CARE DISPARITIES BETWEEN AFRICAN-AMERICANS AND WHITES LIVING WITH HIV/AIDS IN CENTRAL TEXAS

By
Nicole T. Evans

A Master's Paper submitted to the faculty of the University of North Carolina at Chapel Hill In partial fulfillment of the requirements for the degree of Master of Public Health in the Public Health Leadership Program.

Chapel Hill
Fall 2017

Advisor: William A. Sollecito, DrPH

Second Reader: Dr. Rosanna Barrett, DrPH

________________________________
Date
Abstract

African Americans have higher rates of HIV infection, and lower retention to care (or lost to care) rates than Whites, although they are a significantly smaller number in the population than Whites. This means there are fewer African-Americans in the US population, and they are infected with HIV in greater numbers than Whites (McCray, 2016). When looking deeper into surveillance data, African-American men are at greatest risk for new HIV infections, and account for the highest numbers of African-Americans living with HIV. The urban myth is an African-American man “on the down low (DL)” or “men who have sex with men (MSM)” illustrate this disproportion. Stigma and poor HIV literacy contribute to care disparities. Ironically, using labels such as “DL” and “MSM” are argued to perpetuate the disparity. African-American men are reluctant to identify with any label, be it DL, MSM, gay or bisexual. African-American men are caught at an intersection of apathy, limited cultural competency, and label stigma. Ironically it is the labels used to capture surveillance data that disenfranchise African-American men from accessing the HIV Care Continuum through engagement in medical care. Based on my review of current HIV/AIDS Bureau, Ryan White funding I identified two policy recommendations to address these issues. First, a policy alternative to Human Resources and Services Administration Ryan White Program that expands its Minority AIDS Initiative to include earmarked dollars, and required reporting, for annual cultural competency training for HIV Prevention and AIDS service providers, and Pre-Exposure Prophylactic (PrEP) treatment in high-risk groups like African-American men. Last, revise Austin Area Comprehensive HIV Planning Council’s guidelines to establish annual reporting to the Administrative agent annual cultural competency training for provider staff, allocate
additional resources to needs identified through the Needs Assessment, and annually, recognize AIDS service providers who execute the most innovative methods for managing engagement to medical care barriers resulting in low retention in care rates for high risk or target groups.
# LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Disorder Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-Retroviral Therapy</td>
</tr>
<tr>
<td>ATEC</td>
<td>AIDS Training and Education Center</td>
</tr>
<tr>
<td>CARE</td>
<td>Ryan White Comprehensive AIDS Resources Emergency Act</td>
</tr>
<tr>
<td>DL</td>
<td>Down Low</td>
</tr>
<tr>
<td>HAB</td>
<td>HIV/AIDS Bureau</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRSA</td>
<td>Human Resources and Services Administration</td>
</tr>
<tr>
<td>HSDA</td>
<td>HIV Service Delivery Area</td>
</tr>
<tr>
<td>NMAC</td>
<td>National Minority AIDS Council</td>
</tr>
<tr>
<td>PLWH</td>
<td>People Living With HIV</td>
</tr>
<tr>
<td>PLWA</td>
<td>People Living With AIDS</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylactic treatment</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Who Have Sex with Men</td>
</tr>
<tr>
<td>MMWR</td>
<td>Morbidity and Mortality Weekly Report</td>
</tr>
<tr>
<td>NMAI</td>
<td>National Minority AIDS Initiative</td>
</tr>
<tr>
<td>SPNS</td>
<td>Special Projects of National Significance (SPNS) program</td>
</tr>
<tr>
<td>TGA</td>
<td>Transitional Grant Area</td>
</tr>
</tbody>
</table>
Separate and Unequal

Over ten years ago at the University of North Carolina 28th Annual Minority Health Conference Dr. David Malebranche delivered the 9th Annual William T. Small, Jr. Keynote Lecture, boldly confronting stigma and establishing HIV as a social disease, underlining separate and unequal HIV/AIDS treatment options for African Americans compared to Whites, and highlighting the absence of an active program or strategy for HIV/AIDS in the United States (Malebranche, 2007). Fast forward nine years and Dr. Malebranche is a facilitator for a breakout session at the 2016 National Minority AIDS Council (NMAC) challenging assumptions and calling out misperceptions of Black Men “On the Down Low.” Dr. Malebranche’s work on representation of African Americans in data, as compared to Whites, is intriguing. Specifically, his exploration of labels “bisexual’, “men who have sex with men (MSM)”, and Down Low (DL)” (Malebranche, 2008) and their relationship to underrepresentation of African-American men in research or studies. In both settings, Dr. Malebranche’s assertions seem to be underpinnings for care disparities between African-Americans and Whites.

What is Care?

“Care” in this paper are defined as “retention in care” as opposed to “linkage to care” illustrated in the HIV Care Continuum (HIV Care Continuum, 2016).

The Care Continuum, or treatment cascade, draws a direct relationship between care and viral suppression (HRSA, 2014).
Figure 1 illustrates the HIV Care Continuum that is the evidence-based standard for achieving viral suppression, a low level of HIV in the body (HIV Basics, 2015). Forty percent of the continuum focuses on how newly diagnosed HIV individuals engage with care. Quantitative data for “linked in care” and “retained in care” are measured as:

1. Linked to Care—One medical appointment within 30 days of diagnosis

2. Retained in Care—Received care for an HIV infection (CDC, 2017)

In 2015, rates showed 1 in 3 of African Americans were lost to care over a three-year period, compared to 1 in 5 Whites (Barclay, 2016). Lack of engagement in medical care once diagnosed creates “lost to care” opportunities. Deficiencies in engagement with medical care for people living with HIV directly relate to:

These deficiencies represent lost to care opportunities in the care continuum pipeline before reaching retention in care point, and deficiencies at the point of retention in care. At all points before anti-retroviral therapy (ART) African-Americans are disproportionately impacted, and they experience care disparities in the least favorable HIV Care Continuum.
outcomes. In 2014, 53% of HIV/AIDS deaths were African-American people (CDC, 2014).

Care Disproportionality and Care Disparities

It is important to establish a distinction between disproportion and disparity. Data indicates that African-Americans are disproportionately impacted by HIV and bear a heavier burden for HIV/AIDS than Whites. Nationally, African-Americans represent one-third of all people living with HIV (PLWH) and almost half of all new HIV infections. In 2015, HIV incidence among African-Americans was almost eight times higher than that of whites (CDC, 2016).

In Central Texas, disproportion impacts the Austin Area Transitional Grant Area (TGA) of the Ryan White Program. There are 254 counties in Texas, of the Top 25 counties with the highest HIV case numbers, three out of twenty-five counties (Travis, Hays, and Williamson counties) are in the Austin TGA. Three of Top 25 counties with the highest HIV case rates are also in the Austin TGA (Caldwell, Travis, and Bastrop counties). Lastly, the City of Austin ranks in the Top 5 cities with the highest HIV and AIDS diagnoses, at #4 after Houston, Dallas, and San Antonio (HIV Surveillance, 2017).

Local Impact of Ryan White Program Funding

Ryan White funding exists to respond to disproportional and disparate engagement in medical care. As the oversight body, the Austin Area Comprehensive HIV Planning Council plays a primary role in consumer and provider engagement to affect retention in care disparities. The Council is a volunteer planning group of community members appointed by the Mayor of Austin. The Council applies for grant funding and receives
about $5 million annually from the Human Resource and Services Administration (HRSA) through Ryan White Program funding to help people living with HIV/AIDS who reside in the Austin TGA (Austin Area Comprehensive HIV/AIDS Planning Council, n.d.).

The Council’s main charter is to plan and decide how to distribute the Ryan White grant funds in the community through various services. Its goal is to efficiently fund services that meet the multiple care needs of HIV/AIDS consumers who have limited or no financial resources. The Council allocates funds to support many of the comprehensive programs and care services available to people living with HIV/AIDS (Ryan White Program, 2013).


In 2017, the Council began implementation of its 2017-2021 Integrated HIV Prevention and Care Plan. Two of the plans goal specifically speak to retention in care and disparities:

**Goal 2: Increase Access to Care and Improve Health outcomes for PLWH**

**Objective 2: Increase the percentage of PLWHA who are retained in HIV medical care from 79% to at least 85%;**

**Goal 3: Reduce HIV related disparities and health inequalities**

**Objective 1: By 2021, reduce disparities in the rate of new diagnoses by at least 15% in Black MSM, Black Women, Hispanics, Youth and IDU**
The Council is aligned with federal strategies, and positioned to action a prevention and care plan to respond to retention to care disparities for African-Americans in its TGA within Central Texas.

**Objectives**

The objectives of this paper are (1) identify challenges to retention in care for African-Americans in the five-county area of the Austin TGA; (2) review of retention in care activities from Austin Area Comprehensive HIV Planning Council Integrated Care Plan around Goal #2 and Goal #3; (3) Policy recommendations for Ryan White program funding and the Council’s Integrated HIV Prevention and Care Plan.
Objective 1

**Barriers to retention in care for African-Americans in Austin Transitional Grant Area (TGA);**

In popular African-American culture “keeping it on the down low” is a common phrase used to refer to anything that is kept in secret. The concept of a “down low brother” contributes to the lack of engagement in medical care for African-American men diagnosed with HIV. For white men the label most identified with HIV infection is “gay” or “MSM.” Both terms connotate lifestyles, not just behaviors. In contrast, African-American men diagnosed with HIV do not readily identify with “gay” or even “bisexual”, conversely this limit has allowed for generous exaggeration of the “down low” label or category (Innes, 2014).

A cultural competency barrier such as this has unbounded downstream impacts. Use and application of “down low” when targeting African-American heterosexual women at risk for HIV infection, implies HIV transmission only happens to African-American men “on the down low” (Malebranche, 2003). Both barriers inherently add stigma to an African-American man’s experience newly diagnosed with HIV. Applying “down low” as an identity rather than a behavior implies judgement by the person using the label/category, to the person hearing the label/category (Hart & Peterson, 2004; Rotheram-Borus, Marelich, & Srinivasan, 1999). It establishes a difference that does not exist for White men, and a gap for evidence-based interventions, The Council’s Needs Assessment survey and Texas surveillance data capture have been limited to identifying people not behaviors to be able to report findings to state and federal funding agencies. When the labels/categories were challenged, the council responded they follow federal guidelines
for defining groups to compare data across the TGA, against other TGAs, and against national standards and trends. In essence, the Council limits its ability to reach African-American men it recognizes it must reach to achieve neighborhood viral suppression, to secure and maintain funding to target African-American men.

So why aren’t African-American men literally raising their hands when asked about their sexual behaviors if it means not getting HIV? It seems reasonable to presume there is a greater fear of identifying with sexual behaviors that put them at risk for HIV infection, than HIV infection itself. In my opinion, stigma is fueled by HIV illiteracy, and questionable cultural competency confronts African-American men before they test. Public health professionals see their statistics before they see them as a person and determinedly target them to lower rates of new HIV infections. During the Council’s Business meetings, discussions include Federal, state and local strategies that seem to support stigma while trying to dispel stigma. HIV prevention campaigns that target African-American MSM, as a rule, include initiatives toward African-American men believed to be on the “DL.” Pursuing a concept that is based in racial discrimination, instead of engagement in medical care perpetuates stigma and institutional racism. Ultimately existing as, or evolving into, a barrier to retention to care. Fear of violence or being ostracized from African-American communities moves African-American men further from entering the HIV Care Continuum pipeline and accessing key ART medications to achieve viral suppression. A pillar of the African-American community is the African-American Church. Historically, the African-American Church has not widely adopted, or supported interventions or HIV prevention aimed at its African-American congregation. Despite sermons of love and acceptance, African-American Church Pastors view men who have
sex with men as a sin (Quinn, Dickson-Gomez, Young, 2016). Lastly, extreme themes of masculinity in African-American communities reach back to times of slavery (Malebranche, Bryant, 2005). Deprivation of being defined as a “man” began during slavery and some would argue still exist today. If there was no question about the value or importance of African-American male life, Black Lives Matter could be a very different advocacy movement. In 2010, over half a million African-American men and over 3.2 million White men were living in the US. HIV prevalence rates in African-American men was 32% compared to 8% for Whites. African-American men were disproportionately impacted by HIV infection, and care disparities were most notable at the retention to care point in the HIV Care Continuum, only 33% of African-American diagnosed MSM retained compared to 51% of White men. At the end of the continuum, just 16% of African-American and MSM were estimated to have attained HIV virological suppression, while 34% of white men reached the same (Rosenberg et al, 2014).

Opportunities for care disparities exist throughout the HIV Care Continuum pipeline as illustrated below:
A known challenge to retaining PLWH in care is lack of engagement of the newly diagnosed person resulting in the leaky pipe of the HIV Care Continuum. In a February 2013 publication of *Morbidity and Mortality Weekly Report (MMWR)*, the CDC acknowledged the disproportionate prevalence of HIV in the African American community. From 2010-2014, HIV infection rates dropped, but in each year, almost half of all diagnoses happened in the African-American community. Notably, diagnoses occurred in African-American gay or bisexual men (CDC, 2013). Lost or no engagement directly relates to lower retention in care rates, limited or no access to anti-retroviral therapy, and tie to higher new infection rates for African-Americans than they number in the overall population. In 2013, African-Americans were 12% of the population with 45% of new HIV infections occurring in more men than women. Taking a deeper dive into rates, 38% of blacks with HIV infection were consistently retained in care during 2011–2013, compared with 49% of non-Hispanic whites. (CDC, 2013). The Council’s Integrated Prevention and Care Plan acknowledges success along the HIV Care Continuum, and identifies disparities when targeting priority populations (Austin Area Integrated Plan, 2016). “Particular challenges” with the care continuum and African-American MSM linkage to care, not retention to care, suggests the Council feels retention in care disparities have been managed or do not exist.
Figure 5. is a 2016 HIV Care Continuum Parity Table for Austin TGA (Austin HSDA, 2016) that depicts retention in care rates for Austin TGA as significantly higher than national rates for African-Americans.

Based on data focused on African-American engagement in HIV medical care, and lost to care opportunities in the HIV Care Continuum pipeline, this seems to be an oversight by the Council, perhaps based on the data of the Parity Table. The Council's plan should incorporate retention to care interventions and activities to ensure a return on investment in linkage to care interventions and activities. This data is an example of a leak in the HIV Care Continuum. Misrepresented data can lead to misperceptions that
prevention and care plans are more effective than reality suggests. Based on the data in the table above, the Council’s plan should have no reference to disparities.

Accurately translating (or initially capturing) research into lay terms for community consumption, outdated or offensive cultural terminology and concepts, disproportionality and disparity along the HIV Care Continuum appear to be barriers to retention to care in Austin TGA. In my observations from working with, and within, the HIV/AIDS community in the Austin TGA, systems, methods and applications appear to be serving funding services through reporting requirements as opposed to serving the most vulnerable groups at risk for HIV infection. By using labels that address a person, not a behavior, it seems public health professionals are perpetuating the thought that African-American men are beyond reach.
Objective 2

Review of Austin Area Comprehensive HIV Planning Council Integrated Care Plan activities around Goal #2 and Goal #3

Goal #2, Objective #2 of the Council’s Integrated Prevention and Care Plan speaks to improving the percentage of consumers retained in care through specific activities aimed at removing care disparities along the HIV Care Continuum, and improving cultural competency.

Objective 2: Increase the percentage of PLWHA who are retained in HIV medical care from 79 percent to at least (85) percent.

*Strategy 1: Strengthen a comprehensive, patient-centered approach to HIV care that addresses HIV-related co-occurring conditions and chronic disease management.*

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Activity</th>
<th>Responsible Parties</th>
<th>Target Population</th>
<th>Data Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Promote and collaborate with peer support programs, support groups, meet ups, and events.</td>
<td>HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)</td>
<td>HIV+ Individuals, Community AIDS Service Organizations</td>
<td>Number of events and programs</td>
</tr>
<tr>
<td>A2</td>
<td>Launch a re-linkage to care project that develops an expedited into care system for recently released HIV+ individuals.</td>
<td>HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)</td>
<td>Recently released HIV+ Individuals, Medical Providers</td>
<td>Project implementation</td>
</tr>
<tr>
<td>A3</td>
<td>Educate providers regarding patient-centered care.</td>
<td>HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)</td>
<td>Medical Providers</td>
<td>Number of providers educated</td>
</tr>
</tbody>
</table>
Of the activities in Strategy 1, activities A1 and A3 relate to areas of deficiency alongside the HIV Care Continuum. HIV prevention is undergirded with advanced education to raise HIV literacy and reduce stigma (Herek, 2005). Working with traditional and non-traditional community partners maximize community mobilization and yields several opportunities. First, engaging with traditional and non-traditional community partners bridges the Council to consumers and provides for recruitment to the Council. Participating in the process of allocating resources and operationalizing the prevention and care plan provides African-American PLWH the chance to engage in the process and inform community decisions. Currently, there is a disparity among Council members with one African American male member, and three African American women out of 13 total Council members.

<table>
<thead>
<tr>
<th></th>
<th>2017-2021</th>
<th>Promote the use of case management to support those living with HIV.</th>
<th>HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)</th>
<th>HIV+ Individuals; Service Providers</th>
<th>Number of Ryan White clients utilizing service</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4</td>
<td>ONGOING</td>
<td>Monday through Friday</td>
<td>Monday through Friday</td>
<td>Monday through Friday</td>
<td>Monday through Friday</td>
</tr>
<tr>
<td>A5</td>
<td>PROJECT</td>
<td>Explore the potential of integrating HIV medical and related services into a “one-stop” shop so all appointments can be done at the same place and time.</td>
<td>HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)</td>
<td>HIV+ Individuals</td>
<td>Project implementation</td>
</tr>
<tr>
<td>A6</td>
<td>ONGOING</td>
<td>Provide prioritized, safety net, core medical and support services for Ryan White eligible clients using Ryan White funding sources.</td>
<td>HIV Planning Council</td>
<td>HIV+ Individuals</td>
<td>Number/percent of clients who receive each type of core medical and support service</td>
</tr>
</tbody>
</table>

*Figure 5. Austin Area HIV Planning Council, Integrated Prevention and Care Plan, 2017-2021.*
Taking this approach meets the target population “where they are” in the community. It offers a layer of privacy and cultural understanding that responds to fear of testing, fear of seeking services, and fear of knowing one’s status. In this way, the Council put the emphasis on sexual health and wellness, and less on sexual risk behaviors or racial disparities. Shifting the paradigm in this direction also creates a “safe passage” into the HIV Care Continuum, something that the care continuum does not currently have, and is a point of disparity for African-Americans. Racial care disparities at the entrance point of the HIV Care Continuum are not navigable because there are few evidence-based interventions that are tailored to the African-American community, or African-American men who do not identify with a label/category in person or behavior, or African-American women at-risk in heterosexual encounters. In a meta-analyses of HIV risk behaviors of Black and White MSM, disparities were addressed that can occur at any place in the care continuum pipeline (Millett, 2008).

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sexual risk. Black MSM are more likely than other MSM to engage in high-risk sexual behavior</td>
<td>a. Unprotected anal intercourse</td>
</tr>
<tr>
<td>2. Identity/disclosure. Black MSM are less likely than other MSM to identify as gay or to disclose their sexual identity, which may lead to increased HIV risk behavior</td>
<td>b. No sex partners</td>
</tr>
<tr>
<td>3. Substance use. Black MSM are more likely than other MSM to abuse substances, especially injection drugs, that increase their risk for HIV infection</td>
<td>c. Commercial sex work activity</td>
</tr>
<tr>
<td>4. STD history. Black MSM are more likely than other MSM to contract STD that facilitate the acquisition and transmission of HIV</td>
<td>a. Nongay identity</td>
</tr>
<tr>
<td>5. HIV testing. Black MSM are less likely than other MSM to be tested for HIV or to know their HIV status, and they may unknowingly expose their sexual partners to HIV</td>
<td>b. Nongay identity and HIV risk</td>
</tr>
<tr>
<td>6. Black MSM are genetically more susceptible to HIV than other MSM</td>
<td>c. Nongay identity and HIV risk</td>
</tr>
<tr>
<td>7. Black MSM are less likely than other MSM to be circumcised, increasing their risk for HIV infection</td>
<td>d. Nongay identity and HIV risk</td>
</tr>
<tr>
<td>8. ART use. HIV-positive black MSM are infectious for a longer time than other HIV-positive MSM</td>
<td>a. General drug use</td>
</tr>
<tr>
<td>9. Sex with HIV-positive partners. Black MSM are more likely than other MSM to have sex with partners known to be HIV positive</td>
<td>b. Alcohol use</td>
</tr>
<tr>
<td>10. The sexual networks of Black MSM place them at greater risk for HIV infection than the sexual networks of other MSM</td>
<td>c. Marijuana</td>
</tr>
<tr>
<td>11. Black MSM are more likely than other MSM to be incarcerated, which increases the likelihood of exposure to HIV</td>
<td>d. Injection drug use</td>
</tr>
<tr>
<td>12. Black MSM are more likely than other MSM to engage in anorectal douching, which increases their risk for HIV infection</td>
<td>e. Amphetamines</td>
</tr>
<tr>
<td>f. Cocaine (including crack)</td>
<td>g. Needle sharing</td>
</tr>
<tr>
<td>h. Hallucinogens</td>
<td>i. Amyl nitrites ('poppers')</td>
</tr>
<tr>
<td>j. Opiates</td>
<td>k. Drug use during intercourse</td>
</tr>
<tr>
<td>a. HIV testing (ever)</td>
<td>b. HIV testing frequency</td>
</tr>
<tr>
<td>c. Unrecognized HIV infection</td>
<td>d. Healthcare service access and insurance</td>
</tr>
<tr>
<td>e. Adherence to ART</td>
<td>f. ART use</td>
</tr>
</tbody>
</table>

MSM, men who have sex with men; UAI, unprotected anal intercourse; STD, sexually transmitted diseases; ART, antiretroviral therapy. Note that these authors found no support for hypotheses 1–3, support for 4 and 5, and insufficient or inconclusive support for 6–12. a Denotes subtopics in a hypothesis for which there were insufficient quantitative data (i.e., <3 effect sizes from unrelated studies) to perform a meta-analysis.
Racial disparities were proposed to exist beyond behaviors. Table 1 captures proposed racial disparities that affront African-American men who have sex with men.

Strategy 2 includes activities that reinforces the notion that a cultural competency piece is missing from the HIV Care Continuum. In terms of African-Americans disproportionately impacted by HIV infection and separated in engagement to medical care, training the staff of providers to be able to manage conversations around entering the care continuum and being successfully retained in care is a needed step.

| Strategy 2: Increase awareness and access to HIV-related support services available in the community upon HIV diagnosis. |
|---|---|---|---|---|
| **Timeframe** | **Activity** | **Responsible Parties** | **Target Population** | **Data Indicators** |
| A1a 2017-2019 PROJECT | Conduct a survey of what barriers exist for newly diagnosed individuals that prevent or delay access to support services. | HIV Planning Council; City of Austin HHS (HIV Resource Administration unit) | Newly diagnosed individuals | Creation of Needs Assessment Survey; Number of survey respondents; Percent of newly diagnosed people that were knowledgeable about or have accessed support services |
| A1b 2020-2021 PROJECT | Develop training for front line staff designed to facilitate conversations about available services for HIV+ individuals and reduce barriers for attending their first medical appointment. Develop Ryan White services brochure for clients. | HIV Planning Council; City of Austin HHS (HIV Resource Administration and Communicable Disease units); HIV Taskforce | Front line workers including prevention specialists from Ryan White funded agencies | Training Created; Number of front line workers educated; Client Brochure Created; Number of brochures distributed; Survey Results from linkage survey |

Figure 6. AAHPC, Integrated Prevention and Care Plan, 2017-2021.
Cultural competency as it relates to Hispanics is often called out or required when delivering care to this community, with translator services or Spanish speaking staff in a provider’s offices is often recommended. (National Alliance for Hispanic Health, 2001). It is understood that these elements are needed and necessary for the Hispanic population, yet when discussing African-American consumers, there tends to be little discussion around ensuring they too have access to providers who are fluent in their culture and speak this community’s language. I also think the assumption is Whites do not need these considerations since they are experiencing greater access to the HIV care continuum than African-Americans. The Council recognizes conducting needs assessments and developing tailored cultural competency service provider staff training is needed to reach the objective. Within this strategy, there is space to design projects that combine cultural competency and sensitivities to overcome racial care disparities.

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Activity</th>
<th>Responsible Parties</th>
<th>Target Population</th>
<th>Data Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 2017-2021 ANNUAL MEETING</td>
<td>Host forum/town hall addressing HIV clinical and service topics, including, but not limited to: care of transgender clients, CLAS standards, times of services, number of HIV service providers, and geographic availability of HIV services.</td>
<td>HIV Planning Council; City of Austin HHS (HIV Resource Administration unit)</td>
<td>HIV Clinical and Service Providers HIV+ Individuals</td>
<td>Number of forums held; Number of Attendees</td>
</tr>
</tbody>
</table>

*Figure 7. AAHPC, Integrated Prevention and Care Plan, 2017-2021.*
Strategy 3, activity 1, of the plan includes a variety of activities aimed at community mobilization. Paul Semugoma, Health 4Men Programme, Anova Health Institute, stated “If there is one word I’d emphasize, it is community, community community. The 90-90-90 target cannot be delivered without engaging the community.” Again, meeting the African-American community “where they are” is a step in acknowledging the racial disparities of the HIV Care Continuum, and the disproportionality of HIV in their community compared to Whites.

Community mobilization activates community engagement. Moving into a space where discussion is promoted to definable and actionable solutions is parallel to Dr. Eugene McCray’s comments on CDC’s efforts to respond to the African-American men living with or at risk for HIV. Dr. McCray highlights a couple of points that support CDC’s February 2016 MMWR. He calls out social inequities that make the care continuum vulnerable to racial care disparities (McCray, 2016). To drive down HIV infection in African-Americans, Dr. McCray reports CDC’s efforts to collaborate at local levels to develop local sustainable solutions for prevention that address comprehensive care. Care that includes behavioral health in tandem with physical health, and social supports that encourage African-American men to enter the care continuum. Dr. McCray also speaks to funding projects that specifically target points in the care continuum such as retention in care. It is clear that racial care disparities are present along the HIV care continuum and a forward step to partnering with African-American men is funding community engagement projects, and actioning local solutions through community mobilization.
Goal #3 of the Council’s Integrated Prevention and Care Plan speaks to reducing disparities through dissemination of evidence-based programs.

Short and long-term strategies focus on reducing HIV infection disparities. Goal #3 includes short and long-term strategies focused on reducing HIV infection disparities. It is important not to overlook this necessary acknowledgement of disparities, however, the Council has taken what could be argued as a softer approach by not calling out racial disparities along the HIV Care Continuum. The goal is relevant to the Austin TGA; however, it is very broad in its scope. It also implies that the disparities it seeks to reduce are in key populations where injection drug use is the mode of transmission and men who have sex with men is an ongoing behavior. As Millet et al. uncovered, neither of these are behaviors or identities in African-Americans disproportionately impacted by HIV infection. This is a missed opportunity to specifically address the African-American man in the Austin TGA who continues to live with, or be infected with, HIV at greater rates than Whites.

Based on data focused on African-American engagement in HIV medical care, and lost to care opportunities in the HIV Care Continuum pipeline, the Council’s prevention and care plan should incorporate retention to care interventions and activities to ensure a return on investment in linkage to care interventions and activities. Although the parity
table depicts retention in care much higher than national rates, there is also data that indicates the rate of PLWH (40%) is highest in African Americans even though they represent only 12% of the U.S. population (Highleyman, 2017). This is compelling data to step up activities to initiate the HIV Care Continuum with African-Americans and retain them in care.

This data is an example of a leak in the HIV Care Continuum. Misrepresented data can lead to misperceptions that prevention and care plans are more effective than reality suggests. Based on the data in the table above, the Council’s plan should have no reference to disparities.

Accurately translating (or initially capturing) research into lay terms for community consumption, outdated or offensive cultural terminology and concepts, disproportionality and disparity along the HIV Care Continuum appear to be barriers to retention to care in Austin TGA. In my observations from working with, and within, the HIV/AIDS community in the Austin TGA, systems, methods and applications appear to be serving funding services through reporting requirements as opposed to serving the most vulnerable groups at risk for HIV infection. By using labels that address a person, not a behavior, it seems public health professionals are perpetuating the thought that African-American men are beyond reach.
Policy Alternative Recommendation--Minority AIDS Initiative and Cultural Competency

In 1996, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act added Part F. This section of the Act is aimed at support services for key populations impacted by HIV/AIDS. Part F includes AIDS Education and Training Center (AETCs), the Special Projects of National Significance (SPNS) program, the Dental Reimbursement Program, and the National Minority AIDS Initiative (NMAI) (Ryan White Program Part F, n.d.). Agencies can pursue NMAI funding, as with the other parts of CARE, separately. There is no requirement, or incentive to pursue NMAI or Part F as such, the full benefits of Part F are not leveraged despite proven histories of efficacy.

AIDS Education and training Centers were instrumental in educating providers in the 1980’s when the AIDS deaths were at historically high rates. Specifically, AETCs worked to train providers on how to manage Mother-to-child transmission. As time went on and technology advanced in medication treatment, AETCs began to focus on clinical training programs to support providers who managing higher patient volumes. As time went on AETCs advanced as HIV/AIDS outcomes advanced. Training was expanded to include medication adherence, behavioral change techniques, and comorbidities (Ryan White Program Part F, n.d.).

Utilizing this existing resource is a low to no cost option in terms or policy alternatives. Employing ATECs as “hubs” for new and contemporary resources to address the HIV/AIDS is proven and well received by providers and in the community. Early on, ATECs played a role in educating and training in Migrant Health Centers. Using this successful model, ATECs should refresh and develop tailored cultural competency toolkits, training and key population specific materials to assist providers and their staff
deliver culturally competent care when initiating the HIV Care Continuum for African-American men. ATECs can also be used for community facing activities that focus on newly diagnosed African-Americans, and African-Americans at risk for HIV who do not know their status. The centers have provided one-on-one consultations in the past and should rebuild this model to facilitate needs assessments and focus groups. With eleven sites, ATECs can be used to move African-American communities at-risk for HIV to viral suppression.

Figure 6 gives a timeline of the evolution of ATECs. It is also a visual representation of their ability to grow, adapt and remain a relevant resource. Enhancing the ATEC roster with the following national training centers makes the strongest case for expansion, and adoption of an agenda focused on African-Americans, the HIV Care Continuum, and racial retention to care disparities:

1. AETC National Resource Center—single information and dissemination access point for providers;
2. AETC National Evaluation Center—provide program evaluation, reports, and additional resources.

3. National HIV/AIDS Clinicians’ Consultation Center—Peer-to-Peer consults

4. National Minority AETC—Resource repository centered on best practices for cultural competency to address minority HIV/AIDS

Establishing NMAI as an included funding source for Part A will ensure it is actively used to help African-Americans living with, or at risk, for HIV are engaged in medical care and retained in care until viral suppression is achieved. Including NMAI as a requirement of Part A also triggers TGAs to respond to a national epidemic of HIV/AIDS in the African-American community. Transferring NMAI to Part A can be done as a requirement of grantees Integrated Prevention and Care Plan. This is a seamless transition and will bolster the credibility of prevention and care plans, as well as motivate planning councils to recruit a Council that represents the community they serve, not the data it receives from other state agencies.
Policy Alternative Recommendation- Pre-Exposure Prophylaxis (PrEP)

Through the eleven sites and four national centers, providers can receive education on federal, state and local resources that support PrEP. PrEP is an evidence-based intervention that provides people who do not have HIV, but are at-risk, an opportunity to limit the transmission of the infection by taking one pill a day, Truvada. While PreP’s efficacy in HIV prevention is known, it is not being used in the African-American population. (Trykowski, 2017).

In 2012, when Truvada came to market its manufacturer Gilead shared data that indicted African-American men were less likely to use Truvada. Of almost 49,158 users who started Truvada between 2012 and 2015, data on race/ethnicity was available for less than half of the users (43%). Within that percentage, Whites filled 74% of Truvada prescriptions compared to 10% that were filled by African-Americans. More importantly, the percentage of African-American users dropped from 12% in 2010 to 10% in 2015. Also, although an average of 2500 woman started Truvada each year, African-American women were four times less likely to start than White women. These numbers do not align with the disproportionately high HIV rates in the African-American community. With almost half of HIV infections happening to African-Americans, and 26% of those infections happening with African-American women, the percentages of African-American men and women using Truvada is remarkably low. (Highleyman, 2016)

HIV-negative African-American men who are at risk for HIV are not using PrEP. A 2015 UCLA/APLA survey found that while 13.9 % of white young MSM respondents were on PrEP, compared to 9.8 % of African-American MSM were using PrEP (HIV & AIDS Information, 2015). It has been discussed that the importance of seeing oneself use PrEP
has been underestimated. PrEP will not be as successful if the folks at risk are not talking about it, using it and sharing their stories (Newman, 2015). Ryan White Part A policy can be used to spread a better, more purposed and intentional message within the African-American community. Pulling the Minority AIDS Initiative in to HIV Prevention and Care Plans as a requirement that is satisfied through goal setting around PrEP, improves access to PrEP in the African-American community.

With funding behind the message, and required reporting to maintain funding, grant recipients should be more motivated to actively disseminate information about PrEP.

Policy Alternative Recommendation- Austin Area Comprehensive HIV Council

Within the Council’s existing Integrated Prevention Care Plan, Goals #2 and #3, there is opportunity to combine its resource allocation function with enhancements to the activities included in their plan. First, local data should be challenged through revised Needs Assessment Surveys and focus groups. Engaging with non-traditional AIDS service providers offers many benefits as previously discussed. Next, taking a refreshed approach acknowledges the disproportion and disparity of HIV retention in care rates in the African-American community. This type of community mobilization builds credibility, and expands communication pathways between the African-American community and the Council.
Discussion

After assessment of the objectives, the recommendation is a revision to current Health Resources and Services Administration (HRSA), Ryan White Program policy to address African-American retention in African-American care disparities. Expanding the Ryan White Part F Minority AIDS Initiative to require grantees provide annual reporting for cultural competency provider training, and pre-exposure prophylactic (PrEP) treatment in African-American men. Additional recommendations include expanding required activities for the Austin Area Integrated HIV Prevention and Care Plan. Lastly, renewing the Council’s focus on care disproportionality and disparities positions the Council to partner with local community leaders to develop sustainable long-term solutions. All steps to improve engagement and in turn retention in care rates for African-Americans diagnosed, or living with, HIV (Gardner, 2011).

The Council has greater feasibility to operationalize the recommendations within its existing plan, over the next 5 years. While it is still feasible for HRSA to operationalize these policy alternative recommendations, a timeline to establish these policy alternatives is dependent on HRSA agenda and priorities.
REFERENCES


HIV Cascade Framework. (October 2015). Available at


Human Resources and Services Administration. HRSA's HIV Care Continuum Efforts Bring Country One Step Closer to Achieving an AIDS-free Generation, 2014.

Human Resources and Services Administration. Ryan White HIV/AIDS Program Services: Eligible Individuals and Allowable Uses of Funds Policy Clarification Notice #16-02, 2016. Available at

Available at


Texas Department of State Health Services, HIV/STD Prevention and Care Branch Austin HIV Service Delivery Area (HSDA) Data Sheet (December 2016).
