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Improving the HIV Prevention Landscape to Reduce Disparities for Black MSM in the South

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Abstract

Black men who have sex with men (MSM) in the South have the highest rates of HIV diagnosis in the country adding to the persistent racial disparities in HIV experienced by this population. The current HIV prevention and care landscape is heavily driven by individual-level clinical and biomedical approaches that have shown progress in reducing HIV diagnoses, but yield less than adequate results in reducing the HIV racial disparities for Black MSM in the South. In efforts to enhance focus on reducing the racial HIV disparities and more completely address the needs of Black MSM in the South, we offer insight on comprehensive approaches that can complement our current HIV prevention and care portfolio. There are five domains we discuss which include: (1) leveraging and integrating resources; (2) building upon existing program models designed to reduce disparities; (3) workforce development and cultural sensitivity; (4) social determinants of health data utilization; and 5) policy considerations. We urge public health practitioners and healthcare providers to consider and incorporate the outlined approaches to improve HIV outcomes along the continuum of care and ultimately reduce disparities in HIV affecting the quality of life of Black MSM living in the South.

Keywords

HIV; Southern US; Black MSM; Disparities

Introduction

Almost 40 years ago, the human immunodeficiency virus (HIV) wreaked havoc in communities of gay, bisexual, and other men who have sex men (MSM). Although initially regarded as a disease primarily affecting White gay men, the face of the HIV epidemic has become African American/Black MSM. Recent HIV trend data show HIV incidence among this population has stabilized [1, 2]; however, HIV surveillance data consistently indicate that Black MSM are disproportionately affected by HIV dating back to the late 1990s [3]. Despite progress in reducing new HIV infections, the racial disparity between Black MSM

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in comparison to other racial/ethnic MSM groups, particularly White MSM, continues to persist [1, 2, 4]. Regionally, the southern US continues to have the highest HIV diagnoses and death rates in comparison to the rest of the country [5, 6]. The racial disparity is also evident when examining and comparing outcomes along the HIV care continuum (HCC) for these two populations. Despite an overall stabilization of HIV diagnoses among Black MSM, Black MSM in the South continue to yield unfavorable HCC outcomes such as antiretroviral therapy (ART) initiation, retention in care, and achieving viral suppression [7, 8].

As noted in the new Health and Human Services (HHS) initiative: "Ending the HIV Epidemic: A Plan for America" [9], biomedical advances in HIV prevention, including pre-exposure prophylaxis (PrEP), have resulted in critical tools for making major advances toward drastically reducing rates of new infections. Strategies such as high-impact prevention (HIP) and treatment as prevention (TasP) similarly aim to scale up effective interventions and best practices that reduce new infections and improve HIV treatment and care in prioritized populations most affected by HIV [10]. These approaches mostly emphasize clinical or individual-level interventions of risk. Regarding tailored interventions for Black MSM, there is only one evidence-based HIV behavioral intervention specifically designed for Black MSM, *Many Men, Many Voices (3MV)* listed in CDC's compendium of HIV behavioral interventions [11]. *3MV*, a group-level intervention, was designed to improve HIV behavioral outcomes (e.g., increased condom use) by lowering HIV risk behaviors and addressing social and structural factors like homophobia and racism [12]. This intervention was novel in its design specifically for Black MSM; however, its primary focus encourages individual-level protective behaviors. This approach may be effective at reducing individual-level risk for HIV; however, research [8] shows that individual-level risk behaviors are often less likely to be reported among Black MSM compared to MSM of other races and thus, may not be likely to have major effects on factors associated with racial disparities in HIV.

An additional consideration is that recent data indicate that uptake of PrEP, a central tool in preventing HIV, among Black persons and Black MSM is substantially lower than uptake among White persons and White MSM and PrEP uptake among Black MSM in the South is slowly progressing [13–15]. Coupled with low ART initiation, retention in HIV care, and viral suppression rates among Black MSM, these factors have serious implications for worsening the racial HIV disparity between these groups. At a time when our HIV prevention toolbox has many efficacious biomedical interventions while racial disparities remain high, it is important to consider how we are falling short of adequately addressing the needs of Black MSM and reducing racial disparities in HIV, particularly in the southern US.

It is well-documented that individual-level HIV risk behaviors alone do not explain the racial disparity in HIV among Black MSM [8, 16] and the disparity may be better explained by social and structural factors impacting HIV prevention, treatment, and care among this population. Over a decade ago, HIV prevention scientists offered recommendations on future directions to address underlying factors perpetuating the racial disparities in HIV among Black MSM [17]. Some of the overarching recommendations included the following: (1) conduct research and design interventions that seek to understand and

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address the impact of social and structural barriers on HIV-related outcomes (e.g., stigma, discrimination, un/under-employment, low education, unstable housing, etc.); (2) implement population-focused and holistic approaches to HIV prevention in addition to individual-level interventions; and (3) collaborate with entities and organizations that address these barriers in efforts to provide comprehensive prevention that is also inclusive of HIV prevention strategies. Since that time, the approach to reduce the HIV disparity among Black MSM has been inadequate and ineffective. To date, we have not seen a substantial reduction in disparities among Black MSM as best exemplified in the South. Due to the nature of current approaches, a significant reduction in HIV-related disparities may be insurmountable given that social and structural factors are so strongly associated with creating and sustaining these racial disparities and continue to be inadequately addressed. This omission constitutes a prominent gap in the domestic HIV prevention portfolio.

The purpose of this commentary is to heighten the focus of reducing HIV-related disparities among Black MSM, particularly those residing in the South, and propose models, strategies, and approaches that will complement our current national HIV prevention activities. Reducing racial disparities in HIV remains a major goal for HIV prevention nationally [18, 19]. Despite growing examples of strategies to address social and structural factors associated with these disparities [20, 21], the preponderance of evidence-based strategies remain individual or clinically focused [11]. Research suggests that social and structural factors such as unemployment, low income, lack of health insurance, and various forms of stigma and discrimination (e.g., racism, homophobia, and HIV-related stigma) contribute to the less than favorable clinical outcomes along the HCC [22–25]. As we progress, it is critical to ensure that our behavioral, biomedical, social and structural approaches work synergistically to reduce racial HIV disparities for Black MSM in the South.

Given the many social stigmas (e.g., HIV-related stigma, racism, homophobia, provider bias) [26–29] and structural barriers (e.g., medical distrust, lack of healthcare access) [29–32] that affect HIV outcomes and their documented association with racial disparities, it is important that efforts addressing these factors are integrated into HIV prevention and care strategies with prioritization of Black MSM in the South. We utilized Ecological Models of Health [33] and intersectionality frameworks [34, 35] to inform our suggested approaches and to identify social and structural factors salient to Black MSM in their encounters with HIV prevention and care services. It is important to note that the identified factors intersect and create compounded barriers to reducing disparities for Black MSM in the South. While some of the suggested approaches are not new, the proposed strategies have not achieved a large-scale of implementation to witness a substantial reduction in the racial HIV disparity among Black MSM in the South.

In the remainder of this commentary, we discuss approaches and strategies categorized into five domains that may assist with reducing the racial disparity in HIV for Black MSM in the South. The five domains include (1) leveraging and integrating resources; (2) building upon existing program models designed to reduce disparities; (3) workforce development and cultural sensitivity; (4) social determinants of health data utilization; and (5) policy considerations. Table 1 includes a summary of the suggested approaches outlined in the commentary.

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Suggested Approaches

Leveraging and Integrating Resources

Programs that address factors associated with racial disparities (e.g., unemployment, low income, lack of healthcare access, stigma) in HIV receive funding from a variety of entities (e.g., federal, state, and local government and private sources), and leveraging those programs have the potential to increase the overall reach and impact of HIV prevention programs. Given the variation in organizational and programmatic missions associated with such diverse funders, coordinating across these programs is far from automatic. Although challenging to achieve, coordination and integration of such programs makes it possible for each programmatic effort to have a greater impact on improving health outcomes, and ultimately reducing disparities.

Local HIV prevention planning groups routinely conduct environmental scans to identify local needs and resources. This process often does, and should routinely include explicit considerations regarding strategies to coordinate resources that can address social determinants of health (SDH) [36] related to racial disparities in local priority populations. Doing so may increase the ability of available resources to reach local HIV prevention targets. An integrated local strategy can potentially have synergistic effects by addressing social and structural factors associated with HIV disparities. Combining and coordinating resources in this way can also work to address factors at a larger scale than any single program or resource alone. For example, working to integrate the services of separate mental health, employment services and housing programs with HIV prevention and care services may result in better client outcomes by addressing factors associated with poor linkage, retention and viral suppression and may lead to a new model of service provision. Given that much of the HIV epidemic in the South is rural; such an approach may also increase accessibility when multiple programs are combined or when integrated via telehealth methods. Such leveraged approaches may also have the benefit of increased sustainability due to the multiple sources of funding.

Building on Existing Program Models Designed to Reduce Disparities

The HIV prevention field can gain valuable insight from utilizing on-going disparities reduction work implemented in other fields. For instance, CDC's National Center for Chronic Disease Prevention and Health Promotion led a program, *Racial and Ethnic Approaches to Community Health (REACH)*, designed to address social determinants of health and reduce disparities in racial/ethnic minority communities [37]. Work from chronic disease prevention incorporated methods of, and established partnerships with, agencies that fostered the development of programs designed to address SDH with strict emphasis on reducing disparities in communities of color. The *REACH* program demonstrated progress at reducing disparities within these communities through a variety of comprehensive health initiatives. Some of the initiatives included (1) smoking cessation programs for Asian men; (2) increased cholesterol screening among Latino populations; and (3) diabetes management programs aimed at reducing amputations in Black communities [38–41]. Given these programs focused on similar root causes of health disparities, adopting and adapting models of these chronic disease prevention programs can assist in progressing HIV prevention

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strategies to reduce racial disparities in HIV for Black MSM in the South. Although these programs showed promise in reducing disparities, funding sustainable programs that address social determinants of health remain a challenge. This further highlights the importance of leveraging resources that assist with on-going endeavors to reduce health disparities and sustain health disparities-reducing activities.

HIV prevention and care programs that directly address social and structural issues affecting HIV outcomes are relatively uncommon; however, the CDC led an extensive collaboration to address social determinants of HIV through the *Care and Prevention in the United States (CAPUS)* demonstration project. This project received funding through the Secretary's Minority AIDS Initiative Fund (SMAIF) from 2012 to 2016 to address social and structural barriers directly as they pertain to HIV prevention and care. The collaborative agencies included CDC, HRSA, OHAIDP, Office of Minority Health, SAMHSA, Office of Women's Health, and cooperative agreements with state health departments [42]. Participating health departments demonstrated the feasibility of conducting activities and employing strategies that address social determinants of HIV. Some examples of the health departments' approaches included cultural humility/sensitivity trainings for service providers for reducing institutionalized racism, homophobia, and transphobia; social marketing campaigns targeted to providers to address implicit biases; and housing and employment re-entry programs for PWH recently released from incarceration [21].

Some of the strategies from *CAPUS* showed promise of reducing disparities for racial/ ethnic minority communities; however, there is an overwhelming need to conduct rigorous evaluation of those and similar programs to determine their level of effectiveness in reducing HIV-related disparities especially for Black MSM in the South. Such additional evaluation activities can produce actionable data on the feasibility, acceptability, utilization, and effectiveness of programs tailored for Black MSM that address social determinants of HIV. *CAPUS* was the first project that directed local and state health departments to incorporate activities that address social and structural factors into their provision of HIV prevention and care services. Since the inception of *CAPUS*, the Minority AIDS Initiative funded subsequent projects that address factors such as lack of healthcare access [43], social and institutional stigmas influencing PrEP uptake, linkage and retention in HIV care [44, 45], and the coordination of housing and employment services with HIV care and treatment services [46], for example. These projects address social determinants of HIV due to specialized funding earmarked for racial/ethnic minorities, but there remains a critical need to fund routinely the development, implementation, and evaluation of projects with similar approaches to reduce disparities for Black MSM in the South.

Workforce Development and Cultural Sensitivity

A recent systematic review on HIV-related stigma among healthcare providers indicated that providers often exhibit stigmatizing attitudes towards their patients [47]. In a health-care structure that is dependent upon the provider-patient interaction, it is imperative that providers as well as frontline staff (e.g., receptionists, patient navigators, insurance personnel, etc.) deliver culturally appropriate services. Furthermore, recent reports show that clinicians' biases towards minority patients, particularly Black patients, can influence

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their decision making regarding providing treatment or prevention services and decrease the quality of care their patients receive [27, 48, 49]. Consistent with these reports, a commonly cited barrier to accessing HIV prevention and care among Black MSM is the perception of being unwelcomed or judged during the provision of HIV services [26, 31] and these types of experiences are more pervasive in the South [5].

The southern US has unique challenges in its provision of HIV prevention and care services for Black MSM due to a protracted history of racial oppression and related stigmas in the region [50–52]. Further complicating challenges in the South are the shortages of HIV providers and a need to improve the cultural sensitivity of providers that serve Black MSM in this region [50]. Doing so can assist with combatting the disproportionate rates of HIV among Black MSM in the South. Often the faces of HIV prevention and care, health care professionals represent a key potential point of intervention. One approach is to enhance cultural sensitivity and humility trainings among providers in efforts to improve HIV outcomes for this population. Additionally, system-level changes requiring the provision of culturally appropriate HIV prevention and care services could assist with improving HIV outcomes for Black MSM [28, 53]; however, this may require a substantial amount of time given the painful history of Black communities with medical establishments in the US [54, 55].

A longstanding history of medical distrust within Black communities [32, 55] underscores the need to educate and enlighten providers on the cultural nuances of their Black MSM clients. Unfortunately, historical implications surrounding medical distrust within Black communities is deeply entrenched in the psyche of many Black people in this country [30, 54–56]. Medical distrust and consistent negative encounters with the healthcare systems create and sustain barriers for Black MSM when trying to navigate intricate health systems due to not only their race, but also their sexual orientation [26, 32, 57]. Based on evidence that culturally sensitive interventions can improve the provider-patient dynamic and HIV-related outcomes among the general population [53, 58], tailoring approaches specifically to Black MSM in the South may help improve outcomes along the HCC and engagement in other HIV prevention strategies such as PrEP.

Another consideration to improve Black MSM patient-provider interactions include the development or enhancement of curricula for medical students, currently practicing physicians, and other healthcare providers on cultural humility/sensitivity when working with this population. Providing culturally sensitive curricula and trainings should assist in ameliorating deleterious HIV-related disparities outcomes for Black MSM. Furthermore, healthcare providers could benefit from programs or short interventions designed to enhance their interpersonal skills when interacting with Black MSM in the South, particularly as it relates to the multiple layers of stigma this community encounters.

Although the cultural and institutional history of the southern US presents challenges, progress towards addressing these barriers is achievable for Black MSM. One such example includes the work the Louisiana Department of Health and Hospitals conducted in the *CAPUS* project [21]. This health department delivered an intensive cultural sensitivity intervention to a large proportion of their HIV prevention workforce, which included HIV

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services providers and community partners, to specifically address institutional racism [59]. Due to the successful implementation and reception to the intervention, this set the stage for the development of additional programs focused on reducing homophobia and transphobia. As health departments recognize the need to address HIV-related disparities for populations like Black MSM, other health departments can continue to incorporate these types of interventions into their provision of services. This example demonstrates how existing programs can assist with increasing capacity around cultural sensitivity and humility for the public health workforce.

Social Determinants of Health (SDH) Data Utilization

Other considerations for programs seeking to reduce HIV-related disparities include creating opportunities to collect salient data on the social determinants of HIV within jurisdictions prioritizing Black MSM in the South. The collection and use of public health data on social and structural factors can serve as powerful tools in working to reduce racial disparities. Fremont and Lurie [60] note that in addition to helping to document disparities, data should also be routinely used to shed light on the related causes and consequences of disparities. Documenting differences regarding access to and quality of care is also a key element in taking steps to reduce and eliminate disparities. One example of exploring disparities comes from An et al. [61], where they examined social economic position (SEP) data from the US Census in conjunction with HIV surveillance data to explore associations with racial disparities in HIV. Two key findings from this analysis were that SEP and HIV infection were inversely related and that Black people experienced higher HIV diagnosis rates than other groups across all SEP levels. Analyses like these on SEP and other social determinants of HIV can help identify factors associated with HIV outcomes and opportunities for interventions that improve HIV outcomes for Black MSM in the South.

Health departments and other public health agencies can use SDH data to identify factors most pertinent to address in local jurisdictions with HIV rates disproportionately affecting Black MSM in the South. For example, CDC annually generates a supplemental report to the National HIV Surveillance report that tracks key SDH indicators such as employment, poverty, insurance coverage, and housing status for PWH at the Census-tract and county-levels [62, 63]. The data presented in these reports are not inclusive of all social and structural factors that affect HIV outcomes for Black MSM; however, these data coupled with other SDH data sources, can augment the identification of social and structural factors of focus for this population. For instance, data from the American Community Survey [64], the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) AtlasPlus [65], and the National HIV Behavioral Surveillance (NHBS) [66] collect data on similar and other SDH variables that can assist in the identification of additional factors to intervene to reduce HIV-related disparities for Black MSM in the South. NHBS collects MSM-specific data every 3 years from participating sites, of which approximately a third of the data represents data from southern jurisdictions. Although, the primary data collected for NHBS is HIV behavioral data, participating jurisdictions have the option to collect local information on social and structural factors (e.g., healthcare access, various forms of stigma, and patient-provider interactions) that can inform disparities reducing approaches for HIV outcomes for both PWH and HIV negative MSM.

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Utilization of SDH data can advance HIV-related disparities reduction work; however, opportunities exist to improve on routinizing SDH data collection for both PWH and HIV negative Black MSM, as some data sources are specific only to PWH (e.g. HIV Surveillance supplemental reports). There are opportunities to create routine collection of these data and develop specific guidance on how to best use SDH-related data, particularly for HIV prevention and care programs that receive funding through flagship HIV prevention and care funding opportunities. Not only does this have the potential to enhance use of these data, but it can help to standardize the collection of critical factors impacting HIV outcomes, and assist with targeted collaborative efforts to address the identified factors. This can be achieved through the implementation of policies that require funded jurisdictions to collect these data and develop specific activities that address those salient social and structural factors.

Policy Consideration

One primary means of affecting change in public health practice is through the development and implementation of policies and procedures. Although there are several policies to consider at a national level, examining how regional and local policies affect HIV prevention efforts can help identify some specific actions that can have local impact. For example, the effect of laws that criminalize HIV infection are important to understand in a local context. These laws are often associated with uneven enforcement such that racial and ethnic minorities are more negatively affected [67]. Given that such laws also contribute to HIV stigma, local awareness of these laws and their effects can improve communication about and possibly provision of service delivery for PWH as well as inform local advocacy efforts. These are critical considerations regarding service provision for PWH, especially in the southern US where HIV stigma is often pervasive [5].

Similarly, another national policy with local effects is Medicaid expansion. Given the observed increases in health-care coverage in states that have opted in [68] and the forecasted negative effects of states opting out of the expansion [69], that so many states in the South have opted out of this program presents additional challenges for increasing coverage. It is therefore critical to explore opportunities for local policies to support bridging this gap in healthcare coverage. Examining how existing policies are implemented or how they can be revised may also present opportunities for local policies to play a role in reducing factors contributing to racial disparities. Ensuring routine HIV testing in settings such as emergency rooms and correctional facilities are examples of institutional policies that can help identify undiagnosed HIV infections especially in regions with higher HIV prevalence such as the southern US [70–72]. State and local governments could also develop policies that help to ensure better coordination among services by introducing language into required elements of funding mechanisms. For example, they could require applicants to articulate opportunities to leverage existing resources in support of increased impact or sustainability. Institutions applying for project funds could independently also make this routine.

Furthermore, institutional policy changes that support addressing factors associated with disparities can result in widespread systemic changes across an organization. For example,

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the Louisiana Department of Health and Hospitals successfully mandated participation in a required training called Undoing Racism for all HIV prevention staff and their funded partnering agencies [73]. Similar organizational changes across health departments and other HIV service agencies in the South can assist in shifting the HIV prevention and care paradigm to one with emphasis on reducing HIV-related disparities for Black MSM.

Conclusion

In this commentary, we provide practical ideas to reverse the widening racial gap in HIV and to help improve the HIV care and prevention of Black MSM in the South. As a national HIV prevention goal [18, 19] and a critical step to ending the HIV epidemic in the US [9], much work remains to reduce and ultimately eliminate racial disparities in HIV. The intense focus of the first phase of the Ending the HIV Epidemic plan appropriately includes a heavy focus on the southern US where HIV disparities are high. The strategies and approaches we provide can enhance the focus of our current HIV prevention and care efforts to eliminate racial HIV disparities and improve HIV outcomes specifically for Black MSM in the South. These strategies and approaches encourage more holistic approaches rather than a relatively narrow focus on individual-level strategies. As public health practitioners and medical service providers begin to bridge the gap on service delivery, data utilization, policy development and implementation, and improved cultural sensitivity, tangible progress for this population may be achievable. Through such integrated behavioral, biomedical, and social/structural approaches, HIV-related outcomes for Black MSM in the South may begin to improve with the ultimate goal of reducing the racial disparities in HIV in these communities.

The southern US is unique in that the culture of the region and heightened levels of HIV-related stigma, in addition to the history of systemic and institutional barriers, compound the adverse HIV continuum of care outcomes for Black MSM. Despite the complex and contextually specific experiences of Black MSM in the South, many of the activities and strategies presented here may also apply to other populations and regions. Given the approaches suggested in this paper and revisiting the aforementioned recommendations [17], we are in prime position to sharpen our response to this epidemic in a more comprehensive manner. We should note, although not discussed in detail, that engagement of Black MSM communities should occur from program planning, implementation, and through evaluation. Community engagement can occur through the solicitation of input from local community advisory boards or more indepth approaches such as community-based participatory research [74, 75] and can increase the community support of local programs. Increasing HIV prevention efforts that address systematic barriers to HIV care and prevention for Black MSM in the South may enhance the overall impact of the efforts to reduce racial disparities in HIV. A shift to a more comprehensive focus on reducing disparities is necessary to serve Black MSM living in the South more justly and efficiently. It is unprecedented to have a large-scale implementation of a combination HIV prevention approach that includes biomedical, behavioral, and social/structural strategies focused on issues associated with racial HIV disparities in the southern US or in the US as a whole. We propose that in order to eliminate racial disparities in HIV in the US, and the South in particular, the HIV prevention field must continue to increase the emphasis on addressing

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factors associated with racial HIV disparities with strategies like those presented in this commentary.

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Table 1

Suggested approaches to address to reduce HIV-related disparities for Black MSM in the South

Leveraging & integrating resources

- Integrate (or if not possible, coordinate) programs from diverse funding sources to increase impact and possibly increase sustainability
- Seek out opportunities to coordinate with programs addressing factors impacting health outcomes for Black MSM (e.g., integration of mental health, housing, employment services)

Build upon existing program models designed to reduce disparities

- Scale-up programs addressing social and structural barriers
- Adapt disparities reduction models used to address other health conditions
- Conduct rigorous evaluation of HIV prevention and care programs addressing social and structural factors

Workforce development & cultural sensitivity

- Implement cultural sensitivity interventions specific to Black MSM for HIV services providers and staff
- Develop or enhance culturally appropriate curriculum for medical students and other HIV services providers specific to Black MSM

Social determinants of health data utilization

- Routinize collection of SDH variables to inform HIV prevention and care services for Black MSM
- Conduct local analyses to identify salient social and structural factors to address for Black MSM with SDH data sources
- Standardize collection of SDH variables in flagship funding announcements that will assist in reducing disparities
- Develop guidance on how to best use SDH data that inform programs or interventions addressing social and structural factors specific to Black MSM

Policy considerations

- Be aware of local impact of HIV criminalization laws
- Implement institutional policies that address institutional racism and homophobia/anti-gay stigma
- Implement policies to routinize the collection of data on social and structural factors affecting Black MSM
- Develop policies to ensure local coordination of services (e.g., HIV, mental health, housing, employment services)