Stigma, Implicit Bias, and Long-Lasting Prevention Interventions to End the Domestic HIV/AIDS Epidemic

See also Kapadia and Landers, p. 15; and the *AJPH* Ending the HIV Epidemic section, pp. 22–68.

Ending the domestic HIV/AIDS epidemic will require collaborative, innovative, and community-informed approaches since the factors fueling the epidemic in the United States are largely social and structural. It is no coincidence that the communities most disproportionately affected by HIV (i.e., racial/ethnic minorities, sexual and gender minorities, and immigrants) share devalued identities and carry a legacy of violence, victimization, stigma, and discrimination.[1] To successfully meet the goals of the federal End the HIV Epidemic proposal, effective interventions must be developed and implemented in three domains: (1) addressing stigma and discrimination, (2) increasing awareness and building capacity to address implicit bias, and (3) developing an effective preventive HIV vaccine or similar long-acting biomedical prevention strategy.

ADDRESSING STIGMA AND DISCRIMINATION

The proposed plan to end the epidemic pays little attention to adequately addressing pervasive stigma and decades of institutional discrimination. Black and Latino/a persons, especially men who have sex with men (MSM) and transgender individuals, disproportionately experience health care services that are of lower quality, are more expensive, have limited availability because of limited access to Medicaid or no Medicaid expansion, lack cultural responsiveness (ability to learn from and relate respectfully with people from other cultures), and fail to provide population-focused health services (emphasizing the needs of a whole population, not individual members, to eliminate inequalities and stress prevention).[2,3] The impact of these inequities is most evident in Black and Latino/a MSM and transgender individuals, who experience markedly lower access to preexposure prophylaxis (PrEP), delays in early diagnosis and treatment, and lower likelihood of virological suppression.[4,5]

Interventions aimed at eliminating the discriminatory policies and practices that have resulted in barriers to obtaining and maintaining health care, lower-quality care, homelessness, incarceration, and poverty are critical in our efforts to end HIV. These include, but are not limited to, affordable housing, moving away from criminalization and toward effective interventions (e.g., harm reduction)[6] and support services (e.g., promoting and supporting leadership) for drug users and sex workers, decriminalization of HIV transmission, decreasing intimate partner violence, increased access to health care, and increased civil rights and protections for racial/ethnic minorities, sexual and gender minorities, and immigrants. We must specifically address the stigmatizing and discriminatory practices of our health care system. For example, 30 states (60%) either ban transgender health care or do not clearly state their Medicaid policy on such care, further stigmatizing transgender individuals and perpetuating mistrust of the medical community. Any HIV prevention efforts must include collaborative efforts that focus on addressing these institutional, social, and structural barriers that negatively affect HIV risk, transmission, and infection. To ensure meaningful engagement of communities, these efforts must utilize community-based participatory research approaches[7] and include health as part of a larger program that meets other community-identified needs.

INCREASING AWARENESS TO ADDRESS BIAS

Any successful plan to end HIV must also address the implicit biases that fuel pervasive stigma and discrimination. Biases held by health care workers and service providers influence patient–provider relationships and communication; treatment recommendations; quality of care; empathy; prophylactic, diagnostic, and treatment decisions; treatment adherence; and patient outcomes. For HIV populations, bias is implicated in experiencing delays in initiating HIV care, being denied care, challenges linking to care, lower likelihood of being prescribed antiretroviral therapy (ART), lower adherence to ART, verbal harassment, and being refused treatment.

For people living with HIV (PLWH), the ultimate goal is viral suppression, and this too is affected by pervasive implicit biases. People of color are less likely to be virally suppressed; this is particularly true of Black people, who, even after adjusting for ART use and adherence, are less likely to be virally suppressed. Among all PLWH subgroups, Black and Latina women experience higher rates of morbidity and mortality and Latino/Hispanic

ABOUT THE AUTHORS

All of the authors are with the HIV Vaccine Trials Network and the Fred Hutch Vaccine and Infectious Disease Division, Seattle, WA.

Correspondence should be sent to Michele Andrasik, PhD, EdM, HIV Vaccine Trials Network, 1100 Fairview Ave N, E3-300, Seattle, WA 98109 (e-mail: mandrasik@fredhutch.org). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This editorial was accepted October 12, 2019.

doi: 10.2105/AJPH.2019.305454

men experience shorter life expectancy.

To end HIV domestically, the plan must explicitly address providers' implicit biases. At a minimum, health care providers, HIV prevention researchers, and service providers must receive formal education (i.e., in medical, nursing, and graduate school) to learn how their implicit biases influence their practice of medicine; research questions, designs, methods, and interpretation of results; and health care service provision. It is imperative that we build the capacity of these individuals, providing them with the skills they need to reduce negative behaviors and mitigate negative outcomes associated with these biases. Institutions and organizations must also develop and implement metrics to identify disparities and inequities in their services and practices in real time to inform effective interventions to eliminate them.

DEVELOPING AN EFFECTIVE HIV VACCINE

Ultimately, any plan to end the HIV epidemic requires an effective long-acting biomedical prevention method, such as a vaccine, that is acceptable to populations at greatest risk. Historically, vaccines have been required to prevent infectious diseases. The numerous available HIV prevention methods, including PrEP, provide individuals with many choices, but most are dependent on behavior changes relating to adherence and the faithful and continuous use of the prevention method selected. Only long-acting interventions like vaccines and other injectables can overcome these adherence issues, and are required to reduce the acquisition rates to nonepidemic levels.

Any effort will require partnering with communities to ensure that proposed plans are acceptable and meet the needs of the community, and that implementation is feasible. This is a complex field of trust, commitment, expectation, and belief. Such arrangements need to start somewhere but take years to be optimally successful. The HIV Vaccine Trials Network (HVTN) started its community engagement program 20 years ago. It is in the last five years that we have seen ongoing and iterative HVTN community engagement efforts lead to increases in minority and transgender enrollment and favorable participant experiences. These efforts have included targeted community stakeholder engagement, community consultations, protocol-specific community working groups, utilization of community-based participatory research approaches, and cultural responsiveness training. Most of our participants join our trials for altruistic reasons, and 80% report experiencing social benefits as a result of their participation. To ensure that this translates to acceptability and uptake, a commitment to community engagement needs to extend post licensure. The human papilloma virus vaccine has taught us that the development of an effective vaccine does not guarantee acceptance or uptake, so continued community engagement is not only necessary, it is critical.

To ensure the realization of ending the HIV epidemic domestically, we will need to focus on community-based work to establish and maintain relationships that build health and sexual literacy, normalize discussions about sex, and overcome the pervasive mistrust of medical institutions resulting from decades of ethical violations and abuses of marginalized populations. Traditional models of medicine and clinical trials have not supported community acceptance and ownership of biomedical HIV tools broadly, especially in populations most vulnerable to HIV. To support community acceptance and ownership, the plan must invite clinical trialists and the larger medical community—the entire community, not simply those most convenient and accessible for our work—to join in engaging participants, patients, and communities as full partners in the process. This work entails recognizing that community partners have agency, assets, and contributions that extend far beyond testing investigational agents and receiving products to respond to disease, and these communities must be considered as more than the recipients of a service or product. It will also require efforts to increase the abysmally low numbers of racial, ethnic, and gender minority health care providers and researchers working in the field.

Although this work may seem daunting, it simply represents a paradigm shift in which we center social justice, trauma-informed and patient-centered care, and harm reduction in our work. Now that we have the tools necessary to see the end of HIV in the United States, we must be bold enough to tackle the underlying issues that, until they are addressed, will render these tools useless for the most vulnerable populations. AJPH

Michele Andrasik, PhD, EdM
Gail Broder, MHS
Linda Oseso, MPH
Stephaun Wallace, PhD
Francisco Rentas, MAT
Lawrence Corey, MD

CONTRIBUTORS

M. Andrasik led the writing and editing of the manuscript. All other authors contributed equally to the manuscript.

ACKNOWLEDGMENTS

A special thank you to Mindy Miner for her editorial assistance.

CONFLICTS OF INTEREST

The authors report no conflicts of interest.

REFERENCES

1. Walters KL, Mohammed SA, Evans-Campbell T, et al. Bodies don't just tell stories, they tell histories. *Du Bois Review*. 2011;8(1):179–189.

2. Halkitis PN, Wolitski RJ, Millet GA. A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men. *Am Psychol*. 2013;68(4):261–273.

3. James SE, Herman JL, Rankin S, et al. *The Report of the 2015 US Transgender Survey*. Washington, DC: National Center for Transgender Equality; 2016.

4. Hall HI, Frazier EL, Rhodes P, et al. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. *JAMA Intern Med*. 2013;173(14):1337–1344.

5. Highleyman L. PrEP use is rising fast in the US, but large racial disparities remain. Aidsmap, 2016. Available at: http://www.aidsmap.com/PrEP-use-is-rising-fast-in-US-but-large-racial-disparities-remain/page/3065545. Accessed August 19, 2019.

6. Collins SE, Clifasefi SL, Logan DE, Samples L, Somers J, Marlatt GA. Current status, historical highlights and basic principles of harm reduction. In: Marlatt GA, Witkiewitz K, Larimer ME, eds. *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*. 2nd ed. New York, NY: Guilford; 2011:3–35.

7. Wallerstein N, Duran B, Oetzel J, Minkler M. *Community-Based Participatory Research for Health*. 3rd ed. San Francisco, CA: Jossey Bass; 2017.