About this Fact Sheet and the Related Course

The information in this fact sheet is related to the online, self-study module *"HIV Treatment Cascade & Stigma's Impact on MSM on the U.S./Mexico Border."* This course was created in collaboration with the Dallas STD/HIV Prevention Training Center at UT Southwestern Medical Center and the Texas/Oklahoma AIDS Education & Training Center.

At the end of the course, participants will be able to:

♦ Define the HIV treatment continuum of care and treatment cascade;

♦ Identify social and cultural attitudes and beliefs related to stigma affecting HIV-positive Latino men who have sex with men (MSM);

♦ Describe how stigma contributes to unfair practices that impact linkage to and engagement in HIV care for these patients;

♦ Define three levels of potential intervention within health care facilities to address stigma; and

♦ Utilize a three-step process to address stigma-related barriers to linkage and engagement within clinical settings.
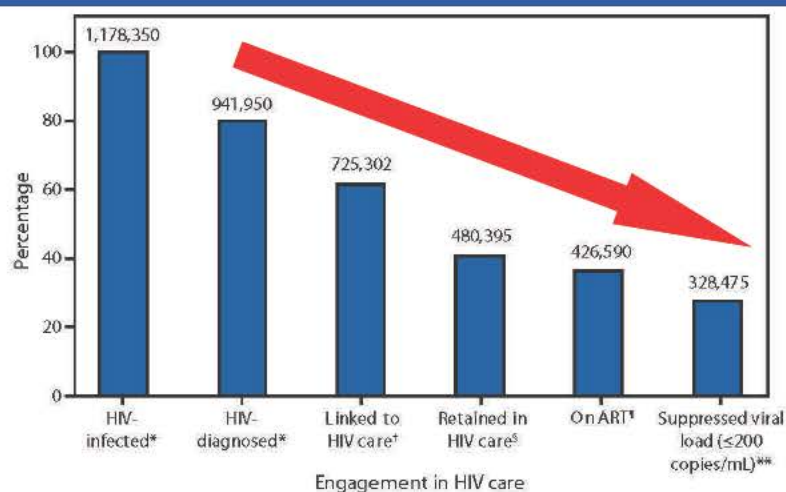
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The HIV treatment cascade, described independently by both Stacy M. Cohen, *et al*[1], and Edward M. Gardner, *et al*[2], shows a progressive lack of engagement in care among HIV-infected people from the time of initial diagnosis through viral suppression. While Cohen (*see chart below*) estimates that only 28% of infected patients achieve viral suppression (≤ 200 copies/mL), Gardner projects that only 19% reach this benchmark. Their research suggests hundreds of thousands of patients who could benefit from antiretroviral therapy are not in care, which means increased morbidity and HIV transmission risks.

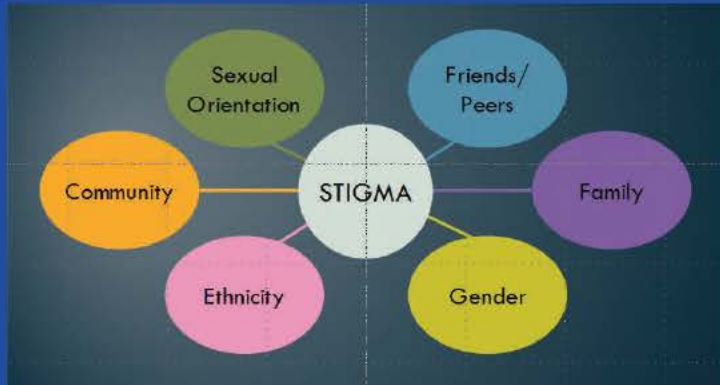# HIV TREATMENT CASCADE

COHEN & GARDNER

Cohen Cascade

[1] Cohen, SM, *et al*. Vital Signs: HIV Prevention Through Care and Treatment - United States. *Morbidity and Mortality Weekly Report* 2011; 60:1621.

[2] Gardner EM, *et al*. The Spectrum of Engagement in HIV Care and its Relevance to Test-and Treat Strategies for Prevention of HIV Infection. *Clinical Infectious Diseases* 2011; 52:796.

RELATED FACTORS

SOCIAL AND CULTURAL

Various social and cultural influences contribute to stigma. Latino MSM in particular may feel accountable to specifically defined traditional community, cultural, and social standards. Adherence to established gender norms may inhibit Latino MSM from acknowledging sexual risk behaviors. Allegiance to deeply held cultural norms and traditions may cause Latino MSM to internalize homophobic or negative messages about their sexuality. HIV infection often creates additional stigma for Latino MSM. Disclosure of HIV status may force disclosure of same gender sexual behavior. Family members, friends, and others in the patient's community may make judgments related to this disclosure. All this may lead to rejection and feelings of low self-worth and depressive symptoms.

What is Stigma?

The Joint United Nations Programme on HIV/AIDS, or UNAIDS, in 2003 defined HIV-related discrimination and stigma as "a 'process of devaluation' of people either living with or associated with HIV and AIDS." UNAIDS noted further that discrimination resulted from stigma and entailed "the unfair treatment of an individual based on his or her real or perceived HIV status." In short, stigma is a negative perception of a person being labeled with a perceived or real trait, characteristic, or condition. These stigmatizing attitudes and beliefs can become part of an individual's self-concept, resulting in internalized stigma. The combined effects of stigma are limiting to the personhood of the individual being discriminated against. Stigma can originate externally from attitudes and beliefs of friends, family members, or society in general.

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HIV-related Stigma

Individuals living with HIV face specific and insidious stigma related to their serostatus. People may believe that the infection is the result of moral fault or the result of personal irresponsibility that deserves to be punished. HIV infection is often associated with socially stigmatized behaviors, such as men having sex with men, drug use, prostitution, or having multiple sex partners. Because most people become infected through sex, and many people ascribe moral judgments to sexual behavior, HIV infection often carries this judgment. Since the infection is potentially life threatening, misperceptions about its etiology and transmission can provoke irrational, fear-based reactions. The use of antiretroviral therapy can result in forced disclosure, stigmatization, and discrimination.

In a video about HIV-related stigma in the Latino community, Catalina Sol, Director HIV/AIDS Department, La Clinica del Pueblo, talks about how this type of stigma can lead "to fear of testing or fear of seeking care, even when those services are available, and also a lack of practice and comfort with talking about the things that place you at risk for HIV, such as sexuality or drug use."
To access the video, go to http://www.youtube.com/embed/ jRcQZkk_9AU or click here.

Stigma in Clinical Settings

While there are many social and cultural barriers to linking and engaging HIV-positive Latino MSM in treatment, the clinical context in which services are delivered may also create barriers to this population accessing needed care. Conducting a brief assessment of patients' experiences in the clinic is one way providers can understand if stigma is impacting patient care. A general patient satisfaction survey or other written assessment of their perceptions about their experiences can be an initial step toward building a clinical environment that is supportive of engaging and retaining clients in care.

Sample Assessment Questions

♦ Have you ever felt as though you were treated inappropriately by any employee at this facility due to your HIV status and/or sexual orientation? If so, what happened?

♦ Have you ever intentionally avoided making an appointment or keeping an appointment because of how you were treated, due to your HIV status and/or sexual orientation? If so, how often has this happened?
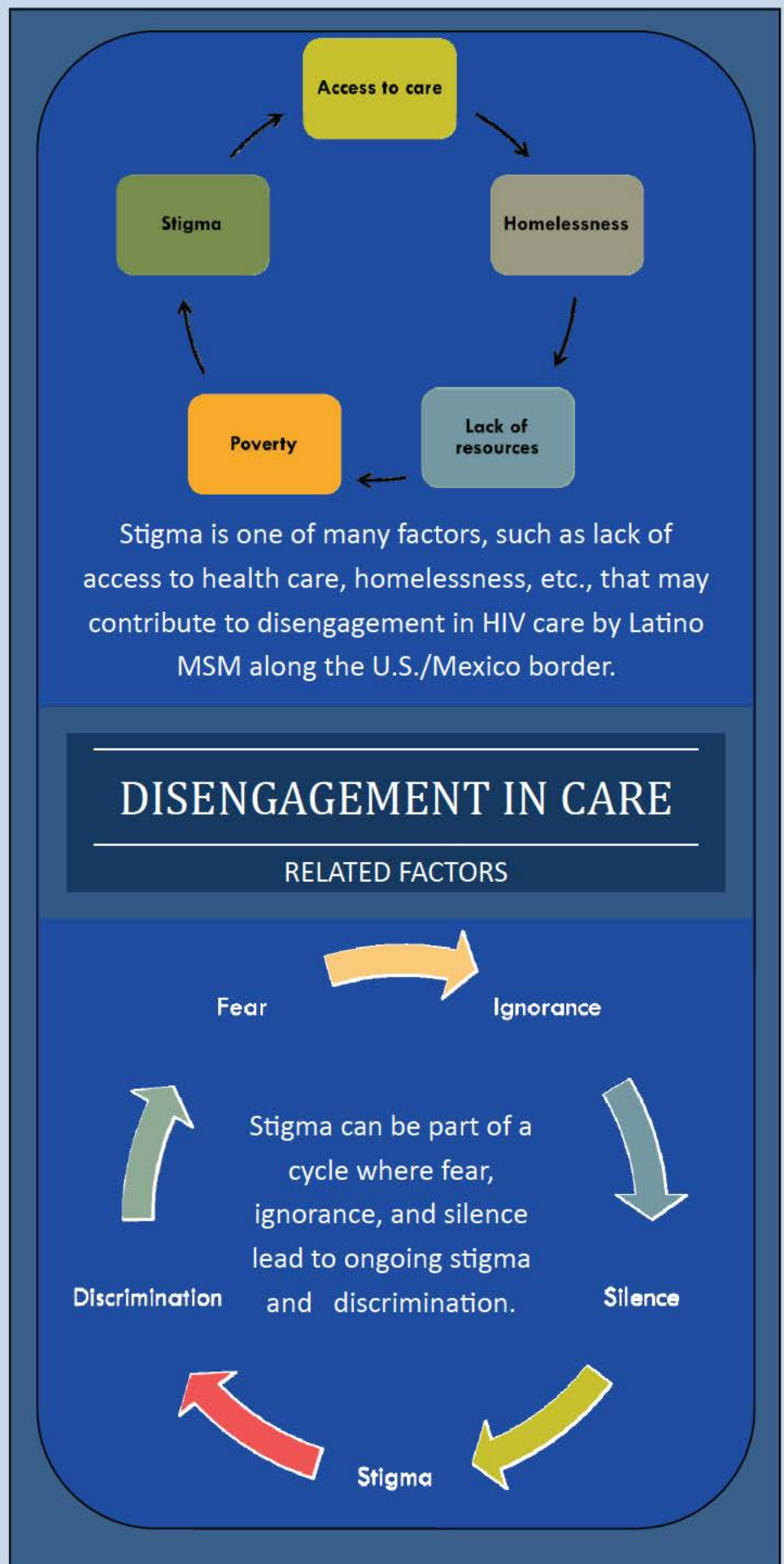
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Impact on Treatment

Stigma can have an adverse impact on how individuals make treatment decisions. Various factors can make persons living with the virus unlikely to seek care and receive treatment that could lower their viral load and reduce risks of HIV transmission to partners.

♦ Individuals may fear their family will discover their status by seeing HIV medications or asking about side effects. The related stress can lead to a lack of adherence even among patients who do seek treatment.

♦ Some patients may not be comfortable disclosing their status, even to medical providers.

♦ Beginning treatment starts a lifelong identification with HIV, which some patients may want to postpone.

Access to care

Stigma

Homelessness

Poverty

Lack of resources

Stigma is one of many factors, such as lack of access to health care, homelessness, etc., that may contribute to disengagement in HIV care by Latino MSM along the U.S./Mexico border.

DISENGAGEMENT IN CARE

RELATED FACTORS

Fear

Ignorance

Discrimination

Stigma can be part of a cycle where fear, ignorance, and silence lead to ongoing stigma and discrimination.
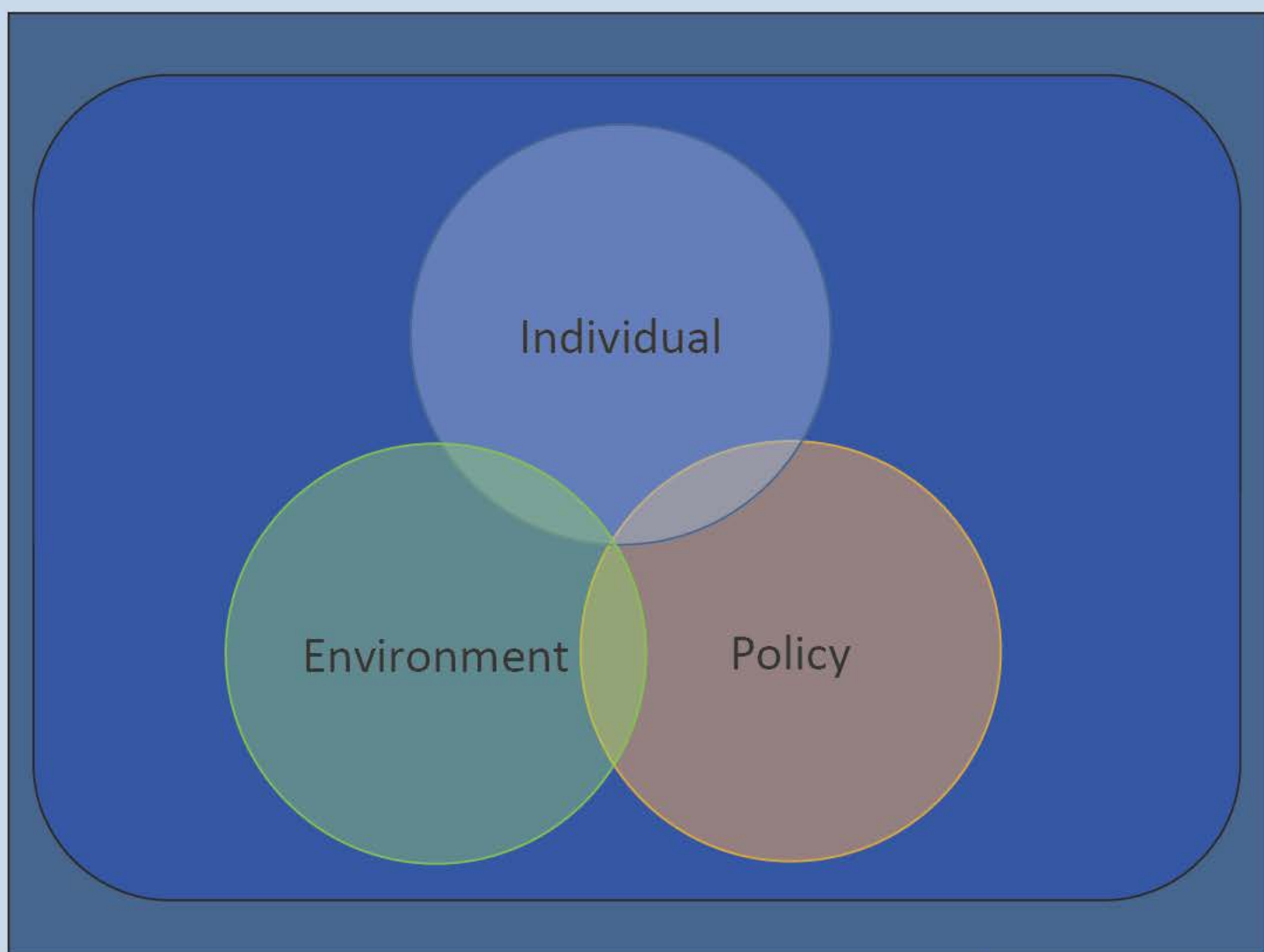
Silence

Stigma

Levels of Intervention to Address Stigma in Clinical Settings

Nyblade, *et al*[3], refer to three distinct levels of possible intervention to address HIV-related stigma within health care facilities: individual, environmental, and policy levels. At the individual level, attitudes and beliefs of providers can manifest as stigmatizing responses. The setting or environment in which care is provided can communicate unintentional stigmatizing messages. Even policies within the care facility can inadvertently perpetuate stigma. To enhance the engagement and retention in treatment of Latino MSM living with HIV, providers should assess potential need for interventions at each of these levels.

[3] Nyblade, L, *et al*. Combating HIV Stigma in Health Care Settings: What Works? J Intl AIDS Soc, 12:15, 2009. doi: 10.1186/1758-2652-12-15.

ACE: THREE-STEP PROCESS

One way to address potentially stigmatizing practices within a health care facility involves using a three-step process known as ACE, which stands for:

- Assess,
- Create, and
- Evaluate.

For each of the three levels mentioned by Nyblade, *et al*,[3] assess what may be contributing to stigma. Next, create and implement a plan to address the identified issues. Finally, evaluate the plan's effectiveness by reassessment.

[3] Nyblade, L, *et al*. 2009.

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Individual

On an individual level, using ACE could involve assessing staff attitudes and beliefs to identify ones that might lead to stigmatizing actions; creating and implementing a plan to raise awareness of the challenges Latino MSM face; and evaluating effectiveness of the plan by reassessing attitudes and beliefs of the providers and other staff.

Environment

At the environmental level, ACE could involve assessing the patients' perceptions of the care environment; creating and implementing a plan to address perceived barriers; and evaluating effectiveness by reassessing patients' perceptions of the changed environment.

Policy

At the policy level, providers and administrators might assess policies and procedures regarding how services are provided to Latino MSM living with HIV; create and implement a plan to make any needed revisions; and evaluate levels of linkage to and retention in care of these patients.

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