Curriculum:
Providing Culturally Competent Care for Young African American MSM who are HIV Positive

Introduction

Welcome to the National Multicultural Center's curriculum on "Providing Culturally Competent Care for Young African American MSM who are HIV Positive," one of a series of curricula covering a wide range of topics concerning the provision of culturally competent HIV-related healthcare services to individuals belonging to diverse ethnic, racial, and cultural groups.

African Americans bear the heaviest share of the burden of the HIV epidemic among all US racial/ethnic groups. In 2009, African Americans represented 14% of the US population but comprised 44% of all new HIV infections. In addition, African Americans account for a higher proportion of HIV infections at all stages of disease—from new infections to deaths.

Within African American communities, men who have sex with men (MSM) continue to experience the greatest impact, and in 2009, they represented an estimated 73% of new infections among all African American men and 37% among all MSM. More new HIV infections occurred among young African American MSM (13 to 29 years of age) than among any other age and racial group of MSM, and new infections among young African American MSM increased by 48% from 2006 to 2009. These young men are particularly at risk for acquiring HIV infection, due to several factors, including:

- African American MSM are more likely than other MSM to have either current or previous sexually transmitted infections that can facilitate both the acquisition and the transmission of HIV infection.
- African American MSM are less likely than other MSM to be tested for HIV or to know their HIV status; therefore, those who are HIV-positive may unknowingly transmit HIV infection, as well as experience HIV disease progression themselves.

The contents of this curriculum will use the following definitions in discussing young African American MSM:

- MSM encompasses a wide range of men who express varying social identities concerning their sexual and/or relationship practices with other men.
- "African American" includes persons of African descent, including those who might have been born in Africa or the Caribbean, as well as those born in the United States.
- "Young" and "youth" encompasses adolescents and young adults 13 to 24 years of age.

This curriculum will offer data, other information, and resources designed to increase understanding of the above issues and to support approaches that optimize patient outcomes among practitioners who manage the care of young African American MSM who are HIV-positive. This entire subject is full of complex issues regarding these youths' risks for HIV transmission, access to care, and adherence to therapy. This curriculum cannot claim to be comprehensive, but the list of resources in Module 4 and the references in each module can provide a wealth of additional information.

The 5 modules in this curriculum are:

1. The HIV Epidemic Among African Americans
2. HIV Transmission and Treatment Risk Factors
3. Cultural Competence Challenges
4. Implementing Culturally Competent Care for Young African American MSM
5. Case Studies

Learning Objectives of the Overall Curriculum

- Describe the impact of the HIV epidemic among African American communities
- Discuss the impact of the HIV epidemic on young African American men who have sex with men (MSM)
- List the risk factors associated with disproportionately high HIV infection rates among young African American MSM
- Describe the challenges of providing HIV testing and access to and retention in care for young African American MSM
- Identify key elements of culturally competent HIV treatment and prevention approaches for young African American MSM

Module 1—HIV Epidemic Among African Americans

Learning Objective(s)

- Describe the impact of the HIV epidemic among African American communities
- Discuss the impact of the HIV epidemic on young African American men who have sex with men (MSM)

Pretraining Assessment

1. Which of the following most accurately describes the percentage of new HIV infections that are attributable to male-to-male sexual activity among African American males?

A. More than 70% of new infections are attributable to male-to-male sexual activity.

B. Approximately 50% of new infections are attributable to male-to-male sexual activity.

C. Fewer than 50% of new infections are attributable to male-to-male sexual activity

D. None of the above

2. Among African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010, which of the following statements is True?

A. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was comparable to the percentage of whites in that age group.

B. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was greater than the percentages of whites and Latinos in that age group combined.

C. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was comparable to that of Latinos in that age group.

D. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was significantly lower than that of other racial/ethnic groups.

Overview of HIV Epidemiology Among African Americans

Many people who are no more than casually familiar with the HIV epidemic in the United States are aware that a large percentage of African Americans are HIV-positive. However, the real extent of how disproportionately HIV has affected African American communities is less well known.

Today more persons who have been diagnosed with HIV infection or with an AIDS-defining condition or who have died of an HIV-related condition are African American than any other racial or ethnic group.[CDC Diagnoses, Prejean 2011, CDC Estimates, CDC Monitoring, CDC Deaths 2010] Of the estimated more than 1.1 million Americans living with HIV, approximately 510,000 are African American.[CDC Monitoring 2010] A 2008 analysis of national household survey data by McQuillan and colleagues reported found that 2% of African Americans were HIV positive vs 0.23% of whites; this is a higher proportion than that experienced by any other racial/ethnic group.[McQuillan 2008] A range of factors and circumstances also pose greater barriers to accessing HIV testing and linkages to care for African Americans.[Cunningham 2006, Giordano 2007, Beer 2009, Fleishman 2005]

Other key data regarding the HIV epidemic among African Americans include:

- Although the numbers of annual new HIV infections among African Americans peaked in the late 1980s, new infections have been higher than among whites since then and have remained stable in recent years.[Prejean 2011, Hall 2008]
- Throughout the epidemic, African Americans have constituted an increasing percentage of AIDS diagnoses—from 25% in 1985 to 48% in 2010.[CDC Diagnoses 2010]
- The number of African Americans diagnosed with AIDS increased by 8% between 2007 and 2009 vs 5% among whites. [CDC Diagnoses 2010]
- AIDS-related deaths among African Americans decreased by 3% between 2007 and 2009 vs a 4% increase among Latinos and a 5% increase among whites.[CDC Diagnoses 2010]

To place these and the following data in context, African Americans comprised 14% of the US population in 2009 but 44% of all new HIV infections in the same year [U.S. Census Bureau 2010]. Across the entire spectrum of HIV disease—from new infections to AIDS-related deaths—African Americans account for a higher proportion of the epidemic's impact.

New Infections in 2009

The most recently compiled and analyzed set of HIV epidemiologic data are from 2009 [CDC 2011].

- An estimated 70% of all new HIV infections among African Americans were in males. The rate of new infections among African American males was > 6.5 times higher than that among white males, and 2.5 times higher than that of Latino men or African American women.
- African American men who have sex with men (MSM) were estimated to comprise 73% of new infections among African American males and 37% among all MSM. More new HIV infections occurred among young (13 to 29 years of age) African American MSM than in any other MSM age and racial group, and reported new HIV infections among young African American MSM increased by 48% between 2006 and 2009.

Current Trends in HIV and AIDS Diagnoses and Deaths [CDC 2009]

- From 2006 to 2009, the estimated number and rate of HIV diagnoses among African Americans remained stable in the 40 states with long-term confidential name-based HIV reporting.

- At some point in their lifetimes, an estimated 1 in 16 African American men and 1 in 32 African American women will be diagnosed with HIV infection.
- In 2009, an estimated 16,741 African Americans received a diagnosis of AIDS; that number has continue to slowly decline since 2006.
- Through 2008, an estimated 240,627 African Americans with an AIDS diagnosis had died.

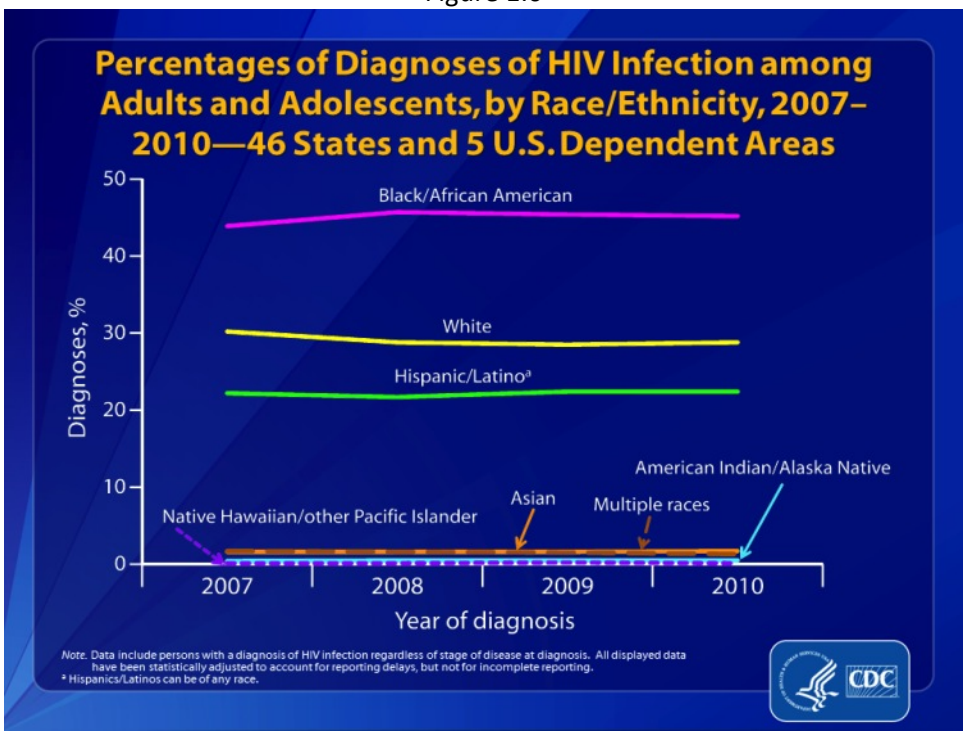
In 2007, HIV was the ninth-leading cause of death among African Americans and the third-leading cause of death for African Americans 35 to 44 years of age.

Visual Impact of the HIV Epidemic Among African Americans

In the graphs that follow, the data include anyone who has received a diagnosis of HIV infection, regardless of the stage of disease at diagnosis.

Although the demographics of the HIV epidemic have evolved considerably since the first cases were reported in the early 1980s, the graph below clearly illustrates the epidemic's disproportionate impact among African Americans in more recent years. (The data are from the 46 US states and 5 dependent areas that have long-term, confidential name-based reporting of HIV infections.) In 2010, 45% of diagnoses were among African Americans, vs 29% among whites and 22% among Latinos (the 3 largest components of the overall US population).

Figure 1.0

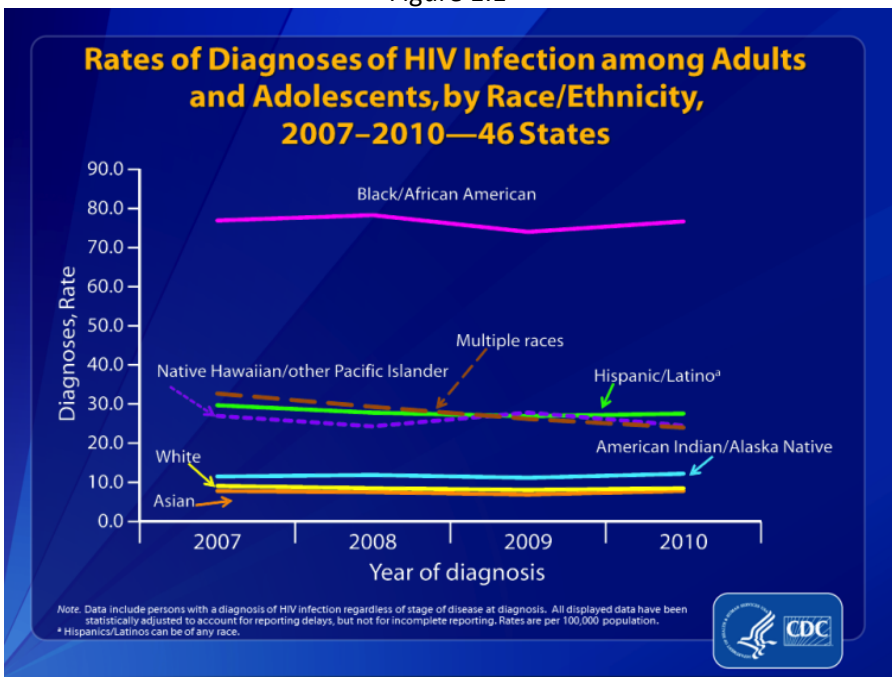


Source: CDC 2010

Rates per 100,000 Population

Figure 1.1 shows another important way to consider the impact of HIV on African American communities—the number of HIV infections per 100,000 population of diverse racial/ethnic groups. Although the rates decreased among Latinos and whites during the 2007 to 2010 period, they remained stable among African Americans.

Figure 1.1

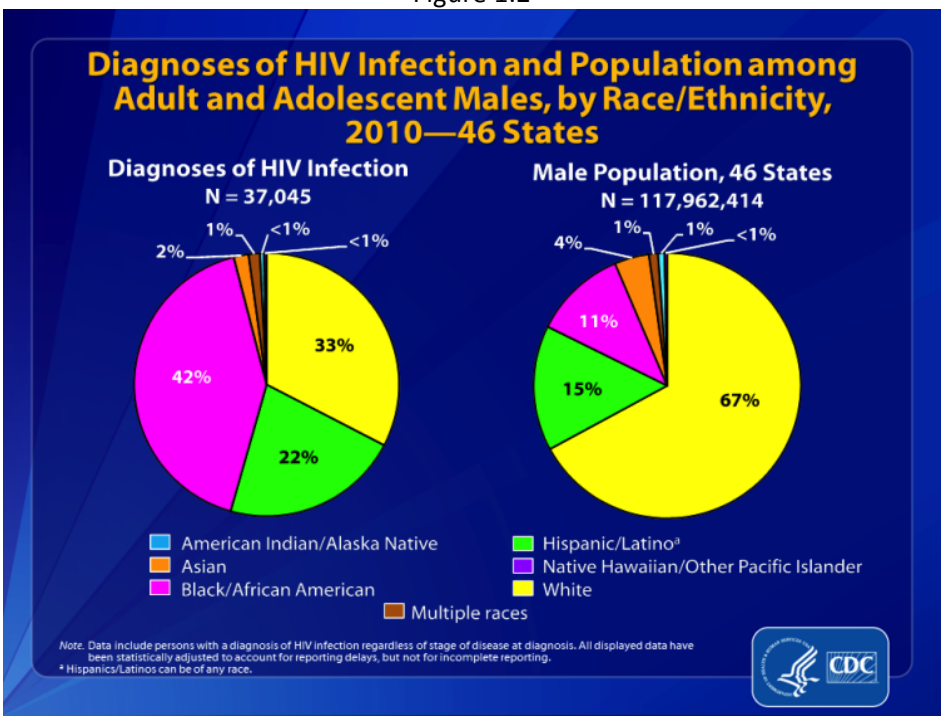


Source: CDC 2010

Rates Among All Men and Across Modes of Transmission

In 2010, African American males experienced HIV infection rates that were nearly 4 times greater than their proportion of the US male population (42% vs 11%, respectively).

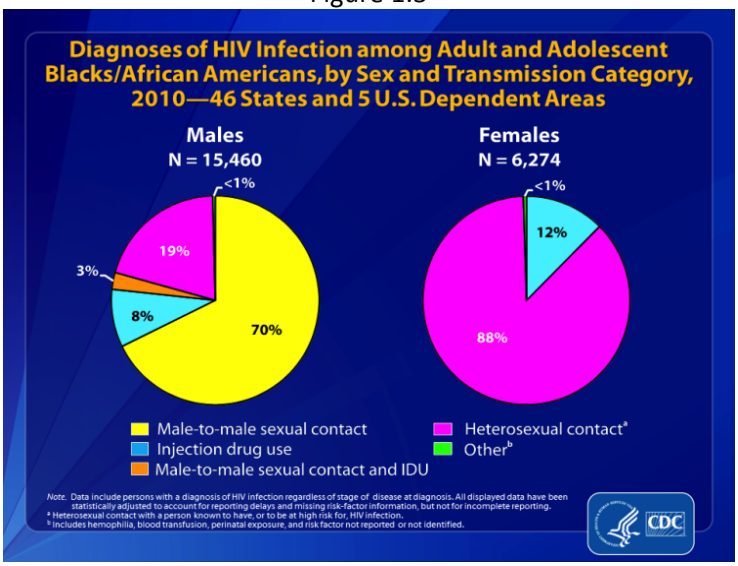
Figure 1.2



Source: CDC 2011

Figure 1.3 illustrates, the vast majority (70%) of HIV infections among African American males in 2010 resulted from male-to-male sexual activity. An additional 3% of cases were due to male-to-male sexual activity plus injection drug use (IDU). Data such as these further underline the great need to develop and expand efforts to identify cases of HIV infection among African American MSM and to link them to care as quickly as possible.

Figure 1.3

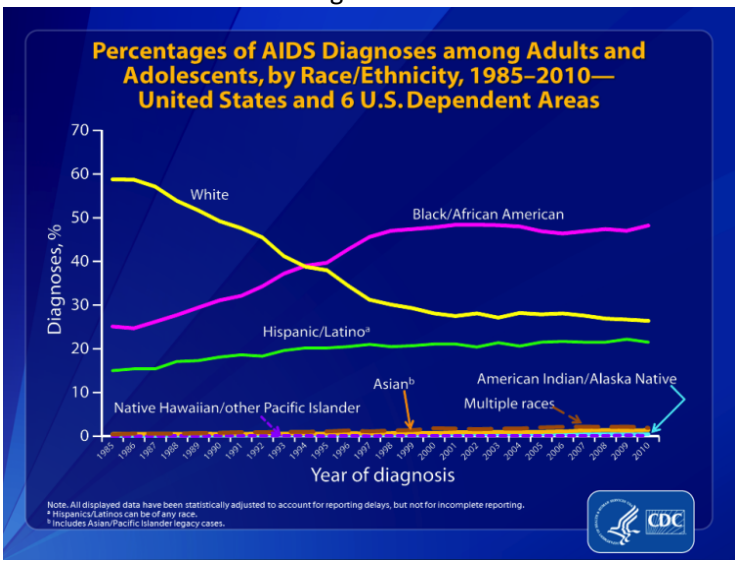


Source: CDC 2011

HIV's Evolving Racial Profile

Figure 1.4 dramatically illustrates the change in the racial/ethnic profile of individuals who have been diagnosed with an AIDS-defining condition since the earliest years of the epidemic, when a substantial majority of AIDS cases were among whites. In 1994, however, the percentage of AIDS diagnoses among adult and adolescent African Americans exceeded that of whites for the first time, and that disproportion has continued to grow since then. In 2010, an estimated 48% of new AIDS diagnoses were among African Americans, vs 26% among whites and 22% among Latinos.

Figure 1.4



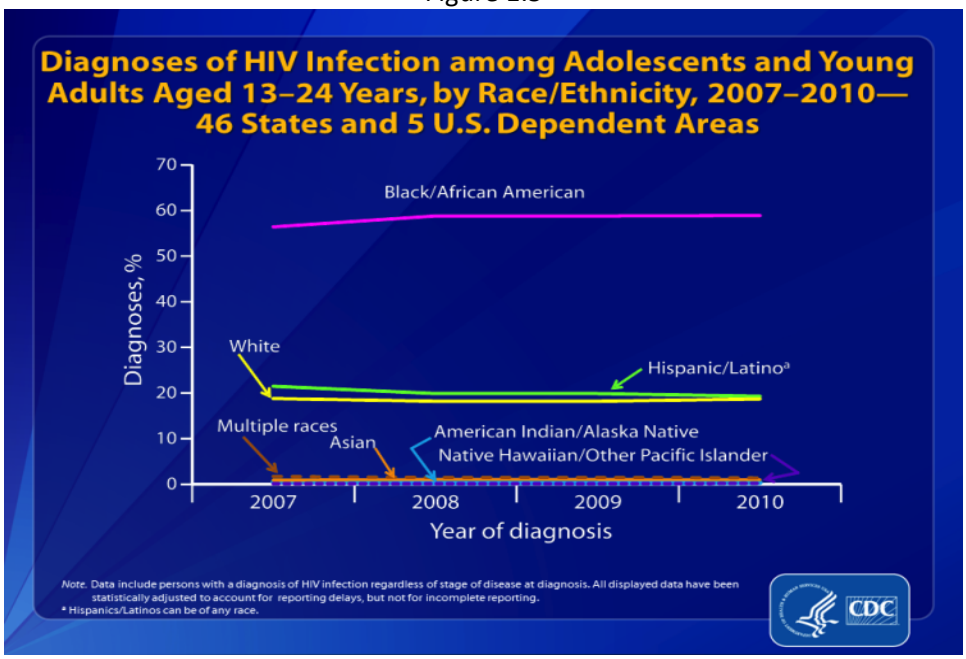
Source: CDC 2011

HIV's Impact on US Adolescents and Young Adults

The following 5 figures —which illustrate the demographics of the HIV epidemic among young people (ie, those 13 to 24 years of age) in the United States—clearly demonstrate the extent of the epidemic's impact on young African Americans, particularly among adolescent and young adult African American MSM.

In this age group, from 2007 through 2010, African Americans comprised > 55% of cases in the 46 states and 5 dependent areas that have had confidential name-based HIV reporting since at least January 2007, but in 2010 alone, 59% were African American, vs 19% white and 19% Latino. This racial/ethnic distribution is significantly different from the distribution in 2010 of HIV diagnoses among all adults and adolescents (ie, anyone 13 years and older)—45% African American, vs 29% white and 22% Latino.

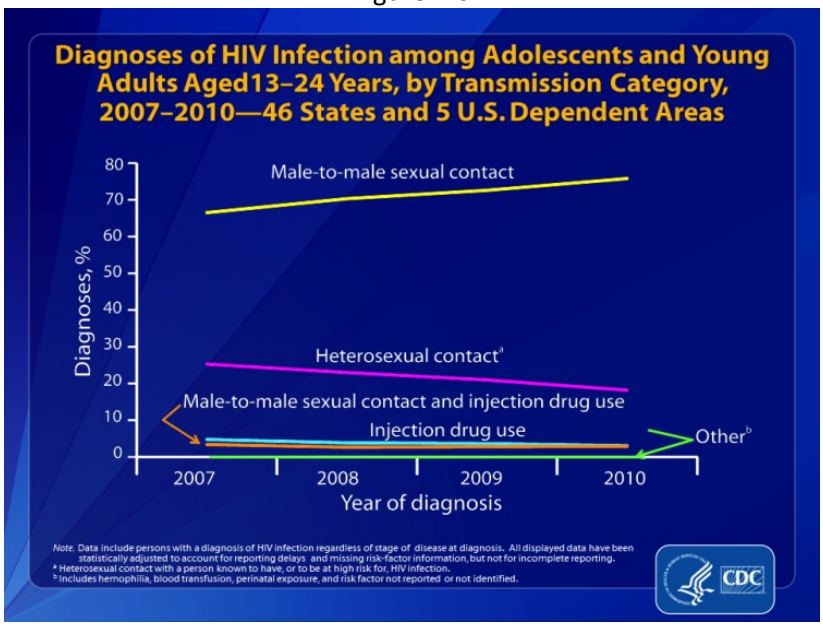
Figure 1.5



Source: CDC 2011

The estimated percentage of HIV infections attributed to male-to-male sexual activity increased from 67% in 2007 to 76% in 2010 among adolescents and young adults, whereas the percentage attributed to male-to-male sexual activity plus injection drug use remained relatively stable during that time.

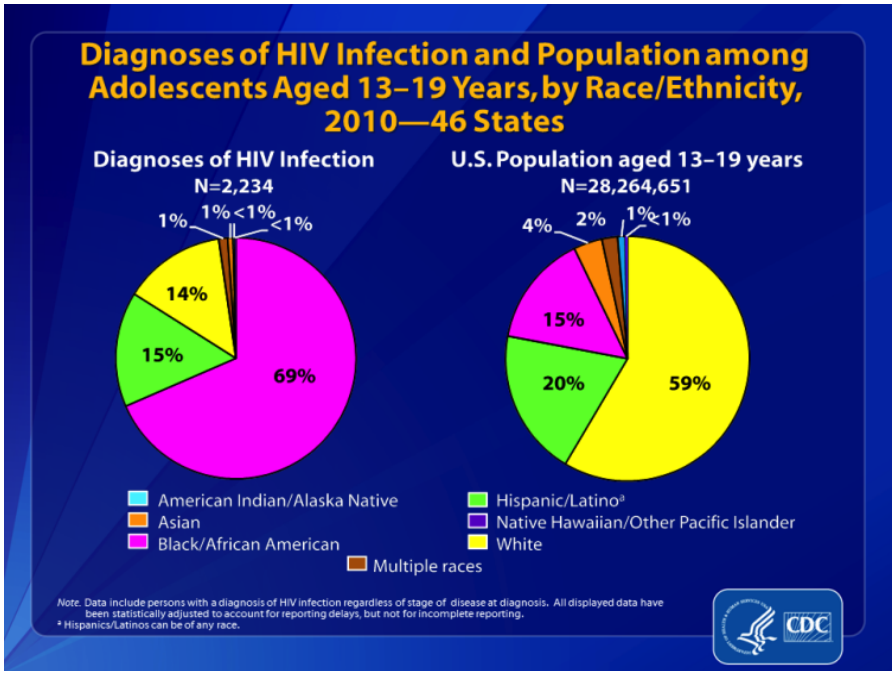
Figure 1.6



Source: CDC 2011

Different impacts between adolescents and young adults. The next 2 figures show how extraordinarily disproportionate the impact of the HIV epidemic has been among African American adolescents and young adults. In 2010, an estimated 69% of HIV diagnoses among 13 to 19 year olds were in African American adolescents, although only 15% of US adolescents were African American.

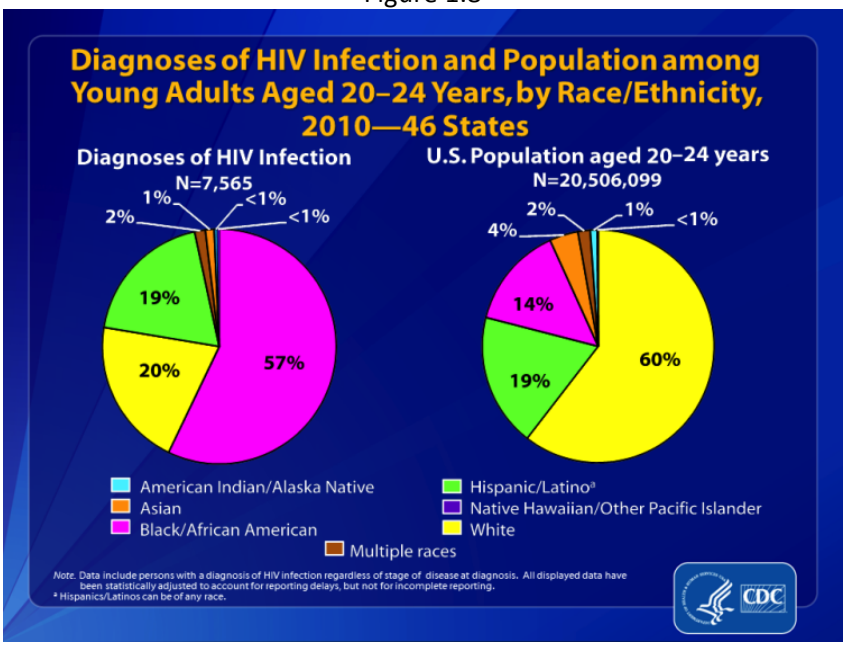
Figure 1.7



Source: CDC 2011

Similarly, in 2010, an estimated 57% of HIV diagnoses in all individuals 20 to 24 years of age were in African Americans, although only 14% of US young adults were African American.

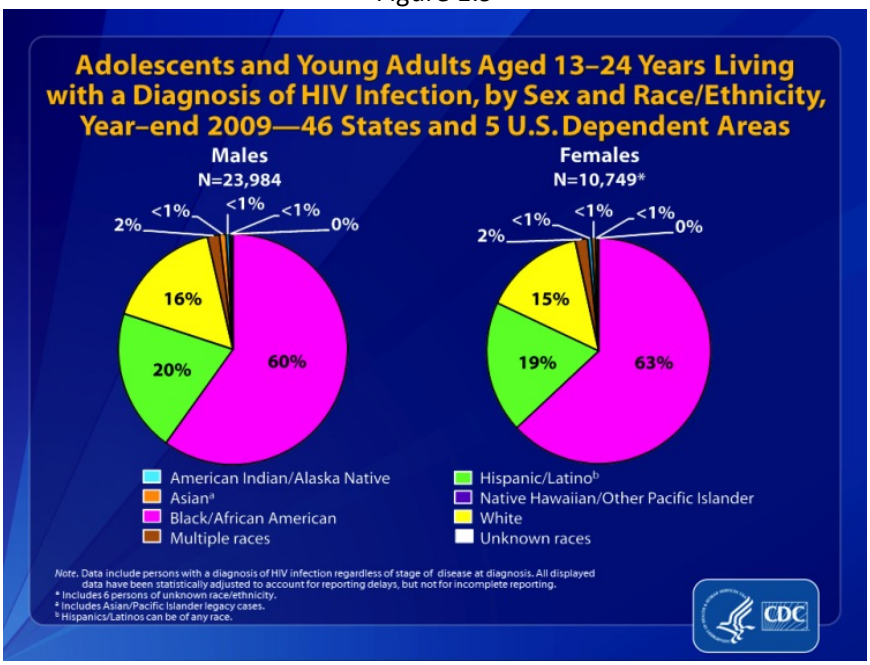
Figure 1.8



Source: CDC 2011

Cumulative impact. At the end of 2009, an estimated 34,733 US adolescents and young adults 13 to 24 years of age were living with HIV infection. Of the 23,984 males in this population, 60% were African American, vs 20% Latino and 16% white.

Figure 1.9



Source: CDC 2011

Summary

Compared with other racial or ethnic groups, more African Americans have been diagnosed with HIV infection or with an AIDS-defining condition—in 2009, African Americans comprised 14% of the US population but 44% of all new HIV infections. Furthermore, in 2010, African American males' HIV infection rates were nearly 4 times greater than their proportion of the overall US male population (42% vs 11%, respectively), and the vast majority (70%) of HIV infections among African American males are attributable to male-to-male sexual activity. Men who have sex with men (MSM) were estimated to comprise 73% of new infections among African American males and 37% among all HIV-positive MSM. The data are especially alarming young people: More new HIV infections occurred among young (13 to 29 years of age) African American MSM than among any other age and racial group of MSM, and reported new HIV infections among young African American MSM increased by 48% between 2006 and 2009. At the end of 2009, an estimated 34,733 US adolescents and young adults 13 to 24 years of age were living with HIV infection. Of the 23,984 males in this population, 60% were African American, vs 20% Latino and 16% white.

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Assessment Questions

1. Which of the following most accurately describes the percentage of new HIV infections that are attributable to male-to-male sexual activity among African American males?

A. More than 70% of new infections are attributable to male-to-male sexual activity.

B. Approximately 50% of new infections are attributable to male-to-male sexual activity.

C. Fewer than 50% of new infections are attributable to male-to-male sexual activity

D. None of the above

2. Among African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010, which of the following statements is True?

A. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was comparable to the percentage of whites in that age group.

B. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was greater than the percentages of whites and Latinos in that age group combined.

C. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was comparable to that of Latinos in that age group.

D. The percentage of African Americans 13 to 24 years of age who were diagnosed with HIV infection in 2010 was significantly lower than that of other racial/ethnic groups.

Module 2—HIV Transmission and Treatment Risk Factors

Learning Objective

- List the risk factors associated with disproportionately high HIV infection rates among young African American MSM

Pretraining Assessment

1. Which of the following factors has been found to be associated with higher rates of HIV infection among African American MSM?

A. More likely than other MSM to engage in sexual behaviors that pose higher risk of HIV transmission

B. More likely than other MSM to have sexually transmitted infections

C. Higher rates of incarceration

D. All of the above

2. The percentage of African Americans who have no health insurance coverage is which of the following?

A. 44%

B. 17%

C. 22%

D. None of the above

As Module 1 in this curriculum discussed, HIV prevalence and rates of new infections among African Americans are significantly disproportionate compared to the percentage of the US population that is African American, and African American men who have sex with men (MSM) continue to experience particularly disproportionate impacts of the epidemic. Numerous studies and hypotheses have tried to determine what factors and circumstances—e.g., more high-risk sexual behaviors, rate of injection drug use (IDU), prevalence of sexually transmitted infections (STIs)—could account for these disproportions. Although the issue has been clarified in recent years, there is no single cause of the high rates of HIV infection among African American MSM.

Nevertheless, the need to understand which factors are or are not associated with the higher risk for HIV infection and poorer treatment outcomes among young African American MSM remains urgent. Doing so will allow practitioners:

- To identify more undiagnosed cases of HIV disease and link more patients to care
- To focus prevention efforts on groups and geographic areas where they are most likely to succeed
- To minimize waste of limited human and financial resources

To sort out the factors that are, are not, or may be associated with risk for HIV infection among African American men, Millett and colleagues conducted a literature review of studies that have examined risk factors among a comprehensive range of African American MSM.[Millett 2006] The investigators classified their findings into 3 groups:

- Explanations shown to be associated with HIV risk by scientific evidence
- Explanations not shown to be associated with HIV risk by scientific evidence
- Explanations for which scientific evidence is either absent or conflicting

The bullet points that follow list the factors that the Millett analysis identified for each of these 3 categories. Some of these will be discussed further in later sections of this curriculum.

Factors Associated with HIV Risk

- African American MSM are more likely than other MSM to have sexually transmitted infections, either currently or in the past that can facilitate both the acquisition and the transmission of HIV infection.
- African American MSM are less likely than other MSM to be tested for HIV or to know their HIV status; therefore, HIV-positive MSM may unknowingly expose sexual partners to HIV infection, in addition to experiencing HIV disease progression themselves.

Factors Not Associated with HIV Risk

- African American MSM are more likely than other MSM to engage in sexual behaviors that pose higher risk of HIV transmission. This finding contradicted a common misperception.
- African American MSM are less likely than other MSM to self-identify as gay or to disclose their sexual identity, which may lead to increased HIV risk behavior.
- African American MSM are more likely than other MSM to abuse substances—especially injection drugs—that increase the risk for HIV infection.

Factors Having Unclear Association with HIV Risk

- African Americans are genetically more susceptible to HIV than others.
- African American MSM are less likely than other MSM to be circumcised; a number of studies have shown decreased risk of HIV infection in males who have been circumcised.
- African American MSM who are HIV-positive are infectious for a longer time compared to other HIV-positive MSM.
- African American MSM are more likely than other MSM to have sex with partners known to be HIV-positive.
- The sexual networks of African American MSM place them at greater risk for HIV infection than the sexual networks of other MSM.
- Higher rates of incarceration among African American MSM vs other MSM are associated with increased likelihood of exposure to HIV infection.
- African American MSM are more likely than other MSM to engage in anorectal douching, which increases the risk for HIV infection.[Millet 2006]

Additional Investigations

Regarding the factors for which the evidence was found to be indeterminate, the investigators cautioned that these factors cannot be ruled out as contributors to HIV prevalence among African American MSM but that further research should assess the extent to which they may contribute to the disproportionately high HIV infection rates in this population.[Millett 2006] These findings by Millett and colleagues by no means represent the final word on the factors that are associated with the higher rates of HIV disease among African American males. In fact, a range of other studies have in many case lent support to their findings, whereas others have shed additional light on some of the factors that the Millett analysis found to have unclear association with HIV infection.[Millett 2007, Flores 2009, Eaton 2010, Oster 2011, Clerkin 2011]

Sociocultural Issues

Sociocultural issues contribute to both the risk of HIV transmission and the risk of not accessing high-quality HIV and other healthcare services for young African American males. Negative attitudes among family and community regarding homosexuality can lead to rejection or alienation from friends and family, discrimination, and even violence. In such circumstances, some MSM do not feel free to be open with others about their behaviors—potentially increasing stress, limiting social support, and negatively affecting health. Because of homophobia and HIV discrimination, some African American MSM do not seek out HIV prevention or testing services, do not consistently practice safer sex (e.g., use of condoms), and are reluctant to talk about issues concerning sex and HIV.

Some members of African American communities regard homosexuality as inconsistent with accepted gender roles and community norms about sexuality and, particularly among religious groups, as sinful or unnatural. For some young MSM, the rejection and discrimination that can result from such attitudes can lead to loss of employment, dropping out of school, or having to leave home (with the risk of living on the streets). Many homeless youth resort to sex work to support themselves, thereby incurring higher risk for acquiring HIV infection. The stigma associated with sex work can make these young people more difficult to reach with HIV education, prevention, and healthcare services.[Koll 2009]

HIV stigma and homophobia continue to be closely related, as significantly more than half of new HIV diagnoses are among MSM[CDC HIV Gay and Bisexual Men 2012], and HIV discrimination and

homophobia can hamper HIV prevention and treatment efforts, in part by shrouding discussion of these issues in silence. African-American MSM may be reluctant to be tested for HIV infection due to a misconception that being tested equates with admission of risky behavior. In addition, some African-American males regard condom use as a threat to masculinity or as admission of having sex outside a relationship or having a sexually transmitted infection (STI).[Koll 2009] Such attitudes clearly have negative implications for successful public health efforts to increase HIV awareness and testing and to promote access to care for individuals who are diagnosed with HIV infection.

A 1998 study by Stokes and Peterson assessed the perceptions of African American men 18 to 29 years of age attitudes toward homophobia, self-esteem, and risk for HIV infection.[Stokes 1998] They reported that study participants felt that members of their communities held negative attitudes toward homosexuality and that many participants thought the African American community was less accepting of homosexuality than white communities. In addition, they found evidence that some of the respondents themselves had internalized these negative attitudes, with resulting lower self-esteem and psychological distress in MSM.

In an evaluation of stressors such as racism and gay bashing among African American MSM, Zamboni and Crawford looked at the effects between stress and sexual difficulties.[Zamboni 2007] The researchers reported that measures of self-esteem, stress concerning male gender roles, engagement in HIV prevention efforts, lifetime experiences with racial discrimination, gay bashing, low life satisfaction, and limited social support were all significantly associated with sexual problems. A variety of other studies have similarly reported clear associations among homophobia (both community and internalized), racism, low self-esteem and social support, and the risk for HIV transmission.[Myers 2003, Operario 2008, Shoptaw 2009]

Socioeconomic Issues

Economic challenges represent another group of complex risk factors faced by young HIV-positive African American males. Approximately twice as many African American families as white families have incomes below the federally defined poverty line.[Census Income 2010High rates of unemployment and underemployment contribute to the risks of acquiring HIV infection and of accessing care once HIV infection is diagnosed, leading to lower rates of health insurance coverage and difficulties in affording both medical care and transportation to healthcare facilities, both of which may receive a lower priority than more pressing financial needs.

The unemployment rate among African Americans in 2012 stood at 15.8%, which is twice as high as the rate among whites.[Department of Labor African American labor force 2012 However, among African American males 18 to 24 years of age, the 2010 unemployment rate was 32.6% vs 17.5% among white males of that age group.[Demos. State of Young America2011 The high rate of incarceration among young African American males further underlines the gravity of this issue: 1 in 9 African American males 25 to 29 years of age was in prison or jail in 2009 v 1 in 27 Latino males and 1 in 60 white males in that age group, and only 46% of ex-offenders had attained employment 7 months after their release.[Demos. State of Young America 2011

Inadequate or no health insurance coverage acts as another finance-related barrier to receiving appropriate access to HIV and other healthcare services. The percentage of African Americans who are uninsured is approximately 1.5 times that of whites.[Surgeon General Supplement 2001 According to the HIV Cost and Services Utilization Study (HCSUS) 1999 African-Americans who are HIV-positive are more likely either to have no health insurance or to be publicly insured vs whites who are HIV-positive—

more than half (59%) of African Americans rely on Medicaid vs 32% of whites. More than one-fifth (22%) of African Americans who are HIV-positive were uninsured vs 17% of whites and were also much less likely to have private health insurance than whites (14% vs 44%). At least as worrisome is the fact that African Americans' health insurance status also varies at the time of HIV diagnosis. Analysis of data from 25 states between 1994 and 2000 found that African Americans were less likely than whites to have private health insurance coverage and more likely to be covered by Medicaid or not insured at all when they receive their HIV diagnosis.[Kaiser Black Americans on HIV/AIDS Survey Report, 1998

Summary

Year after year, epidemiologic data have shown that African American males experience disproportionately high rates of HIV infection and HIV-related mortality, compared with African Americans' representation in the total US population. A large number of studies have sought answers about what factors and circumstances contribute to these disproportionately high rates, and some answers have emerged in recent years, although no studies have been able to identify a single cause of the high rates of HIV infection among African American MSM. However, continuing to search for answers remains a high priority in efforts to reduce the number of HIV infections and to improve treatment outcomes among young African American MSM. Moreover, certain economic and cultural issues within African American communities provide an important part of the context in which HIV disease occurs among young African Americans. HIV stigma and homophobia are intertwined, with significantly more than half of new HIV diagnoses occurring among MSM, and HIV stigma and homophobia can hamper HIV prevention and treatment efforts. In addition, high rates of unemployment and underemployment contribute to the risks of acquiring HIV infection and of accessing care after HIV infection is diagnosed, leading to lower rates of health insurance coverage and difficulties in affording both medical care and transportation to healthcare facilities.

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Assessment Questions

1. Which of the following factors has been found to be associated with higher rates of HIV infection among African American MSM?

A. More likely than other MSM to engage in sexual behaviors that pose higher risk of HIV transmission

B. More likely than other MSM to have sexually transmitted infections

C. Higher rates of incarceration

D. All of the above

2. The percentage of African Americans who have no health insurance coverage is which of the following?

A. 44%

B. 17%

C. 22%

D. None of the above

Module 3—Cultural Competence Challenges

Learning Objective

- Describe the challenges of providing HIV testing and access to and retention in care for young African American MSM

Pretraining Assessment

1. Which of the following statements is True?

A. African Americans are more likely than whites to report having been tested for HIV infection in the previous 12 months.

B. Whites are more likely than African Americans to report having been tested for HIV infection in the previous 12 months.

C. African Americans and whites are equally likely to report having been tested for HIV infection in the previous 12 months.

D. None of the above

2. Is the following statement True or False?
Compared with non-down-low–identified African American men, down-low–identified African American men are less likely to report instances of unprotected receptive anal intercourse.

A. True

B. False

3. Which of the following sexually transmitted infections has been shown to occur at higher rates among African Americans vs other racial/ethnic communities?

A. Syphilis

B. Gonorrhea

C. Chlamydia

D. All of the above

This module will discuss some of the principal challenges that practitioners need to be aware of as they plan and deliver culturally competent care to young African American males who are HIV positive. An appreciation of these challenges can lay the foundation for adopting the types of practices that will be discussed in the following module.

HIV Testing and Related Challenges

Of the estimated 18,849 people under 25 years of age who were diagnosed with HIV infection during 2001 to 2004 in the states with long-term confidential name-based HIV reporting, 11,554 (61%) were African American.[CDC Racial/Ethnic Disparities 2006 However, Swenson and colleagues found that only 29% of persons in that age group reported ever having been tested for HIV infection and that the strongest predictor of being tested for HIV for both male and female young African Americans was having ≥ 1 STI test.[Swenson 2009]

Although African Americans 18 to 64 years of age are more likely than whites to report having been tested for HIV infection in the previous 12 months (43% vs 15%)[KFF 2011 Survey], 31% of African Americans who received a positive diagnosis were tested at a late stage of HIV progression. This means that these individuals received a diagnosis of an AIDS-defining condition within 1 year of testing HIV-positive.[CDC Diagnoses 2010] The estimated 1 in 5 US adults and adolescents who are HIV-positive and are unaware of their status includes approximately 117,000 African Americans. Late HIV diagnosis is associated with missed opportunities both to access early medical care and to prevent transmission:

- Individuals who are diagnosed late are more likely than those diagnosed early to have greater immune deficiency and therefore are at risk of poorer clinical outcomes.
- Individuals who are diagnosed late are more likely to have high HIV RNA levels, and therefore are able to more easily transmit HIV infection to others. This not only presents transmission risks to individual sexual partners but also can increase community viral load. (CDC studies have shown that undiagnosed HIV infection is responsible for > 50% of new sexually transmitted HIV infections annually.[Marks 2006])

The "Down Low" Phenomenon

In recent years, there has been considerable discussion about the phenomenon of African American MSM who describe themselves, or are described by others, as "on the down low." Generically, "down low" refers to keeping certain information, acts, or behavior secret or private. As it relates to sexual behaviors (including those associated with HIV transmission), the term typically is used to describe the behavior of men who have sexual relations with both men and women and who do not self-identify as gay or bisexual. These men may refer to themselves as being "on the down low" or "on the DL," and the term most often has been associated with African American men.[CDC Questions and Answers 2004]

Much of the media and popular discussion about men on the down low and HIV infection has concerned whether down-low behaviors may provide a bridge for transmission of HIV infection between MSM and heterosexual women. However, whether that is in fact a primary explanation for the rates of HIV infection among African American women is not clear, although studies increasingly seem to indicate that MSM behaviors are not a key driver of the epidemic in women.

A study by Bond and colleagues sought to evaluate the extent of African American MSM sexual behaviors associated with the risk of HIV transmission and the possible association with risks both to other MSM and to heterosexual women.[Bond 2009] Regarding how the study participants self-identified, the researchers found:

- Down-low MSM vs non-down-low MSM were more likely to indicate their sexual identity as bisexual and that it was ''very important'' to keep their same-sex behaviors secret.
- One fourth of down-low MSM indicated that they had a gay sexual identity.
- 11.1% of down-low MSM indicated that they were straight or heterosexual.

The investigators also found that comparable proportions of down-low and non-down-low MSM reported insertive unprotected anal intercourse, but that down-low MSM were significantly less likely to report receptive unprotected anal intercourse vs non-down-low MSM. One-fourth of non-down-low men reported recent sexual activity with a woman, and down-low MSM and non-down-low MSM reported comparable rates of unprotected sex with women. They went on to observe that they had found no significant differences in the proportions of down-low–identified vs non-down-low identified–men reporting unprotected sex either with female partners who were HIV negative or whose HIV status was unknown or with male partners.

Bond and colleagues concluded:

- Down-low identity was not associated with participation in greater sexual risk behaviors with either female or male partners. Self-identified down-low African Americans—whether HIV-positive or -negative—engaged in similar sexual risks with male and female partners as non-down-low–identified MSM. Although down-low MSM vs non-down-low MSM were more likely to report a female sex partner, both groups engaged in comparable sexual risks with female partners.
- Equally important, identifying as down low was not necessarily associated with having female sex partners. Half of the down-low participants reported no recent sexual activity with a woman, whereas 23% of non-down-low men reported a recent female sex partner.
- Their findings challenge the assumption that down-low men identify as primarily heterosexual. In fact, down-low MSM were much more likely to identify as bisexual or homosexual than heterosexual, and non-down-low MSM were as likely as down-low MSM to self-identify as heterosexual.
- Compared with non-down-low MSM, down low–identified MSM reported fewer instances of unprotected receptive anal intercourse with male partners and were less likely to test HIV-positive.

Mental Health Concerns

In addition to all of the emotional, social, and sexual challenges of adolescence and young adulthood, young African American MSM often must also deal with the mental health challenges that can affect African American communities. Misdiagnosis, under-diagnosis, and inadequate treatment of mental disorders are all too common in African American communities:[NAMI African American 2009]

- Historical experiences of misdiagnoses, inadequate or no treatment, and cultural barriers to communication have limited access to both general healthcare and mental healthcare services.

- African Americans are seriously under-represented among mental health professionals, with only 2% of psychiatrists, 2% of psychologists, and 4% of social workers being African American.
- For emotional support, African Americans traditionally have been more likely to turn to family members, religious institutions, and social networks, rather than to mental health professionals.
- Mental disorders may be stigmatized or not understood as serious concerns that merit professional care.
- Unemployment and underemployment and lack of insurance coverage limit access to both medical and mental healthcare service.

In addition, significant numbers of African Americans experience social circumstances that can be associated with a greater likelihood of developing a mental disorder [BMJ.2000, Psychiatric ANN. 2001, ArchGen Psychiatric. 2001]:

- Children who are in foster care or child welfare systems are more likely to develop mental disorders, and 45% of the public foster care population is African American children.
- Exposure to violence increases vulnerability to mental disorders, and more than 25% of African American children who are exposed to violence meet the criteria for post-traumatic stress disorder.
- Homelessness is associated with greater risk of developing a mental disorder, and African Americans comprise approximately 40% of the homeless population but only approximately 12% of the total US population.
- Incarcerated individuals are highly vulnerable to developing a mental disorder, and nearly one-half of US inmates are African American.

Associations Between HIV Disease and Mental Disorders

The causes of the various emotional, cognitive, and neurological concerns that can accompany HIV disease can be multifaceted and challenging to disentangle and may include:[Fernandez 2010]

- Mental disorders existing before becoming HIV-infected
- Psychological stress associated with HIV diagnosis and treatment
- HIV-related opportunistic infections or neoplasms, with potential nervous system effects
- Adverse nervous system events associated with some antiretroviral agents (Efavirenz being the most well-known example).[]

In addition, HIV has long been known to directly infect cells of the brain and central nervous system (CNS) soon after acute HIV infection, with the potential for CNS impairment.[Ferrando 2008]

Effective management of HIV-infected patients requires coordination among several types of healthcare providers, including primary care physicians, infectious disease specialists, and mental health professionals. Among the key aspects of comorbid HIV disease and mental disorders are the following:

- Mental disorders can increase the risk of acquiring or transmitting sexually transmitted diseases, including HIV. [Ramrakha 2000]
- Mental disorders, including substance abuse, can predate and or complicate HIV-related illness. [Cournos 2001]
- The proportion of mental health and/or substance abuse disorders among persons who are HIV-positive is nearly 5 times as great as that found in the general population. [Bing 2001]
- Persons with a severe mental illness are disproportionately vulnerable to infection with HIV and other sexually transmitted infections. [Weiser 2004]
- Mental disorders can affect adherence to HAART. [Farber 1999]

- Severely immune-compromised individuals—ie, those with advanced HIV disease—may be at particular risk for the HIV-related CNS complications that can cause acute mental status changes. [Álvarez-Segura 2008]

For more complete discussion of mental disorders among African Americans who are HIV-positive, please review the curriculum, "Triple Whammy—HIV, Mental Disorders, African Americans."

Sexual Networks

In recent years, researchers have identified sexual networks—ie, sexual activity among people who live in the same communities—as an important driver of the HIV epidemic; this is particularly a common phenomenon among African Americans. As a consequence, young people who live in communities that have a high prevalence of HIV infection are at a greater risk for HIV transmission even if their sexual risk behaviors are comparable to those of young people who live in communities that have a lower prevalence of HIV infection.[Millett 2007, Adimora 2006, Hallfors 2007, Adimora 2009]

Perhaps the best-known study of a single sexual network of young African American MSM is Hightow and colleagues' study of the spread of HIV infection among MSM college students in North Carolina.[Hightow 2005]

These investigators discussed a previously unrecognized HIV epidemic among primarily young African American MSM and men who have sex with men and women (MSM/W) attending college in North Carolina. They found that these students' sexual networks were complex and wide-spread, extending into 5 other southeastern US states. An additional concern that they identified is college students' perception of low personal risk for acquiring HIV infection and confidence in their ability to select HIV-negative sex partners. Moreover, a significant percentage of the study participants were found to be newly HIV-infected. This is especially alarming in light of the established association of high viral load during acute HIV infection and the consequent greater transmissibility of the virus during that period.[Pilcher 2001] Hightow and colleagues concluded that this may partly explain the rapid increase in newly reported HIV diagnoses within an existing sexual network of African American MSM attending college.

High Incidence of Sexually Transmitted Infections

STIs—including chlamydia, gonorrhea, and syphilis—occur at higher rates in African American communities vs other racial/ethnic communities. In addition, some of the highest rates of STI occur among young people, especially those who belong to racial/ethnic minority communities. The presence of certain STIs can significantly increase the chance of both acquiring and transmitting HIV infection.[CDC HIV among African Americans, Fleming 1999, Cohen 2004]

Millett and colleagues reported finding significantly higher rates of STIs among African American MSM, e.g.,:[Millett 2007]

- African American MSM are twice as likely as white MSM to be diagnosed with a current STI.
- African American MSM are 50% more likely to be diagnosed with gonorrhea.
- African American MSM are twice as likely as white MSM to be diagnosed with syphilis.

Moreover, rates of coinfection with HIV and an STI are higher among African American MSM vs MSM of most other racial/ethnic groups.[Torian 2002] The continuing high prevalence of STIs among young African American MSM suggests that STI prevention and treatment efforts should be emphasized as a means to help reduce the disproportionately high rates of HIV diagnoses in this population.

Conspiracy Beliefs

Almost from the beginning of the HIV epidemic, some individuals have maintained and advocated conspiracy beliefs about the origins of the virus, the drugs used to treat it, or the organizations involved in developing treatments and vaccines. Conspiracy beliefs have tended to be more widespread in African American communities—where medical distrust in general is more common—compared to other racial/ethnic groups. Conspiracy beliefs have included the ideas that:

- HIV was developed in government laboratories (as a weapon, as a means to reduce nonwhite populations, and so forth)
- Patients receiving antiretroviral therapy are guinea pigs for pharmaceutical companies
- The lack of a vaccine or cure is intentional

In recent years, several studies have sought to determine if there are correlations between holding HIV-related conspiracy beliefs and reluctance to be tested for HIV infection, to use safer sex practices, or to adhere to antiretroviral therapy. In general, the results of these studies indicate that such correlations are minimal, although the findings from different studies emphasize different conclusions.

After analyzing the results of a survey of 113 patients who are HIV-positive to determine the prevalence of conspiracy beliefs, Clark and colleagues reported that 63% of participants held ≥ 1 conspiracy belief (African Americans, 73%; whites, 52%; other/mixed race, 47%.) Compared to patients who reported holding no conspiracy beliefs, those holding ≥ 1 conspiracy belief had higher CD4+ cell counts at diagnosis, similar rates of receiving HAART, and slightly lower rates of adherence. These investigators concluded that maintaining HIV conspiracy beliefs did not have a negative impact on access or adherence to HIV care and that efforts aimed at improving adherence may not need to focus on eliminating conspiracy beliefs.[Clark 2008]

After surveying 214 HIV-positive African American men, Bogart and colleagues reached a somewhat different conclusion. They found 2 distinct types of conspiracy beliefs: genocidal (eg, HIV is manmade) and treatment-related (eg, people receiving antiretroviral treatments are guinea pigs for the government). They then observed that persons holding treatment-related conspiracy beliefs were less likely to maintain optimal adherence to HAART and concluded that interventions meant to promote better adherence among African Americans should openly address such beliefs.[Bogart 2010]

Another study by Bogart and colleagues evaluated the correlation between HIV conspiracy beliefs and sexual behaviors with risk of HIV transmission in 181 African American males who are HIV-positive. These researchers reported that men who held HIV conspiracy beliefs were more likely to report having participated in unprotected sexual intercourse (54%) vs those who did not hold conspiracy beliefs (39%). They concluded that secondary prevention interventions may need to address medical distrust as a contributor to risky sexual practices among HIV-positive African Americans.[Bogart 2011]

Summary

Although a higher percentage of African Americans report having been tested for HIV infection during the previous 12 months, almost one-third of African Americans receive an AIDS diagnosis within 1 year after testing HIV-positive. This poses risks of poorer clinical outcomes for individual patients and continuing HIV transmission and higher community viral load. Although the phenomenon of "down-low" behaviors by African American males has received considerable media attention, studies have not found that these behaviors are associated with significantly higher rates of risky sexual behaviors with either male or female sexual partners. Within African American communities, mental disorders are often misdiagnosed, under-diagnosed, or inadequately treated, leading to higher risks for HIV transmission and less than optimal clinical outcomes for HIV-positive individuals. Sexual networks among young African American males can contribute to rapid and wider spread of HIV infection. In addition, higher rates of certain STIs in African American communities can lead to increased HIV transmission, due to the STIs' association with greater transmissibility of HIV infection. Although conspiracy beliefs about HIV disease and treatments have circulated in African American communities since early in the epidemic, evidence is limited that such beliefs are associated with riskier sexual behaviors or inadequate antiretroviral adherence.

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Assessment Questions

1. Which of the following statements is True?

A. African Americans are more likely than whites to report having been tested for HIV infection in the previous 12 months.

B. Whites are more likely than African Americans to report having been tested for HIV infection in the previous 12 months.

C. African Americans and whites are equally likely to report having been tested for HIV infection in the previous 12 months.

D. None of the above

2. Is the following statement True or False?
Compared with non-down-low–identified African American men, down-low–identified African American men are less likely to report instances of unprotected receptive anal intercourse.

A. True

B. False

3. Which of the following sexually transmitted infections has been shown to occur at higher rates among African Americans vs other racial/ethnic communities?

A. Syphilis

B. Gonorrhea

C. Chlamydia

D. All of the above

Module 4—Implementing Culturally Competent Care for Young African American MSM

Learning Objective(s)

- Identify key elements of culturally competent HIV treatment and prevention approaches for young African American MSM

Pretraining Assessment

1. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

A. Discussing what HIV means to the patient

B. Asking the patient about his or her preferences regarding healthcare

C. Inquiring about sources of stress in the patient's life

D. All of the above

E. A and B only

2. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

A. Active substance use

B. Depression

C. Race or ethnicity

D. All of the above

E. A and B only

3. Which of the following statements is True?

A. White and African American HIV-positive patients experience similar average delays between HIV diagnosis and starting HAART.

B. African American HIV-positive patients experience longer average delays between HIV diagnosis and starting HAART vs white patients.

C. White HIV-positive patients experience longer average delays between HIV diagnosis and starting HAART vs African American patients.

D. None of the above

4. Is the following statement True or False?
A wide variety of HIV prevention and care interventions specifically targeting African American MSM have been shown to be efficacious.

A. True

B. False

Elements of a Cultural Competence Framework

Many clinicians treat patients from a variety of racial/ethnic and cultural backgrounds, and being able to provide care that is appropriate for each patient's particular needs is a critical skill. One renowned HIV clinician has advocated the use of "a cultural competence framework."[Stone 2004, Carrillo 1999] This framework, as outlined below, offers the advantage of not requiring a clinician to memorize all of the specific beliefs and practices that are characteristic of each different group. Rather, it utilizes a structured provider-patient dialogue that allows the patient to introduce key issues that are important to her or him, whether involving culture, lifestyle, religion, sexual behaviors, or other factors.

The steps to employ this cultural competence framework are:

- Identify the patient's core cultural issues—by asking about values and preferences regarding healthcare, while watching for any spoken or nonverbal hints about these preferences.
- Explore what HIV means to the patient by asking what the patient believes might have caused it and how it affects his or her life. This can elicit information about how the patient regards his own culture's values.
- Inquire about the patient's social context:
    - To what extent does the patient feel in control of life—e.g., are there financial or other material constraints?
    - Has the patient experienced any change in environment, such as immigration or relocation?
    - What is the patient's preferred language and what is her or his literacy level?
    - What kind of support systems does the patient have, including factors such as sources of stress, living situation, religious affiliation, family and friends?
- Negotiate with the patient to develop a treatment plan that is agreeable to both the patient and the practitioner.

This framework allows a practitioner to learn the key issues that are important to the patient—e.g., the extent to which he or she adheres to the traditional values of his culture or is more acculturated to mainstream U.S. society—and to incorporate them into a treatment plan. In addition, however, practitioners who are managing diverse groups of patients need to take additional measures to optimize patient outcome, as discussed in the following sections.

Improving Communication in the Clinical Setting

Several studies have identified inadequate or ineffective communication as a key driver of non-white patients' dissatisfaction with the healthcare care services that they receive. The amount of time spent with a healthcare provider can be a valuable predictor of patient satisfaction[Warde 2001], and young African American MSM who are HIV-positive often require more time than members of some other groups to understand the available HIV treatment options and to make appropriate decisions regarding them. To the extent possible, clinicians should try to spend more time with these patients, particularly focusing on listening to the patient. Clinicians can enhance patients' comprehension by assessing their understanding in a sensitive, non-condescending manner—e.g., by asking, "Does that make sense to you?" or asking the patient to repeat back the treatment plan that has been agreed upon. Providing written materials in the patient's preferred language and at an appropriate literacy level can further enhance comprehension. In addition, other clinical staff—such as nurses, physician assistants, case

managers, or peer counselors—can be assigned to spend more time with the patient and answer any further questions. For some young African American MSM this may mean becoming familiar with some of the slang and street terms often used in their peer groups, particularly regarding sexual practices, recreational drugs, and so forth.

Importance of Staff Diversity

According to an analysis from the HIV Cost and Services Utilization Study (HCSUS), racial concordance between HIV-positive patients and their providers is associated with the elimination of disparities in time to starting HAART for African American patients.[Stone 2004] Such findings confirm the important potential benefit of diversifying the clinical staff who are involved in providing care for HIV-positive patients. However, few of the physicians who manage HIV patients are members of racial/ethnic minorities. Although recruiting HIV-specializing physicians presents unique challenges, adding other patient-facing staff who are African American can substantially increase young African American MSM patients' comfort level. Such staff may include front-desk staff, medical assistants, and others. Furthermore, both current and new staff members at all levels should receive regular cultural competence education and training. (Please review the curriculum "Understanding and Implementing the CLAS Standards" [] for more thorough discussion of the types of training that are available and who should participate in them.)

Optimizing HIV Care and HAART

Since the early years of the HIV epidemic, disparities in care, including in the receipt of antiretroviral therapy, have been reported among patients belonging to racial/ethnic minorities. For example, nonwhite patients often experience a longer average delay after being diagnosed with HIV infection until accessing HIV care, and, once linked to care, they are still less likely to receive HAART than white patients.[Stone 2004, Cunningham 2006, Dennis 2011]

Practitioners who manage young African American MSM should become familiar with this pattern of disparities and should establish clinical strategies to optimize the probability that HAART will be recommended to these patients and that they will in fact take their medications. Such strategies include working to build trust in the patient-provider relationship, ensuring that the patient participates in decisions about his or her own care, and providing enough time and information—from other clinical staff members if there is not adequate physician time to do so—for the patient to make an informed decision and understand the importance of taking the medications as directed.[Stone Perspectives 2004] Moreover, practitioners should develop approaches to manage co-morbidities (such as hepatitis C co-infection or substance use disorders) and patients' concerns about antiretroviral adverse effects or other medication-related toxicities. This can help to minimize the risks of nonadherence and to optimize the likelihood of attaining full virologic suppression.

Enhancing Adherence to HAART

Researchers and clinicians have known for many years that patient adherence is critical to achieving full virologic suppression and good immune reconstitution in patients receiving HAART. Once this became well established, interest began to grow in whether certain factors could be associated with predicting

adherence and, therefore, whether certain patients might be at greater risk for nonadherence and treatment failure. As far back as 2001, investigators showed that a patient's demographic characteristics generally are not predictive of adherence to HAART—when other key predictors of nonadherence are taken into account.[Stone 2001, Battaglioli-DeNero 2007] Studies of HAART adherence have demonstrated that only a limited number of patient factors and behaviors can reliably be associated with inadequate adherence:[Malcolm 2003, Alfonso 2006, Malta 2008, Cohn 2011]

- Depression
- Active alcohol abuse
- Active injection drug use (former users seem to have adherence rates similar to patients with no history of substance use)
- Low health literacy

Depression, substance use. Depression is common in HIV-positive persons, as is alcohol and substance abuse; some patients experience both types of concerns.[Angelino 2001, Angelino 2008, Tegger 2008, Starace 2002] Furthermore, in nonwhite patients, depression may be more difficult to diagnose. For these reasons, practitioners who manage HIV-infected patients should perform routine screening for depression in all patients before initiating HAART. (For more detailed discussion of this subject, please review the curriculum, "Triple Whammy—HIV, Mental Disorder, African Americans."[Likewise, all patients—not just those who likely became HIV-positive via injection drug use—should be screened for potential substance abuse issues. (For more detailed discussion of this subject, please review the curriculum, "Culturally Competent Care for Substance Users Diagnosed with HIV Disease."[Before prescribing HAART for patients in whom depression, substance or alcohol use issues, or some combination of these is identified, clinicians should have a management plan in place. The risk of poor adherence is greater if these issues remain unaddressed. HIV practitioners should make an effort to collaborate with patients' mental health or drug treatment providers to optimize both HIV treatment and mental health and substance use outcomes.[Stone 2004]

Health literacy. Clinicians should endeavor to assess patients' health literacy levels and to correct any misconceptions.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Zekeri 2009, Sebbing 2004] Although a patient's racial/ethnic background has generally not been found to be predictive of adherence, some highly charged emotional factors may disproportionately affect nonwhite patients' willingness and ability to adhere to HAART. These include distrust of traditional healthcare practices and concerns about potential harm associated with medications that some may regard as toxic, experimental, or ineffective.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Stone 2004, Cunningham 2000] Support groups, peer educators, and treatment buddies are among the strategies that clinical staff can use to help patients develop more positive attitudes about HAART.

Cultivating a trusting clinician-patient relationship before beginning HAART can enhance adherence. Several important studies of adherence have shown that the quality of the patient-provider relationship may be one of the most important predictors of adherence, particularly for nonwhite patients.[Stone 2004, Simoni 2008, Malcolm 2003] Logistical supports—such as directly observed therapy—can significantly enhance patients' adherence to HAART if a practitioner observes indications that a patient may be at risk for poor adherence.[Moitra 2011, Mitty 2002, Goggin 2007]

Improving Use of HIV Testing and Access to Care

Within a cultural competence framework for managing HIV-positive patients like the one by Stone outlined above, there are several broad strategic approaches that are key to achieving an overall enhanced level of appropriate care for HIV-positive young African American MSM.

Increasing the numbers of young African American MSM who are aware of their HIV status represents a critical first step. Studies have shown that individuals who know that they are HIV-positive typically reduce risky sexual behaviors, thereby contributing to reductions of further HIV transmission and community viral load.[Colfax 2002] In addition, HIV-positive persons who are not aware of their status are the primary cause of new HIV infections.[Marks 2006] Efforts to expand the number of young African American MSM who are aware of their HIV status will require that both these youth and the healthcare providers who work with them become knowledgeable about the Centers for Disease Control and Prevention's current guidelines for HIV testing.[Branson 2006] (For more detailed discussion of testing issues, please review the curriculum, "Promoting HIV Testing in Diverse Populations.")[]

Similarly, healthcare providers and facilities need to develop and implement approaches that take into account the risks and challenges discussed in Modules 2 and 3 of this curriculum in order to link young African American MSM HIV-positive patients to HIV care—and to ensure that they are retained in care.

Involvement of Community-Based Organizations

A host of programs designed to increase the rates of testing and to expand access to care among young African American MSM HIV-positive individuals have been developed, tested, and implemented. Some of these have succeeded, some have not, and some are ongoing. A number of the resources listed at the end of this module discuss these programs. The following section will provide a discussion of just 2 of these programs.

STYLE

One such program, called the YMSM of Color Initiative, was developed by the US Health Resources and Services Administration (HRSA), a program of the Department of Health and Human Services. By using a social marketing campaign aimed at young people and members of their sexual and social networks on college campuses and within broader communities, Hightow-Weidman and colleagues developed STYLE (Strength Through Youth Livin' Empowered).[Hightow-Weidman 2011] STYLE is an intervention meant to diagnose, engage, and retain young African American HIV-positive and Latino MSM in HIV primary care services. Through STYLE, the researchers evaluated 81 MSM who were either newly diagnosed or reengaged in care during a 3-year period. Retention in care was defined as attending ≥ 1 medical visit every 4 months; overall, 63% of participants were retained in clinical care.

The main components of STYLE are:

- A social marketing campaign developed with input from a youth advisory board and focus groups
- Intensified outreach—through social and sexual networks—to groups serving young African Americans and Latinos, both on college campuses and within broader communities
- A tightly linked network of medical and social support (including an infectious disease physician overseeing the care of all patients) for HIV-positive youth who are newly diagnosed or reengaging in care, with the majority receiving care at either a local academic medical center or a local health department)

One goal of STYLE was to address these young people's previously unmet needs by providing an array of services beyond the standard of care, including:

- A peer outreach worker
- A case manager
- Research staff members who formed a medical/social support system (e.g., weekly support group meetings and staff members available by text or phone to assist with appointment scheduling or to answer medical questions)

Participants, who were identified at STYLE-sponsored HIV testing events or through testing done through partner agencies and local health departments, received a physician appointment within 72 hours, thereby almost immediately linking them to care. In addition to HIV medical care, STYLE provided clients with related social support services (including case management and support groups) by partnering with a local AIDS service organization (ASO). With this approach, STYLE could leverage the resources of an academic medical center, an ASO, and a local historically African American university to provide a comprehensive strategy to identify, test, and link young MSM HIV-positive individuals into care.

Outcomes. The researchers reported that 63% of the overall STYLE participants were retained in clinical care (ie, 67% of the newly diagnosed group and 55% of the reengaging group kept all of their scheduled visits). Still, among those who missed at least one 4-month visit—and therefore were considered not retained in regular care—the newly diagnosed participants kept 73% of their visits, and the reengaged kept 67% of their visits, with forgetting and transportation difficulties cited as the most common reasons for missing appointments.

Fifty participants (62%) began HAART during their enrollment in STYLE, and ≥ 1 year of follow-up data were available for 34 of the 50—79%, 75%, and 76% achieved HIV RNA < 200 copies/mL at 3, 6, and 12 months, respectively. The mean change in CD4+ cell count for all patients was an increase of 100 cells/mm^3, and the percentage with CD4+ cell count ≥ 350 cells/mm^3 increased from 71% at baseline to 85% at study end.

Previous studies have reported that predictors of missed clinic visits and poor retention in care include being young, being non-white, and having a history of substance abuse or mental illness.[Mugavero 2009, Napravnik 2008, Katz 2000] Nevertheless, two-thirds of STYLE participants were retained in care, even though they had a mean age of 21 years, 83% were African American, and nearly half reported drug use and/or depressive symptoms.

Recommendations. Regarding the components of a successful outreach effort for young African Americans who are HIV-positive, Hightow-Weidman and colleagues observed that having young people actively involved in making their healthcare decisions is key and that doing so requires a multidisciplinary care team that provides comprehensive, culturally sensitive care for all of the patients' developmental, physical, and mental health issues. Important elements of a successful multidisciplinary approach should involve HIV counseling, testing, and referral services at venues frequented by young African American MSM or through outreach to make testing easily accessible and linkage to care seamless.

These researchers suggest that future efforts might include:

- Use of cell phone and Internet-based interventions for adherence counseling
- Ability to schedule walk-in appointments online

- Providing travel reimbursement with taxi vouchers or gas cards

Measures such as these could contribute to increased communication between young people and their healthcare providers and reduce overall costs through improved patient outcomes, decreased use of emergency rooms, and fewer hospitalizations.[Whetten 2006]

Popular Opinion Leader (POL) Approach

In the context of the very small number of HIV interventions designed specifically for African American MSM, Jones and colleagues took an approach that adapted a proven intervention that had been developed for MSM populations generally.[Jones 2008] The investigators chose as their model the Popular Opinion Leader (POL) intervention, a community-level intervention that seeks to increase safer-sex norms among members of a well-defined target population, in this case, white MSM in Southern cities.[Kelly 1991, Kelly 1997, Kelly 1992] The POL approach recruits and trains opinion leaders to engage friends and acquaintances in risk reduction conversations, with the goal of increasing healthy sexual behaviors.

Jones and colleagues targeted African American MSM 18 to 30 years of age by conducting the study's recruitment and evaluation in nightclubs frequented by the target population. During the initial interviews, they asked participants to identify issues and challenges facing MSM, barriers to accessing prevention services, topics that prevention activities should address, and the best approaches to marketing interventions for African American MSM. The information garnered from the interviews was used to adapt the POL intervention. In a series of 4 interviews over a 1-year period, they gathered a total of 1,190 responses to the questionnaires.

Results. The researchers reported the following findings:

- Significant decreases in unprotected receptive anal intercourse at 4 months (by 23.8%) and 8 months (by 24.7%)
- Significant decreases in unprotected insertive anal intercourse (by 35.2%), unprotected receptive anal intercourse (by 44.1%), and any unprotected anal intercourse (by 31.8%) at 12 months
- Decrease of 40.5% in the mean number of partners for unprotected receptive anal intercourse at 12 months
- 53% decrease in the mean number of unprotected insertive anal intercourse episodes
- 56.8% decrease in the mean number of unprotected receptive anal intercourse episodes
- Increases in the percentage of respondents reporting always using condoms for insertive and receptive anal intercourse of 23% and 30.3%, respectively.

Recommendations. The researchers stress that, because data on the results of interventions designed specifically for African American MSM remains quite limited, it is important to adapt interventions that have demonstrated efficacy in other groups, e.g., MSM and African Americans in general. They concluded that successful interventions for African American MSM should include these elements:

- Dispel myths about HIV disease, including those involving conspiracy beliefs, as these are associated with inconsistent condom use among African American men
- Assess community and agency needs and challenges and establish appropriate linkages among researchers, the target population, and community-based agencies before designing, implementing, or evaluating interventions

- Employ investigators and project staff who are demographically similar to the target population (race, gender, age, and sexual identity) to design, implement, and evaluate interventions for African American MSM

Use of these tactics will help ensure that interventions that are adapted from other proven ones are culturally relevant and meet the needs of community-based organizations.

Select Resources

African-American AIDS Support Services and Survival Institute (AMASSI)
A community center in Inglewood, CA (Los Angeles) that provides preventive health services for HIV, STIs, cancer, diabetes, and other diseases; psychological and therapeutic assistance; and math and literacy tutoring. www.amassi.com.

The Balm in Gilead
Mobilizes African American churches to respond to the HIV epidemic. www.balmingilead.org.

BEBASHI
A Philadelphia organization that provides HIV prevention and support services to that city's African American community. www.bebashi.org.

Black AIDS Institute
A policy center dedicated to reducing HIV-related health disparities by mobilizing community institutions and individuals to confront the epidemic in their communities. www.blackaids.org.

Black Brothers Esteem
A of the San Francisco AIDS Foundation program for African American gay, bisexual, and same gender-loving men regardless of HIV serostatus. www.sfaf.org/client-services/black-brothers-esteem/?utm_source=url-redirect&utm_medium=url-redirect&utm_term=sfaf.org%2FBBE&utm_campaign=SFAF-org-redirect.

Black Coalition on AIDS
A San Francisco–based alliance providing education, services, treatment, emotional support, and research in African-American communities. www.bcoa.org.

Minority HIV/AIDS Initiative
The Minority HIV/AIDS Initiative is one of 6 focus areas of the US Department of Health and Human Services' Initiative to Eliminate Racial and Ethnic Disparities in Health.
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=36.

National Black Leadership Commission on AIDS
An organization aiming to educate, organize, and empower African American leaders—including clergy, elected officials, medical practitioners, business professionals, policy experts, and media—to address HIV and other health disparities in their communities. www.nblca.org.

National Medical Association: HIV/AIDS Program

The NMA is a professional association of physicians of African descent. The goals of this program are development of a capacity assessment, HIV practice standards for physicians, and training materials, in addition to training 2,000 NMA physicians. www.nmanet.org/HIVJoomla/index.php.

National Minority AIDS Council
NMAC's mission is to develop leadership in communities of color to end the HIV epidemic. http://nmac.org.

Office of Minority Health
OMH is a part of the US Department of Health and Human Services, with the goal of improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. http://minorityhealth.hhs.gov.

Whitman-Walker Clinic
Whitman-Walker provides prevention and care services throughout the Washington, DC, area. www.whitman-walker.org.

Summary

In managing the care of young HIV-positive African American MSM, practitioners should be familiar with the key risk factors for HIV transmission and inadequate access to care and with the very serious challenges related to these young people's social, cultural, and financial circumstances. Moreover, practitioners should learn how to apply this knowledge during clinical encounters. Appreciation of young African American MSM's beliefs, attitudes, and behaviors can be practically applied through a "cultural competence framework" that allows a practitioner to learn the issues that are important to the patient and to incorporate them into treatment plans. Effective communication is key to patient satisfaction with healthcare encounters. Practitioners should take appropriate measures to ensure that patients understand and agree with recommended treatment plans. Staff diversity plays an important role in enhancing patients' comfort in accessing HIV care services. Adherence to HAART is critical to optimal clinical outcomes, and studies have shown that race/ethnicity are not associated with patients' ability to achieve optimal adherence. Factors associated with greater risk of poor adherence include: depression, active alcohol or substance abuse, and low health literacy. Intervention approaches that specifically target young African American MSM have only recently begun to be shown to be effective. However, a wide range of resources is available to assist practitioners in understanding HIV-related behaviors, risks, and clinical management among HIV-positive African American youth.

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Assessment Questions

1. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

A. Discussing what HIV means to the patient

B. Asking the patient about his or her preferences regarding healthcare

C. Inquiring about sources of stress in the patient's life

D. All of the above

E. A and B only

2. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

A. Active substance use

B. Depression

C. Race or ethnicity

D. All of the above

E. A and B only

3. Which of the following statements is True?

A. White and African American HIV-positive patients experience similar average delays between HIV diagnosis and starting HAART.

B. African American HIV-positive patients experience longer average delays between HIV diagnosis and starting HAART vs white patients.

C. White HIV-positive patients experience longer average delays between HIV diagnosis and starting HAART vs African American patients.

D. None of the above

4. Is the following statement True or False?

A wide variety of HIV prevention and care interventions specifically targeting African American MSM have been shown to be efficacious.

A. True

B. False

Module 5—Case Studies

01: Case Study Adapted from Addressing HIV Care and African American Model

A 25-year-old African-American man was diagnosed with HIV five years ago. After his initial diagnosis, he did not return for follow up care because he felt fine and did not see a reason to see the doctor. Also, he did not want to go to the HIV clinic and be recognized by any of his friends. He never sought treatment, but was eventually started on antiretrovirals when he developed a case of pneumonia. He was referred to the health department for case management services. During his application for these services, he brought in an application form to be completed by his health care provider. This form requested detailed medical information about his health status. In keeping with the policy of the clinic, a signed informed consent was requested for the release of information.

Several weeks later, the patient returned to the clinic, indignant, because his HIV status was disclosed in the form. After calming the patient down, it was discovered that he understood the informed consent to mean permission to say he had a medical condition, but not the details of his HIV status.

This case raises two points:

(a) The unique issues related to the continued stigma surrounding HIV/AIDS.

(b) The confusion about the purpose regarding informed consent.

Whetten-Goldstein et al. (2001) conducted a qualitative study of patients with HIV and their perceived breaches of confidentiality in hospitals, clinics, and health departments by health care professionals. The findings of this study revealed that these patients perceived that breaches occurred by word of mouth, computers, facsimile and writing. Patients also indicated that sharing stigmatizing medical information among medical providers is a breach of confidence.

- Discuss what steps providers should employ to ensure patient confidentiality in each care setting.
- Discuss other Cultural Competence issues that may impact retention into care and treatment.

42: Case Study Adapted from Addressing HIV Care and African American Model

Jasmine, a 26 year old woman whose ancestry was a mixture of African American and multiple Southwestern tribes presented to a clinic for a same-day appointment with complaint of a sore throat.

The exam showed obesity and thrush. Her past medical history showed she had thrush one other time, one year ago.

The Physician Assistant (PA) told her of his concern of both diabetes and HIV, and asked her to be tested for both. Because of her ethnicity and family history of diabetes, she agreed.

A week later, another physician in the group was asked to see the patient as a walk-in because "someone at the clinic told her to come in for her results." The original PA who saw her was not working that day. Upon reviewing the chart, the physician could not find a pre-test consent to draw the HIV test, and was uncertain if the patient really had given informed consent.

Discussion Questions

1. What are the ethical concerns at this point for the provider?

2. How could this case have been handled in a more culturally competent manner?

3. What should the provider do now?

4. Discuss other Cultural Competence issues that may impact retention into care and treatment

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