Curriculum:
Culturally Competent Care for Young Latino MSM who are HIV-Positive

Introduction

Welcome to the National Multicultural Center's curriculum on "Culturally Competent Care for Young Latino MSM who are HIV-Positive," one of a series of curricula covering a wide range of topics concerning the provision of culturally competent HIV-related healthcare services to individuals belonging to diverse ethnic, racial, and cultural groups.

Latinos represent the most rapidly growing segment of the U.S. population; and the HIV epidemic poses a serious public health issue in Latino communities. In 2009, Latinos represented 16% of the U.S. population and accounted for 20% of new HIV infections. The HIV infection rate among Latinos in 2009 was nearly three times as high as that of non-Latino whites (26.4 vs. 9.1 per 100,000 population). Young Latino men who have sex with men (MSM) are particularly at risk for acquiring HIV infection, due to several factors, including:

- Certain Latino cultural beliefs and practices
- Inadequate understanding of HIV disease and the available treatments
- Poverty and lack of access to HIV testing and care services
- Injection drug use and sexually transmitted infections

The contents of this curriculum will use the following definitions in its discussion of young Latino MSM:

- "Latino" denotes a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish-speaking culture or origin, regardless of race. [U.S. Census Bureau 2010]
- MSM encompasses a wide range of men who have varying self-designated social identities concerning their sexual and/or relationship practices with other men.
- "Young" refers to adolescents and young adults between 13 and 24 years of age.

This curriculum will offer data, other information, and resources designed to increase understanding of the above issues and to support approaches that optimize patient outcomes among practitioners who manage the care of HIV-positive young Latino MSM.

The 5 modules in this curriculum are:

1. The HIV Epidemic in Latino Communities
2. Prevention and Treatment Risk Factors
3. Cultural Competence Issues and Challenges
4. Implementing Approaches to Optimize Diagnosis and Care of Young Latino MSM
5. Case Studies

Learning Objectives of the Overall Curriculum

- Describe the extent of the HIV epidemic among the U.S. Latino population
- Discuss the impact of the HIV epidemic among young Latino men who have sex with men (MSM)
- List the risk factors for HIV transmission among young Latino MSM
- Describe the key characteristics of a successful HIV prevention intervention targeting young Latino MSM
- Discuss the cultural competence challenges of providing HIV testing, access to care and retention in care for young Latino MSM
- Identify key elements of a culturally competent approach to HIV prevention and treatment for young Latino MSM

Module 1: The HIV Epidemic in Latino Communities

Learning Objective(s)

- Describe the extent of the HIV epidemic among the U.S. Latino population
- Discuss the impact of the HIV epidemic among young Latino men who have sex with men (MSM)

Pretraining Assessment

1. Which of the following statements is True?

A. Among Latino men who have sex with men (MSM), 45% of new HIV infections occurred in males under the age of 30 years.

B. Among Latino men who have sex with men (MSM), 45% of new HIV infections occurred in males under the age of 18 years.

C. Among Latino men who have sex with men (MSM), 45% of new HIV infections occurred in males under the age of 45 years.

D. None of the above

2. Which of the following statement is True?

A. Latinos born in the United States are more likely than Latinos born in other areas to acquire HIV infection via IDU or high-risk heterosexual contact.

B. Latinos in the United States who were born in Mexico are more likely than Latinos born in other areas to acquire HIV infection via IDU or high-risk heterosexual contact.

C. Latinos in the United States who were born in Puerto Rico are more likely than those born in other areas to acquire HIV infection via IDU or high-risk heterosexual contact.

D. Latinos in the United States who were born in Cuba are more likely than those born in other areas to acquire HIV infection via IDU or high-risk heterosexual contact.

Overview of HIV Epidemiology in Latino Communities

HIV disease remains a serious public health issue in U.S. Latino communities and is increasingly prevalent among young Latino men who have sex with men (MSM). Latinos comprise approximately 16% of the total US population. As of 2010 over 1.1 million persons in the United States were HIV-positive; approximately 220,000 of those persons were Latino.[CDC Monitoring 2010 In 2009, Latinos accounted for 20% of new HIV infections and 19% of all HIV-infected individuals[Prejean 2011, CDC Estimates, CDC Monitoring 4 2010] as well as 22% of new AIDS diagnoses in 2010.[CDC Diagnoses 2010]

In 2010 the rate of new AIDS diagnosis per 100,000 was 20.4 among Latino adults and adolescents. This was the second highest of any U.S. racial/ethnic group in 2010.The rate among Latinos was approximately three times higher than that of whites (7.3) and one-third that of African Americans (62.0).[CDC Diagnoses 2010, Prejean [Prejean 2011] found that Latinos ranked second in rates of new AIDS diagnoses from 2006 through 2009, with rates approximately three times higher than whites throughout this time. In 2007, HIV was the sixth leading cause of death among Latinos 25 to 44 years of age.[CDC Diagnoses 2010]

Trends Over Time

The number of new HIV infections among Latinos peaked in the late 1980s and has declined since then. As of 2009, Latinos represented 20% of new AIDS cases (n=9,400). However, Latinos have comprised a growing share of annual AIDS diagnoses over the course of the epidemic—15% in 1985 and 22% in 2010. The number of Latinos living with an AIDS diagnosis has increased, in part due to treatment advances.[CDC Diagnoses 2010] The number of deaths among Latinos diagnosed with an AIDS-defining condition increased 4% between 2007 and 2009. It increased 5% among whites while it decreased 3% among African Americans.[CDC Diagnoses 2010]

HIV Infection Among Men and MSM

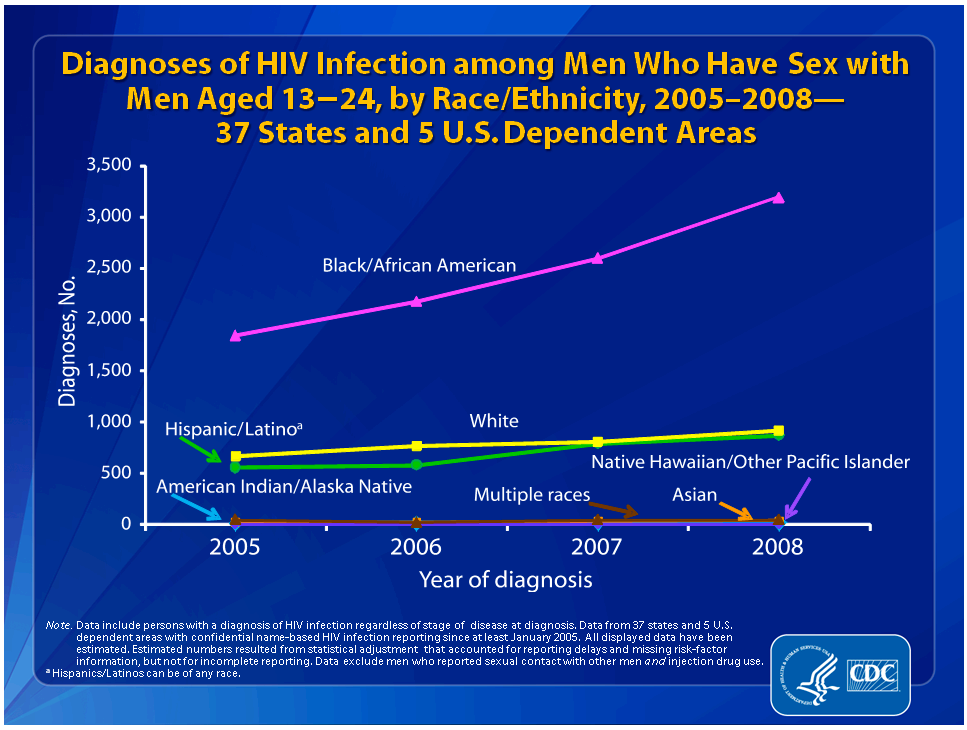
In 2009, Latino men accounted for 79% of new infections among all Latinos (n=7,400). The rate of new infections among Latino men was approximately 2.5 times greater than that among white men (39.9/100,000 vs. 15.9/100,000). The HIV epidemic has particularly affected Latino men who have sex with men (MSM). In 2009, Latino MSM accounted for 81% (6,000) of new HIV infections among all Latino men and 20% among all MSM. Among Latino MSM, 45% of new HIV infections occurred in males under the age of 30 years. [CDC Estimates 2011]

Figure 1.0

Source: CDC 2011.

Among adolescents and young adults(those 13 to 24 years of age) the estimated percentage of diagnosed HIV infections attributed to MSM increased from 57% in 2005 to 68% in 2008, whereas the percentage attributed to heterosexual contact decreased from 32% to 25% during this time (Figure 1.1). The percentage of HIV infections attributed to injection drug use (IDU) decreased from 7% to 4%, but the percentage attributed to MSM plus IDU remained stable from 2005 through 2008.

Figure 1.1



Source: CDC 2011.

Between 2005 and 2008 rates of HIV diagnosis remained stable for most racial/ethnic groups of young MSM. However, rates notably increased for African American and Latino men. In 2009 Latinos aged 13 to 19 years accounted for 19% of new AIDS diagnoses among all teenagers. Latinos 20 to 24 years of age accounted for 21% of new AIDS diagnoses reported among young adults.[CDC Estimates 2011]

Transmission Risks

HIV transmission patterns among Latino men differ from those among white men. Although both groups are most likely to acquire HIV infection via MSM behaviors, heterosexual transmission accounts for a greater share of new infections among Latino men than among white men.[CDC Estimates, Prejean 2011]

Studies have found a high prevalence of HIV infection among Latino gay and bisexual men. A study performed in 21 major U.S. cities found that 18% of Latino MSM participants were HIV-infected compared to 28% of African American and 16% of white MSM. Many of these men were not aware of their positive HIV status. Newly infected Latino MSM are younger than their white counterparts. In 2009 13-19-year-olds accounted for 45% of new HIV infections among Latino MSM. This age group accounted for 28% of new HIV infections among white MSM.[Prejean 2011]

Another aspect of the frequency of MSM HIV transmission among Latinos concerns the risk to Latino women. Because of cultural stigma and discrimination regarding MSM behaviors, Latino MSM often are more likely vs non-Latino whites to self-identify as heterosexual or bisexual and to be married to or sexually involved with women, thereby leading to increased risk for HIV transmission to women partners.[CDC, HIV among Latinos; Virginia HIV Planning Committee; Ruiz et al., 2003]

Geographic Considerations

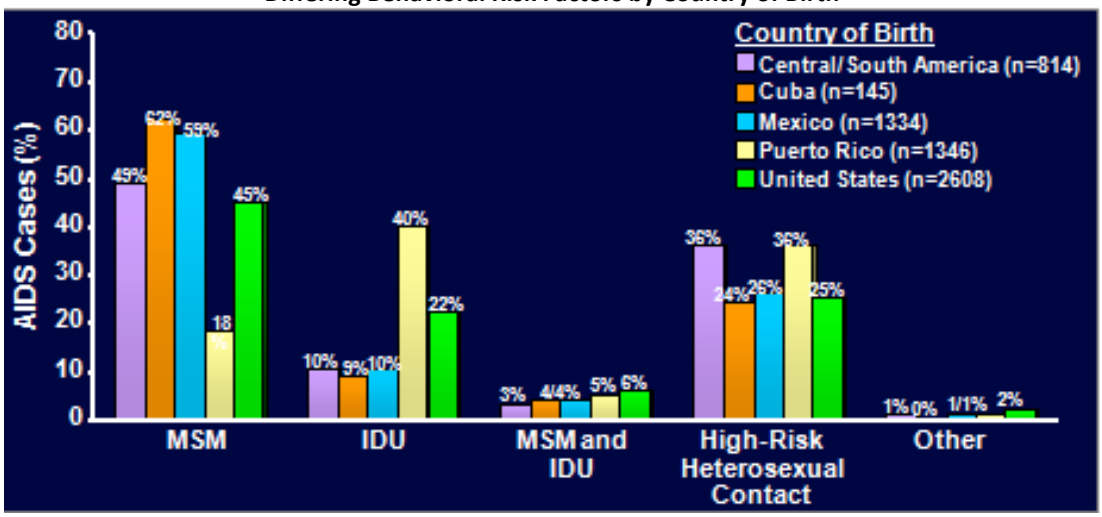
Rates of new AIDS diagnoses per 100,000 population among Latinos are highest in the East, particularly the Northeast.[Kaiser Estimated 2011] In 2009, 10 states or territories accounted for 87% of Latinos estimated to have been diagnosed with AIDS, with New York, California, and Puerto Rico being the top three. The majority of new AIDS diagnoses (84%) among Latinos in 2010 also occurred in 10 states.[Kaiser Estimated 2011]

Figure 1.2

Source: CDC, 2010)

Figure 1.3

Differing Behavioral Risk Factors by Country of Birth



HIV transmission patterns among Latinos vary by place of birth:[CDC Diagnoses 2010]

- Latinos born in Puerto Rico are more likely than those born in other areas to acquire HIV infection via IDU or high-risk heterosexual contact. Figure 1.2
- MSM contact is the primary transmission mode among Latino men born in Central or South America, Cuba, Mexico, or the United States. Figure 1.3

These issues will be discussed further in other modules in this curriculum.

HIV Screening Patterns

Among individuals 18 to 64 years of age, Latinos are more likely than whites to report having been tested for HIV in the preceding 12 months (24% vs 15%, respectively).[Kaiser 2011 Survey] According to the Centers for Disease Control and Prevention (CDC), more than one-third of HIV-positive Latinos (36%) were diagnosed late in disease progression (within 1 year of testing positive). This rate is slightly higher than rates for African Americans (31%) and whites (32%).[CDC Diagnoses 2010]

Community Concerns

In 2011 the Kaiser Family Foundation conducted a survey and found that approximately 1 in 10 Latinos consider HIV disease the most urgent health problem facing the nation. Approximately 3 in 10 consider it a more urgent problem for their community than it was several years earlier. In addition, 27% of Latinos indicated that they were personally very concerned about becoming infected with HIV, a proportion that has declined since the mid-1990s. A total of 41% of Latino parents expressed that they were "very concerned" about a son or daughter becoming HIV-infected.[Kaiser 2011 Survey]

Summary

Latinos comprised approximately 16% of the total U.S. population, 20% of new HIV infections and 19% of all HIV-infected individuals in 2009, and 22% of new AIDS diagnoses in 2010. The HIV epidemic has particularly affected Latino MSM, who accounted for 81% (6,000) of new HIV infections among all Latino men and 20% among all MSM in 2009. Among Latino MSM, 45% of new HIV infections occurred in males under the age of 30 years. A study conducted in 21 major U.S. cities found that 18% of Latino MSM participants were HIV-infected. Rates of HIV infection and modes of transmission are associated with Latinos' country of birth or the culture with which they are primarily affiliated.

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Assessment Questions

1. Which of the following statements is True?

A. Among Latino men who have sex with men (MSM), 45% of new HIV infections occurred in males under the age of 30 years.

B. Among Latino men who have sex with men (MSM), 45% of new HIV infections occurred in males under the age of 18 years.

C. Among Latino men who have sex with men (MSM), 45% of new HIV infections occurred in males under the age of 45 years.

D. None of the above

2. Which of the following statement is True?

A. Latinos born in the United States vs those born in other areas are more likely to acquire HIV infection via IDU or high-risk heterosexual contact.

B. Latinos born in Mexico vs those born in other areas are more likely to acquire HIV infection via IDU or high-risk heterosexual contact.

C. Latinos born in Puerto Rico vs those born in other areas are more likely to acquire HIV infection via IDU or high-risk heterosexual contact.

D. Latinos born in Cuba vs those born in other areas are more likely to acquire HIV infection via IDU or high-risk heterosexual contact.

Module 2: Prevention and Treatment Risk Factors

Learning Objective(s)

- List the risk factors for HIV transmission among young Latino MSM
- Describe the key characteristics of a successful HIV prevention intervention targeting young Latino MSM

Pre-training Assessment

1. Is the following statement True or False?
Among U.S. racial/ethnic groups, Latinos are least likely to be tested for HIV.
A. True

B. False

2. Which of the following Latino populations has the highest proportion of HIV infections attributed to injection drug use?

A. Puerto Rican

B. Cuban

C. Mexican

D. Central American

3. Which of the following is NOT associated with the cultural concept of *machismo*?

A. Protection of the family

B. First sexual encounter at an early age

C. Potential incentive to reduce unprotected sexual activity

D. Perceived invulnerability to HIV infection

E. None of the above

Impact of Country of Birth or Cultural Association

As mentioned in Module 1 of this curriculum Latinos' country of birth or cultural association can be associated with both risk of HIV infection and particular mode of HIV transmission.

Reported country of birth among adult and adolescent Latino males diagnosed with HIV infection in 2009 included:

- United States: 37%
- Mexico: 14%
- Puerto Rico: 12%
- Central America: 7%
- South American: 5%
- Cuba: 3%
- Country other than the above: 4%

An estimated 19% of Latino males did not report their country of birth.

Transmission Mode

According to the Centers for Disease Control and Prevention (CDC), the mode of HIV infection among Latinos varies by place of birth, with MSM contact more common among those born in South America (65%), Cuba (62%), and Mexico (54%) than among those born in the United States (46%). A greater proportion of Latinos born in the Dominican Republic (47%) and Central America (45%) than those born in the U.S. (28%) became infected through high-risk heterosexual contact. Latinos born in Puerto Rico had a greater proportion of HIV infections attributed to injection drug use (IDU) (33%) than those born in the United States (22%).[CDC Surveillance 2006]

A study of HIV risk behaviors among men who have sex with men (MSM) by Rhodes and colleagues reported that Latino and non-Latino black MSM were more likely than non-Latino white MSM to report inconsistent condom use during anal sex.[Rhodes 2006] HIV knowledge and perceptions of risk differ among U.S. Latino subcultures. Immigrants born in Cuba, Mexico, and Puerto Rico who were injection-drug users reported less HIV knowledge than U.S.-born injection-drug users.[Freeman 1999]

The finding that a greater proportion of Puerto Rico-born Latinos acquired HIV infection through IDU may be a result of both greater prevalence of IDU and increased levels of high-risk behaviors associated with IDU (e.g., frequency of injecting and sharing syringes) compared with other Latinos.[Diaz 1993, Deren 2003] U.S. Latinos of various national origins or ancestries differ in their IDU-related behaviors. Puerto Rico–born IDUs are more likely to share syringes, cotton, or rinse water and to inject more frequently than U.S.-born Puerto Ricans.[Finlinson 2006]

Language Issues

Young Latino MSM language skills can vary widely, including:

- Monolingual Spanish-speaking
- Limited English language ability
- Full bilingual skills
- Monolingual English-speaking

The implications that this range of abilities has for men's HIV risk behaviors, comprehension of prevention messages, and patient-provider communication are significant. Language challenges are associated with increased likelihood of risky sexual behaviors, poor adherence to provider instructions, and lower patient satisfaction with healthcare encounters. Concerns that have been recognized among patients with little or no English-speaking ability or access to Spanish-speaking providers or interpreters include:

- Less understanding of recommended treatment plans, instructions for taking prescribed medications, and plans for follow-up care than is observed without these language barriers
- Greater dissatisfaction with care, with the risk of being less willing to return if problems arise
- Greater likelihood of reporting problems with healthcare providers or facilities
- Reduced satisfaction with the patient-provider relationship

Issues such as these can result in poor treatment adherence, missed appointments, and poorer treatment outcomes, including increased risk of HIV-related complications and greater risk of HIV transmission.[Betancourt 2003]

Socioeconomic Issues

More than 1 in 4 (26.7%) Latinos live in poverty, the second highest rate among race/ethnic groups in the U.S., following African Americans (27.5%) and significantly above the rate for the U.S. population as a whole (15.2%).[Census Poverty 2012] Various socioeconomic problems associated with poverty—including lack of formal education, unemployment, no or inadequate health insurance, and limited access to high-quality healthcare services—can directly or indirectly increase a person's risk for HIV infection. Latinos are more likely than non-Latino whites to become diagnosed as HIV-positive later in the course of HIV disease (sometimes at the same time as receiving a diagnosis of AIDS). This suggests that Latinos are not accessing HIV testing or other healthcare services where HIV infection could be diagnosed at an earlier stage.[CDC Prevention Challenges 2008] Among transient Latino immigrants, migration patterns, social isolation, language barriers, and lack of access to regular healthcare services can limit awareness of and access to HIV prevention and care.

HCSUS

The HIV Cost and Services Utilization Study (HCSUS)—a nationally representative study of HIV-positive individuals receiving regular medical care for HIV disease—found poorer outcomes among Latinos on several important measures of healthcare access and quality, including lack of transportation and delayed care after receiving an HIV diagnosis.[Kaiser 2011 Survey] Health insurance coverage was identified as an area of particular concern:

- HIV-positive Latinos were more likely than non-Latino whites to be publicly insured or uninsured, with 50% vs 32%, respectively, relying on Medicaid.
- Nearly one-fourth (24%) of HIV-positive Latinos were uninsured versus 17% of non-Latino whites.
- A much smaller proportion of Latinos than non-Latino whites had private health insurance (23% vs. 44%, respectively).

Poverty Among Latino MSM

Diaz conducted an early (2001) study to evaluate the effects of poverty, racism, and homophobia in a population of gay and bisexual Latino men.[Diaz 2001] The majority of the men (61%) reported that they had run out of money for basic necessities and had needed to borrow money (54%) at least once or twice in the preceding year. Nearly half of the men interviewed (45%) had needed to look for work at least once or twice during the preceding year.

Cultural Beliefs, Practices, and Related Issues

Machismo

Across Latino cultures, *machismo* is a complicated concept that provides frameworks for values and behaviors that seek to define what is "manly" with regard to masculinity, pride, bravery, and invulnerability. Within Latino MSM communities, *machismo* can involve strict ideas regarding gender-roles such as the desire to be the insertive partner in anal sexual activity, perceived low sexual self-control, and using sexual encounters as a route to assert masculinity.[Jarama 2005] In Latino communities, machismo can serve both positive and negative purposes:

- Positive:
  - Strength and protection of the family
  - Expecting respect from others
  - Adhering to one's beliefs and commitments
- Negative:
  - Engaging in risky sexual behaviors as a way to prove masculinity through power and dominance (e.g., first sexual encounter at an early age, multiple sex partners)
  - Associating machismo with number of sexual partners
  - Using physical and sexual aggressiveness as expressions of heightened masculinity
  - Perceiving oneself as invulnerable to HIV infection

Familismo

Another key value of Latino communities is the concept of *familismo*— strong ties to immediate and extended family members. *Familismo* emphasizes the importance of maintaining good family relations and of giving the family's needs priority over personal needs.[Herbst 2007] Some aspects of *familismo* may affect Latino males' experience of homophobia and discrimination. Some implications of *familismo* for understanding the behaviors of young Latino MSM and for managing their treatment include:

- Potentially significant incentive for some Latino men to reduce unprotected sexual activity, particularly with casual partners
- Potential source of conflict for young Latino MSM, whose families may have a negative view of homosexuality
- HIV prevention messages that are developed primarily for gay men possibly ineffective for many Latino MSM who self-identify as heterosexual
- Delay or refusal of testing or treatment because of family advice and opinions

Behavioral Implications of Emotional Distress and Cultural Change

Studies have examined the emotional and psychological difficulties experienced by Latino MSM that can affect their sexual behaviors and place them at risk for HIV transmission. In a study of racism,

homophobia, and poverty on the mental health Latino MSM, Diaz and colleagues observed that a large proportion of Latino MSM living in U.S. urban centers exhibits a relatively high frequency of symptoms of psychological distress. These symptoms are closely associated with lifetime and current experiences of social discrimination related to sexual orientation and race/ethnicity, as well as to high levels of financial hardship due to severe unemployment and poverty. Moreover, they reported higher levels of psychological symptoms among study participants who were HIV-positive.[Diaz 2001] A range of other studies have reported very similar findings.[Ryan 2009, Nakamura 2010, Ayala 2012]

Acculturation and Migration

Acculturation is the exchange or acceptance of cultural features that can develop when groups of individuals of different cultures come into continuous direct contact with each other. For Latinos, greater acculturation to the dominant U.S. culture can have both protective and harmful effects:

- Positive:
  - Reduced levels of homophobia and greater sexual freedom compared with country of birth. Many Latino MSM have reported that they came to the United States to escape homophobia in their native countries and to achieve greater sexual freedom.
  - Increased tendency to communicate with sexual partners about HIV risk-reduction behaviors
  - More encouragement to disclose positive HIV serostatus
- Negative:
  - Among younger MSM—tendency to engage in frequent sexual activity, including behaviors that may increase risk for HIV infection, during the early period after arrival
  - Higher likelihood of using drugs before or during sexual activity

Migration. Certain HIV risk factors are associated with migrant living:[Organista 1997, Rhodes 2010, Magis-Rodriguez 2009]

- Frequent mobility
- Geographic barriers to healthcare services
- Limited education
- Psychosocial factors
  - Isolation
  - Discrimination
- Poverty
  - Chronic underemployment
  - Substandard housing

The following HIV risk behaviors have been identified among migrant workers:[Public Health Service 1994, Apostolopoulos 2006, Denner 2005]

- Adoption of new sexual practices
  - Seeking companionship to compensate for the alienating aspects of their migration experience
  - Fewer social constraints on behaviors
  - Exposure to previously unfamiliar or unacceptable sexual behaviors
  - Exchanging sexual services for money, food, or housing
- Limited knowledge of how HIV infection is transmitted and can be prevented
- Multiple sexual partners

- Increased alcohol and drug use
- Limited access to medical care and HIV testing

Health Disparities and Barriers to HIV Prevention and Care for Young Latino MSM

Young Latino MSM frequently experience health issues that both increase their risk of HIV transmission and hinder them from accessing appropriate prevention and treatment services. These include:

- Substance and alcohol use
- Engagement in behaviors associated with risk of HIV transmission
- High rates of sexually transmitted infections (STIs)
- Low HIV testing rates
- Limited access to healthcare services, particularly for HIV disease

Drug and Alcohol Use

Several studies have reported high rates of substance and alcohol use among Latino men, particular young MSM. Summarizing some of these findings, Ramirez-Valles and colleagues reported that prevalence of past 6 months drug use among Latino MSM ranged from approximately 40% in New York City and Los Angeles to 16% in Miami, with the most commonly used drugs being marijuana, amyl nitrites (poppers), cocaine, and methamphetamine. Another study found that 49% of respondents used club drugs (e.g., cocaine, crystal methamphetamine, ketamine, volatile nitrites) in the past 6 months, with poppers being the most popular (32%).[Ramirez-Valles 2008] Rates of heavy alcohol use in the preceding 6 months were 37% and 15%, respectively. These same investigators reported that the use of club and other drugs was associated with nearly double the estimated odds of engaging in unprotected anal intercourse. Younger study participants were more likely than older ones to have unprotected anal intercourse. Numerous other studies have found associations between heavy use of alcohol, club drugs, and methamphetamines and unprotected anal intercourse.[Diaz 2005, Fernandez 2005, Dolezal 2000]

Sexually Transmitted Infections

(STI surveillance data from the CDC indicate that between 1996 and 2008 rates of chlamydia and gonorrhea were significantly higher among young (20 to 29 years of age) Latino men than among non-Latino white men.

Researchers have known for more than 20 years that individuals who are infected with an STI are 2 to 5 times more likely to acquire HIV infection if exposed to HIV through sexual contact. In addition, if an HIV-positive individual is also infected with another STI, he or she is more likely than other HIV-infected persons to transmit HIV through sexual contact.[Wasserheit 1992] Inflammation from genital ulcers or non-ulcerative STIs (e.g., chlamydia, gonorrhea, and trichomoniasis) increases the concentration of CD4+ cells in genital secretions. HIV-positive individuals with other STIs are also likely to shed HIV in their genital secretions. The median concentration of HIV in semen is up to 10 times higher in HIV-positive men who are also infected with gonorrhea than in men infected only with HIV. The higher the concentration of HIV in semen or genital fluids, the greater the risk of HIV transmission to a sexual partner.

HIV Testing Rates and Risks

In a 2009 Kaiser study, higher proportions of African Americans (73%) and Latinos (60%) than whites (53%) reported ever having been tested for HIV. A 2009 CDC report on late HIV testing (defined as receiving an AIDS diagnosis within 3 years after testing HIV-positive) found that Latinos had the second-highest rate of late HIV diagnosis (48%) among racial/ethnic groups in the United States (the highest late testing rate (50%) was among Asian-Americans).[MMWR 2009] There are 2 key concerns related to late HIV diagnosis:

- Individuals who are diagnosed late are more likely than those diagnosed early to have greater immune deficiency and therefore are at risk of poorer clinical outcomes.
- Individuals who are diagnosed late are more likely to have high HIV RNA levels, and therefore are able to more easily transmit HIV infection to others.

Summary

Latinos' country of birth or cultural association can be associated with both risk of HIV infection and particular route of HIV transmission, with HIV knowledge and perceptions of risk differing among Latino subcultures. Language skills among U.S. Latinos range from monolingual Spanish-speaking to monolingual English-speaking, with significant implications for men's HIV risk behaviors, comprehension of prevention messages, and patient-provider communication, potentially resulting in risky behaviors, poor adherence, and increased patient dissatisfaction. With the second-highest poverty rate among racial/ethnic groups in the United States, Latinos are at risk for limited access to healthcare services and poorer clinical outcomes. Important cultural characteristics like *machismo* and *familismo* have both positive and negative implications for HIV transmission and treatment among young MSM. Early experiences of discrimination, homophobia, and poverty play important roles in shaping Latino MSM's sexual behaviors and HIV transmission risks, migrant living posing particularly challenging concerns. Health disparities and barriers to care for young Latino MSM include high rates of substance and alcohol use, high rates of sexually transmitted infections, limited access to HIV prevention and care services, and high rates of late diagnosis of HIV infection.

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Assessment Questions

1. Is the following statement True or False?
Among U.S. racial/ethnic groups, Latinos are least likely to be tested for HIV infection.

A. True

B. False

2. Which of the following Latino populations has the highest proportion of HIV infections attributed to injection drug use?

A. Puerto Rican

B. Cuban

C. Mexican

D. Central American

3. Which of the following is NOT associated with the cultural concept of *machismo*?

A. Protection of the family

B. First sexual encounter at an early age

C. Potential incentive to reduce unprotected sexual activity

D. Perceived invulnerability to HIV infection

E. None of the above

Module 3: Cultural Competence Issues and Challenges

Learning Objective(s)

- Discuss the cultural competence challenges of providing HIV testing and access to and retention in care for young Latino MSM

Pre-training Assessment

1. Which of the following statements is True?

A. Comparable percentages of Latinos and non-Latino whites rely on Medicaid for health insurance coverage.

B. A significantly larger percentage of Latinos than non-Latino whites relies on Medicaid for health insurance coverage.

C. A significantly larger percentage of non-Latino whites than Latinos rely on Medicaid for health insurance coverage.

D. Very few Latinos rely on Medicaid for health insurance coverage.

2. Migrant workers experience which of the following risk factors for acquiring HIV infection?

A. Multiple sexual partners

B. Adoption of new sexual behaviors

C. Increased rate of alcohol and drug use

D. A and B only

E. All of the above

3. Which of the following statements is True?

A. In 2012, the unemployment rate among Latinos 16 to 19 years of age was 31%.

B. In 2012, the unemployment rate among Latinos 16 to 19 years of age was > 50%.

C. In 2012, the unemployment rate among Latinos 16 to 19 years of age was < 30%.

D. None of the above.

Economic Barriers

As discussed in Module 2 of this curriculum, many Latino communities and individuals experience high levels of poverty and related financial difficulties. With a poverty rate of 26.7%, Latinos experience poverty much more frequently than the U.S. population as a whole (15.2%).[Census Poverty 2012] Poverty is associated with other problems that can negatively affect ability to access and benefit from healthcare services, including:

- Unemployment or irregular employment
- Lack of formal education
- Limited transportation options for accessing treatment and prevention services
- No or inadequate health insurance coverage
- Limited access to high-quality healthcare services

Each of these can contribute both to a person's risk for HIV transmission and to the probability of poorer clinical outcomes in persons who are already HIV-positive. The fact that Latinos are more likely than non-Latino whites to receive an HIV diagnosis later in the course of HIV disease (sometimes simultaneously with a diagnosis of AIDS) suggests that they are not accessing HIV testing or other healthcare services which would allow diagnosis at an earlier disease stage.[CDC Prevention Challenges 2008]

Insurance Coverage

The HIV Cost and Services Utilization Study (HCSUS)—a national study of HIV-positive patients receiving regular HIV medical care—reported that Latinos had poorer outcomes on several important measures of healthcare access and quality, including lack of transportation and delayed care after receiving an HIV diagnosis.[Kaiser 2011 Survey] HCSUS identified health insurance coverage as an area of particular concern:

- HIV-positive Latinos were more likely to be publicly insured or uninsured than non-Latino whites, with 50% vs 32%, respectively, relying on Medicaid.
- Nearly one-quarter (24%) of HIV-positive Latinos were uninsured, compared to 17% of non-Latino whites.
- A much smaller proportion of Latinos than non-Latino whites had private health insurance (23% vs 44%, respectively).

Poverty and HIV Risk

A 2001 study by Diaz and colleagues evaluated the effects of poverty, racism, and homophobia in a population of gay and bisexual Latino men.[Diaz 2001] The majority of the men (61%) reported that they had run out of money for basic necessities and had needed to borrow money (54%) at least once or twice in the preceding year. In addition, nearly half of the men interviewed (45%) had needed to look for work at least once or twice during the preceding year. More recently, Ayala and colleagues examined the impacts of financial hardship and discrimination on HIV risk among nearly 2,300 Latino and African American MSM. They found that homophobia, discrimination, financial hardship, and lack of social support were associated with unprotected anal intercourse with a partner whose HIV status was either different from the participants' or unknown.[Ayala 2012] Unprotected anal sex is the sexual behavior associated with the greatest risk of HIV transmission.

Undocumented Status

Undocumented Latinos in the United States experience unique risk factors for acquiring HIV infection and for limited or no access to appropriate healthcare services if already HIV-positive. These risks include migration patterns, social isolation due to being in a less familiar culture, language barriers, and poverty and irregular income.

Four themes. Using in-depth interviews with healthcare providers and HIV-positive Latino men, Bowden and colleagues identified four themes that illustrate the sociologic and cultural influences on the sexual risk behaviors of such men:[Bowden 2006]

- Misconceptions about HIV prevention and treatment
- "Sexual silence" that leads to misconceptions about sexual behaviors and the risk of HIV transmission
- Discrimination within the community against HIV-positive individuals
- Desire for culturally relevant and gender-specific health education

HIV risk factors. Researchers have found that Latino MSM often have come to the United States to escape homophobia and to gain greater sexual freedom. For migrant workers particularly, some HIV risk factors are associated with migrant living:[Organista 1997, Rhodes 2010, Magis-Rodriguez 2009]

- Frequent mobility
- Geographic barriers to healthcare services
- Limited education
- Psychosocial factors
    - Isolation
    - Discrimination
- Poverty
    - Chronic underemployment
    - Substandard housing

The following specific HIV risk behaviors have been identified among migrant workers:[Public Health Service 1994, Apostolopoulos 2006, Denner 2005]

- Adoption of new sexual practices
    - Seeking companionship to compensate for social isolation
    - Fewer social constraints on behaviors
    - Exposure to different sexual behaviors
    - Exchanging sexual services for money, food, or housing
- Limited knowledge of HIV transmission and prevention
- Multiple sexual partners
- Increased alcohol and drug use
- Limited access to medical care and HIV testing

Cultural Beliefs and Practices

Lengthier discussion of Latino cultural beliefs and practices related to preventing and managing HIV disease in young Latino MSM was presented in Module 2 of this curriculum, "Prevention and Treatment Risk Factors." The discussion that follows will briefly summarize those issues.

Language Issues

Young Latino MSM's language skills can range from monolingual Spanish through limited English fluency to monolingual English. Individuals' language facility can impact their ability to comprehend prevention messages, adherence to provider instructions, and satisfaction with various healthcare encounters—all of which can result in poor treatment adherence, missed appointments, and poorer treatment outcomes.[Betancourt 2003] A tangential language barrier is the practice among some Latino cultures of using two, often hyphenated, last names. Practitioners and healthcare facilities' lack of familiarity with this practice may lead to confusion in the maintenance of patient records and of breakdowns in communication with patients.

Alternative Medicine and Practitioners

Latinos of various ethnic and cultural backgrounds—particularly more recent immigrants—sometimes patronize *botanicos*, which are stores that sell traditional herbal medicines and related items. *Botanicos* and related medical practices often provide a treatment approach for individuals who either do not want mainstream treatments or do not have access to them. For some people, *botanicos* may also provide a complement to mainstream treatments. For these reasons, *botanicos* can serve as focal points for obtaining treatment and information in Latino communities. In addition, *botanicos* staff provide services and merchandise that are considered to support a more holistic approach to health issues—one that regards health as a network of physical, emotional, and spiritual factors.[Anderson 2008, DeStefano 2001, Zacharias 2006, Ortiz 2007; Santiago-Saavedra 2004]

Studies have reported that a substantial proportion of HIV-positive Latino patients seek treatment at *botanicos*.[Chang 2003, Foote-Ardah 2003, Josephs 2007, Ladenheim 2008, Rivera 2006, Rivera 2005] Ortiz and colleagues reported that patients often feel that *curanderos* (practitioners of folk medicine) offer supportive encounters that they do not receive from mainstream practitioners.[Ortiz 2007] In addition, some patients—typically ones having lower incomes, less English proficiency, and less formal education[Mikail 2004, Gomez-Beloz 2001]—seek care at *botanicos* because they lack access to conventional healthcare services.[Zacharias 2006]

Family and Gender Issues

Machismo. "*Machismo*" aims to define what is masculine in many Latino cultures, and among Latino MSM, *machismo* can involve strict gender roles regarding sexual practices and a way to assert masculinity.[Jarama 2005] Machismo can provide both positives and negatives—protecting the family on the one hand and engaging in risky sexual behaviors as a way to assert masculinity on the other hand.

Familismo. *Familismo*—strong ties to immediate and extended family members—stresses the importance of maintaining good family relations and giving the family's needs priority over personal needs.[Herbst 2007] For young Latino MSM, *familismo* may be a significant incentive to reduce risky sexual behaviors, but it may also serve as a source of conflict if families have a negative view of homosexuality:

- HIV prevention messages that are developed primarily for gay men may be ineffective for many Latino MSM who self-identify as heterosexual

- Delay or refusal of testing or treatment because of family advice and opinions

Fatalismo. *Fatalismo* (fatalism) may convince some Latinos that chronic disease is ordained by God and must be accepted as punishment for personal sins. For some Latinos this can engender an attitude that HIV disease is part of their destiny.

Healthcare System Barriers

In addition to patient-related barriers to accessing healthcare services, young Latino MSM encounter a number of barriers that arise from the U.S. healthcare system itself.

Complexity of the Healthcare System

Young Latino MSM experience a greater risk of having inadequate or no health insurance coverage.[Kaiser 2011 Survey] Americans typically obtain health insurance coverage through their place of employment. Young Latino MSM often experience irregular employment (migrant work or day labor), underemployment, or unemployment. A disproportionate number of Latinos work in fields that have experienced some of the largest job losses (e.g., construction, hospitality, recreation) since the start of the economic crisis in 2008. In June 2012, the official unemployment rate among Latinos stood at 11% vs. 8.2% in the overall US population. Among Latinos 16 to 19 years of age, the unemployment rate was 31%.[Bureau of Labor Statistics Summary 2012

The poverty rate that results from such unemployment figures was 26.7% in 2010. In addition to issues of no or inadequate insurance coverage, high poverty rates limit Latinos' ability to pay out of pocket for healthcare costs, which, for treatment of HIV disease, can amount to hundreds of dollars per month.

Healthcare Staffing

An earlier study by Evans found that fewer than 2% of senior healthcare management positions are filled by non-whites.[Evans 1999] A recent survey by the American Hospital Association has indicated that Latino, African American, and other non-white representation in senior positions has improved somewhat but still falls far short of being representative of the U.S. population as a whole. Several studies over the years have shown that lack of diversity in healthcare leadership and staff positions is associated with policies, procedures, and delivery systems that are less than fully appropriate for the needs of patient populations being served.[Betancourt 2003] Structural barriers to culturally appropriate healthcare include:

- Limited clinic hours that do not accommodate the working patterns of members of the relevant communities
- Complex registration and intake procedures that may discourage undocumented individuals from seeking care
- Long waits to schedule appointments or in the waiting room at the time of visits
- Lack of printed materials and signage in the appropriate language or at the appropriate literacy level

Language barriers can be particularly challenging. Spanish-speaking patients, for example, report being more satisfied when they receive care from Spanish-speaking providers or when interpreters were present during healthcare encounters.[Morales 1999, Moreno 2010]

Difficulty accessing specialty care is another structural barrier to accessing appropriate care. A survey by the Commonwealth Fund (a foundation specializing in health-related policies and processes) reported that 22% of Hispanics and 16% of African Americans, and 8% of whites, experienced a "major" problem accessing specialty care.[Collins 1999] This is of particular importance to HIV-positive patients, as a number of studies have demonstrated that receiving treatment from a practitioner with significant experience in managing HIV patients is associated with optimal patient outcomes.[Sangsari 2012, Stone 2003]

Healthcare practices that have implemented the guidelines and recommendations of the Culturally and Linguistically Appropriate Services (CLAS) standards developed by the U.S. Office of Minority Health are less likely to present structural barriers to young Latino MSM seeking HIV management services.[OMH CLAS 2012.] [www.omhrc.hhs.gov; www.thinkculturalhealth.hhs.gov]

Access to HIV Testing and Care

Access to HIV testing services can serve as a strong motivator for increasing individuals' awareness of behaviors that may place them at risk for HIV infection. Persons who receive a positive HIV diagnosis typically become less likely to engage in risky behaviors. However, relatively few free or low-cost clinics that offer HIV screening are located in areas with high Latino populations. This can limit young Latino MSM's access to both HIV testing and subsequent linkage to care.[Ayala 2003] Lopez-Quintero and colleagues also reported finding large differences in HIV testing rates among different Latino subgroups, with Puerto Ricans being the most likely to have been tested and Mexicans the least likely.[Lopez-Quintero 2005]

Ensuring that HIV prevention and treatment materials are available in the appropriate language and at appropriate literacy levels represent a critical issue. An analysis by Ebrahim and colleagues of data from the Behavioral Risk Factor Surveillance System (BRFSS) found that Latinos who report having been tested for HIV are the least likely among racial/ethnic groups to have knowledge about available treatments.[Ebrahim 2004]

Latinos who receive a positive HIV diagnosis may be less likely to access care immediately. Even in the U.S. military services, where access to healthcare services is more equalized, studies have found that baseline CD4+ cell counts tend to be lower among Latinos, indicating more advanced HIV progression.[Paris 2002]. A number of studies have found that Latinos are more likely than non-Latino whites and African Americans to initiate HIV care when HIV RNA levels are higher and to present with AIDS-defining conditions.[Dennis 2011]

Inadequate Prevention

Another healthcare system barrier is the lack of prevention interventions that are culturally relevant to young Latino MSM. A study by Carballo-Diéguez and colleagues reported that data are very limited regarding HIV prevention efforts specifically targeting young Latino MSM but that an approach tailored to the needs of this population has shown evidence of efficacy.[Carballo-Diéguez 2005] An in-depth analysis by Johnson and colleagues found that HIV prevention interventions for young Latino MSM typically were more effective when their content included information for individuals who did not self-identify as gay.[Johnson 2008]

Summary

Latinos experience poverty much more frequently than the U.S. population as a whole, leading to a range of problems that can impede their ability to access and benefit from healthcare services. Latinos are less likely than non-Latino whites to have private health insurance coverage and more likely to be enrolled in Medicaid. Undocumented immigrants experience certain increased risks for HIV transmission, including adoption of new sexual behaviors, limited access to HIV testing and care, and social isolation. Cultural factors affecting care include: a wide range of English language fluency, the advantages and disadvantages of *machismo* and *familismo*, and use of alternative medical practices. Lack of diversity in the leadership and staffing of healthcare organizations is associated with less than optimal clinical outcomes. The limited availability of HIV testing facilities in Latino communities can restrict young Latino MSM's access to HIV testing and linkage to care and to culturally appropriate prevention services.

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Assessment Questions

1. Which of the following statements is True?

A. Comparable percentages of Latinos and non-Latino whites rely on Medicaid for health insurance coverage.

B. A significantly larger percentage of Latinos than non-Latino whites rely on Medicaid for health insurance coverage.

C. A significantly larger percentage of non-Latino whites than Latinos rely on Medicaid for health insurance coverage.

D. Very few Latinos rely on Medicaid for health insurance coverage.

2. Migrant workers experience which of the following risk factors for acquiring HIV infection?

A. Multiple sexual partners

B. Adoption of new sexual behaviors

C. Increased rate of alcohol and drug use

D. A and B only

E. All of the above

3. Which of the following statements is True?

A. In 2012, the unemployment rate among Latinos 16 to 19 years of age was 31%.

B. In 2012, the unemployment rate among Latinos 16 to 19 years of age was > 50%.

C. In 2012, the unemployment rate among Latinos 16 to 19 years of age was < 30%.

D. None of the above.

Module 4: Implementing Approaches to Optimize Diagnosis and Care of Young Latino MSM

Learning Objective(s)

- Discuss the cultural competence challenges of providing HIV testing and access to and retention in care for young Latino MSM
- Identify key elements of a culturally competent approach to HIV prevention and treatment for young Latino MSM

Pre-training Assessment

1. Which of the following practices indicate(s) a practitioner's awareness of key Latino cultural values?

A. Maintaining eye contact during clinical encounters

B. Addressing the patient by his first name

C. Offering the use of an interpreter

D. Offering the patient a handshake at the beginning and end of the clinical encounter

E. All of the above

F. A, C, and D

2. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

A. Discussing what HIV means to the patient

B. Asking the patient about his or her preferences regarding healthcare

C. Inquiring about sources of stress in the patient's life

D. All of the above

E. A and B only

3. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

A. Active substance use

B. Depression

C. Race or ethnicity

D. All of the above

E. A and B only

The preceding modules in this curriculum provide the background with which practitioners should be familiar in order to deliver culturally competent care to HIV-positive young Latino MSM—eg, the social, epidemiologic, economic context in which these young people live, socialize, and work. The present module will discuss the clinical application of these factors in ways that help to optimize clinical outcomes and patient satisfaction.

Culture-Specific Approaches

Healthcare providers across the whole spectrum of patient contact need to be aware of the sociocultural issues that contribute to determining the beliefs, behaviors, and attitudes of young Latino MSM to ensure that these patients understand what being HIV-positive means and how it can be effectively clinically managed. Knowing of the importance of two values that are prized in any human interaction among Latino cultures can provide practitioners key tools to enhance provider-patient communications:

- ***Personalismo***. In Latino communities, *personalismo* represents a preference for personal relationships and human interactions that are characterized by a sense of familiarity and warmth. Practitioners who appreciate the value of personalismo and try to act accordingly during patient encounters are more likely to gain patients' trust. Patients, in turn, may be more receptive to clinicians' instructions and more likely to adhere to treatment plans after they have experienced a warm, respectful interaction.
- ***Simpatia***. For many Latinos, *simpatia* (kindness) stresses the importance of polite, empathetic social relations; *simpatia* also involves avoiding assertiveness, negativity, and criticism in conversation and other types of interaction. Practitioners should keep in mind that for some Latino patients, this may lead to a reluctance to question a provider's instructions or to ask for clarification, which increases risk for inadequate adherence and poorer outcomes.

Intergenerational differences typically characterize the degree to which individual patients incorporate these values into their own lives. Some younger Latinos are less influenced than older Latinos by *personalismo*, *simpatia*, and other Latino cultural values. However, recent immigrants and migrant workers of any age may be more likely to embrace these values.

Application. The following include some of the measures that practitioners can enact to incorporate *personalismo* and *simpatia* into clinical encounters with their HIV-positive young Latino MSM patients:

- Maintain eye contact as a way of showing respect.
- Use facial expressions such as an unforced, friendly smile to help make the patient feel comfortable and involved in the encounter.
- Valuable gestures can include walking up to and greeting the patient with a handshake at the start of the clinical encounter, as well as offering a handshake at its end.
- In addressing Latino patients, use appropriate titles—eg, Mr., Ms., and so forth.
  If the patient requires or requests the use of an interpreter to guarantee appropriate communication and understanding, be sure that one is available

Elements of a Cultural Competence Framework

Many clinicians manage the treatment of patients from a variety of different racial/ethnic and cultural backgrounds, and being able to provide care that is appropriate for each patient's particular needs is a critical skill. Stone, a widely published and renowned HIV clinician has advocated the use of "a cultural competence framework" first proposed by Carrillo and colleagues.[Stone 2004, Carrillo 1999] This framework, as outlined below, offers the advantage of not requiring the clinician to memorize all of the specific beliefs and practices unique to each different group. Rather, it utilizes a structured provider-patient dialogue that allows the patient to introduce key issues that are important to her or him, whether involving culture, lifestyle, religion, sexual behaviors, or other factors.

The steps to employ this cultural competence framework are:

- Identify the patient's core cultural issues— by asking about values and preferences regarding healthcare, while watching for any spoken or nonverbal hints about these preferences.
- Explore the meaning of HIV to the patient—by asking what the patient believes might have caused it and how it affects his or life. This can elicit information about how the patient regards his own culture's values.
- Inquire about the patient's social context:
    - To what extent does the patient feel in control of life—Are there financial or other material constraints?
    - Has the patient experienced any change in environment, such as immigration?
    - What is the patient's preferred language and what is her or his literacy level?
    - What kind of support systems does the patient have, including factors such as sources of stress?
- Negotiate across the patient-physician culture to develop a treatment plan that is agreeable to both participants in the dialog.

This framework allows a practitioner to learn the key issues that are important to the patient—e.g., the extent to which he adheres to the traditional values of his culture or is more acculturated to mainstream U.S. society—and to incorporate them into a treatment plan. Practitioners who are managing diverse groups of patients need to take additional measures to optimize patient outcome, as discussed in the following sections.

Improving Communication in the Clinical Setting

Several studies have identified inadequate or ineffective communication as a key driver of non-white patients' dissatisfaction with the healthcare care services that they receive. The amount of time spent with a healthcare provider can be a key predictor of patient satisfaction,[Warde 2001];and young Latino MSM often require more time than other subpopulations to understand the available HIV treatment options and make appropriate decisions regarding them. To the extent possible, clinicians should try to spend more time with these patients, particularly focusing on listening to the patient. Clinicians can enhance patients' comprehension by assessing their understanding in a sensitive, noncondescending manner—e.g., by asking, "Does that make sense to you?" or asking the patient to repeat back the treatment plan that has been agreed upon. Providing written materials in the patient's preferred language and at an appropriate literacy level can further enhance comprehension. In addition, other clinical staff—such as nurses, physician assistants, case managers, or peer counselors—can be assigned

to spend more time with the patient and answer any further questions. For young Latino MSM who are not fluent in English, medical interpreters are a necessary part of clinical encounters to minimize any language barriers between the patient and the provider.

Importance of Staff Diversity

According to an earlier analysis from the HIV Cost and Services Utilization Study, racial concordance between HIV-infected patients and their providers is associated with the elimination of disparities in time to receipt of HAART for African American patients.[Stone 2004] Such findings confirm the importance of the potential benefit of diversifying the clinical staff who are involved in providing care for HIV-positive patients. However, few of the physicians who manage HIV patients are members of racial/ethnic minorities. Although recruiting HIV-specializing physicians presents unique challenges, adding other patient-facing staff of the same racial/ethnic background as the patients being served can substantially increase patients' comfort level. Such staff may include front-desk staff, medical assistants, and others. Furthermore, both current and new staff members at all levels should receive regular cultural competence education and training. (Please review the curriculum "Understanding and Implementing the CLAS Standards" for more thorough discussion of the types of training that are available and who should participate in them.)

Optimizing HIV Care and HAART

Since the early years of the HIV epidemic, disparities in care, including in the receipt of antiretroviral therapy, have been reported among patients belonging to racial/ethnic minorities. For example, nonwhite patients often experience a longer average delay after being diagnosed with HIV infection until the initiation of HIV care, and, once linked to care, they are still less likely to receive HAART than white patients.[Stone 2004, Cunningham 2006, Dennis 2011]

Practitioners who manage young Latino MSM should be familiar with this pattern of disparities and should put in place clinical strategies to optimize the probability that HAART will be recommended to these patients and that they will in fact take their antiretroviral medications. Such strategies include working to build trust in the patient-provider relationship, ensuring that the patient participates in decisions about his or her own care, and providing enough time and information—from other clinical staff members if physician time is not sufficient to do so—for the patient to make an informed decision and understand the importance of taking the medications as directed.[Stone Perspectives 2004] Practitioners should develop approaches to manage comorbidities (such as hepatitis C infection or substance use disorders) and patients' concerns about antiretroviral adverse effects or other medication-related toxicities. This can help to minimize the risks of nonadherence and to optimize the likelihood of attaining full virologic suppression.

Enhancing Adherence to HAART

Researchers and clinicians have known for many years that patient adherence is critical to achieving full virologic suppression and appropriate immune reconstitution with HAART. Once this became well established, interest began to grow regarding whether certain factors could be associated with

predicting adherence and, therefore, whether certain patients might be at greater risk for nonadherence and treatment failure. As far back as 2001, investigators showed that a patient's demographic characteristics generally are not predictive of adherence to HAART—when other key predictors of nonadherence are taken into account.[Stone 2001, Battaglioli-DeNero 2007] Studies of HAART adherence have demonstrated that only a limited number of patient factors and behaviors can reliably be associated with inadequate adherence:[Malcolm 2003, Alfonso 2006, Malta 2008, Cohn 2011]

- Depression
- Active alcohol abuse
- Active injection drug use, with former users seeming to have adherence rates similar to patients with no history of substance use
- Low health literacy

Depression, substance use. Depression is common in HIV-positive persons, as is alcohol and substance abuse; some experience both types of concerns.[Angelino 2001, Angelino 2008, Tegger 2008, Starace 2002] Furthermore, in nonwhite patients, depression may be more difficult to diagnose. For these reasons, practitioners who manage HIV-infected patients should perform routine screening for depression in all patients before initiating HAART. Likewise, all patients—not just those who likely became HIV-positive via injection drug use—should be screened for potential substance abuse issues. Before prescribing HAART for patients in whom depression, substance or alcohol use issues, or some combination of these is identified, clinicians should have in place a management plan. The risk of poor adherence is greater if these issues remain unaddressed. HIV practitioners should make an effort to collaborate with patients' mental health or drug treatment providers to optimize both HIV treatment and mental health and substance use outcomes.[Stone 2004]

Health literacy. Clinicians should endeavor to assess patients' health literacy levels and to correct any misconceptions.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Zekeri 2009, Sebbing 2004] Although a patient's racial/ethnic background has generally not been found to be predictive of adherence, some highly charged emotional factors may disproportionately affect nonwhite patients' willingness and ability to adhere to HAART. These include distrust of traditional healthcare practices and concerns about potential harm associated with medications that some may regard as toxic, experimental, or ineffective.[Corbie-Smith 2002, Kumar 2009, Armstrong 2007, Stone 2004, Cunningham 2000] Support groups, peer educators, and treatment buddies are among the strategies that clinical staff can use to help patients develop more positive attitudes and beliefs about HAART. One such strategy is discussed in the next section.

Cultivating a trusting clinician-patient relationship before beginning HAART can enhance adherence. Several important studies of adherence have shown that the quality of the patient-provider relationship may be one of the most important predictors of adherence, particularly for nonwhite patients.[Stone 2004, Simoni 2008, Malcolm 2003] Logistical supports—such as directly observed therapy—can significantly enhance patients' adherence to HAART.[Moitra 2011, Mitty 2002, Goggin 2007]

¡Cuidate!

Developed as an HIV prevention tool for Latino young people, the *¡Cuídate!* (Take Care of Yourself) program also offers techniques and lessons concerning sexual and other behaviors that are applicable to

maintaining health and reducing risky behaviors among young Latino MSM who are already HIV-infected.

¡Cuídate! is a culturally based intervention consisting of six 60-minute modules presented to small, mixed-gender groups. *¡Cuídate!* incorporates important features of Latino culture, including *familismo* and expectations regarding gender roles. These cultural beliefs are used to frame abstinence and condom use as culturally accepted and effective ways to prevent sexually transmitted diseases, including HIV. *¡Cuídate! employs* role playing, videos, and music to increase participants' knowledge of HIV disease and their skills for negotiating sexual behaviors, including safer sex practices and abstinence. The *¡Cuídate!* curriculum is available in both English and Spanish.[CDC *¡Cuídate!* 2006]

Selected Resources

A large range of resources relevant to understanding HIV-related behaviors, risks, and clinical management among Latino youth is available. The following list represents just a select few of those resources, and most of these include references to further resources:

- AIDS Project Los Angeles (a long-established, comprehensive HIV service organization offering many Spanish-language programs and resources). www.apla.org.

- *AmbienteJoven* (Spanish-language website for young Latino MSM and for Latino gay, lesbian, bisexual, transgender, and questioning youth). www.ambientejoven.org/.

- AVERT (a United Kingdom–based HIV education and service organization). "HIV, AIDS, and Young Gay Men." Available at: www.avert.org/young-gay-men.htm.

- Diaz RM. Latino Gay Men and HIV: Culture, Sexuality, and Risk Behavior. Taylor and Francis; 1997.

- Identity (an organization serving Latino young people and their families, www.identity-youth.org/). "Needs Assessment of Young Latino Men Who Have Sex with Men." Identity; Gaithersburg, MD; June 2011.

- Latino Commission on AIDS (a community-based HIV education and advocacy organization). www.latinoaids.org/.

- Minority HIV/AIDS Initiative (a program of the Office of Minority Health, US Department of Health and Human Services). http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=36.

- National Alliance of State and Territorial AIDS Directors. www.nastad.org. NASTAD provides a host of educational, technical assistance, and mentoring services to its member organizations, plus numerous publications that are available for anyone to download, including, "HIV/AIDS: Crisis among Young Black and Latino Gay Men and Other Men Who Have Sex with Men (MSM)."

- National Latino AIDS Action Network (an educational and advocacy organization with the goals of preventing HIV infection, increasing access to care, and providing information to address the needs of diverse Latino communities). http://nlaan.org/.

- National Minority AIDS Council (an association of > 3,000 HIV service organizations serving people of color). www.nmac.org/.

Summary

In managing the care of young Latino MSM who are HIV-positive, practitioners should be aware of the importance of cultural values like *personalismo* and *simpatia* and learn how to apply them during clinical encounters. Appreciation of Latino cultural beliefs and practices can be practically applied through a "cultural competence framework" that allows a practitioner to learn the issues that are important to the patient and to incorporate them into treatment plans. Effective communication is critical to patient satisfaction with healthcare encounters. Practitioners should take appropriate measures to ensure that patients understand and agree with recommended treatment plans. Staff diversity is key to enhancing patients' comfort in accessing HIV care services. Adherence to HAART is critical to optimal clinical outcomes, and studies have shown that race/ethnicity is not associated with patients' ability to achieve optimal adherence. Factors associated with greater risk of poor adherence include: depression, active alcohol or substance abuse, and low health literacy. A wide range of resources is available to assist practitioners in understanding HIV-related behaviors, risks, and clinical management among Latino youth.

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Assessment Questions

1. Which of the following practices indicate a practitioner's awareness of key Latino cultural values?

A. Maintaining eye contact during clinical encounters

B. Addressing the patient by his first name

C. Offering the use of an interpreter

D. Offering the patient a handshake at the beginning and end of the clinical encounter

E. All of the above

F. A, C, and D

2. A productive cultural competence framework in managing diverse patient populations includes which of the following elements?

A. Discussing what HIV means to the patient

B. Asking the patient about his or her preferences regarding healthcare

C. Inquiring about sources of stress in the patient's life

D. All of the above

E. A and B only

3. Studies have demonstrated that which of the following factors is (are) associated with greater risk of poor adherence to HAART?

A. Active substance use

B. Depression

C. Race or ethnicity

D. All of the above

E. A and B only

Module 5—Cases

MARIA: Case Study Adapted from Addressing HIV Care and Latino Model

Maria, a 42-year-old Latina, reported for the results of her HIV test a month after being tested. Maria is not fluent in English so she brought her two teenage sons, Miguel and Javier, to help translate for her. The clinic does not have bilingual staff or hired interpreters, so when Miguel explains that he and his brother will translate for their mother, who is not proficient in English, the clinic staff does not oppose this arrangement.

While the counselor feels uncomfortable about sharing the results of Maria's HIV test with her two sons, the counselor proceeds to do so because she knows of no other way to communicate the results to Maria. As the counselor begins to inform the sons that their mother has tested positive for HIV, Javier becomes very upset and starts crying. Miguel translates the results to his mother and begins accusing her of sexual promiscuity.

Discussion Questions

1. What breach occurred during this session?

2. What could have been done differently to prevent this situation from occurring?

3. If placed in a similar situation and lacking a certified interpreter, what are some options for overcoming language barriers in a culturally sensitive manner?

4. Is it ever appropriate to ask or allow a patient's family members to serve as interpreters, and if so, should the age and gender of family members be taken into consideration.

5. Discuss other Cultural Competence issues that may impact retention into care and treatment.

ANGELA: Case Study Adapted from Addressing HIV Care and Transgender Communities

Angela is a 22 year old Chinese transgender male to female person. She seems nervous and does not make eye contact. English is not her first language. She is currently going through estrogen hormone therapy. She has a history of depression and drug use. Angela was referred by a local CBO to your clinic to obtain an annual physical examination.

Discussion Questions

1. Estrogen Hormone Therapy
   - Where does she receive therapy? Is she using clean needles?
   - Are there side effects?

- How does she pay for it? Is she employed?

2. Assess Social Support
   - Does she have family? Do they support her gender identity/transition? If not, how does this affect her?
   - Where does she get social support from?
   - Where does she live?
3. Assess Depression
   - Is she receiving treatment?
   - Is she on medication (s) for her depression?

4. Assess Capacity to Understand her Current Medical Condition

   -Does she need a medical interpreter due to her limited English speaking skills?
   -What is her literacy level?
   -Does she understand fully her medical condition?

5. Assess Drug Use
   a. Is she currently using substances? If so, what kind? Assess for HIV/Hepatitis C risk if needles are involved
6. Assess Sexual History and Risk
   a. Has she been tested for HIV/STDs?
   b. If involved in commercial sex work, ask about use of condoms

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