Cultural Competence: Strengthening the Clinicians Role in Delivering Quality HIV Care within African American Adolescent MSM Communities

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Learning Objectives

- Understand the impact of the HIV epidemic among young black men who have sex with men (MSM)
- Describe factors associated with disproportionate infection rates
- Provide an example of a successful HIV prevention intervention with Black MSM
- Identify important priorities for maintaining the health and wellness of young Black MSM

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Terminology

- MSM embodies a wide range of men with varying social identities related to their sexual and or relationship practices with other men.
- The term “Black” is used to be inclusive of peoples of African descent, including those who may be from Africa, the Caribbean, as well as men born in the U.S.
- Youth/Young encompasses adolescents and young adults ages 13-24 years.

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Diagnoses of HIV Infection among Adult and Adolescent Males, 2005–2008—37 States and 5 U.S. Dependent Areas

Of the 161,795 diagnoses of HIV Infection among adults and adolescents from 2005–2008,

74 % were in males

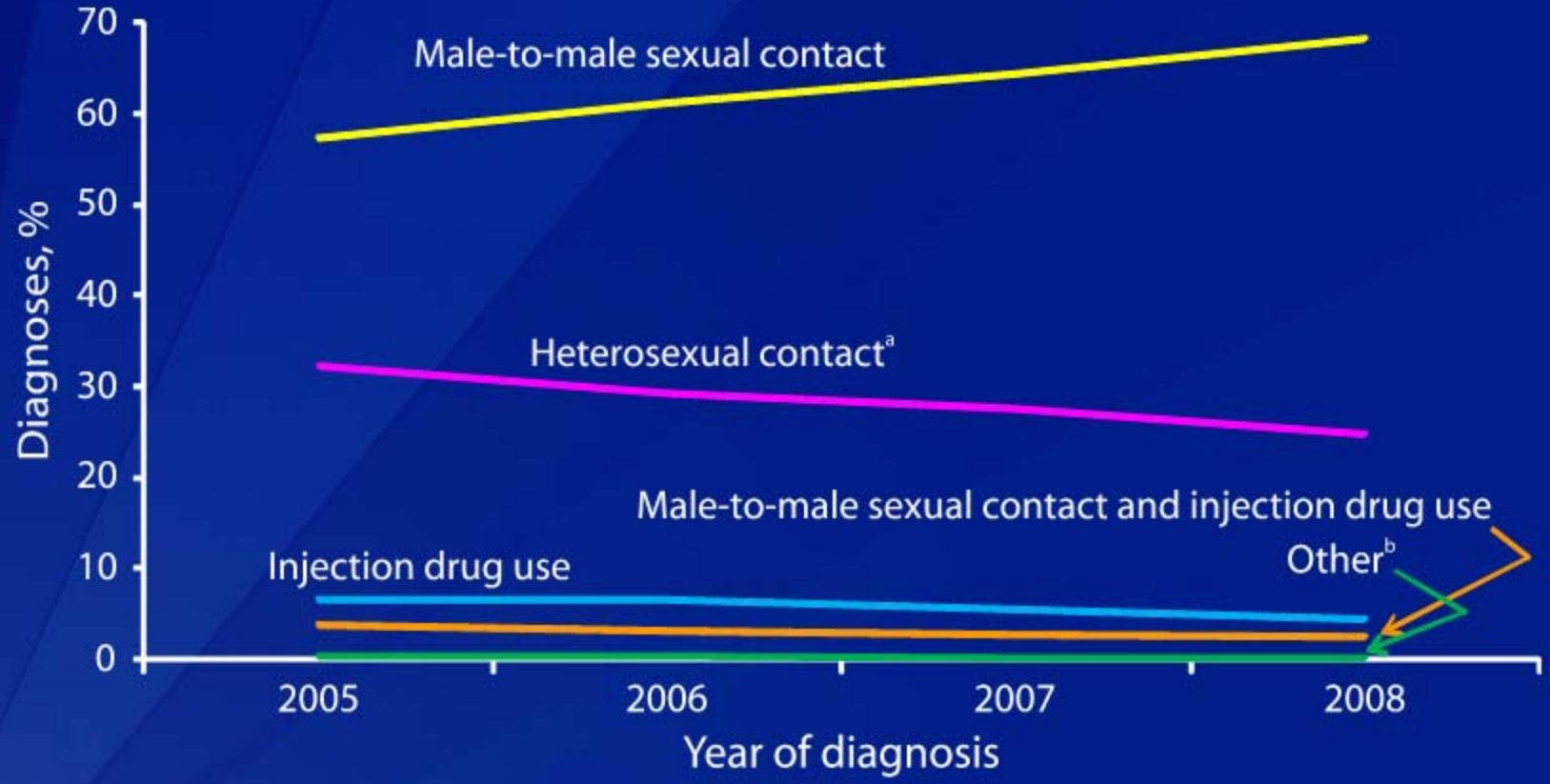
- **70 %** of diagnosed HIV infections in males were attributed to male-to-male sexual contact
- **16 %** of diagnosed HIV infections in males were in those aged 13-24
  - **85 %** of diagnosed HIV infections in males aged 13-24 were attributed to male-to-male sexual contact

In 2008, **54 %** of HIV infections diagnosed among adults and adolescents were attributed to male-to-male sexual contact.

Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. Data from 37 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting since at least January 2005. All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays and missing risk-factor information, but not for incomplete reporting. Data on male-to-male sexual contact exclude men who reported sexual contact with other men *and* injection drug use.

CDC

Diagnoses of HIV Infection among Adolescents and Young Adults 13–24 Years of Age, by Transmission Category, 2005–2008—37 States and 5 U.S. Dependent Areas

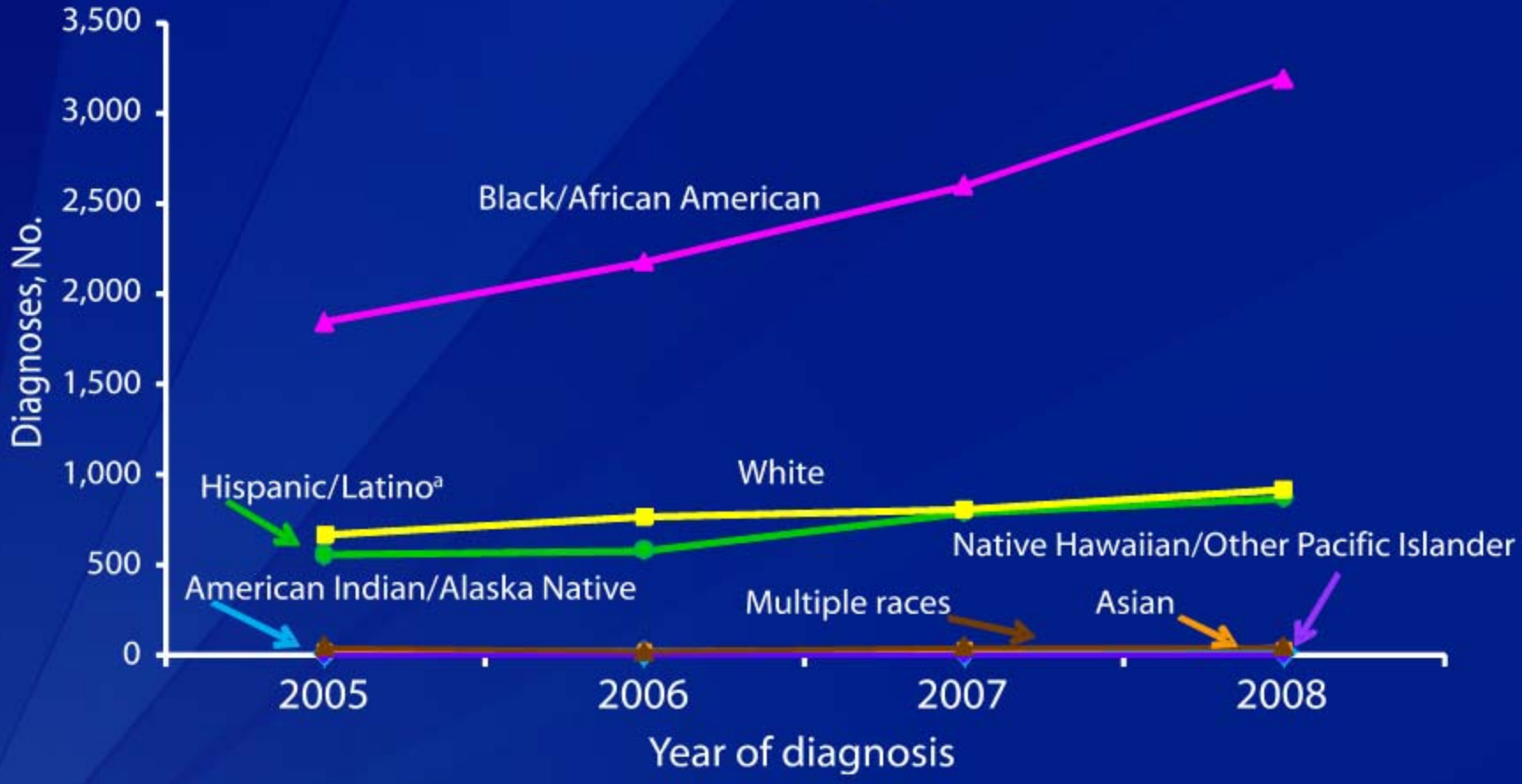


Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. Data from 37 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting since at least January 2005. All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays and missing risk-factor information, but not for incomplete reporting.

[a] Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

[b] Includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.

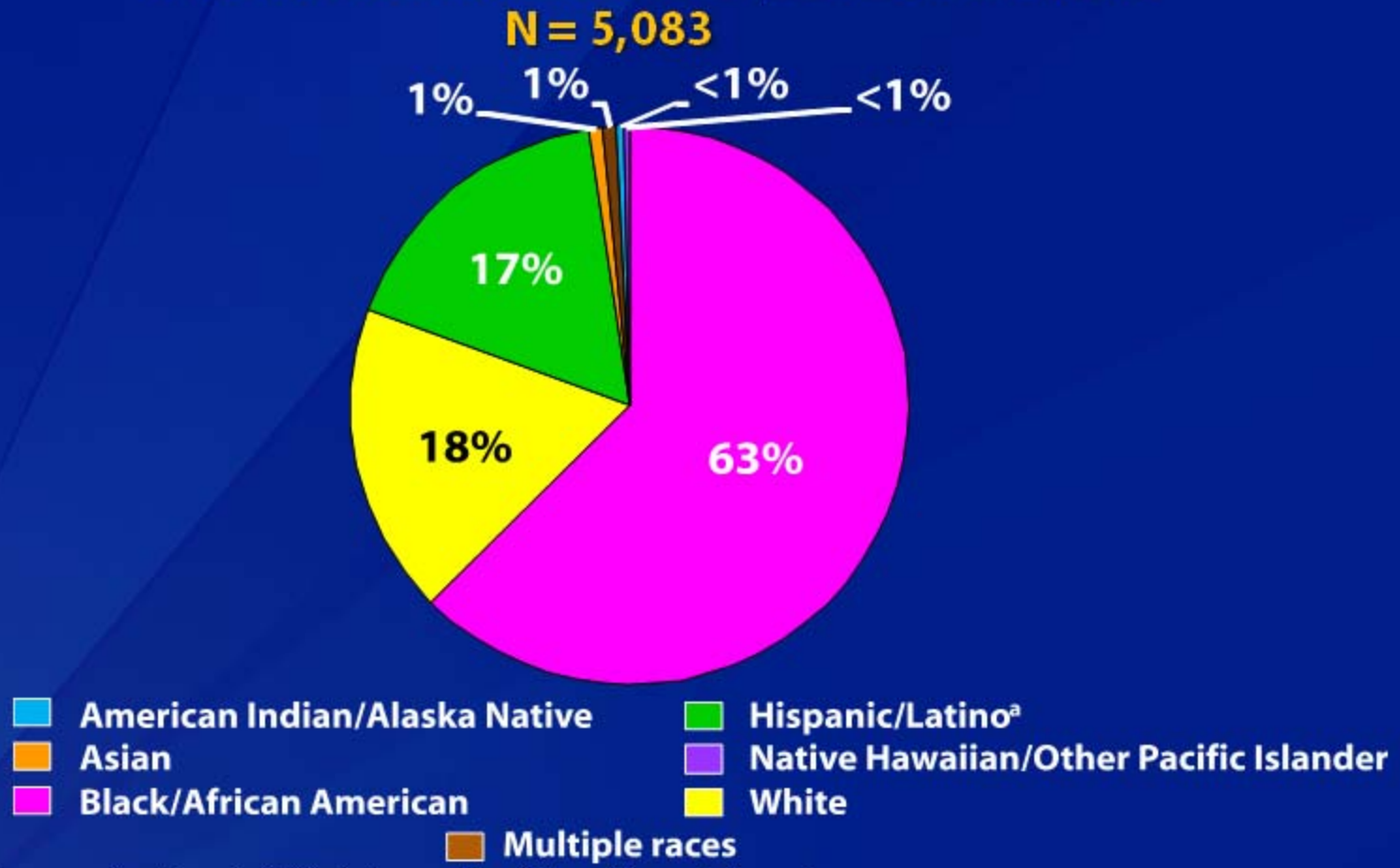
Diagnoses of HIV Infection among Men Who Have Sex with Men Aged 13–24, by Race/Ethnicity, 2005–2008— 37 States and 5 U.S. Dependent Areas



Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. Data from 37 states and 5 U.S. dependent areas with confidential name-based HIV infection reporting since at least January 2005. All displayed data have been estimated. Estimated numbers resulted from statistical adjustment that accounted for reporting delays and missing risk-factor information, but not for incomplete reporting. Data exclude men who reported sexual contact with other men *and* injection drug use.

[a] Hispanics/Latinos can be of any race.

Diagnoses of HIV Infection among Men Who Have Sex with Men Aged 13–24, by Race/Ethnicity, 2008— 37 States and 5 U.S. Dependent Areas



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[a] Hispanics/Latinos can be of any race.

FACTORS ASSOCIATED WITH DISPROPORTIONATE INFECTION RATES

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Are Black MSM more likely than other MSM to engage in high-risk sexual behavior?

- **Comparable or lower self-reported risks of UAI**
- **Compared with other MSM, Black MSM have the same number or smaller number of male sex partners**
- **Most studies show no racial differences in prevalence of engaging in commercial sex work**

Millett , *AJPH* 2006; Harawa, *JAIDS*, 2004; Bingham, *AIDS Ed Prev*, 2003; Stokes, *J Sex Res*, 1996; Bartholow, *JAIDS*, 2005, Newman, *AJPH*, 2004

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Why the Disparity?

- **Factors can influence risk**
  - **Sociocultural factors (racial discrimination, homophobia and stigmatization)**
  - **Sexual network issues**
  - **High rates of STIs**
  - **Low testing rates**
    - **Lack of awareness of ones own HIV status and leading to continued risk behavior**
  - **Socioeconomic issues**
    - **Poverty, incarceration, drug use, lack of access to care**

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Focusing "down low": bisexual black men, HIV risk and heterosexual transmission

- **BMSM are more likely than MSM of other races to identify as bisexual and be bisexually active**
- **Heterosexual identity and corresponding sexual behavior among black men are sometimes incongruent, but this discordance is not exclusive nor greatest among black men**
- **BMSM are less likely than other MSM to disclose their homosexual behavior or identity but non disclosing BMSM may engage in few sexual risks with male partners than disclosing BMSM**

Bisexual Activity among HIV-positive Men of Various Sexual Identities				
	Heterosexual (%)	Homosexual (%)	Bisexual (%)	Other (%)
Black (n=530)	12	22	61	5
Hispanic (n=258)	10	28	59	3
White (n=326)	9	31	56	4

Millett, *J Natl Med Assoc,* 2005; Montgomery *AIDS Care* 2003; Millett, *AJPH*, 2006

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Focusing "down low": bisexual black men, HIV risk and heterosexual transmission

- **Conclusions:**
  - **Black men who are currently bisexually active account for a very small proportion of the overall population of black men (~2%).**
  - **The high prevalence of HIV in the black community and the greater likelihood of bisexuality among black men may place heterosexual black women at risk for HIV infection.**
  - **However, the contribution of high-risk heterosexual black men to the rising HIV caseload among black women has been largely ignored.**

Millett, *J Natl Med Assoc*, 2005

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Young Black MSM Have a Higher Prevalence of MSM/W and Lower Prevalence of UAI

Differences in Proportion of MSM/W and UAI by Racial/Ethnic Group, CITY Project 1999-2002

Racial/Ethnic Group	n	%MSM/W	OR (95% CI)	P	%UAI	OR (95% CI)	P
Black	2914	19	–	–	24	–	–
Latino	3814	14	0.66 (0.58-0.75)	<.001	29	1.28 (1.15-1.43)	<.001
Asian/Pacific Islander	1059	11	0.51 (0.42-0.64)	<.001	36	1.76 (1.52-2.05)	<.001
White	2294	11	0.52 (0.44-0.60)	<.001	35	1.66 (1.47-1.88)	<.001

Flores, *STD*, 2009

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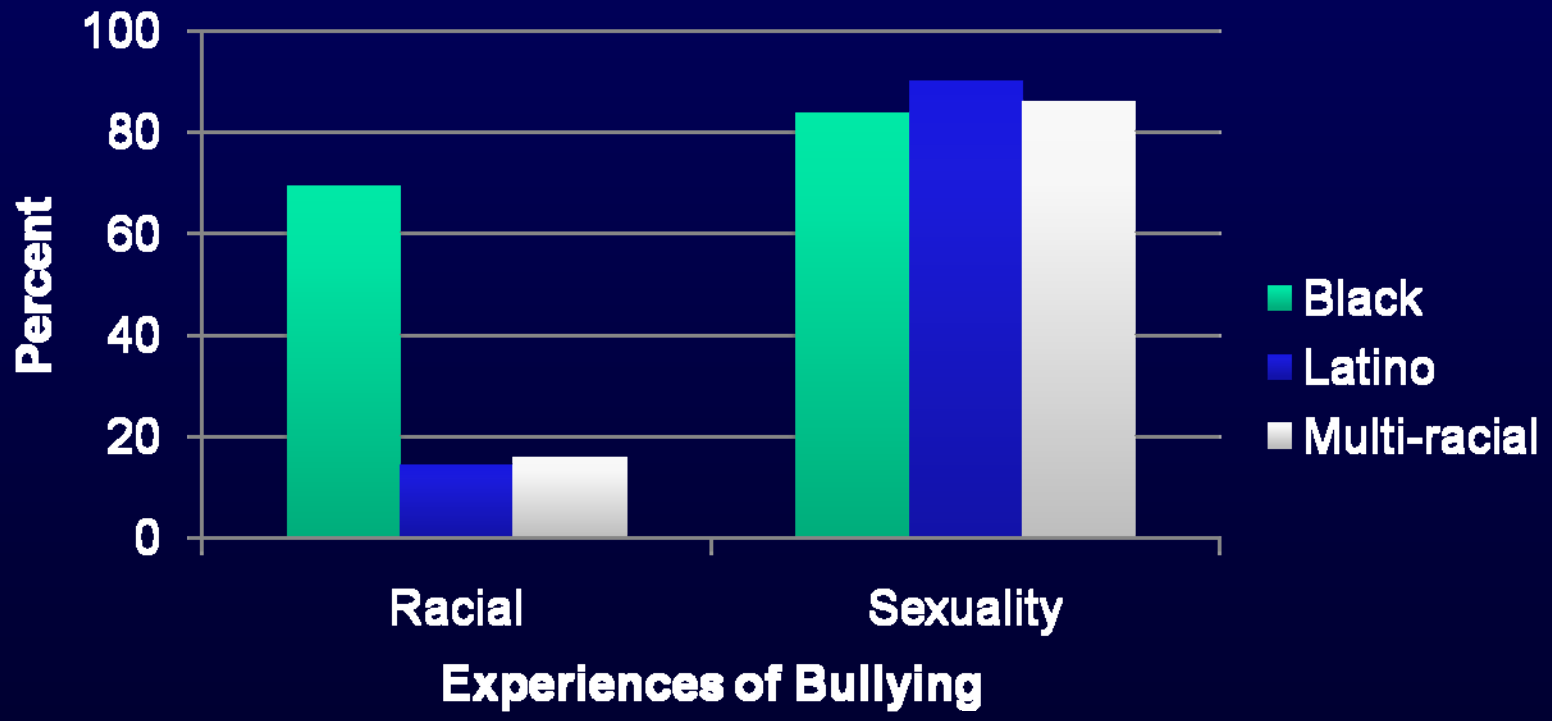
Experiences of Discrimination by Young Black MSM

- **Multisite study of 351 racial/ethnic HIV+ minority young MSM**



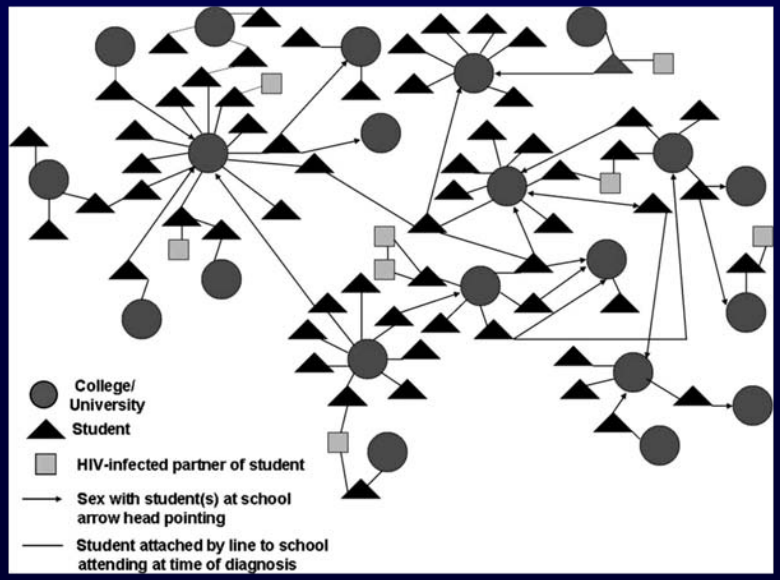
Hightow-Weidman, *AIDS Patient Care and STDs*, in press

HIV Spread through a Network

The Unexpected Movement of the HIV Epidemic in the Southeastern United States

Transmission Among College Students

Lisa B. Hightow, MD, MPH, Pia D. M. MacDonald, PhD, MPH,†§ Christopher D. Pilcher, MD,* Andrew H. Kaplan, MD,*‖ Evelyn Foust, MPH,‡ Trang Q. Nguyen, MPH,† and Peter A. Leone, MD*†‡*



- An epidemic of HIV infection occurring in North Carolina college students, primarily involving African American MSM and MSM/W.
- Newly diagnosed HIV infection was found in men in 37 colleges located in North Carolina or surrounding states and a sexual partner network investigation linked 21 colleges, 61 students, and 8 partners of students.

Hightow, *JAIDS* 2005

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High rates of STIs associated with increased HIV risk

- Presence of STIs facilitates HIV acquisition and transmission[1]
- STI rates are higher for Black MSM[2]
  - Black MSM 2x more likely to be diagnosed with a current STI
  - 50% more likely to have gonorrhea
  - 2x more likely to have syphilis
- Coinfection rates are higher
  - HIV+ Black MSM more likely to be coinfected with gonorrhea, syphilis or nongonococcal urethritis than HIV+ White MSM (60% vs. 18%)

[1]Fleming, *STI*, 1999; Rothenberg, *STD*, 2000. [2]Millett, *AIDS,* 2007. [3]Torian, *STD*, 2002.

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Young MSM (ages 15-22): Substance Use and Sexual Risk Behavior

	% Black (n=814)	% White (n=1259)
Drug use past 6 months		
Injection drug use	3.1	9.9
Uppers/speed	16.2	49.6
Powder Cocaine	11.6	38.8
Crack Cocaine	4.6	12.2
Nitrites/poppers	6.4	28.8
Sexual behavior past 6 months		
Casual male sex partner	49.3	59.7
HIV+ male sex partner	4.8	6.1
UAI	48	59

Yet compared with White MSM in this sample Black MSM were 9 times more likely to be HIV-positive

Harawa, , *JAIDS*, 2004

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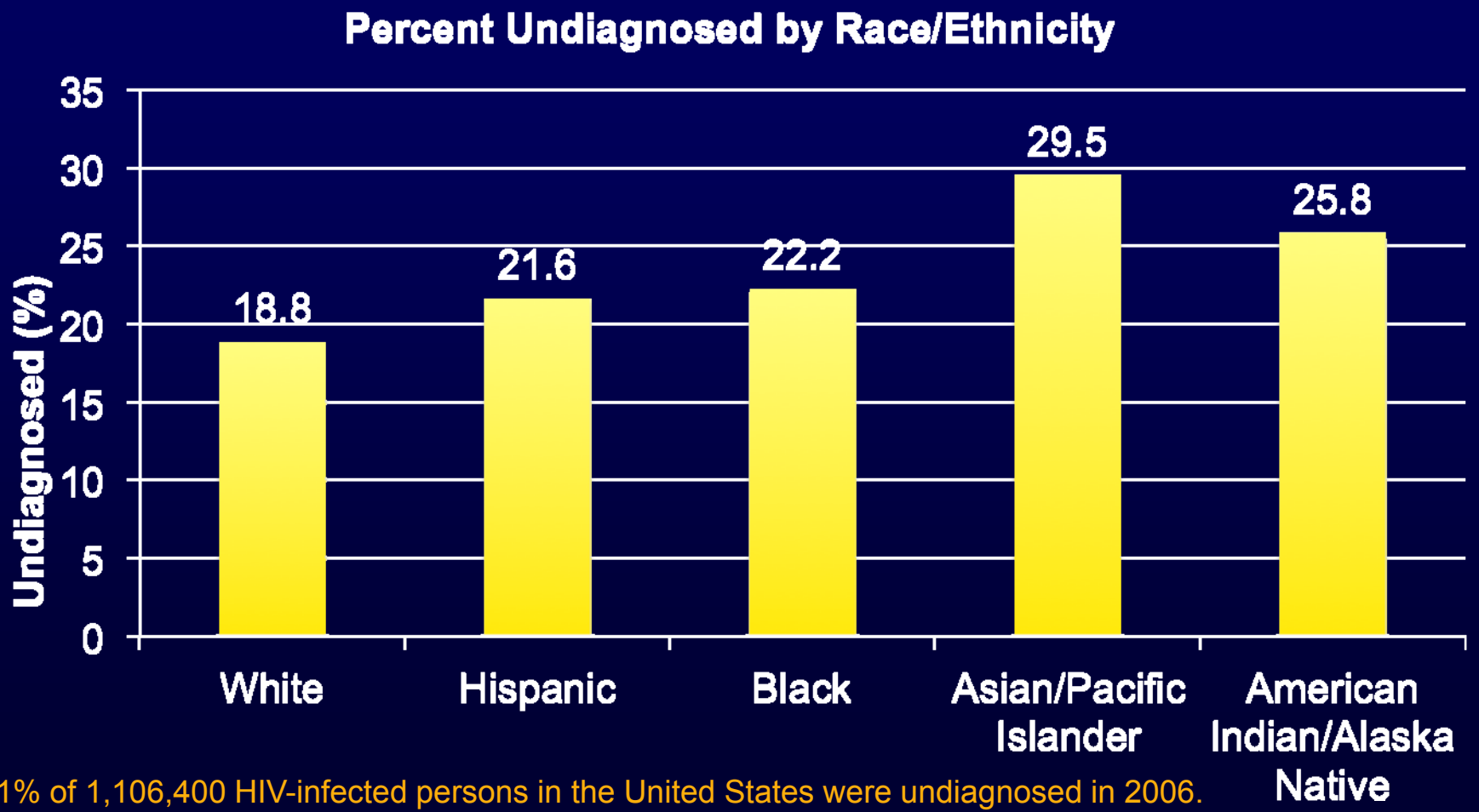
CDC: Estimated Prevalence of Undiagnosed HIV Infection in the United States (2006)



21% of 1,106,400 HIV-infected persons in the United States were undiagnosed in 2006.

Campsmith, *JAIDS*. 2009

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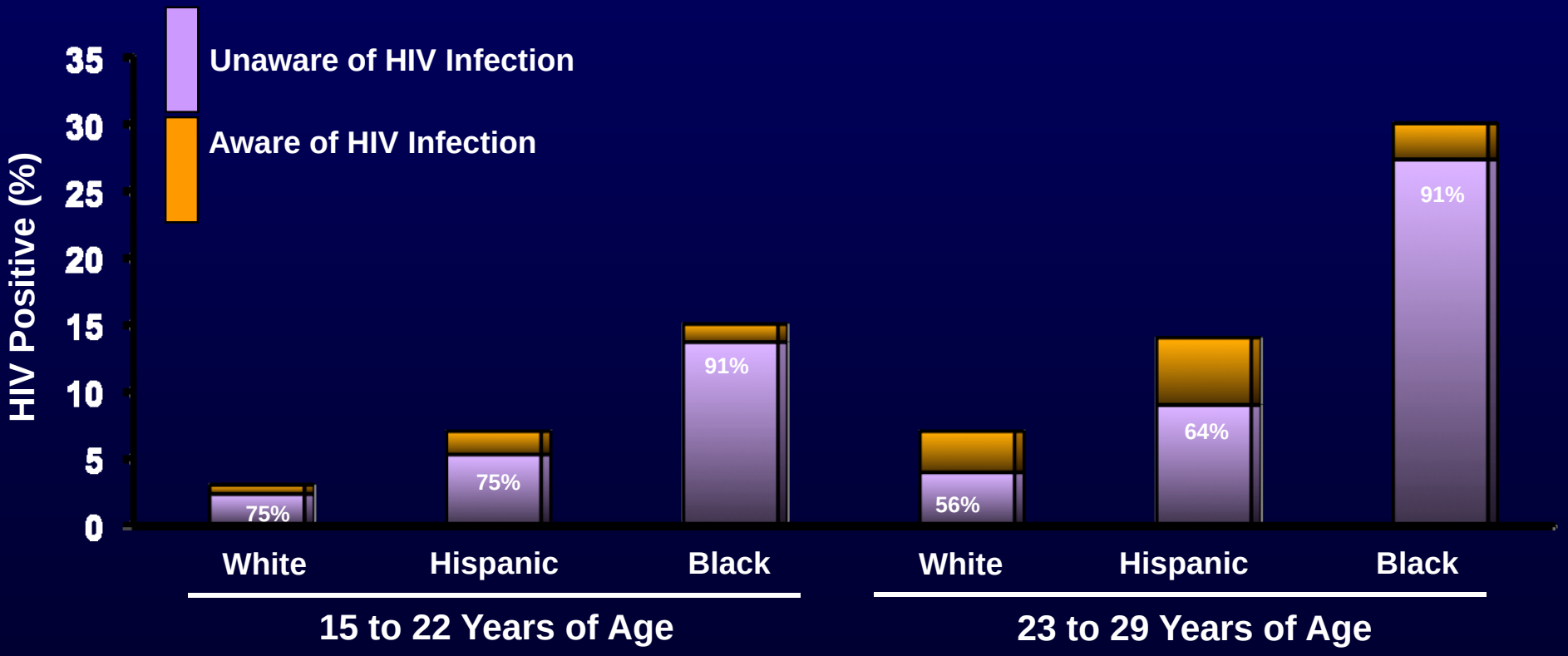
Young Men's Survey (1994-2000): Prevalence and Unrecognized HIV Infection

10% of 5649 Young MSM Tested Were HIV Positive
77% Were Unaware They Were HIV Infected



Conducted in Baltimore, Dallas, Los Angeles, Miami, New York, and Seattle.

MacKellar DA, et al. *JAIDS.* 2005;38:603-614.

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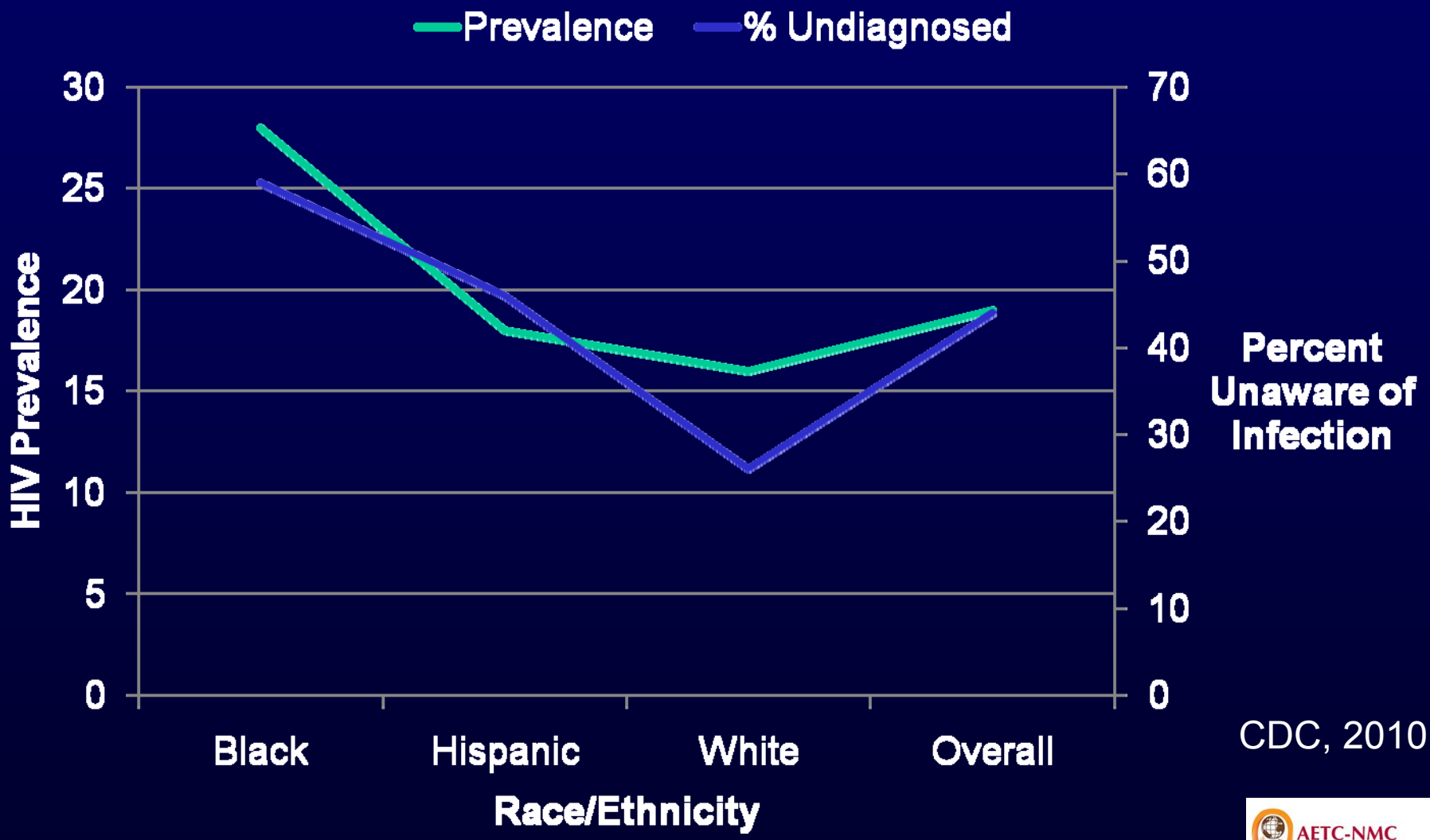
Prevalence and Awareness of HIV Infection Among Men Who Have Sex With Men — 21 Cities, United States, 2008



CDC, 2010

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Prevalence of Undiagnosed HIV infection Young MSM of Color

- Multi-site study of the social and sexual networks Black (n=1140) and Latino (n=1065) MSM
  - 11% of the men had undiagnosed HIV infection
  - Unrecognized infection was more prevalent among Black MSM (17%) than Latino MSM (5%).
- For both Latino and Black MSM, the prevalence of HIV sexual transmission risk behavior was approximately 50% lower among HIV-positive/aware men compared with the HIV-positive/unaware men

Marks, AIDS Behav, 2008

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Use of antiretroviral therapy is less common among Black HIV+ MSM

- **Use of ART reduces viral load and infectiousness**
- **Utilization: HIV-positive Black MSM 57% less likely to access ART compared with HIV-positive White MSM**
- **Adherence: Less likely to adhere to meds**

Cohen MS (*personal communication HPTN 052 trial*; Granich, Curr Opin HIV AIDS. Berry, AIDS, 2007; Millett, *AIDS, 2007*, Kleeberger, *AIDS,* 2004, Halkitis, *AIDS Care,* 2003.

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BEHAVIORAL INTERVENTIONS FOR YOUNG BLACK MSM

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d-up: Defend Yourself!

- **Cultural adaptation of Popular Opinion Leader (POL)**
  - **Identifies and trains opinion leaders—trusted and respected members of the targeted social network**
- **Developed by and for Black MSM**
- **Community level intervention designed to change norms around condom use**
  - **Reflects the cultural nuances, communication styles, and preferences of Black MSM**

Jones, *AJPH*, 2007

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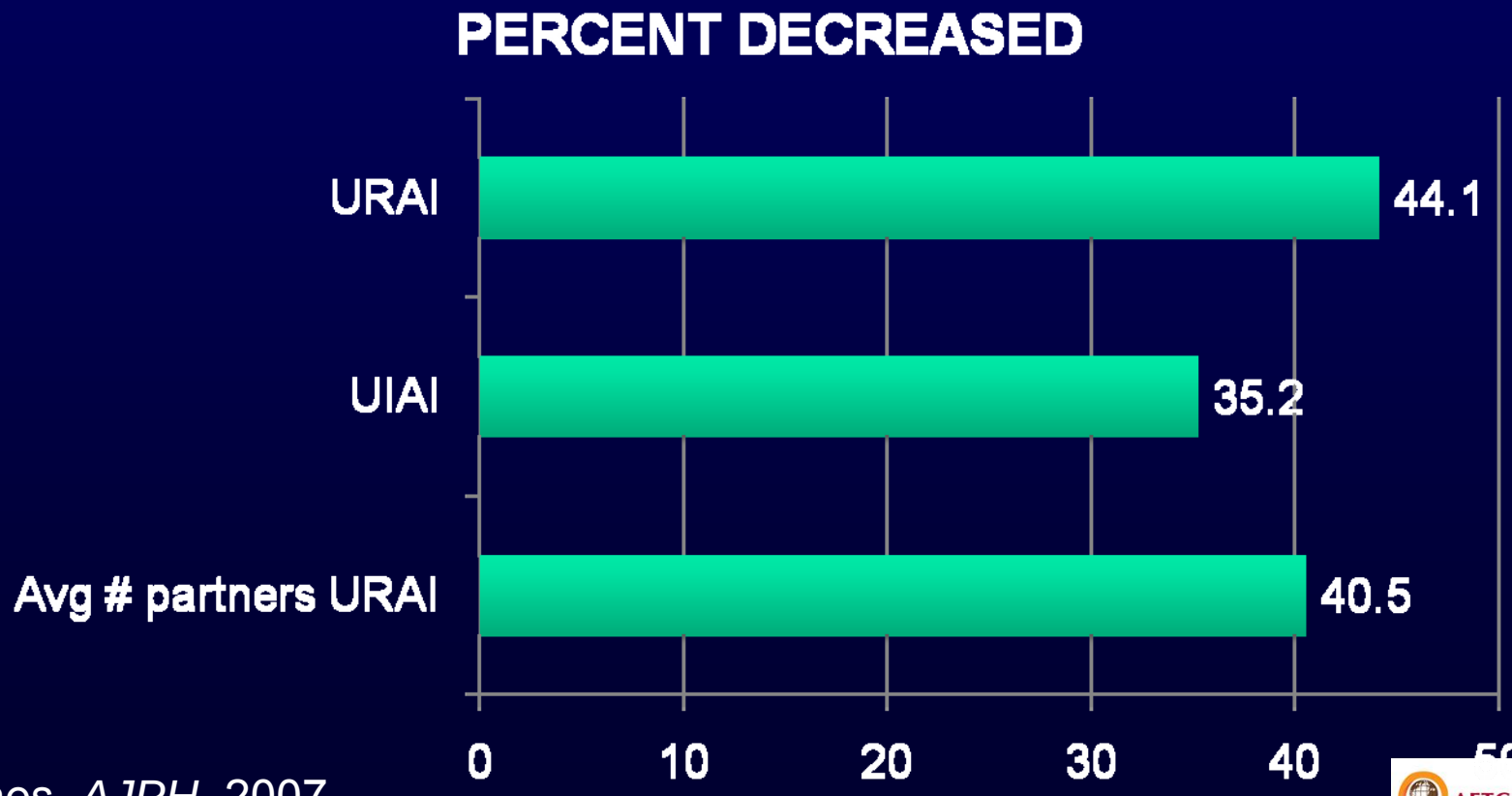
d-up: Defend Yourself!

d-up! achieved the following results among targeted social networks of Black MSM in three North Carolina cities



Jones, *AJPH*, 2007

Culturally Specific Prevention Opportunities: House Ball Community

- **House: collective of people, frequently gay or transgender Black and Latino youth who share a communal lifestyle**
- **Ball: social event in which houses and individuals engage in dance and performance competitions**
- **Community: provides social framework and source of support for young Black and Latino MSM**

Murrill, *AJPH*, 2008

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Why should we care?

Gay families/houses are a primary source (if not THE source) of support & health/sex information

Those in this "scene" are in it because they don't have anything else – often very transient, hard to keep in care

Retention

- Tumultuous lives: unstable housing, relationships, employment, cell phone service, transportation, support networks
- Typically come in with a lot of baggage (history of abuse, abusive relationships, violence, bullying, homelessness)
- Their priorities ≠ our priorities

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CASE PRESENTATION

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Case Study: John

- John, an 18 year-old African American male, presents to his primary care physician for enlarged lymph nodes.
- He reports swelling in his throat for the past two weeks and believes he is experiencing some continuing effects from a “really bad” case of the flu he had two weeks ago.
- He reports that he is extremely tired, has frequent headaches, and has also had a rash.

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Case: continued

- Physical exam reveals inguinal lymphadenopathy, erythematous throat
- Patient states has same sex partner “Courtney” for past 4 months, they are monogamous and not using condoms
- States sex partner had similar symptoms about three months ago but they resolved on their own
  - Is John at risk for HIV? If so what test should be ordered?
  - John does not use his partner’s gender in dicussion, only their name, how should this be handled?

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Recognizing Acute HIV Infection

- Acute HIV is defined as a transient symptomatic illness that begins within days to weeks after HIV exposure that may last from a few days to several months[1]:
  - Fever, fatigue, rash, headache, and lymphadenopathy
  - Additional symptoms include pharyngitis, myalgia, nausea, vomiting, and diarrhea
- 75% of patients have a mononucleosis-like syndrome that may include[1]
  - Rash, fever, sore throat, headache within 2 to 6 weeks of infection[2]

1. Perlmutter BL et al. *Am Fam Physician*. 1999;60:535-542.
2. Vergis EN, Mellors JW. *Infect Dis Clin North Am*. 2000;14:809-825.

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Diagnostic Issues in Acute HIV Infection

- Acute HIV infection is associated with high viral loads (>100,000 copies/mL); however, initial level is not always predictive of disease course[1]
- HIV-1 RNA is considered the test of choice for confirming an HIV diagnosis made through standard HIV testing
  - False-positives at low levels (eg, <3,000 copies/mL) in noninfected persons may lead to misdiagnosis of HIV[1,2]

1. DHHS. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. 2011;1-164. http://www.aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf. Accessed January 19, 2011.
2. Rich JD et al. *Ann Intern Med*. 1999;130:37-39.

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Case continued

- John is referred to an HIV provider
  - He opts to defer starting HAART because his life is “too complicated”
- He is followed up every 3 months for 9 months
- At last visit
  - HIV-1 RNA was 88,500 copies/mL
  - CD4+ cell is 380 cells/mm^3

What now?

Provide Culturally Competent HIV Care

- **Build trust and optimize patient-provider encounter**
  - **Be aware of health-related cultural beliefs, including stigma, within the predominant minority groups in your practice**
- **Be comfortable and skilled in eliciting personal and cultural views and perspective of each individual patient and applying a cultural competency framework for each visit**

Stone V, et al. *HIV/AIDS in U.S. Communities of Color.* Springer; New York, NY: 2009.

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Provide Culturally Competent HIV Care

- Identify the patient's core cultural issues
- Explore the meaning of the illness to the patient
- Explore the patient's social context
  - Life control
  - Change in environment
  - Literacy and language
  - Support systems
- Negotiate across patient-physician culture to develop a treatment plan that is mutually agreeable

Stone V, et al. *HIV/AIDS in U.S. Communities of Color.* Springer; New York, NY: 2009.
Carrillo JE, et al. *Ann Intern Med.* 1999;130:829-834.
Stone VE. *Clin Infect Dis.* 2004;38:400-404.

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Assess Readiness for HAART

- **Key issues to explore with the patient**
  - **Are they ready to begin HAART**
  - **Can they take and adhere to the prescribed HAART regimen**
  - **Do they believe the medications are effective and can make a difference**
- **Evaluate for depression and active substance abuse**
- **Evaluate for heath literacy level**
- **Become familiar with the patient's social situation, stability of social and living situation, psychosocial supports and key people in their life**
- **Logistical aspects**
  - **Medication organizers**

Stone V, et al. *HIV/AIDS in U.S. Communities of Color.* Springer; New York, NY: 2009.

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THE WAY FORWARD

Priorities (1)

- **Increase the number of young Black MSM who know their HIV status**
  - Persons aware of their HIV infection reduce their risk behaviors, which could reduce HIV transmission (Colfax, 2002)
  - People with unrecognized infection primarily responsible for ongoing epidemic (Marks, 2006)
  - Efforts to ensure at least annual HIV testing for young Black MSM should be strengthened
  - Increased efforts to educate young Black MSM and health-care providers about HIV testing guidelines and to reduce barriers to HIV testing

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Priorities (2)

- **Structural interventions and policy changes to improve the long term health of Black MSM and reduce HIV/STD disease burden**
  - Work to eliminate stigma, discrimination and homophobia
  - Provide comprehensive sex education in schools that is appropriate for both heterosexual and homosexual students
  - Ensure that laws and policies promote the basic human rights of MSM and protect them from hate crimes
  - Educate and support parents of young gay, bisexual Black men

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Priorities (3)

- **Create and Implement New Evidence-Based Behavioral Interventions for HIV- and HIV+ Young Black MSM**
  - There is an urgent need for innovative approaches to address the paucity of efficacious and culturally appropriate HIV/STI prevention interventions that are available for Young Black MSM
  - Must partner with communities
  - Tailor existing effective behavioral interventions for MSM for Black MSM populations
    - Black MSM are not homogenous (i.e. drug use by coast, multiethnic vs not)

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Priorities (4)

- **Address Barriers to HIV Access, Engagment and Retention in Care and Treatment**
  - Culturally competent strategies are needed to encourage Black MSM to seek testing and, once aware of their status, to obtain and remain in care.
  - Effective strategies to urge HIV-positive Young Black MSM to access care must consider the many nuances, social constraints, and homophobia (both external and internal) that define the realities of Black MSM.

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Priorities (5)

- **Provide Comprehensive Health and Wellness for Young Black MSM**
  - Support men throughout their lifetime, not just when they are young or when they are HIV-negative (or positive)
  - Focus on the whole person
  - Operate from an ‘asset’ rather a ‘deficit’ model (resiliency)
  - Include enhanced access to mental health services and substance use treatment

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