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## Addressing racism's role in the US HIV epidemic: Qualitative findings from three Ending the HIV Epidemic (EHE) Prevention Projects

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### Abstract

**Background:** Racist socio-political and economic systems in the United States (US) are root causes of HIV disparities among minoritized individuals. However, within HIV implementation

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science literature there is scarce empirical research on how to effectively counter racism. This paper names racism and White supremacy as key challenges to the success of the Ending the HIV Epidemic (EHE) initiative and delineates opportunities to integrate anti-racism into HIV interventions.

**Methods:** Formative data were synthesized from three EHE studies in California, North Carolina, and South Carolina. Each study engaged with community stakeholders to inform Pre-Exposure Prophylaxis (PrEP) interventions. Key informant interviews and focus groups were used to query individuals—including Black individuals—about implementation challenges. While racism was not an *a priori* focus of included studies, discourse on race and racism emerged as key study findings from all projects.

**Results:** Across diverse stakeholder groups and EHE locales, participants described racism as a threat to the success of the EHE initiative. Institutional and structural racism, intersectional stigma, and maltreatment of minoritized individuals within healthcare systems were cited as challenges to PrEP scale-up. Some recommendations for addressing racism were given—yet these primarily focused on the individual level (e.g., enhanced training, outreach).

**Conclusions:** EHE implementation scientists should commit to measurable anti-racist actions. To this end, we present a series of recommendations to help investigators evaluate the extent to which they are taking actionable steps to counter racism in order to improve the adoption, implementation, and real-world impact of EHE interventions for people of color.

## Keywords

HIV; racism; health disparities; stigma; implementation science

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The Ending the HIV Epidemic (EHE) plan has been touted as a once in a generation opportunity to leverage the scientific advances in HIV of the past two decades in order to dramatically reduce HIV incidence in the United States (US).<sup>1</sup> Central to EHE is a geographic focus on 57 ‘hot spot’ jurisdictions—including US counties, territories, and states—that account for a majority of new HIV diagnoses.<sup>1</sup> The plan is a data-driven response to stagnated progress in reducing HIV incidence in the US and reflects a significant scale-up in HIV-allocated federal resources.<sup>2,3</sup> The four pillars of EHE (i.e., diagnose, prevent, treat, respond) rely upon local community engagement and planning, and the EHE initiative espouses a strong commitment to “expanded, inclusive, and sustained action to address disparities... [including] racial/ethnic disparities that have contributed to gaps in HIV prevention and treatment for far too long.”<sup>4</sup>

This focus is much needed as the US HIV epidemic continues to be characterized by low prevalence among the general population and high prevalence among select groups, notably sexual and gender minority individuals who are also minoritized by their race and/or ethnicity. In 2018, Black and/or African-American individuals (i.e., hereafter referred to as Black) accounted for 13% of the US population but 43% of new HIV cases.<sup>5</sup> While general HIV prevalence among the US adult population is very low (i.e., ~0.36%),<sup>6</sup> Black men who have sex with men (MSM) face a 50% lifetime risk of acquiring HIV if current trends persist.<sup>7</sup>

The US HIV epidemic has also had an escalating impact on Latinx communities that has been largely unrecognized, leading it to be recently dubbed the nation's 'invisible' HIV crisis.<sup>8</sup> Despite overall reductions in new HIV diagnoses from 2010 to 2016, HIV incidence among Latinx MSM increased during that period by 30%, with a 68% increase among young Latinx MSM (i.e., aged 25–34 years).<sup>8,9</sup> Data from 2018 suggests that Latinx people accounted for 18% of the population but 26% of new HIV diagnoses in that year.<sup>10</sup>

Racial and ethnic disparities are particularly stark within the transgender community, with recent national surveillance data finding an HIV prevalence rate of 65% among Black transgender individuals and 35% among Hispanic or Latina trans individuals.<sup>10</sup> These rates stand in contrast to an HIV prevalence rate of 17% for White transgender individuals in the US.<sup>10</sup> Among cisgender women, racial HIV disparities are extremely pronounced, with Black women making up 14% of the US population yet accounting for 58% of new diagnoses among women.<sup>10</sup>

Extreme racial and ethnic disparities were not prominent features of the early US HIV epidemic; thus, when considering shifts over time in who is disproportionately impacted, understanding why such disparities exist and what can be done about them is important. The HIV epidemic emerged in the US during the early 1980s<sup>11</sup> as a largely bicoastal phenomenon, with the brunt of new infections occurring in large metropolitan areas and among White gay men.<sup>12</sup> However, cases among Black residents increased steadily, and by 1996, more cases occurred among Black individuals than any other groups, with marked increases also noted for other minoritized groups.<sup>12</sup> Reductions in transmission during the era of 'treatment as prevention' and scale-up of Pre-Exposure Prophylaxis (PrEP) also reflect these racial disparities, with minoritized individuals continuing to be left behind in efforts to end the US HIV epidemic.

Although much research has focused on individual risk behaviors, these factors cannot explain the racial disparities in HIV rates. A meta-analysis of 174 studies in the US found that despite similar or fewer risk behaviors, Black MSM had a greater likelihood of HIV infection than other MSM.<sup>13</sup> Thus rather than rooted in individual risk, current HIV disparities are largely driven by societal and community-level variables, which are fueled by racism.<sup>14,15</sup> Structural racism has been defined as the totality of ways that societies foster racial discrimination through mutually reinforcing systems that in turn reinforce discriminatory beliefs, values, and practices, as well as shape the distribution of wealth and other societal resources.<sup>16</sup> There are several domains of structural racism that mutually reinforce each other, including civil and political rights, land and housing ownership, education and economic opportunities, criminal justice and legal systems, healthcare systems, migration and movement control, and racial climate.<sup>16,17</sup> Collectively, these domains limit minoritized groups' access to resources and opportunities that promote health.<sup>17</sup> For example, housing and employment discrimination limits access to and ability to pay for quality healthcare.<sup>16</sup> A focus on structural racism stands in contrast to much of the previous empirical research on racism and health that largely focused on interpersonal racism (i.e., individual experiences of racial discrimination)<sup>16,18</sup> and offers the opportunity to consider upstream interventions to reduce and eliminate current health inequities for minoritized individuals.

Within the context of the HIV epidemic among Black individuals, limited local resources (e.g., lack of clinics, healthcare provider shortages) are barriers to engagement in HIV care.<sup>19</sup> Those who are underinsured or uninsured, have lower incomes, or have unstable housing are less likely to achieve viral suppression, which in turn heightens the risk of onward transmission.<sup>20</sup> Moreover, historical medical racism, such as the Tuskegee Syphilis study, and ongoing anticipated and actual discrimination from healthcare professionals lead to medical distrust,<sup>21–23</sup> which predicts poor engagement in HIV care.<sup>24</sup> Racism also interacts with stigma surrounding HIV,<sup>25</sup> poverty,<sup>19</sup> and sexual identity<sup>23,25</sup> to increase medical distrust and, thus, poor engagement in care.

While racial and ethnic disparities are highlighted within the EHE plan, thus far there is limited empirical work on how EHE interventions and programs can effectively address racism nor the structural drivers that have created current HIV disparities. This paper synthesizes findings from three distinct EHE-funded PrEP projects in order to examine the role of racism in producing and maintaining current HIV disparities in the US. Each project aimed to inform the development of a PrEP-focused EHE program, campaign, or intervention, and all projects were in pre-implementation stages (e.g., exploration via formative data collection, engaging with partners to plan for future implementation).<sup>26</sup>

## METHODS & RESULTS

In March 2021, study leaders and team members from three independent EHE PrEP implementation projects embarked on a series of collaborative meetings to share insights and preliminary findings for gathered qualitative data. The projects were unique in geographic location (e.g., urban/suburban South, rural South, West Coast) and focal population (e.g., transgender people of color, MSM, young MSM and transgender youth). However, all projects prioritized community engagement and utilized community-academic partnerships. None of the projects aimed *a priori* to investigate the role of racism as a primary aim; yet during collaborative meetings to share initial findings, discourse on race and racism emerged as key study findings across all projects. Thus, study leaders embarked on producing this synthesis of findings related to racism and the EHE initiative. Methods and results from each of the three projects are provided below. In addition, Table 1 provides an overview of each EHE project (e.g., setting, population foci, methodologic approach), with salient findings related to racism shown in Table 2. Interview and focus groups guides from all projects are provided in Appendix A.

### PROJECT 1: TRANSforming the Carolinas (TTC)

**Methods.**—This formative study aimed to identify barriers and facilitators to HIV prevention and care engagement among transgender people of color. All members of the data collection and analysis team for TTC were Black, cisgender, and queer-identified; further, the team brought a social justice lens to study questions and interpretation of the data. Members of the research team conducted key informant interviews (KIIs) with adults (1) aged 18 years, (2) English speaking, and (3) working with an organization that provided HIV-related and/or social services for transgender adults in North Carolina (NC) or South Carolina (SC). Key informants were recruited via email invitations to leaders

of relevant organizations, yielding 12 informants. Key informants did not report on their socio-demographic characteristics; instead, they reported on their professional roles and expertise. Informants included healthcare providers ( $n=4$ ), advocates ( $n=4$ ), faith leaders ( $n=2$ ); and public health administrators ( $n=2$ ). Interviews were conducted from November 2019 to March 2020 via a HIPAA-secure web-based conferencing platform. The study was approved by the Institutional Review Board of the University of North Carolina Chapel Hill, and participants provided verbal informed consent before participating. An experienced, Black, queer-identifying qualitative researcher conducted the interviews, which lasted 25–60 minutes. Interviews were audio-recorded and transcribed verbatim.

The first phase of data analysis involved reading each transcript and writing memos that informed codebook development. Two trained researchers used the codebook to code each transcript independently, meeting bimonthly for debriefing sessions until completion of coding. The current analysis focused on text that was labeled with two categorical codes: “Social factors: Intersectionality” and “Improving Strategies and Access.” These codes were created in response to the question, “How do you feel social issues like discrimination affect how transgender people of color access HIV care and prevention services?” and “Tell me about existing strategies meant to help transgender people of color overcome barriers to HIV care and prevention services? (e.g. social services, targeted initiatives),” respectively. Constant comparison across transcripts was used to identify salient themes related to the role of racism in efforts to end the HIV epidemic.

**Results.**—Two main themes emerged: racism as a salient social factor and disconnect between social factors and recommended strategies. While some informants focused solely on gender identity, the majority raised issues of intersectionality and/or racism when asked about social issues affecting transgender people of color. For example, one key informant explained, “*Systemic racism is built into how we combat these issues...and as long as we are talking people of color and people who aren’t [people of color] feel like these issues do not affect them, we’re going to be fighting for legislation and greater funding to combat these ills.*” They described challenges faced by transgender people of color at the intersection of multiple oppressions (e.g., “*that can be poverty, it can be racism, homophobia, mental illness, substance use, and all of those things can be intertwined.*”) One key informant asserted that racism plays a bigger role than transphobia, while another noted challenges in finding and keeping staff who were culturally competent to provide services for Black and Latinx transgender people.

Despite the recurring theme of intersectionality and racism as social factors driving health inequities, few key informants raised anti-racist interventions as a strategy for overcoming barriers. Of the 51 coded suggestions, only nine specifically referenced race. The most common race-related suggestions were to increase cultural competency, improve outreach to communities of color, increase representation and leadership of people of color, and pay for participation (see Table 3). Notably, a majority of these suggestions involved addressing individual and interpersonal “competency” but not necessarily systemic, structural racism.

## PROJECT 2: Connecting resources for rural and urban sexual health: CRRUSH-Sacramento

**Methods.**—This formative study is part of a larger implementation science endeavor initiated in 2019 to increase PrEP use in Sacramento County, California. Members of the research team conducted semi-structured interviews to inform the development of a discrete choice experiment survey to measure and quantify preferences for sexual health services, including PrEP and other HIV prevention methods. Participants were recruited through community partners and advertisements on Craigslist. From March to April 2020, 22 interviews were conducted with potential PrEP candidates (see Supplementary Table 1 for participant demographics). All were between the ages of 18–34 years. Participants responded to a series of open-ended prompts and questions, such as “Tell me about your experiences accessing sexual health services (e.g., PrEP)” and “What do you think would work to help us [make] PrEP and STI services easily available and community-friendly?”. Individuals received \$50 for participation. The University of California, San Francisco Institutional Review Board approved this study.

The research team was diverse in terms of training, sexual orientation, age, race, and ethnicity; each had expert capacity in qualitative interviewing. Audio-recorded interviews were conducted via video conferencing or phone, lasting ~60 minutes. Interview domains included attitudes and experiences with healthcare systems, challenges related to seeking sexual healthcare, attitudes about PrEP, and preferences for optimal sexual health service delivery. Interviews were professionally transcribed, cleaned and uploaded to Dedoose to facilitate data management. This analysis focused on how race and ethnicity, sexual identity, and class status impacted healthcare experiences, attitudes, and preferences for future service delivery. Excerpts labeled with ‘sexual healthcare experiences’ and ‘preferences for sexual health services’ were closely read and each case was compared against the others to develop an understanding of similarities and differences among participants.

**Results.**—The main themes related to experiences with homophobia, classism, and racism while interfacing with healthcare systems. These experiences ranged from judgmental providers to highly unequal access to sexual health services that were dependent on insurance status and ability to move around the sprawling city. White participants reported uncomplicated healthcare experiences and expressed trust in the system more often than Black and Latinx participants. Narratives from Black and Latinx participants described healthcare interactions as “degrading” or discriminatory, as illustrated by one 26-year-old Black gay man who stated, “*there’s nothing worse than being stigmatized by the doctor you’re going to for support and care*”. They also faced barriers to care based on insurance status and transportation issues. Black and Latinx participants experienced both excess pressure to test for sexually transmitted infections and having their medical concerns minimized or dismissed (e.g., “*they kept telling me I was fine.*”) These findings are now being used to inform the development of an easily accessible, low or no cost comprehensive sexual health services delivered by non-judgmental providers reflective of the community they serve. Implementation strategies will directly strive to redress long-standing structural racism, classism, and homophobia.



### PROJECT 3: Ending the HIV Epidemic: Integrated Technology Solutions

**Methods.**—This project was launched in 2019 with the goal of building an academic-clinical-community partnership and collecting formative data to inform development of a digital health intervention to improve engagement in HIV prevention among young MSM and young transgender women (YMSM and YTW) from NC and SC. This formative study recruited YMSM and YTW to participate in focus group discussions (FGDs) on preferences for sexual health and HIV prevention services, as well as barriers and facilitators of PrEP use. Youth were recruited via community-based organization referrals, word of mouth, and advertisements on social media. Eligibility criteria for FGDs included: (1) aged 16–24 years, (2) English speaking, (3) resident of NC or SC, (4) assigned male sex at birth, and (5) sexual history or intention to have sex with men. In total, 23 YMSM and YTW took part in FGDs ( $M_{age}=20.5$  years); full socio-demographic characteristics of youth are reported in Supplementary Table 2. In addition, KIIs were completed with 14 individuals working for organizations in NC and SC that provide HIV prevention and/or other advocacy and social services for sexual and gender minority populations. Other eligibility criteria for KIIs included: (1) aged 18 years and (2) English speaking. Key informants were recruited through recommendations from community partners, online searches for relevant organizations, and word of mouth.

Prior to the COVID-19 pandemic, one FGD and two KIIS were conducted in person. From March 2020 on, the two remaining FGDs and 12 KIIs were conducted online via a HIPAA-compliant video conferencing platform; interviews lasted 45–90 minutes and FGDs lasted ~90 minutes. Sample prompts posed to KIIs included, “Tell me about barriers to that YMSM and YTW may have in accessing HIV prevention services” and “What are some existing strategies that your organization has implemented, or that are you aware of, which are meant to help YMSM and YTW overcome barriers to HIV care and prevention services?” Focus group participants were asked complementary questions such as, “What are some things that get in the way of using PrEP” and “What would make it more likely for young people to use [PrEP]?”. All participants were eligible to receive a small monetary incentive in appreciation of their participation, and study procedures were approved by the University of North Carolina Chapel Hill Institutional Review Board.

Audio recordings of KIIs and FGDs were transcribed verbatim, cross-checked for accuracy, and imported into Dedoose for line-by-line coding. A team of five coders trained in qualitative methodology utilized an inductive-deductive coding process to identify emergent themes. Our team included one cisgender White Latina, two cisgender White women, one Black cisgender woman, and one white transgender man. Our data collection and analytic approaches emphasize client-centeredness, anti-racism, and multi-level factors for health disparities. Throughout the coding process, themes related to racism and White supremacy, as well as stigma and discrimination emerged. All excerpts coded with ‘racism’ were extracted and reviewed for the present study.

**Results.**—Analyses of the transcripts identified 52 excerpts that contained themes related to racism and White supremacy. *Intersectional stigma* (i.e., compounded effects of stigma due to racial, ethnic, gender, and/or sexual identities) was a commonly reported barrier

to HIV prevention and care across KIIs and FGDs. Beyond individuals' experiences with stigma and discrimination, broader socio-cultural contexts of hostility and violence toward Black individuals in the South were reported to create challenges for recruiting and engaging youth of color in HIV prevention and care services. Notably, some respondents described challenges reaching youth who avoid services out of fear. The influence of White supremacy in state political systems, as well as lack of minoritized leadership in state and local HIV service organizations were other common themes. The healthcare systems' role in upholding White supremacy (e.g., persistent healthcare disparities among people of color, hostility in the healthcare system) was also frequently mentioned. Medical distrust was another prominent theme, with the Tuskegee experiment mentioned by multiple key informants. Like the suggestions from participants in the TTC study, KII and FGD participants alluded to increasing cultural competency, increasing outreach to communities of color, and increasing representation and leadership of people of color. This included descriptions of siloed and stilted community efforts to address the HIV epidemic within Black communities, with one KII stating,

*[Organizations] don't...reach out except...when it's December, World AIDS Day or in the Black community [when it's] Black History Month.... it's great that you have all these wonderful numbers present today, but what happens beyond today? A conversation is ongoing. It doesn't happen once a week or once every month in order to tear down stigma. It has to happen all of the time.*

## DISCUSSION

Findings from three independent EHE projects, unique in terms of geography and priority population, coalesce around racism as a key barrier to ending the US HIV epidemic. Qualitative data from projects in EHE sites of Sacramento County, CA, Mecklenburg County, NC, and the rural state of SC document racism's role in maintaining current HIV inequities. Key themes included persistent mistreatment, devaluing, and silencing of people of color within healthcare settings; medical distrust and skepticism from current and historical maltreatment of minoritized individuals; concerns for physical safety; and lack of racial and ethnic diversity in organizational leadership. These findings are consistent with previous research describing racism as a pervasive determinant of HIV-related outcomes.<sup>27,28</sup> In addition, addressing intersectional stigma experienced by minoritized groups was a common concern across projects.

Intersectionality frameworks highlight the problematic nature of focusing on single categories of identity (e.g., HIV status, race, gender); by treating social identities as discrete, the challenges experienced by individuals who face interlocking systems of inequity can become obscured.<sup>29,30</sup> Across the three EHE projects featured here, individuals from minoritized races, ethnicities, and sexual and gender identities—and those that work with them—describe continued experiences of stigma and marginalization within HIV prevention and care systems. Themes reflected marginalization that occurs from institutions and systems (e.g., healthcare, housing), from communities, and from other individuals.<sup>30</sup>



Reducing stigma has been increasingly recognized as central to the success of the EHE effort,<sup>31</sup> yet how this is to be accomplished remains unclear. A recent review on stigma reduction interventions for Black women living with HIV identified only two published studies evaluating stigma reduction interventions that were culturally tailored for this group.<sup>32</sup> Notably, the interventions that have been developed and evaluated in this area often focus on helping individuals cope with personal experiences of stigma rather than addressing stigma and discrimination at the community level or addressing discrimination at institutional or structural levels.<sup>33,34</sup> Results from the current studies suggest that increasing the number of providers from historically marginalized and stigmatized communities may create more equitable environments for persons seeking HIV prevention. Notably, participants spoke of the importance of receiving HIV prevention services from supportive and caring providers who are from similar communities to them and endorsed the need to feel a sense of safety and belonging in the physical places where they seek care.

A lack of attention to structural barriers was also reflected in the current findings. Formative data showed a ‘mismatch’ in the barriers most often identified by stakeholders and the recommendations or strategies that were presented. Specifically, while institutional or structural barriers were often described as being prominent causes of HIV inequities, proposed solutions tended to be individual-focused (e.g., improve recruitment of minoritized individuals, educate providers about stigma). Notably absent were recommendations for legislative and policy changes or increased pressure on local, state, and federal legislators and agencies to counter the effects of systemic racism across multiple sectors (e.g., healthcare, housing, employment, education).

Following the work of feminist, Black, and critical scholars,<sup>29,35–39</sup> our authorship team posits that naming racism as a barrier is not enough, and that EHE interventionists should adopt anti-racist actions at each stage of program implementation. Antiracism requires a rejection of racism and active efforts to ‘undo’ both current and historic effects of racism. Therefore, guided by the RE-AIM framework, we have developed a series of anti-racism recommendations that flow from findings of the three EHE projects highlighted here (see Table 3); RE-AIM was selected because of its usefulness in examining under-explored factors that impact sustainable adoption and implementation of an intervention.<sup>40,41</sup> These recommendations are meant to aid investigators in paying increased attention to the role of racism as a factor that threatens the adoption, implementation, and real-world impact of EHE interventions; they may also help investigators to evaluate the extent to which they are taking actionable steps across the various stages of RE-AIM.<sup>40</sup>

These recommendations were developed collaboratively by the authors in response to themes and specific quotes detailing how historical and current racism threatens the success of the EHE initiative. For example, a KII from the Integrated Technology Solutions project (i.e., Project #3) based in NC and SC described the experience of “not seeing people who look like you” when entering PrEP clinics that are “almost entirely staffed by cisgender white women”. This input, supplemented by the expertise of the transdisciplinary authorship team, resulted in a recommendation that intervention developers expand representation of people of color across organizational levels, including leadership as well as staff who develop and deliver PrEP services, programs, and campaigns. Beyond demanding

representation within intervention teams, interventionists should also consider partnering with organizations that have adopted institutional policies that promote racial equity.

A number of strong implementation tools (e.g., Implementation Research Logic Model [IRLM],<sup>44</sup> HIV Implementation Outcomes Crosswalk<sup>45</sup>) have recently been created to enhance the rigor and transparency of HIV implementation research. More work is needed to understand how these tools can be implemented or adapted in ways that prioritize health equity. For instance, current metrics of the HIV Implementation Outcomes Crosswalk<sup>45</sup> address the representativeness of implementation sites and prompt implementers to consider the consistency of intervention effects across patient groups. Measuring progress in reducing inequities is an important step forward. However, progress toward ending those inequities is likely to be slow and limited without increased attention to systemic and institutional drivers of disparities.

### Limitations

In the current study, data were synthesized across three independent EHE implementation projects, and, thus, have some potential limitations. The studies had unique study aims, research teams, interview guides, and coding processes. This resulted in variation in identified codes, including identification of some themes that were not represented across all projects, which may be due both to the unique settings and populations, as well as to variation in the coding process. Findings are exploratory in nature and will be strengthened through future targeted quantitative and qualitative efforts to inform anti-racist strategies and recommendations. Notably, our finding on the lack of recommendations for structural interventions may be due in part because these were not directly asked for during interviews or focus groups. Querying future community stakeholders on their recommendations for addressing racism at multiple levels (e.g., interpersonal, organizational, structural) would be beneficial. The collection and interpretation of data were also influenced by the distinct contexts of the lived experiences and social positions of each author.<sup>35</sup> Finally, no studies recruited individuals who use injection drugs—a key EHE population that also experiences unique challenges in terms of intersectional stigma. Future qualitative studies with this group are needed.

### Conclusion

Despite these limitations, the three studies highlighted here provide unique insight into current challenges to end the US HIV epidemic and elucidate the need for additional work on addressing systemic and structural drivers of racial and ethnic HIV disparities in the US. Integrating antiracism into EHE projects—at each stage of implementation—is likely to be critical for the long-term success of the initiative.

### Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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- **Evidence-based innovation:** Pre-exposure prophylaxis (PrEP)
- **Innovation recipients:** People at risk for HIV
- **Setting:** Jurisdictions targeted by the *Ending the HIV Epidemic* (EHE) plan
- **Implementation gap:** Racism and White supremacy are threats to equitable and effective scale-up of PrEP, yet limited empirical research has examined how to counter racism within the context of HIV intervention development and implementation
- **Primary research goals:** Identify determinants of implementation and select/pilot implementation strategies
- **Implementation strategy:** Implementation scientists should recognize racism as a threat to the adoption, implementation, and real-world impact of PrEP interventions; a series of recommendations are presented to help investigators consider the extent to which they are taking actionable steps to counter racism across the implementation continuum



**Table 1.** Intervention characteristics of select *Ending the HIV Epidemic (EHE)* implementation projects targeting the PrEP Care Continuum.

	<b>TRANSFORMING the Carolinas</b>	<b>Connecting resources for rural and urban sexual health: CRRUSH-Sacramento</b>	<b>Ending the HIV Epidemic: Integrated Technology Solutions</b>
Location	North Carolina; South Carolina	Sacramento County, California	Mecklenburg County, North Carolina; South Carolina
Population focus	Transgender people of color	Young men who have sex with men (YMSM)	YMSM; young Transgender women
EHE pillar focus/foci	Diagnose, Treat, Prevent	Diagnose, Treat, Prevent	Diagnose, Treat, Prevent
Methodological approach	Mixed methods, including key informant interviews [KIIs] and focus group discussions [FGDs]	Qualitative (i.e., semi-structured interviews)	Qualitative (i.e., semi-structured interviews with KIIs; FGDs)
Primary Aim(s)	Identify intervenable factors to improve engagement in HIV prevention and care for transgender people of color	Inform development of a discrete choice experiment survey to measure and quantify preferences for sexual health services, including HIV prevention among YMSM	Inform development of a stigma-informed recruitment campaign to engage YMSM and young transgender women in the Carolinas in a research-tested technology behavioral intervention to increase engagement in HIV prevention

Table 2. Illustrative themes on racism and White supremacy as barriers to HIV prevention across three *EHE* projects

	TRANSFORMING THE CAROLINAS	CONNECTING RESOURCES FOR RURAL AND URBAN SEXUAL HEALTH: CRRUSH-SACRAMENTO	ENDING THE HIV EPIDEMIC: INTEGRATED TECHNOLOGY SOLUTIONS
Intersectional stigma	<p>As far as providing HIV prevention, messaging, and testing--again, the challenges are just getting people in the door...ensuring that our staff...continue to be trained and deemed competent to provide care for transgender people of any color, but especially those who are African American and Latino. Okay, poverty. Just that. You start adding other things that create intersectionality. Like race. Okay. It's not just poverty, now it's an impoverished Black person. Not just an impoverished Black person, it's an impoverished Black Trans woman...any one of those issues is difficult to deal with by itself. Just being Trans, just being Trans women, just being Black persons, just being poor persons--when you combine those factors, yeah, that's much more difficult. That increases stress, depression, poor health, suicide. So many things.</p> <p>[For] a transgender person of color, just walking out the door in the morning is often an act of courage. They face barriers at every turn... So it's just not that easy to say, 'Oh, just come to your appointments and take your pill, couldn't be any easier.' Well, there's so much more going on in their lives that it can be really hard.</p>		<p>The intersectionality is impossible to ignore. So, with every compounding identity that you have that is marginalized, the way that you're treated is worse exponentially. Your barriers to accessing care are greater exponentially.</p>
Medical mistreatment of people of color & Medical mistrust	<p>Basically, my experience [as a gay Black person] there is that they try to dismiss everything as normal. And that's what you get. So you go in for whatever, 'Oh, it's normal. It will go away.' And they send you out, within five to ten minutes you're out of there. With like no follow-up whatsoever. They just want you out of there. By comparison, right, if you go to the more well-off areas, and you're able to speak English, they actually pay attention to you and try to figure out what's wrong with you, rather than saying it's normal and it's going to go away on its own. A lot of times [doctors] don't take enough time to listen to their patients or take what they're saying seriously enough. And I had a lot of pain in my stomach area for about six years and I kept complaining to the doctor and telling them that I was bleeding and in severe pain and they kept telling me that I was fine. And so I finally...I kept fighting and saying...I needed a referral to someone else. So they referred me to a gastroenterologist [who found] I have Crohn's colitis. So like all those years of me being in pain and bleeding was an actual disease and</p>		<p>Black and Brown folks can go to the doctor and say, 'I'm in pain,' or, 'This is what's wrong. This is what I'm feeling,' [and the doctor says] 'Oh, just here's some ibuprofen. Sleep it off. Here's some simple pain meds if it doesn't get any better.' ... to be brushed off just makes us go back to that [old mentality of], 'See, I told you I'm fine. Nothing's wrong. I'm okay.' And then the next thing you know, somebody's dropping. So the impact of racism when it comes -- it's really hard to navigate.</p> <p>Black and Brown folks, folks who don't speak English...their experiences [of being] just left in the hallway, turned away, not given medicine, treated like they're med seeking when they're not. One of them, there was a Black trans woman [and] her friend--but their relationship was so close that she referred to her as a her sister--died in the waiting room at a hospital because the doctors would not treat her...I've heard horrific stories from people.</p> <p>There is a big distrust in the medical communication, especially as it pertains to the Black community, and so sometimes they're not upfront with things that they're doing, activities that they're participating in because they think that it's gonna go to the government, to the police, and things like that.</p> <p>One [of the biggest barriers] is the lack of knowledge about where to go, and the mistrust and distrust that Black and Brown folks</p>

TRANSforming the Carolinas	Connecting resources for rural and urban sexual health: CRRUSH-Sacramento	Ending the HIV Epidemic: Integrated Technology Solutions
Impact of racism on HIV prevention and care experiences	<p>the doctors weren't listening to what I was saying.            [My providers] would kind of shove propaganda down your throat, make you feel bad about yourself sometimes. But, you know, in all fairness, it was just to protect you from the real world.</p>	<p>have when accessing mental health facilities, or just connecting to providers in the community in general.</p>
	<p>Especially here in South Carolina, I feel like racism plays a bigger role than transphobia. So if you don't know where you can get care in what you would consider a safe place culturally, then you're going to be less likely to get the care.</p>	<p>Whenever someone is discriminated against simply because of the color of their skin, they disconnect [from HIV care] and a lot of times it's a ripple effect because word of mouth travels... And so there might have been 40 or 50 people that were getting ready to come in after me. Now, you'll never see those 40 or 50 people and maybe they need to come in, but they won't because of that experience.            There's a... [local clinic] which is almost entirely staffed by cisgender white women... and they're great... They're fun but also, you're not seeing people who look like you. How comfortable do you feel actually going there?... Are you going to go to a place to get an HIV test? Are you gonna actually get in your car and drive somewhere to go and do that? And, I think largely the answer is, 'No, I'm not.'</p>
Concerns for physical safety	<p>Even though [local homeless shelters] try by law to help trans people of color, trans people of color still feel uncomfortable in those spaces. They don't feel safe in those spaces and they're not treated with respect and dignity.</p>	<p>In [large city in the South], LGBTQ+ or whatever the alphabet is accepted. There's a whole keep [city] weird. But I'm telling, you five minutes outside of here and we have literally gun-toting, rebel flag-waving white men with AK47's. And so there's a lot of fear and there's a lot of legitimate fear, especially for people of color in the queer community.            [We've been] working with a group out of [large city in the South] with primarily Black Trans women. Their biggest concern was safety. A lot of people were getting the shit kicked out of them. People were getting murdered.</p>
Persistent systemic racism	<p>Systemic racism is built into how we combat these issues. So not to be trite, but there was no giant war on drugs until Becky was walking into the hood to get crack. And as long as we are talking people of color and people who aren't feel like these issues do not affect them, we're going to be fighting for legislation and greater funding to combat these ills. This is why community mobilization is so important. We just got to stop this mess.</p>	<p>If you talk housing, if you're talking about HIV information, access to information, healthcare systems, we cannot not talk about racism. You just can't leave [racism] out of the conversation. We basically have as close to a solution as you can come without having to cure for HIV. Since the eighties, have you removed stigma? Have you removed societal disparities? Have you removed racism? Have you removed homophobia, right? We haven't. Those are still issues. And they've changed over time, but they were there then and they're there today.</p>
Racial inequity in organizational leadership and training opportunities	<p>I know there are some national training [opportunities for trans care], but even some of them are not Black specifically, if that makes sense, or African-American. A lot of them, you can tell by some things that they are probably come from</p>	<p>[The] healthcare system, anything that is for-profit, in my experience, has been race-driven... the people that are part of the leadership and making decisions for the community that they're serving, although they're not in the community, are White people, and that's across the board.</p>

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Ending the HIV Epidemic: Integrated Technology Solutions
Connecting resources for rural and urban sexual health: CRRUSH-Sacramento
TRANSforming the Carolinas
more predominantly White institutions and things are different.

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Potential implementation strategies to address racism, organized by the RE-AIM framework<sup>40,41</sup>

**Table 3.**

RE-AIM Stage	Implementation Recommendations
<b>Reach</b>	<ul style="list-style-type: none"> <li>Foster <b>cultural competency among all staff and professionals</b> working in HIV prevention efforts (e.g., provide ongoing efforts to understand and address bias and stigma towards people of color)</li> <li><b>Prioritize outreach</b> efforts to communities of color, including community-based events that address other needs (e.g., food, social services, employment opportunities)</li> <li>Adopt <b>community health worker</b> models to work from within minoritized communities</li> <li>Consider whether <b>advertising and program materials</b> may further stigmatize minoritized groups</li> <li>Prioritize <b>financial incentives</b> to address existing inequities (e.g., income, housing)</li> </ul>
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li><b>Involve minoritized individuals</b> in development, selection, and tailoring of programs</li> <li>Create opportunities for <b>critical reflection on the delivery</b> of culturally competent services</li> </ul>
<b>Adoption</b>	<ul style="list-style-type: none"> <li>Connect with <b>trusted community leaders and organizations</b> with shared goals to facilitate adoption</li> <li><b>Expand representation of people of color</b> across organizational levels (e.g., organizational leadership, staff who deliver programs)</li> </ul>
<b>Implementation</b>	<ul style="list-style-type: none"> <li>Ensure access to <b>basic needs</b> (e.g., food, shelter, safety) for minoritized individuals</li> <li><b>Prioritize physical safety</b> of minoritized individuals who will be accessing services (e.g., develop safety plans, assess locations)</li> <li><b>Embed anti-racist frameworks into existing programs</b> and interventions (i.e., “sometimes we’ve already built out a program around it and sometimes we work with them to develop a program around how we can, almost like a gap analysis”).</li> <li><b>Integrate HIV prevention programs into existing culturally relevant programming</b> (e.g., HIV prevention in STI and teen pregnancy preventions in churches).</li> </ul>
<b>Maintenance</b>	<ul style="list-style-type: none"> <li><b>Build mutually beneficial, long-term relationships</b> with trusted community leaders and organizations.</li> <li>Develop <b>sustainability plans for anti-racist programming</b> (i.e., lasting beyond World AIDS Day or Black History Month).</li> </ul>

*Note.* Some implementation recommendations may fit across multiple stages of the RE-AIM framework; strategies are meant to serve as a starting point for considering the adoption of anti-racism action across the intervention continuum.