should make their missions, at least in part, to reduce stigma around HIV and homosexuality. Lastly, greater numbers of HIV-positive Black and Latino gay men/MSM need to be empowered to publicly disclose their HIV status. Attempts to normalize HIV, promote community perceptions of HIV as a manageable disease, and highlight the presence of HIV-positive Black and Latino gay men/MSM in all parts of the community, from churches to corporate offices, will aid in reducing stigma and negative perceptions around HIV.

DEVELOP TREATMENT REGIMENS THAT DO NOT REQUIRE DAILY USE AND/OR HAVE TREATMENTS THAT CAN BE DELIVERED LESS FREQUENTLY.

Because many Black and Latino gay men/MSM must conceal their HIV status and use of ART, and due to the lack of private spaces these men have to take ART, treatments that do not require frequent use may greatly enhance treatment adherence in this population.

Efforts to develop such regimens are currently underway. When the opportunity presents itself, health departments, researchers, and pharmaceutical companies should work together to promote the dissemination of these treatment regimens, and ensure uptake by patients. These regimens will provide greater options to HIV-positive Black and Latino gay men/MSM and, when implemented with robust efforts to improve access to care, will allow many of these men to experience greater levels of adherence.

PROMOTE KNOWLEDGE OF TREATMENT ADVANCES AND EMPOWER HIV-POSITIVE BLACK AND LATINO GAY MEN/MSM TO BE EDUCATED CONSUMERS OF HIV CARE.

Men need to be made aware of the different treatments available to them, their efficacy, toxicity level, and side effects, and the frequency with which they need to be used in order to be effective.

Tools such as pill boxes, cell phone reminders, and text messaging tools need to be provided in HIV treatment and sexual health clinics, as well as in primary care settings and emergency rooms in which Black and Latino gay men/MSM may access health care. Promoting greater access to these tools will allow men to have more resources that can increase the likelihood of them getting to the 90-95% adherence level that is necessary for most ART in order for viral suppression to occur.

PROMOTE MESSAGES ON THE AVAILABILITY OF PREP FOR HIV-NEGATIVE BLACK AND LATINO GAY MEN/MSM BUT ALSO THE NEED TO BE ADHERENT AMONG THOSE WHO USE IT AS AN HIV PREVENTION STRATEGY.

While our focus on treatment adherence has been targeted to HIV-positive Black and Latino gay men/MSM, it should be noted that adherence is important for at-risk HIV-negative men who may use Pre-Exposure Prophylaxis (PrEP).

While PrEP has shown promise as an HIV prevention tool, like ART, its efficacy is dependent on consistent use as prescribed.