Raising the Bar: Developing a Standard of Care for Black and Latino Gay, Bisexual, and other Men Who have Sex with Men (MSM) in a Clinical Settings

March 18-19, 2012

MEETING SUMMARY
The National Alliance of State and Territorial AIDS Directors (NASTAD) and the National Coalition of STD Directors (NCSD) convened a blue ribbon panel meeting entitled *Raising the Bar: Developing a Standard of Care for Black and Latino Gay, Bisexual, and other Men who have Sex with Men (MSM) in a Clinical Setting*, in Washington DC on March 18-19, 2012. Supported by funding from the MAC AIDS Fund, this meeting allowed for NASTAD and NCSD to engage leading clinicians and community stakeholders regarding the health needs of Black and Latino gay men/men who have sex with men (MSM). The goal of the meeting was to discuss the development of a patient-centered, culturally grounded standard of care for Black and Latino gay/MSM. The meeting participants provided critical feedback in reviewing some of NASTAD and NCSD’s products and efforts to support Black and Latino gay men/MSM, including the *Provider Optimal Care Checklist* (OCC) and the *Institutional and Community Assessment* (ICA).

The meeting was a follow-up to NASTAD and NCSD’s 2010 release of the *Statement of Urgency: Crisis Among Gay Men*. In the statement of urgency, NCSD and NASTAD committed to assist state health departments stem the tide of both sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV) among gay men/MSM of all races and ethnicities. In the statement of urgency, there was also a call for “a sharpening of our focus” on the sexual health needs of gay men/MSM of all races and ethnicities.

### MEETING OBJECTIVES

The meeting focused on the sexual health of Black and Latino gay men/MSM, their patient-provider relationships, and how institutional and community stigma impacts their lives. The objectives of the meeting were to:

- Outline the challenges and barriers clinicians face in developing culturally competent health services for Black and Latino gay men/MSM
- Discuss how NASTAD and NCSD can assist state health departments in improving the standard of care for Black and Latino gay men/MSM in clinical settings
- Review the preliminary findings from NASTAD and NCSD’s *Institutional and Community Assessment* (ICA)
- Collect feedback from clinicians and community stakeholders on the draft *Provider Optimal Care Checklist* (OCC) for Black and Latino gay men/MSM
- Provide a platform for participants to share strategies and lessons-learned in their clinical settings for engaging Black and Latino gay men/MSM in primary care
MEETING STRUCTURE

The one-day meeting consisted of four all-group sessions and two small work group activities (see agenda in Appendix 1). A reception was held the evening before the meeting to create a relaxed environment for the participants to share ideas, discuss their areas of expertise, and their reasons for participating in the meeting.

The first session, “Race Matters”: A Socio-Political Context for Developing a Standard of Care for Black and Latino Gay Men/MSM, included presentations by Terrance Moore, Edgar Rivera-Colon, PhD, and Patrick Wilson, PhD. The session explored the link between the changing health policy landscape, health care and racial and ethnic health disparities. Mr. Moore’s presentation titled, Policy Lay of the Land, highlighted current health policy changes and the potential impact these changes will have on the way health care is delivered in the United States (see Appendix 2). The presentation included discussion of the revised funding priorities for health departments stemming from the new five year cooperative agreement from the Centers for Disease Control and Prevention (CDC), the pending Affordable Care Act (ACA) case before the Supreme Court, and the Presidential election of 2012.

The other two presentations during this session examined the impact of stigma, race/ethnicity and the challenges Black and Latino gay men/MSM face in their patient-provider relationships and within their communities. These two presentations challenged the participants to think about the multiple stigmatized identities that confront many Black and Latino gay men/MSM and how these may impact the patient-provider relationship (e.g., sexual silence, condom negotiation, disclosure and coming out). Dr. Rivera Colón provided a presentation entitled Raising the Bar: Cultural Challenges in Patient-Clinician Communications that addressed the cultural challenges among Latino gay men/MSM and their medical providers (see Appendix 3). Dr. Wilson conducted the final presentation of this session titled “Race Matters”: A Socio-Political Context for Developing a Standard of Care for Black and Latino Gay Men/MSM that examined how social determinants and stigma may limit the ability of Black gay men/MSM to access care (see Appendix 4).

The second session of the day included a presentation by Dr. Wilson, PhD, entitled NASTAD and NCSD Institutional and Community Assessment (ICA). Wilson’s presentation provided the meeting participants with some of the preliminary findings from the ICA. The ICA survey assessed stigma across four domains (i.e., race and ethnicity, same-sex sexuality, gender performance, and HIV/AIDS). The findings sparked a robust dialogue among the participants and presenter that expressed an urgency to address stigma and its impact at the community level in states and regions across the U.S.

During the Solution to Stigma, a small work group activity, participants were divided into two groups. These small groups allowed facilitators to engage the participants, to discuss solutions to addressing stigma, and to capture potentially innovative ideas about how to disseminate the provider OCC and utilize the data from the ICA. Both groups provided the following responses to three questions:
1. **What are some of the best practices for de-stigmatizing HIV and STD testing among patients?**
   - Providers should initiate the conversation of sex and sexuality with their male patients
   - Federally qualified health centers (FQHCs) and other direct clinical service providers could allow patients to self-collect samples for certain STD screenings
   - Visual materials being used to put a face to HIV potentially stigmatize the targeted groups
   - Educating Black and Latino gay men/MSM communities involves more than just clinicians’ input and it requires peer educators to promote sexual health education
   - Patients should be allowed to electronically answer sexual history questions in clinical settings prior to meeting with the clinicians

2. **How have you as a provider educated yourself on the health needs specific to Black and Latino gay men/MSM versus the general health needs of lesbian, gay, bisexual, transgender and questioning (LGBTQ) people?**
   - Patients educate clinicians on the latest technology and trends
   - Partnering with local community-based organizations have provide insight on ways to engage Black and Latino gay men/MSM
   - Role playing with providers to familiarize them with taking sexual health histories with Black and Latino gay men/MSM clients
   - Having a series of forums and town-hall meetings with the community

3. **In working with Black and Latino men, what practices have served you well in forming a good provider-patient relationship?**
   - Building a strong rapport with Black and Latino patients is key
   - Respectful and clear communication is central to ensuring the provider-patient relationship
   - Working in teams with diverse colleagues to best ensure affirming provider-patient relationships at various levels

The afternoon sessions entitled *Community Perspective on Quality Care for Young Black and Latino Gay Men and MSM*, included a panel of HIV-positive and negative young Black and Latino gay men. The young men shared their personal and professional experiences in clinical settings. The panel provided a forum for young Black and Latino gay men/MSM to freely express their views and opinions and inform medical and service providers of their experiences in accessing care. Some of the challenges the panelists highlighted included:
   - The role non-clinical staff (e.g., clinic greeters, administrative staff, etc.) play in creating a welcoming environment
   - Apprehension about accessing services in local community clinics due to fear of stigma and one’s medical information being shared in the community
   - The role of social determinants (e.g., poverty or being without a social security card) in shaping sexual health behaviors and risk of young Black and Latino gay men/MSM

The final presentation, *Optimal Care Checklists Discussion*, served as an opportunity for clinicians and community stakeholders to provide feedback on the provider optimal care checklist (OCC). The provider OCC was developed by NASTAD and NCSD as a tool for clinicians to increase the visibility of the specific sexual health needs of Black and Latino gay men/MSM and to strengthen the sexual health literacy of Black and Latino gay men/MSM. Although the participants thought the provider OCC would be helpful in different clinical settings, the participants identified several barriers or limitations regarding the provider OCC:
Most hospitals/clinics use standard forms that do not include language around gay men/MSM. There was no mention of sexual abuse, Post Exposure Prophylaxis (PEP) and violence. General education that many providers receive does not address issues of specific concern to LGBTQ persons and sexual health, which leaves many providers feeling uncomfortable with asking key questions relating to their patient’s sexual histories, particularly Black and Latino gay men/MSM.

During the Developing a Standard of Care session participants were once again divided into two groups that provided responses to three questions seeking recommendations to strengthen the OCC:

1. **At your place of work, do you educate young Black and Latino gay men/MSM on the importance of non-genital site testing? Why or Why not?**
   - Providers are more likely to provide education on STD screening to HIV positive Black and Latino gay/MSM, than to HIV-negative Black and Latino gay/MSM.

2. **Where do you think the provider Optimal Care Checklist (OCC) would be most useful?**
   - STD clinics
   - Private health care settings
   - Emergency departments’ urgent care and pediatrics
   - Mobile vans that provide health care and testing
   - Medical schools and national medical associations

3. **Is the language of the OCC “provider-friendly?” Is this document accessible for different provider communities to enter into this conversation about the sexual health needs of Black and Latino gay/MSM?**
   - Provide hard copy documents that direct providers to the online version of the OCC tools and possibly make a pocket card with information
   - Condense the document into one page
   - Format the OCC in quick points with hyperlinks and bullet points instead of paragraphs

**Next Steps**

Based off the feedback provided by meeting participants, several changes will be made to the provider optimal care checklist. In addition, NASTAD and NCSD submitted abstracts to several conferences to present about the ICA and the OCCs to several conferences. Data from the ICA will be presented in the poster sessions at the International AIDS Conference in Washington, DC in July 2012. Additionally the OCCs were accepted as a workshop topic at the Gay and Lesbian Medical Association (GLMA) Annual Conference in San Francisco in September 2012. NASTAD and NCSD also plan to provide our members with a toolkit to address stigma and highlight the work of member jurisdictions who have created stigma campaigns.

**EVALUATION REPORT**

**Methodology**

NASTAD and NCSD utilized both quantitative and qualitative methods to evaluate the one day meeting (see Appendix 9). Quantitative data was collected using a survey format, and included questions specific to the agenda and overall objectives of the meeting. The qualitative data was collected by presenting the meeting participants with three open-ended questions in which to
respond. The survey was designed to aid in determining the extent to which the meeting objectives were met as well as the strengths and weaknesses of the meeting format and specific materials presented during the meeting. The intent was to keep the evaluation form short so that attendees would be more apt to complete it. Copies of the surveys were provided to the participants and were collected by NASTAD and NCSD staff facilitators at the end of the meeting.

The comprehensive meeting evaluation was easy for participants to fill out and provided feedback on each agenda item but did not provide comprehensive information and feedback that would be most useful in planning subsequent meetings and materials development. The tool only affords the opportunity to indicate whether agenda items were very helpful, helpful, neutral, unhelpful or very unhelpful. Respondents were not able to quantify specific aspects and reactions to the individual agenda items. The qualitative section of the evaluation form was the only space provided to give more specific and detailed feedback.

Evaluation Findings

There were 19 participants who attended the meeting; 11 submitted evaluation forms, for a 61 percent response rate. Of the 11 completed evaluation forms, three respondents indicated they were community service providers, three were medical providers, four were researchers, three were national stakeholders, and two were other. Among the 11 completed evaluation forms, the 11 respondents in total identified 15 roles or affiliations they had at the meeting. Respondents were allowed to self-identify in terms of their role in the meeting, which may have led to the overlapping of self-identified roles and contribute to the lower or higher representation in certain categories.

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<thead>
<tr>
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<tr>
<td>Community Service Providers</td>
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</tr>
<tr>
<td>Medical Providers</td>
<td>3</td>
</tr>
<tr>
<td>Researcher</td>
<td>4</td>
</tr>
<tr>
<td>National Stakeholders</td>
<td>3</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>2</td>
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Fifty-five percent of respondents (six of 11) answered “Yes” to the question, “Are the meeting goals clear?” The remaining respondents answered “Somewhat”. When asked if the meeting information and discussion was relevant to their overall work with Black and Latino gay men/MSM, 91 percent (10 out of 11) answered “Yes,” with only one answering “Somewhat.”

Additionally, the sessions Race Matters: A Socio-Political Context for Developing a Standard of Care for Black and Latino Gay Men/MSM and NASTAD and NCSD Institutional and Community Assessment were the highest rated sessions with 73 percent of respondents rating each session as “Very Helpful”, with the remaining 27 percent rating the sessions as “Helpful”. Community Perspectives on Quality Care for Young Black and Latino Gay Men/MSM was the only session in which a respondent indicated that the session was “Unhelpful” (nine percent) toward meeting the meeting objectives. The remaining sessions were either identified as “Very Helpful”, “Helpful” or “Neutral”.

Only eight of the 11 (73 percent) respondents answered the question “Were the meeting goals clear.” However, all of them (11 out of 11) felt that the meeting goals were met and plan to share what they learned or discussed during the meeting with colleagues. When asked if the “Information and
the discussion during this meeting” were relevant to [their] “Overall work,” 10 of 11 (91 percent) felt that they were. Only nine percent (one out of 11) felt that the information and the discussion were “Somewhat” relevant to his or her work.

The Provider Checklist for MSM is a tool tailored for clinicians who work directly with Black and Latino gay men/MSM around issues of sexual health. Despite most meeting participants not being medical providers, the majority of respondents (seven out of 11, or 64 percent) answered “Yes” that the Provider Checklists for MSM was relevant to their work. Thirty-six percent (four out of 11) responded that the Provider Checklist for MSM was “Somewhat” relevant to their work. Given that there were only three medical providers out of 18 participants in attendance at the meeting, the evaluation of the Provider Checklists for MSM likely demonstrates the cross-cutting interest that exist to strengthen the patient provider relationship and empower young Black and Latino gay men/MSM around issues of sexual health.

All those who responded to the evaluation survey acknowledged to different extents that the meeting changed their understanding regarding standards of care for Black and Latino gay men/MSM. Eighteen percent (two out of 11) of respondents answered that their understanding of standards of care for Black and Latino gay men/MSM changed “To a great extent.” Six out of 11 (55 percent) responded that their understanding changed “To a moderate extent.” Twenty-seven percent (three out of 11) respondents answered that their understanding changed “To a slight extent.”

Again, all those who responded to the evaluation survey acknowledged to varying degrees that the meeting would assist them in “providing and implementing a standard of care for Black and Latino gay men/MSM.” Thirty-six percent (four out of 11) answered that “to a great extent” that the meeting would assist them in providing and implementing a standard of care for Black and Latino gay men/MSM. An additional, 45 percent (five out of 11) answered “to a moderate extent” that the meeting would assist them in providing and implementing a standard of care for Black and Latino gay men/MSM. Finally, eighteen percent (two out of 11) answered “to a slight extent” that the meeting would assist them in providing and implementing a standard of care for Black and Latino gay men/MSM.

Despite the fact that many of the meeting participants were not medical providers, 91 percent of the participants who completed the evaluation form felt that the “information and the discussions” pertained to their work. Additionally, 82 percent of participants felt that the meeting would assist them to provide a standard of care for Black and Latino gay men/MSM at either a great or moderate degree. All of the participants who responded to the evaluation plan to share what they learned with their colleagues.

The overall participants’ interest in the information and willingness to share with their colleagues suggest there are opportunities: 1) to gather more data from different experts about the needs of Black and Latino gay men/MSM in clinical settings; and 2) to partner with the meeting participants and other key stakeholders for the dissemination of the OCCs.

The evaluation form contained three open-ended questions. These questions gave the participants an opportunity to provide in-depth feedback about what would make the provider OCC better and generally what could improve the standard of care for Black and Latino gay men/MSM. The participants’ feedback were that the OCC should be shortened. Also, the providers felt that the provider OCC should reference Post Exposure Prophylaxis (PEP), sexual abuse and mental health
issues. In addition to their feedback on the actual products and survey tools developed by NASTAD and NCSD, the participants recommended additional ideas regarding with whom to partner in order to improve the training of health care providers (e.g., Association of Medical Colleges (AAMC), Liaison Committee On Medical Education (LCME), and state licensing Boards).

**SUMMARY**

This meeting continues NASTAD and NCSD’s commitment to support health department efforts to prevent new STD and HIV infections among gay men/MSM of all races and ethnicities. In order to sharpen our focus on gay men/MSM health, understanding the nuances in Black and Latino gay/MSM lives is important to creating effective tools and policies that improve sexual health disparities. The meeting served as a way to engage clinicians and community stakeholders who have worked extensively with Black and Latino gay men/MSM. In addition, the meeting served as a way to capture feedback on both the Institutional and Community Assessment and the Provider Optimal Care Checklist. In developing the Institutional and Community Assessment and the Optimal Care Checklists, NASTAD and NCSD sought to provide health departments with new tools and data to better evaluate their efforts and provide care to Black and Latino gay men/MSM.
Appendix 1 - Meeting Agenda

“Raising the Bar”: Developing a Standard of Care for Black and Latino Gay Men and other Men who have Sex with Men (MSM) in Clinical Settings

Hotel Sofitel - 806 15th Street, NW, Washington, D.C.
March 18-19, 2012

AGENDA

Sunday, March 18, 2012
Paris Ballroom Foyer

6:00 – 8:00 PM
Opening Reception

Monday, March 19, 2012
Paris Ballroom

8:30 – 9:00 AM
Registration and Breakfast

9:00 – 9:30 AM
Welcome and Agenda Review
Julie M. Scofield, NASTAD
William Smith, NCSD
Francisco Ruiz, NASTAD

9:30 – 10:10 AM
“Race Matters”: A Socio-Political Context for Developing a Standard of Care for Black and Latino Gay Men/MSM
Terrance Moore, NASTAD
Edgar Rivera-Colon, PhD, Praxis/Kairos Community Research & Mobilization Consultants
Patrick Wilson, PhD, Columbia University

With the full implementation of the Patient Protection and Affordable Care Act in 2014, clinician and stakeholders are preparing for the transformative impact of the way that health care is delivered in the United States. This session will discuss the changing health policy landscape and its influence on healthcare delivery to Black and Latino communities. There will be a particular focus on addressing health disparities among gay men/MSM of color in clinical settings and how addressing these issues are imperative for positive health outcomes.
10:10 – 10:45 AM  **NCSD and NASTAD Institutional and Community Assessment**  
*Patrick Wilson, PhD, Columbia University*

NCSD and NASTAD administered an assessment that sought to measure stigma in four key sub-categories: race and ethnicity, gender, homophobia and HIV/STD stigma. This session will share-out the initial findings from the survey, which captures how health care practitioners, community stakeholders, and other partners navigate stigma in various settings.

10:45 – 11:15 AM  **BREAK**

11:15 – 12:15 PM  **Solutions to Stigma (Small Work Group Activity)**

Participants will break into small work groups to discuss three sources of stigma: race and ethnicity, heterosexism/homophobia and HIV/STD. Work groups will identify solutions at the community, health department, and policy levels to address the impact of stigma.

12:15 – 1:45 PM  **LUNCH PANEL: Community Perspectives on Quality Care for Young Black and Latino Gay Men and MSM**  
*Rena Greifinger, NASTAD consultant  
Blake Rowley, The Fenway Institute  
Juan Carlos Loubriel, Whitman-Walker Clinic  
Venton Jones, National Black Gay Men’s Advocacy Coalition  
Jose Ramírez, Transgender Health Empowerment*

This session will highlight the unique issues affecting HIV positive LGBTQ youth. A panel of young Black and Latino gay men will provide their personal and professional perspectives on ways to create welcoming, culturally responsive clinical environments that foster youth engagement and retention in adult health care settings.

1:45 – 2:00 PM  **BREAK**

2:00 – 2:30 PM  **NCSD Optimal Care Checklists Discussion**  
*William Smith, NCSD  
Justin L. Hill, NCSD and NASTAD*

NASTAD and NCSD collaboratively developed two complementary Optimal Care Checklists: one geared for providers and the other for Black and Latino gay men/MSM. This session will allow NCSD and NASTAD to obtain feedback from meeting participants on key ways to enhance and disseminate these tools to the population and in clinical settings.
2:30 – 3:30 PM  **Developing a Standard of Care (Small Work Group Activity)**
During this session, participants will assess and provide recommendations for innovative practices for service delivery tailored for Black and Latino gay men/MSM.

3:30 – 3:45 PM  **BREAK**

3:45 – 4:20 PM  **Work Group Presentations and Discussion**
This session will serve as an opportunity for participants to report back recommendations and ideas discussed in the small work group sessions to the larger group.

4:20 – 4:45 PM  **Reflections and Closing**
Appendix 2 – Presentations

- **Policy Lay of the Land**
  - Blue Ribbon Panel
  - March 15, 2012

- **New Directions in HIV Prevention**
  - Move towards more nimble, higher-impact evidence-based interventions
  - Increased prioritization of HIV testing
  - Increased emphasis on screening for other STDs
  - Increased focus on Prevention with Positives
  - Increased focus on policy barriers that impede optimal service delivery

- **CDC cooperative agreements formula for HIV prevention funding to health departments**
  - CDC cut $20 million for core prevention (Category A)
  - Very few winners; many states lose up to 50 percent of funding over 5 years
  - Category C – $20 million for innovation (March 2012 awards)
  - NASTAD is calling for restoration of funding for core HIV prevention services
  - New HD Surveillance and STD FOAs under development

- **AIDS Drug Assistance Programs**
  - Waiting lists – 3,840 individuals in 11 states, as of March 15
    - Cost containment measures
  - Support from Congress, President Obama and former President Clinton
    - FY2012
    - World AIDS Day 2011
  - **ADAP Crisis Task Force agreements**
    - ADAP Crisis Task Force negotiations have realized over $1.2 billion in savings since 2003

- **Health Reform Implementation**
  - Politics and Supreme Court decision
  - Implementation is a target in the appropriations process
  - Depends on state implementation of Essential Health Benefits and health of Medicaid programs
  - ADAP and RW Program readiness/.wrap-around
    - Collaboration with other payers and systems (Medicaid, Community Health Centers, Health Exchanges, Private Insurances)
  - Strategy will depend on outcome of 2012 elections and health reform direction (Supreme Court decision)
    - NASTAD, amFAR, HIVMA and TAEP joined NMAC sponsored amicus brief
Testing and Linkages to Care

- Increasing knowledge of status
  - HRSA identification of unmet need (methodologies not consistent with CDC)
- Emphasis on linkages to and retention in care
  - Siloed programs based on funding streams
  - Disconnect between CDC and HRSA definitions
    - Progress at HHS
- CDC CoAg Category B (Expanded Testing)
  - Funding reduced; more jurisdictions eligible
  - NASTAD is advocating for restoration of funding and additional funding making all jurisdictions eligible

Biomedical Interventions and PrEP

- Gilead FDA filing
  - Support services associated with PrEP
- NASTAD preparation for implementation of PrEP
  - Health departments not prepared and unable to implement
  - TA and education to HDs regarding PrEP
  - NASTAD "issues for Consideration"
  - NASTAD participating in community coalitions

Testing and Linkages to Care

- Recent developments in HIV testing technology and policies that impact HD HIV testing programs
  - New algorithm for laboratory testing
  - New tests and algorithms for identifying acute infection
  - Oral fluid testing
  - OraQuick OTC application
  - CDC revised guidelines for HIV testing in non-clinical settings

Thank You!

Terrance E. Moore
Director, Policy and Health Equity
tmoore@NASTAD.org
202-434-8090
Raising the Bar: Cultural Challenges in Patient-Clinician Communications

Edgar Rivera Colón, PhD
Praxis/Kairos Community Research & Mobilization Consultants, LLC

Points of Resistance (Where the structures hit the road)

• Discussing sexual practice with clinicians
• Discussing HIV status with sexual partners
• Discussing practices/identities with families of origin & community members.

What about Latino MSM?

“Shame is the inner life of stigma.”

Sources of Stigma
• Hypermasculinity/Subordinated Masculinity
• Familiism
• Religious Ideologies/Institutions
• Linguistic Chauvinism
• Immigration Status/Racialized Perp Culture/Surplus Labor

Sources of Support
• Overlapping Kinship Structures
• Religious Faith & Community
• Linguistic Inclusion & Affirmation
• Gay/B/DL Latino Social Networks & Hangouts
• Labor Activity

“Narratives * Are Tools For Working with Experience.”

• The stories we create with clients in our clinical interactions CAN bind past & future into a coherent whole.
• They CAN culturally manage pain, uncertainty, fear, & other emotional & physical challenges.
• Clinical Challenge: What are the narratives that your Latino MSM use for their lives? What do they tell you?
• How can we encourage more healing narratives --- not curative ones --- from our Latino MSM clients?

What’s Praxis/Kairos?

Praxis = all human actions that lead to individual AND collective transformation.
Cognate: practice.

Kairos: a key time when change is in the offing AND a decision has to be made to seize the opportunity that has been give.

Praxis/Kairos Community Research & Mobilization Consultants is a collective of forward-thinking researchers who use their social scientific training in the service of community mobilization and organizing.
Thank You!

Edgar Rivera Colón, PhD
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Or chaco64@yahoo.com
Cell: 551 208-4948
"Race Matters": A Socio-Political Context for Developing a Standard of Care for Black and Latino Gay Men/MSM

Patrick A. Wilson, PhD
Columbia University

NASTAD/NCSH Meeting
March 19, 2012

Psychosocial Correlates of HIV infection among Black MSM

- Stigma
  - Sexual stigma/homophobia
  - Anti-femininity attitudes
  - HIV/AIDS stigma
  - Class-based stigma
  - Racism and race-based sexual stereotypes

- Religion and homophobia (e.g., from Black churches)

- Masculine socialization/peer-controlled masculinity, peer norms

- Trauma experiences, mental health

Social Network Factors

- Characteristics of sex partners coupled with background prevalence influences transmission risk
  - Older partners
  - Black partners
  - Earlier sexual debut

- Concurrency not associated with HIV infection
  - Concurrency does not explain greater risk

Trauma among young BMSM

<table>
<thead>
<tr>
<th>Childhood trauma type</th>
<th>Percentage</th>
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<tr>
<td>Bullied</td>
<td>16%</td>
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<tr>
<td>Parental substance abuse</td>
<td>74%</td>
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<tr>
<td>Parent in jail/prison - 1 month</td>
<td>79%</td>
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<tr>
<td>Emotional abuse from parent</td>
<td>13%</td>
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<tr>
<td>Physical abuse from parent</td>
<td>12%</td>
</tr>
<tr>
<td>Unwanted sexual touching</td>
<td>14%</td>
</tr>
<tr>
<td>Forced oral sex</td>
<td>16%</td>
</tr>
<tr>
<td>Forced anal/vaginal intercourse</td>
<td>13%</td>
</tr>
<tr>
<td>Exchanged sex for money/food/housing</td>
<td>16%</td>
</tr>
<tr>
<td>Homelessness</td>
<td>17%</td>
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Wilson, 2012

Social Network Factors

- Most participants gave clear preferences for sex partners of specific ethnic groups

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<tr>
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<td>1. EA men (12%)</td>
<td>1. Latino men (13%)</td>
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<td>2. AA men (12%)</td>
<td>2. API men (26%)</td>
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<td>4. Latino men (26%)</td>
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<td>4. Latino men (6%)</td>
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(Ordered from most preferred to least preferred)
Structural Barriers
Definition: Physical, environmental or social structures, or laws or policies that affect HIV transmission risk.

Structural impediments:
- Poverty
- Homelessness
- Incarceration

Stigma’s impacts on prevention
- Homophobia & racism impacts HIV prevention efforts in 3 ways:
  1. Sexual silence
     - inability to talk about sexuality within the Black communities is a major factor that hinders HIV prevention efforts.
   - community-level homophobia diminishes dialogue about homosexuality and sexual behaviors in which gay men engage
   - instead of talking about sexuality in an open and healthy manner, discussions are more focused on Black gay men as engaging in deviant behaviors that propagate HIV within the community
  2. disclosure and coming out
     - fear of social isolation and physical harm make Black MSM uncomfortable disclosing same-sex sexual behaviors and coming out as gay men
  3. Community mobilization

Questions to consider
- How does layered stigma operate among Black gay men?
  - BMSM contend with multiple stigmatized identities which may intersect and conflict with each other. Correspondingly, addressing one source of stigma that Black gay men experience may serve to enhance the internalization of stigma that comes from another source.
- What are the policy-level interventions that need to be in place to respond to stigma?
  - How do we make sure our prevention responses don’t serve to reinforce stigma?
- What are the research questions that we need to be asking? What are the interventions that we need to be implementing?
  - What is the role of education?

Stigma’s impacts on prevention
- Stigma related to femininity affects HIV prevention efforts in 2 ways:
  1. Accelerated childhood and adolescence for young black men
     - intense pressures for young Black men to engage in masculine behaviors (i.e., being tough, not crying, etc.): “black little boys, particularly, never get to be little boys. You’re always ‘little man’ from the time you can walk...if you fall down, you can’t cry.”
     - young Black gay men, notably those who are effeminate, face social isolation, bullying, and physical violence that increase HIV risk
  2. Socially-rooted expectations for heterosexual marriage and fatherhood
     - expectation that Black men “find a wife,” have a bunch of kids and then carry on that proud black line; this expectation is reinforced given the current rate of incarcerations among Black men
     - being gay means being a disappointment

THANK YOU!

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MAC AIDS Fund – Stigma
Year One in Review

MAC AIDS Fund (M·A·F)

- MAC AIDS Fund (M·A·F) was established in 1994 and donates funds to communities that offer services and help to and prevent the HIV/AIDS through educational programs and services.
- M.A.C. Cosmetics is currently the leading non-pharmaceutical corporate fundraiser for HIV/AIDS worldwide and has raised over $224 million dollars to date thanks to the VIVA GLAM campaign.

VIVA GLAM

- VIVA GLAM is the backbone for M·A·F and was launched in 1994.
- VIVA GLAM is a line of lipsticks and lip-glosses from which every cent of the sale price goes to help those living with HIV/AIDS around the world.

M·A·F Grant

- With the National Coalition of STD Directors (NCSD), NASTAD was awarded funding from M·A·F to explore stigma affecting gay men/MSM, specifically focusing on Black and Latino men.
- The grant work mounts an unprecedented, aggressive, targeted effort across the silos of HIV and STD prevention, treatment & care, to examine and address stigma in public health practice.

Goals of Stigma Work

- Increase comprehensive access to prevention, care and supportive services for HIV positive and negative Black and Latino gay men;
- Target social and sexual networks to promote positive sexual health messages; and
- Establish and promote evidence-based practices and tools to educate NSCD and NASTAD members, key community stakeholders, and public health providers.

Scope of Work

- Increase comprehensive access to prevention, care and supportive services for HIV positive and negative Black and Latino gay men;
- Target social and sexual networks to promote positive sexual health messages; and
- Establish and promote evidence-based practices and tools to educate NSCD and NASTAD members, key community stakeholders, and public health providers.
Goal of Stigma Survey

- The goal of the survey was to assess stigma at the institution/community levels
  - survey explores a broad range of types of stigma, including:
    1. stigma related to HIV/AIDS
    2. stigma related to same-sex sexuality/homophobia
    3. stigma related to gender performance/femininity (among MSM)
    4. stigma related to race/racism
  - Items in survey focus on institutional and community practices (i.e., as opposed to individual-level behaviors)

Development of Survey

- Stigma survey items were developed by the NASTAD Policy & Health Equity team, with the input from consultants
  - Focus group and interview data from NASTAD’s work with Black & Latino MSM was reviewed
  - Related measures, including the Kessler (1999) stigma scale and Herek & Giunt (1995) internalized homophobia scale, were drawn upon
  - Expert review and input
  - The survey was piloted with two jurisdictions (n=56) during October 2011 to gauge response level and clarity of survey questions
    - Survey was refined based on the pilot data

Stigma Survey Measures

Reliability of the stigma survey

- HIV stigma subscale
  - # of items: 8
  - Example: “In my community, most people believe that HIV-positive persons do not disclose their HIV status to their sex partners.”
  - Alpha (reliability) coefficient: 0.66

- Gender-based stigma subscale
  - # of items: 6
  - Example: “In my community, female gay men and/or gay-acting are often the targets of insults, bullying and/or physical violence.”
  - Alpha (reliability) coefficient: 0.74

Reliability of the stigma survey

- Race/ethnicity-based stigma subscale
  - # of items: 12
  - Example: “People in my community believe poor health among Blacks and Latinos is because of their tendency to engage in risky behaviors.”
  - Alpha (reliability) coefficient: 0.77

- Sexuality-based stigma/homophobia subscale
  - # of items: 10
  - Example: “The public schools in my community have sex education programs that address the needs of gay youth.”
  - Alpha (reliability) coefficient: 0.88

Stigma Survey Measures

Reliability of the stigma survey

- Full stigma scale
  - # of items: 45
  - Alpha (reliability) coefficient: 0.93

Sample

- The survey launched on December 1, 2011 and closed on January 31, 2012
  - 1,314 respondents completed the survey
  - 54 different states and territories were represented in the survey
  - 18 states had 25 or more respondents with completed surveys
**Findings – States w/ 25+ Responses**

- **Gender-based stigma:**
  - Lowest: Florida, Washington, Massachusetts, North Carolina
  - Highest: South Carolina, Kentucky, Alabama, Michigan

- **Race/ethnicity-based stigma:**
  - Lowest: North Carolina, Texas, Connecticut, California
  - Highest: South Carolina, Kentucky, Alabama, Michigan

- **Sexuality-based stigma:**
  - Lowest: Massachusetts, California, Connecticut, Washington
  - Highest: Michigan, Kentucky, South Carolina, Alabama

**Initial Findings – States w/ 25+ Responses**

- **States significantly differed on the stigma scale and each of the four subscales**
  - Lowest perceived stigma (overall): Massachusetts, California, Connecticut, Washington
  - Highest perceived stigma (overall): Kentucky, Michigan, Alabama, South Carolina

- **HIV-related stigma:**
  - Lowest: Massachusetts, Washington, California, Texas
  - Highest: Alabama, Virginia, Michigan, South Carolina

**Findings – Neighborhood/Region**

- **Participants from different neighborhood types had significant differences in sexuality-based stigma**
  - Those from rural areas perceived significantly higher levels of sexuality-based stigma than those from urban and suburban areas

**Findings – Racial/Ethnic Group**

- **Across domains, participants from different racial/ethnic groups had significantly different perceptions of stigma**
  - A consistent trend was that White participants expressed the lowest levels of stigma, while Black participants perceived the highest levels

- **HIV-related stigma:**
  - Black participants perceived significantly higher levels than White, Hispanic/Latino, and "Other" race participants

- **Gender-based stigma:**
  - Latino and Black participants perceived significantly higher levels than White and "Other" race participants

- **Race/ethnicity-based stigma:**
  - Latino, Black, and "Other" race participants perceived significantly higher levels than White participants
Findings – Gender

- Gender group differences were observed for gender-based stigma, race/ethnicity-based stigma, and overall perceived stigma
  - Transgender respondents consistently reported higher levels of gender- and race/ethnicity-based stigma than other respondents

Findings – HIV Status

- Across domains, participants from different HIV status groups had significantly different perceptions of stigma
  - HIV-positive participants perceived higher levels of HIV-, gender-, race/ethnicity-, and sexuality-based stigma; unknown status participants perceived the lowest levels of stigma

Findings – Sexual Orientation

- Differences among sexual orientation groups were observed for gender-, race/ethnicity-, and sexuality-based stigma, and overall perceived stigma
  - Overall, sexual minority participants perceived more stigma than heterosexual participants

Findings – Professional/Job

- Participants from different professional backgrounds were significantly different on perceptions of stigma
  - Participants who worked in CBOs perceived significantly higher levels of race/ethnicity- and HIV-based stigma than participants from the health department

Findings – Incidence Regions

- Participants from different HIV incidence regions held significantly different views on stigma
  - Participants from high-to-moderate incidence (>10,000) states perceived significantly higher levels institutional stigma than participants from high incidence (>23,000) states
**Findings – Incidence Regions**

- HIV-, race/ethnicity-, and sexuality-based stigma:
  - Participants from high-to-moderate incidence (>10,000) states consistently perceived significantly higher levels than participants from high incidence (>23,000) states.
  - Participants from high incidence (>23,000) states held the lowest levels of stigma across all domains.

- There were no significant differences on stigma domains for STI incidence region or age group.

**Implications for Health Practice**

- Robust efforts needed from health departments and public health practitioners in order to reduce stigma:
  - Implement hiring practices that aggressively aim to bring greater numbers of ethnic & sexual minorities into the public health workforce.
  - Enhance medical and health provider competency training.
  - Promote efforts to increase the organizational capacity of CBOs that serve marginalized populations.
  - Social marketing campaigns:
    - Campaigns focusing on consciousness-raising and that challenge negative stereotypes and preconceived notions are necessary.

- Relatively high levels of institution- and community-level stigma targeting gay men:
  - Gender-based stigma appeared to be more pervasive than other forms of stigma; race/ethnicity-based stigma was least frequently endorsed.

- Geographic and demographic variability in stigma:
  - Alabama, Kentucky, Michigan, and South Carolina consistently reported high levels of stigma across domains.
  - Those from rural areas, who were non-White, transgender, sexual minorities, or HIV-positive, or who worked at a CBO perceived highest levels of stigma.

**Stigma Team**

- Jamaal Clue, Health Equity
- Justin Hill, NASTAD/NCSD
- Britten Pund, Health Care Access
- Terrance Moore, Policy and Health Equity
- Murray Penner, Domestic Programs
- Francisco Ruiz, Health Equity
- Isaiah Webster, Prevention
- Patrick Wilson, NASTAD Consultant
Appendix 3 – Provider Optimal Care Checklist

Providers can play a critical role in improving the health outcomes for Black and Latino men who have sex with men (MSM). Studies reinforce the significance of clinicians offering vaccines and recommending diagnostic STD testing. In addition to providing vaccinations for patients, HIV/STI counseling and testing, and collecting more comprehensive sexual histories, providers can play a pivotal role in assisting gay, bisexual, and other MSM patients in developing a greater knowledge of their sexual health needs. Higher literacy and understanding of this population is key to addressing issues related to stigma, sex, sexual health, and HIV and other STIs.

The Case for MSM-Centered Care
Some recent data underscores the need to do more to improve adverse sexual health outcomes among MSM – and particularly among MSM of color. For example, one study found that between 2006 and 2009 there was a statistically significant increase in new HIV infections of 48% (12.2% annually) in young, black/African American MSM. In addition, data from 27 states reported an increase in syphilis rates among Black and Latino MSM, which were up to 8 times that of white MSM. The release of recent HIV and STD incidence data highlight the imperative need to address stigma and other barriers role in impeding patient-centered care for Black and Latino MSM.

Cultural competent sexual health history taking Studies show that some MSM, particularly MSM of color, may not identify as gay or bisexual, and that as a result, providers who rely on a patients’ self-reported sexual orientation may not appropriately assess their patient’s risk for STDs and HIV. Therefore taking a sexual health history of each male patient may allow for a better assessment of a patient’s risk factors and may better inform the types of sexual health services a provider provides.

There are additional resources, including samples of sexual health history questionnaires that are available:

1. California Department of Public Health
   a. www.stdcheckup.org
2. Center for Disease Control and Prevention and the Department of Health and Human Services

Taking a sexual history allows you to:
- Identify individuals at risk
- Screen appropriate anatomical sites
- Provide appropriate risk reduction counseling to prevent future exposure to STDs/HIV

Breaking through Stigma
Understanding how stigma associated with STD and HIV infection acts as a barrier to appropriate diagnostic and treatment services for Black and Latino MSM allows providers to deliver culturally appropriate care. Studies suggest that stigma impairs the relationship between providers and MSM patients. In that context, discussing STIs, such as Chlamydia, Gonorrhea, viral hepatitis and HIV/AIDS with a patient can be difficult. In fact, discomfort with the discussion may exist for both the provider and the MSM patient. Some physicians identify stigma-related barriers as the reason for not recommending HIV testing, such as the concern that a
Ways to remove Stigma from the conversation

- Emphasize that you ask every patient the same questions
- Assure patient of confidentiality
- Make NO assumptions about sexual practices
- Assure the patient that regardless of their sexual behaviors/practices their self-reported sexual identity will be respected

The 4 P’s Standard:
As a general rule, taking a sexual health history can be an easier process for providers and their patients by following the 4 “Ps:"

- Partners
- Practices
- Past history of STDs
- Protection from STDs

Here are some sample questions that follow the 4 P’s standard:

- Are you currently sexually active? (Are you having sex? (Partner)
- In recent months, how many sex partners have you had? (Partner)
- Are your sex partners men, women, trans or all of the above? (Partners)
- Do you have oral sex? Are you the oral receptive or insertive partner? (Practices)
- When you have anal sex are you the anal receptive or insertive partner? (Practices)
- Do you or have you ever injected drugs? (Practices)
- Do you get tested for STDs including HIV? When you get tested for STDs have you ever had a rectal or pharyngeal (oral) swab? (Practices)
- Have you or your partner ever had a STD before? If so, which one(s) and where was the infection found? Were you treated? Did you have a follow up with your doctor after treatment? (Past history)
- Do you use condoms? Do you use condoms every time you engage in anal, vaginal and oral sex? (Protection)

The Centers for Disease Control and Prevention (CDC) recommend that sexually active gay, bisexual and other MSM should be annually screened for common STDs:

- Chlamydia
- Gonorrhea
- Syphilis
- HIV

The CDC recommends screening every three to six months for MSM at highest risk (i.e., MSM who use illicit drugs, and/or have multiple sexual partners). Based on what was learned from the sexual health history, screening tests may involve other STDs.

The full CDC guidelines for MSM can be found here: [www.cdc.gov/std/treatment/2010/](http://www.cdc.gov/std/treatment/2010/)

In addition to urine-based tests for Gonorrhea and Chlamydia, studies reinforce that a special emphasis should be placed on rectal and pharyngeal screening for Gonorrhea and rectal screening for Chlamydia for those MSM patients with confirmed risk behaviors. Infections in these sites may often be asymptomatic and, left untreated, may be a contributing factor to HIV acquisition and further spread of the two diseases themselves.

Follow Up Testing:
The CDC recommends that persons treated for Gonorrhea or Chlamydia receive follow-up rescreening three months after treatment due
to the increase rate of Gonorrhea and Chlamydia repeat infections.

**MSM Tailored Screenings Matter:**
Patients listen to their provider. In fact, researchers have found that what made the difference in whether or not a client tested for HIV was if their provider suggested a test to them.\(^{xiv}\) Unfortunately data and some studies suggest that providers:
- are not sufficiently recommending HIV testing
- are not screening at different anatomical sites (i.e., rectal and pharyngeal)
The difference between a patient being tested may be a provider’s recommendation.

**Vaccinations for MSM**
Beyond HIV and STD testing, MSM patients should be strongly encouraged to protect their sexual health by taking advantage of STD vaccines.
The **2010 CDC STD Treatment guidelines** recommends that all MSM should be vaccinated for Hepatitis A and B.\(^{xv}\) The 2010 CDC guidelines also notes that providers can consider Human Papillomavirus (HPV) vaccination for boys age 9 up to young men age 26.\(^{xvi}\)

In considering whether or not HPV immunization is right for an MSM patient, it is important to note about this infection:
- The risk of developing anal cancer is 17 times higher in gay or bisexual men than in heterosexual men\(^{xvii}\)
- HPV is an independent risk factor for HIV infection \(^{xviii}\)
- HPV is associated with approximately 90 percent of anal cancer\(^{xix}\)

**CARE FOR HIV-Positive MSM:**
Providing care to HIV-positive MSM in some ways mirrors the services and patient-centered care offered to presumed HIV-negative MSM. Clinicians who manage the health of HIV positive MSM should routinely screen their patients for:
- Chlamydia (urine-based test, urethral and rectal swabs)
- Gonorrhea (urine-based test, urethral, rectal and pharyngeal swabs)
- Syphilis\(^{xx}\)

There are distinct concerns regarding diseases and routine screenings that can be considered for HIV positive individuals. For example, co-infections are common and present challenges to providing care for HIV positive clients (e.g., Hepatitis C\(^{xxi}\), Syphilis\(^{xxii}\), and HPV related Anal Cancer\(^{xxiii}\)).

This brief Optimal Care Checklist for MSM is designed to facilitate a conversation between you, the provider, and your MSM clients.
9 Center for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010; 59 (No.RR-12): 4,70.
WHO WE ARE:

Situated in the nation’s capital, the National Coalition of STD Directors (NCSD), works toward the development of systemic change and promotion of sexual health and national awareness in the policies that govern sexually transmitted diseases (STDs). We are a membership organization representing health department STD directors, their support staff and community-based partners across 50 states, seven large cities and eight US territories. We use the collective knowledge and experience of our members to successfully advocate for STD policies, programs and funding that helps promote and protect the sexual health of every American.

As the only national organization with a constituency that provides frontline STD programs and services, NCSD uses its experiences to promote informed sexual health policy making. NCSD proactively seeks to increase resources for core STD programs and services. NCSD also responds swiftly to efforts that curtail access to services and sexual health information.

OUR MISSION STATEMENT:

NCSD is a partnership of public health professionals dedicated to promoting sexual health through the prevention of STDs. NCSD provides dynamic leadership that strengthens STD programs by advocating for effective policies, strategies, and sufficient resources and by increasing awareness of their medical and social impact.

OUR OBJECTIVES:

• To create a full partnership among sexually transmitted disease project areas directly funded by the Centers for Disease Control and Prevention, state and local public health agencies, the Federal Government and private agencies to effectively prevent and control STDs in the US and its territories;
• To provide a conduit of communication and technology transfer among and between STD Directors nationally;
• To provide a forum for technical assistance and dissemination of information about effective STD prevention and control programs among members of the Coalition;
• To educate federal, state and local policy makers about issues relevant to STD control and prevention
• To network or affiliate with appropriate organizations working toward comparable goals; and
• To promote adequate and efficient allocation of resources to STD sexual health promotion.
WHAT WE DO FOR ELECTED OFFICIALS:
NCSD serves as an informational resource not only for our members in health departments, but we also hope that elected officials will utilize our knowledge when crafting policies and programs related to sexual health and STDs. Here’s how we can help:

- **Research and Analysis** – If you are working on a bill related to STDs or sexual health, or if want to learn more about one that is before your committee, please contact us. While we do not engage in lobbying or writing legislation, NCSD is equipped to provide model language and in-depth analysis on a variety of sexual health issues.

- **Legislative briefings** – Hosting a legislative briefing can be a great way to bring attention to an issue or a policy on which you are working. NCSD maintains a rich network of knowledgeable health practitioners across the United States, and we can work with you to host educational briefings featuring local experts.

- **Training and education** – NCSD holds an annual meeting with STD and health experts from around the country. This meeting provides a wonderful opportunity for policy makers to learn about STD policies, programs and emerging issues.

- **Liaising with your health department or the CDC** – Ensuring a seamless connection between your state’s health programs and CDC resources is important to us. Similarly, if we can help facilitate important dialogue between your office and the CDC, we are happy to do so. We can also introduce your office to STD program personnel at your department of health. These personnel are an invaluable resource as you work to shape STD and sexual health policy.

MAKING AN IMPACT:

- **Supporting states in creating effective policy** – NCSD is currently working with state-based partners to increase policy education efforts around STDs and other sexual health issues. For example, we are working with community partners to highlight the importance of providing needed resources to prevention programs, policies that give STD personnel new electronic tools to track and prevent the spread of disease, and novel medical practices that reduce STD burden while saving public money.

- **Working to inform Congress** – NCSD is a fixture on the Hill. We spend time educating Members of Congress and their staff about the importance of STD prevention and the vital role public health plays in maintaining a healthy society. For example, NCSD hosts an annual Congressional briefing on Capitol Hill addressing the impact of effective sexual health programs and policies.

Get in Touch with Us:

Please contact our State Policy Associate, Burke Hays, with any questions at 202-842-4660 or via email at StatePolicy@ncsddc.org. You can also visit our website at www.ncsddc.org and take a look at our helpful state policy section.

Nothing contained in this material is intended to influence, support, or defeat any piece of pending or proposed legislation, appropriation, or regulation at any governmental level. This piece is intended for educational purposes only.
Black Americans have been disproportionately affected by HIV/AIDS since the epidemic’s beginning, and that disparity has deepened over time.2 Blacks account for more new HIV infections, AIDS diagnoses, people estimated to be living with HIV disease, and HIV-related deaths than any other racial/ethnic group in the U.S.3,4,5 The epidemic has also had a disproportionate impact on Black women, youth, and gay and bisexual men, and its impact varies across the country. Moreover, Blacks with HIV/AIDS may face greater barriers to accessing care than their white counterparts.6,7,8 Today, there are more than 1.1 million people living with HIV/AIDS in the U.S., including approximately 510,000 who are Black.9 Analysis of national household survey data found that 2% of Blacks in the U.S. were HIV positive, higher than any other group.10

Figure 1: New HIV Infections & U.S. Population, by Race/Ethnicity, 200911

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>New HIV Infections</th>
<th>U.S. Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black, non-Hispanic</td>
<td>44%</td>
<td>65%</td>
</tr>
<tr>
<td>Latino</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Asian</td>
<td>12%</td>
<td>1%</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>32%</td>
<td>1%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Multiple races</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Figure 2: Rate of New AIDS Diagnoses per 100,000, by Race/Ethnicity, for Adults/Adolescents, 201013

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rate (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>43.0</td>
</tr>
<tr>
<td>Latino</td>
<td>13.7</td>
</tr>
<tr>
<td>White</td>
<td>4.4</td>
</tr>
<tr>
<td>Asian</td>
<td>3.5</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander</td>
<td>7.2</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>7.2</td>
</tr>
<tr>
<td>Multiple races</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Key Trends and Current Cases

• The number of new HIV infections per year among Blacks is down from its peak in the late 1980s, but has exceeded the number of infections among whites since that time; new infections among Blacks have remained stable in recent years.1,2
• The share of annual AIDS diagnoses accounted for by Blacks has gone up over time, rising from 25% of diagnoses in 1985 to 48% in 2010; in recent years, this share also has remained relatively stable.1,2
• A recent analysis of 1999-2006 data from a national household survey found that 2% of Blacks in the U.S. (among those ages 16–49) were HIV positive, significantly higher than whites (0.23%). Also, the prevalence of HIV was higher among Black men (2.64%) than Black women (1.49%).10
• The number of Black Americans living with AIDS increased by 8% between 2007 and 2009, compared to a 5% increase among whites.1
• The number of deaths among Blacks with AIDS decreased by 3% between 2007 and 2009; in contrast, deaths increased by 4% among Latinos and 5% among whites.1

Women and Young People

• Black women account for the largest share of new HIV infections among women (57% in 2009) and the incidence rate among Black women is nearly 15 times the rate among white women.3
• Black women also account for the majority of new AIDS diagnoses among women (64% in 2010); white and Latina women account for 15% and 17% of new AIDS diagnoses, respectively.4
• Black women represented more than a third (34%) of new AIDS diagnoses among Blacks (Black men and women combined) in 2010; by comparison, white women represented 14% of new AIDS diagnoses among whites in 2010.1
• Although Black teens (ages 13–19) represented only about 15% of U.S. teenagers,2 they accounted for 70% of new AIDS diagnoses among teens in 2010.1 A similar impact can be seen among Black children.1
• Between 2006 and 2009, new HIV infections among Black gay and bisexual men and other men who have sex with men ages 13–29 increased by 48%—an increase which drove a significant rise in new infections among young gay and bisexual men overall.2

Transmission
• HIV transmission patterns among Black men vary from those of white men. Although both groups are most likely to have been infected through sex with other men, white men are more likely to have been infected this way. Heterosexual transmission and injection drug use account for a greater share of infections among Black men than white men.1,3,18
• Black women are most likely to have been infected through heterosexual transmission, the most common transmission route for women overall. White women are more likely to have been infected through injection drug use than Black women.1,3
• Among gay and bisexual men, Blacks have been disproportionately affected. A study in 21 major U.S. cities found that 28% of Black gay and bisexual men in the study were infected with HIV, compared to 18% of Latino and 16% of white gay and bisexual men. Many of these men did not know they were infected.19 In addition, newly infected Black gay and bisexual men are younger than their white counterparts, with those ages 13–29 accounting for 60% of new HIV infections among Black gay and bisexual men in 2009, compared to 28% among whites.1

HIV Testing
• Among the non-elderly (ages 18–64), Blacks are more likely than whites to report having been tested for HIV in the last 12 months (43% compared to 15%).24
• Among those who are HIV positive, CDC data indicate that 31% of Blacks were tested for HIV late in their illness—that is, diagnosed with AIDS within one year of testing positive for HIV (in those states/areas with HIV name reporting); by comparison, 32% of whites and 36% of Latinos were tested late.1

Concern About HIV/AIDS24
• A recent survey found that Black Americans express concern about HIV/AIDS. About 1 in 5 Black Americans surveyed name HIV/AIDS as the number one health problem in the U.S. and 35% say that HIV/AIDS is a more urgent problem in their community than it was a few years ago.
• Personal concern about becoming infected with HIV is highest among Blacks, as is concern among Black parents about their children becoming infected. However, the proportion of Blacks saying they are personally concerned about becoming infected has declined since the mid-1990s.

Figure 3: Number of Black Americans Estimated to be Living with AIDS, Top 10 States, 200922

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated AIDS cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>34,850</td>
</tr>
<tr>
<td>Florida</td>
<td>25,513</td>
</tr>
<tr>
<td>Georgia</td>
<td>13,773</td>
</tr>
<tr>
<td>Maryland</td>
<td>13,659</td>
</tr>
<tr>
<td>California</td>
<td>12,281</td>
</tr>
<tr>
<td>Texas</td>
<td>12,030</td>
</tr>
<tr>
<td>New Jersey</td>
<td>10,215</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>9,104</td>
</tr>
<tr>
<td>Illinois</td>
<td>8,805</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>4,962</td>
</tr>
</tbody>
</table>

Geography
Although AIDS diagnoses among Blacks have been reported throughout the country, the impact of the epidemic is not uniformly distributed:
• The rates of AIDS diagnoses per 100,000 among Blacks are highest in the eastern part of the U.S. The District of Columbia has the highest rate for Blacks (214.1) in the country.11,21
• More than half of Blacks estimated to be living with AIDS and the majority of new AIDS diagnoses among Blacks occurred in the South.20,22
• Estimated AIDS prevalence among Blacks is clustered in a handful of states, with 10 states accounting for 71% of Blacks estimated to be living with AIDS in 2009. New York, Florida, and Georgia top the list (Figure 3). Ten states also account for the majority of new AIDS diagnoses among Blacks (66% in 2010).20,21

Access to and Use of the Health Care System
• The HIV Cost and Services Utilization Study (HCSUS), the only nationally representative study of people with HIV/AIDS receiving regular or ongoing medical care for HIV, found that Blacks fared more poorly on several important measures of access and quality than whites; these differences diminished over time but were not completely eliminated.7 HCSUS also found that Blacks were more likely to report postponing medical care because they lacked transportation, were too sick to go to the doctor, or had other competing needs.8
• An analysis of data from 2000-2002 in 11 HIV primary and specialty care sites in the U.S. found higher rates of hospitalization among Blacks with HIV/AIDS, but differences in outpatient utilization were not significant.9

Health Insurance
Having health insurance, either public or private, improves access to care. Insurance coverage of those with HIV/AIDS varies by race/ethnicity, as it does for the U.S. population overall:
• According to HCSUS, Blacks with HIV/AIDS were more likely to be publicly insured or uninsured than their white counterparts, with over half (59%) relying on Medicaid compared to 32% of whites. One fifth of Blacks with HIV/AIDS (22%) were uninsured compared to 17% of whites. Blacks were also much less likely to be privately insured than whites (14% compared to 44%).10
• Insurance status also varies at the time of HIV diagnosis. Analysis of data from 25 states between 1994 and 2000 found that Blacks were less likely than whites to have private coverage and more likely to be covered by Medicaid, or uninsured, at the time of their HIV diagnoses.23

2. CDC. Reported Data Requested. 2006.
12. Calculations based only on diagnoses for which race/ethnicity data were provided.
13. Includes estimated diagnoses among those 13 years of age and older. Estimates do not include U.S. dependencies, possessions, and associated nations, and diagnoses of unknown residence.
17. CDC. Slide Set: HIV Surveillance in Adolescents and Young Adults (through 2010).
18. CDC. Slide Set: HIV Surveillance by Race/Ethnicity (through 2010).
21. Estimates include U.S. dependencies, possessions, and associated nations, and diagnoses of unknown residence.
23. Kaiser Family Foundation analysis of CDC data.
Latinos and HIV/AIDS

Latinos in the United States continue to be heavily impacted by HIV/AIDS, accounting for higher rates of new HIV infections, AIDS diagnoses, and people living with HIV than their white counterparts. Moreover, studies have shown that Latinos with HIV/AIDS may face additional barriers to accessing care than whites. Today, there are more than 1.1 million people living with HIV/AIDS in the U.S., including approximately 220,000 Latinos. As the largest and fastest growing ethnic minority group in the U.S., addressing HIV/AIDS in the Latino community takes on increased importance in efforts to improve the nation’s health.

### Key Trends and Current Cases

**Latinos increased by 8% between 2007 and 2009, compared to an 8% increase among Blacks and a 5% increase among whites.**

- The number of deaths among Latinos with AIDS increased 4% between 2007 and 2009; deaths among whites also increased (5%), while deaths among Blacks decreased by 3%.

### Women and Young People

- Among women, Latinas accounted for 18% of new HIV infections and their HIV incidence rate was more than 4 times the rate for white women, but about one third of the rate for Black women, in 2009.

- Looking at new AIDS diagnoses in 2010 among women, Latinas accounted for 17% of new diagnoses; Black women accounted for 64% and white women accounted for 15%.

- Latinas represented 19% of new AIDS diagnoses among all Latinos (men and women combined) in 2010; by comparison, white women represented 14% of new diagnoses among whites, and Black women represented 34% of new diagnoses among Blacks.

- The rate of new AIDS diagnoses per 100,000 among Latinas (7.1) is about 5 times higher than the rate for white women (1.5).

- Latinas represent 18% of new AIDS diagnoses among teens, and Latinas ages 20–24 account for 21% of new AIDS diagnoses reported among young adults.

### Transmission

- HIV transmission patterns among Latino men vary from those of white men. Both groups are most likely to be infected through sex with other men. Heterosexual transmission accounts for a greater share of new infections among Latino men than white men.

- Latinas are somewhat more likely to have been infected through heterosexual transmission than white women, although this is the most common transmission route for both groups and for women overall. White women are more likely to have been infected through injection drug use than Latinas.

- Studies have found high HIV/AIDS prevalence among Latino gay and bisexual men. A study in 21 major U.S. cities found that 18%...
of Latino gay and bisexual men in the study were infected with HIV, compared to 28% of Black and 16% of white gay and bisexual men. Many of these men did not know they were infected. In addition, newly infected Latino gay and bisexual men are younger than their white counterparts, with those ages 13–29 accounting for 45% of new HIV infections among Latino gay and bisexual men in 2009, compared to 28% among whites.

• Insurance status also varies at the time of HIV diagnosis. Analysis of data from 25 states between 1994 and 2000 found that Latinos were less likely than whites to have private coverage and more likely to be covered by Medicaid at the time of their HIV diagnosis. A third of Latinos were uninsured at the time of their diagnosis, higher than other groups.²²

**HIV Testing**
• Among the non-elderly (ages 18–64), Latinos are more likely than whites to report having been tested for HIV in the last 12 months (24% compared to 15%).²¹
• Among those who are HIV positive, CDC data indicate that over a third of Latinos (36%) were tested for HIV late in their illness—that is, diagnosed with AIDS within one year of testing positive (in those states/areas with HIV name reporting); by comparison, 31% of Blacks and 32% of whites were tested late.¹

**Concern About HIV/AIDS²³**
• A recent survey found that Latinos express concern about HIV/AIDS. While about 1 in 10 Latinos name it as the most urgent health problem facing the nation, about 3 in 10 name it as a more urgent problem for their community than it was a few years ago.

• Among Latinos, 27% say they are personally very concerned about becoming infected with HIV, a proportion that has declined since the mid-1990s. Latino parents are more concerned about a son or daughter becoming infected with HIV, with 4 in 10 (41%) reporting they are very concerned.

**Figure 3: Number of Latinos Estimated to be Living with AIDS, Top 10 States/Areas, 2009¹⁶**

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated Number of Latinos Estimated to be Living with AIDS, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>26,470</td>
</tr>
<tr>
<td>California</td>
<td>21,769</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>10,853</td>
</tr>
<tr>
<td>Florida</td>
<td>9,727</td>
</tr>
<tr>
<td>Texas</td>
<td>9,553</td>
</tr>
<tr>
<td>New Jersey</td>
<td>4,214</td>
</tr>
<tr>
<td>Illinois</td>
<td>2,986</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>2,657</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>2,518</td>
</tr>
<tr>
<td>Connecticut</td>
<td>2,204</td>
</tr>
</tbody>
</table>

**Geography**
Although AIDS diagnoses among Latinos have been reported throughout the country, the impact of the epidemic is not uniformly distributed:
• The rates of new AIDS diagnoses per 100,000 among Latinos are highest in the eastern part of the U.S., particularly in the Northeast.¹⁶
• AIDS prevalence among Latinos is clustered in a handful of states, with 10 states accounting for 87% of Latinos estimated to be living with AIDS in 2009. New York, California, and Puerto Rico top the list (Figure 3). Ten states also account for the majority of new AIDS diagnoses among Latinos (84% in 2010).¹⁸ ¹⁷
• AIDS diagnoses among Latinos vary by place of birth. Latinos born in the U.S. accounted for 37% of new AIDS diagnoses among Latinos in 2010, followed by Latinos born in Mexico (17%) and Puerto Rico (14%).¹⁸ ¹⁹ HIV transmission patterns among Latinos also vary by place of birth.¹

**Access to and Use of the Health Care System**
The HIV Cost and Services Utilization Study (HCSUS), the only nationally representative study of people with HIV/AIDS receiving regular or ongoing medical care for HIV infection, found that Latinos fared more poorly on several important measures of access and quality, differences that diminished over time but were not completely eliminated.³ In addition, HCSUS found that Latinos were more likely to report postponing medical care due to factors such as lack of transportation.³ Latinos were also more likely than whites to delay care after their HIV diagnosis.³

**Health Insurance**
Having health insurance, either public or private, improves access to care. Insurance coverage of those with HIV/AIDS varies by race/ethnicity, as it does for the U.S. population overall.
• The HCSUS study found that Latinos with HIV/AIDS were more likely to be publicly insured or uninsured than their white counterparts, with half relying on Medicaid compared to 32% of whites. Approximately one quarter of Latinos with HIV/AIDS (24%) were uninsured compared to 17% of whites. Latinos were also about half as likely to be privately insured as whites (23% compared to 44%).¹⁹

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¹⁰ Calculations based only on diagnoses for which race/ethnicity data were provided.
¹¹ Includes diagnoses among those 13 years of age and older. Estimates do not include diagnoses from the U.S. dependencies, possessions, as well as diagnoses of unknown residence.
¹² CDC. Slide Set: HIV Mortality (through 2008).
¹⁴ CDC. Special Data Request; 2006.
¹⁵ CDC. Slide Set: HIV Surveillance by Race/Ethnicity (through 2010).
¹⁸ Estimates include U.S. dependencies, possessions, and diagnoses of unknown residence.
¹⁹ Calculations based only on diagnoses for which data by place of birth were provided.
²¹ Kaiser Family Foundation analysis of CDC data.

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This publication (#6007-10) is available on the Kaiser Family Foundation’s website at www.kff.org.
Appendix 6 – Evaluation Form

Thank you for your participation in this meeting! To ensure that we are addressing your needs please take a moment to fill out this evaluation. Thank you for your feedback!

Please indicate your affiliation/role at this meeting:
- □ Health department
- □ Federal office
- □ University/college
- □ Local organization
- □ National organization
- □ Other __________________

Were the meeting goals clear (circle one)?
- Yes
- Somewhat
- No

Please briefly explain:

Indicate the extent to which the following agenda items were helpful in meeting the overall objectives:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Very Helpful</th>
<th>Helpful</th>
<th>Neutral</th>
<th>Unhelpful</th>
<th>Very Unhelpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and Agenda Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCSD and NASTAD Institutional and Community Assessment</td>
<td>Very Helpful</td>
<td>Helpful</td>
<td>Neutral</td>
<td>Unhelpful</td>
<td>Very Unhelpful</td>
</tr>
<tr>
<td>Solutions to Stigma</td>
<td>Very Helpful</td>
<td>Helpful</td>
<td>Neutral</td>
<td>Unhelpful</td>
<td>Very Unhelpful</td>
</tr>
<tr>
<td>Community Perspectives on Quality Care for Black and Latino Gay and Bisexual Men</td>
<td>Very Helpful</td>
<td>Helpful</td>
<td>Neutral</td>
<td>Unhelpful</td>
<td>Very Unhelpful</td>
</tr>
<tr>
<td>NCSD Optimal Care Checklists Discussion</td>
<td>Very Helpful</td>
<td>Helpful</td>
<td>Neutral</td>
<td>Unhelpful</td>
<td>Very Unhelpful</td>
</tr>
<tr>
<td>Developing a Standard of Care</td>
<td>Very Helpful</td>
<td>Helpful</td>
<td>Neutral</td>
<td>Unhelpful</td>
<td>Very Unhelpful</td>
</tr>
<tr>
<td>Work Group Presentations and Discussion</td>
<td>Very Helpful</td>
<td>Helpful</td>
<td>Neutral</td>
<td>Unhelpful</td>
<td>Very Unhelpful</td>
</tr>
</tbody>
</table>

Raising the Bar: Developing a Standard of Care for Black and Latino Gay Men and other Men who have Sex with Men (MSM) in Clinical Settings
March 19, 2012
Was the information and discussion during this meeting relevant to your overall work with Black and Latino gay men and other men who have sex with men?

Yes     Somewhat     No

Did you learn new information about standards of care for Black and Latino gay men and other men who have sex with men?

Yes     Somewhat     No

To what extent has your understanding of standards of care for Black Latino gay men and other men who have sex with men changed:

☐ To a great extent
☐ To a moderate extent
☐ To a slight extent
☐ Not at all

Rate the degree to which this meeting will assist you in providing and implementing a standard of care for Black and Latino gay men:

☐ To a great extent
☐ To a moderate extent
☐ To a slight extent
☐ Not at all

Do you plan to share what you learned/discussed during this meeting with your colleagues?

Yes     Unsure     No

Were your meeting goals met?

Yes     Somewhat     No

Please share any additional areas for consideration to develop a standard of care for Black and Latino gay men and other men who have sex with men in clinical settings, that were not discussed during the meeting.

Please share any additional comments:

Thank you for your feedback!
Appendix 7 – Participant List

Raising the Bar: Developing a Standard of Care for Black and Latino Gay Men and other Men who have Sex with Men (MSM) in Clinical Settings

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