Engaging Black MSM in HIV Clinical Care
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Gilead Sciences – PrEP Speaker’s Bureau; Advisor

The following planning members have no financial relationships to disclose: Cynthia Miller, MD, Sarah Walker, MS and Jennifer Price
The goal of His Health is to increase the capacity, quality and effectiveness of health care providers to screen, diagnose, link and engage Black MSM in HIV clinical care.
Objectives

- Recognize and address challenges to healthcare access and utilization for Black MSM
- Obtain a general sexual and mental health history for Black MSM that is culturally appropriate
- Recommend appropriate sexual health screenings and preventive-care strategies for Black MSM
RECOGNIZING AND ADDRESSING CHALLENGES
I shouldn’t have to tell you…

BLACK MSM ARE DISPROPORTIONATELY IMPACTED BY HIV

STI SCREENING RECOMMENDATIONS

VACCINATION RECOMMENDATIONS
New HIV Diagnoses Among Gay and Bisexual Men in the US and Dependent Areas by Age and Race/Ethnicity, 2018

CDC, 2020
AT THE END OF 2016, AN ESTIMATED 225,200 BLACK/AFRICAN AMERICAN GAY AND BISEXUAL MEN HAD HIV.

For every 100 black/African American gay and bisexual men* with HIV in 2016:

- 75 received some HIV care
- 59 were retained in care†
- 57 were virally suppressed‡

8 in 10 KNEW THEY HAD THE VIRUS.*

CDC, 2020
Viral suppression inequity among Black MSM

- 72% vs 91% and 81% for white and Latino MSM
- 52% vs 67% and 61% for white and Latino MSM
- 67% vs 81% for white MSM
- 68.4% vs 87.1% and 86.8 for white and Latino MSM

Buchacz et al., 2018; MMWR, 2017; Knox et al., 2020; Sheehan et al., 2020
Factors influencing viral suppression among Black MSM

- Healthcare access
- Insurance, income, housing inequities
- Positive ethnic/HIV identity formation
- Less likely to “get” ART
- Social capital
- Marijuana use

(Hussen et al., 2018; Harper et al., 2014; Beer et al., 2014; Hightow-Weidman et al., 2017; Knox et al. 2020)
Barriers and Facilitators for ART Adherence Among HIV+ Black and Latino MSM

- Semi-structured interviews
- 84 participants
- Atlanta, Baltimore, DC, LA, Chicago
- 27.4% reported consistently taking ART

“Men were more likely to take ART when having providers who communicated effectively and were perceived to treat them with respect.”

Carey et al., 2019
I also shouldn’t have to tell you...

- Biomedical advances
  - TasP
  - PEP
  - PrEP
  - U = U
RECOMMENDED SEXUAL HEALTH SCREENINGS
STI Screening (at least yearly) - MSM

- HIV
- Syphilis screening (RPR) or Treponemal Ab cascade
- Hepatitis B surface antigen
- Hepatitis C antibody
- Triple site testing for Gonorrhea/Chlamydia (GC/CT) – oral, urethral, pharyngeal

CDC 2015; 2020
Key Vaccinations for MSM

- Hepatitis A
- Hepatitis B
- Gardasil (if under 45)
- Flu shot (yearly)
- Meningococcal – depend on geography
- COVID-19?

CDC, 2020
So what can I add to this conversation?
US Prevention Services Task Force (USPSTF) recommends routine screening for depression.

Patient Health Questionnaire (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless?
2. Little interest or pleasure in doing things?

If “yes” to either question, complete the full PHQ-9
## ACOG guidelines reflect these age-based recommendations for cervical cancer screening

<table>
<thead>
<tr>
<th>Age</th>
<th>Pap†</th>
<th>High-risk HPV</th>
<th>HPV genotyping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 21</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>Not recommended</td>
</tr>
<tr>
<td>21 - 29</td>
<td>Recommended every 3 years</td>
<td>Recommended to be used as a &quot;reflex test&quot; only when Pap result is ASC-US</td>
<td>Not recommended</td>
</tr>
<tr>
<td>30 - 65</td>
<td>Recommended co-testing (using Pap and HPV concurrently) every 5 years (preferred), or cytology alone every 3 years</td>
<td>Option to use as &quot;reflex test&quot; in co-tested patients whose Pap is negative and HPV result is positive</td>
<td></td>
</tr>
<tr>
<td>Over 65</td>
<td>Screening should be discontinued if patient has had adequate negative prior screening results† and no history of CIN2+</td>
<td>Recommend continuing age-based screening for ≥20 years in those patients with a history of CIN2, CIN3, or adenocarcinoma in situ</td>
<td></td>
</tr>
</tbody>
</table>
NO COMPARABLE UNIVERSAL HPV SCREENING RECOMMENDATIONS FOR ANAL CANCER
Anal cancer screening

Not great for general population – low prevalence

Routine Screening of specific populations may be promising

Screening modalities include:

- Anorectal digital exam
- Anal pap smear
- HPV co-testing
- High resolution anoscopy (HRA)

Currently no national guidelines

Leeds and Fang, 2016
# Anal Pap Smear Guidelines?

<table>
<thead>
<tr>
<th>Organization</th>
<th>Routine screening of general population</th>
<th>Routine screening of high-risk individuals</th>
<th>Assesses modalities for diagnosis</th>
<th>Specific modalities assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Society of Colon and Rectal Surgeons[54]</td>
<td>No recommendation</td>
<td>No recommendation</td>
<td>Screening and surveillance</td>
<td>Anal Pap test, high-resolution anoscopy</td>
</tr>
<tr>
<td>European Society of Medical Oncology</td>
<td>No recommendation</td>
<td>No recommendation</td>
<td>Surveillance only</td>
<td>Digital anorectal exam, standard anoscopy, computed tomography, magnetic resonance imaging</td>
</tr>
<tr>
<td>European Society of Surgical Oncology</td>
<td>No recommendation</td>
<td>No recommendation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>European Society for Therapeutic Radiation and Oncology[102]</td>
<td>No recommendation</td>
<td>No recommendation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Comprehensive Cancer Network[103]</td>
<td>No recommendation</td>
<td>No recommendation</td>
<td>Surveillance only</td>
<td>Digital anorectal exam, standard anoscopy</td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention[104]</td>
<td>No recommendation</td>
<td>No recommendation</td>
<td>Screening and surveillance</td>
<td>Digital anorectal exam, HPV testing</td>
</tr>
<tr>
<td>New York State Department of Health[52]</td>
<td>No recommendation</td>
<td>All HIV infected adults</td>
<td>Screening only</td>
<td>Digital anorectal exam, anal Pap test, high resolution anoscopy</td>
</tr>
<tr>
<td>HIV Medicine Association of the Infectious Diseases Society of America[20]</td>
<td>No recommendation</td>
<td>Men who have sex with men, women with a history of abnormal cervical Pap tests, and all HIV-positive persons with genital warts</td>
<td>Screening only</td>
<td>Digital anorectal exam, HPV co-testing, anal Pap test, high resolution anoscopy</td>
</tr>
<tr>
<td>British HIV Association[21]</td>
<td>No recommendation</td>
<td>No recommendation</td>
<td>Screening and surveillance</td>
<td>Digital anorectal exam, anal Pap test, high resolution anoscopy</td>
</tr>
</tbody>
</table>

HIV: Human immunodeficiency virus; HPV: Human papilloma virus; Pap: Papilloma test.
Abnormal pap smear algorithm

Leeds and Fang, 2016
OBTAIN AND GENERAL AND SEXUAL HISTORY
Intersecting inequities

- **BLACK**
  - Poverty
  - Education
  - Employment
  - Access to care
  - Chronic diseases
  - Racism/Profiling
  - Sexual prejudice
  - Insurance
  - Homicide
  - HIV/STI
  - Childhood Sexual Abuse
  - Mental health
  - Homelessness
  - Incarceration
  - Alcohol/Substance abuse

- **MSM**
  - Sexual prejudice
  - Obesity
  - HIV/STI
  - Suicide
  - Alcohol/Substance abuse
  - Homelessness
  - Mental health
  - Access to care
  - Childhood Sexual Abuse
WHOLE HEALTH ASSESSMENT

SOCIAL HISTORY

MEDICAL HISTORY

SURGICAL HISTORY

FAMILY HISTORY

MENTAL HEALTH HISTORY

SEXUAL & REPRODUCTIVE HEALTH HISTORY
Focus on Whole Health

- **Routine Mental Health Screening**
- **Full exam every 1-3 years (starting at 20 to 30 years old)**
- **Blood pressure yearly**
- **Cholesterol after 35 or earlier if family history**
- **Annual digital rectal exam after 40**
- **Aortic aneurysm chest CT from 65 to 75 & smokers**
- **Colonoscopy over 45 or earlier if family history**
- **Prostate exam (PSA) under 75 (if family history)**

**CDC, 2013; APSTF, 2013; MHN, 2013**
Sexual History Taking - The Five “Ps” - CDC

Sexual Risk Assessment², ³

The Centers for Disease Control and Prevention (CDC) has developed a simple categorization of sexual history questions that may help providers, or other members of the clinical care team, remember which topics to cover. These are called the Five P’s:

- Partners
- Practices
- Past History of STDs
- Protection from STDs
- Pregnancy Plans
What’s the Missing “P”?
So what can I tell you?

Story of Andre

- 23 year old Black same gender loving man
- Condomless sex hook-up within 24 hours
- Last HIV negative test 3 months ago
- Doesn’t know HIV status of sexual partner
- Calls you to ask about Post-exposure Prophylaxis (PEP)

What’s your advice to him?
Andre (cont’d)

- Told by NP that he didn’t need PEP because likelihood of him contracting it was “low.”
  - This was according to their protocol

- Patient argued – medical director came

- Sided with NP saying since he “topped” and it was only one time, he “should be fine.”

- NP: “Oh, if you would have told me that there was a condom involved and it broke, then I would have readily prescribed the medication.”
Andre’s thoughts…

- “I didn’t get a chance to explain all of it, because we started arguing, but I did tell him I was out of my mind, my phone was stolen the same night, and that drugs and substances were involved.”

- “The guy was snorting coke and making me inhale the poppers, or whatever that stuff is.”
“I just felt devalued as a person.”
## Reminder - Language Matters

<table>
<thead>
<tr>
<th>Stigmatizing</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-infected person</td>
<td>Person with HIV</td>
</tr>
<tr>
<td>AIDS patient</td>
<td></td>
</tr>
<tr>
<td>Positive or HIVers</td>
<td></td>
</tr>
<tr>
<td>HIV carrier</td>
<td></td>
</tr>
<tr>
<td>Died of AIDS</td>
<td>Died of AIDS-related illness/AIDS-related</td>
</tr>
<tr>
<td></td>
<td>complications</td>
</tr>
<tr>
<td>AIDS virus</td>
<td>HIV (AIDS is a diagnosis)</td>
</tr>
<tr>
<td>Full-blown AIDS</td>
<td>There is no medical definition for this use</td>
</tr>
<tr>
<td>Zero new infections</td>
<td>Zero new transmissions</td>
</tr>
<tr>
<td>Became infected</td>
<td>Contracted/acquired/diagnosed</td>
</tr>
<tr>
<td>Mother-to-child transmission</td>
<td>Vertical transmission; Perinatal transmission</td>
</tr>
<tr>
<td>Compliant</td>
<td>Adherent</td>
</tr>
<tr>
<td>Prostitutes</td>
<td>Sex work, transactional sex</td>
</tr>
</tbody>
</table>

Sexual stigma phrases

- “I did something stupid”
- “I know I’m being paranoid”
- “I’m know I’m being a hypochondriac”
- “I had good sex”
- I know the reality of STIs and HIV out there”
- “I’m proactive about my sexual health”
SHIFT FOCUS

1. Assess safer sex practices
2. Describe geographic risk
3. Discuss sexual networks
4. Offer help, not judgment
Bias
Conscious and Implicit
Global discrimination in Health Care

- HIV stigma exists in medial clinics
  - China, Latin America & the Caribbean
- Fear of discrimination among MSM deters health care utilization in Nigeria and Swaziland
- Challenges with confidence among providers with MSM sexual health counseling in Kenya
- In the United States
  - Discrimination against PLWH is happening in healthcare settings
  - Young Black MSM experience HIV stigma
  - Provider-patient communication appears to play a role

(Laws et al., 2014; Gaston et al., 2013; Li et al., 2008; Cloete et al., 2008; Taegtmeyer et al., 2013; Charurat et al., 2015; Pineirua et al., 2015; Baugher et al., 2018; Jeffries et al., 2015; Geter et al., 2019)
Bias in healthcare

- Implicit Association Test
  - Positive attitudes towards whites
  - Negative attitudes towards Black and Latinx
  - Similar bias as general population

- Provider communication style – racial differences with HIV treatment – ECHO study
  - More verbal dominance, more directives, more dialogue about adherence with Black patients than white patients

- Small studies - ? Influence of bias on outcomes ?

Laws et al., 2013, 2014; Hall et al., 2015; Dehon et al., 2017
Back to Andre…

What would you have done?
Solutions

- There is no “Black gay” manual for patient care
- More Black MSM providers*
- Honest assessment of bias
- Seeing patients as you or your family
- Follow guidelines and use affirming language

*National Bureau of Economic Research, 2018
Solutions (cont’d)

- Needs assessment and survey
- Peer navigators/advocates
- Staff awareness and involvement
- Patient-centered affirmation and empowerment
- Evolve into holistic health approaches/settings
Take home points

- Racial inequities persist in HIV care outcomes

- Treat the whole person FIRST – But “see color”
  Conduct a sensitive and nonjudgmental sexual history
  Offer evidence-based STI screening & vaccinations
  Mental health, mental health, mental health

- Recognize and acknowledge your bias

- More research is needed – facilitators among Black MSM
“Just because something works doesn’t mean it can’t be improved.”

- Princess Shuri
Thank you!

RESOURCES:

- hishealth.org – healthcare provider training – no CME
  - Whole health
  - PrEP
  - Transgender health
  - Linkage and engagement
- wellversed.org – community education/empowerment

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