

San Diego County HIV Needs Assessment: Final Report

June 2021





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Introduction

The San Diego County HIV, STD and Hepatitis Branch (HSHB) and the HIV Planning Group (HPG) contracted with Harder+Company Community Research (Harder+Company) to conduct a Needs Assessment of persons living with HIV or AIDS (PLWHA) and those vulnerable to HIV infection in San Diego County. The purpose of the Needs Assessment was to identify unmet needs and service gaps among PLWHA and the need for HIV prevention resources, including pre-exposure prophylaxis (PrEP). The Needs Assessment also focused on identifying unique needs of specific communities including Hispanic/Latinx, men who have sex with men (MSM), transgender and non-binary, Black/African American and those who may be more vulnerable to HIV infection.

This report provides a summary of key findings from the HIV Needs Assessment Survey and virtual focus groups with community members.

Methods

Harder+Company worked with HSHB and the HPG to develop a Needs Assessment survey, adapted from the previous Needs Assessment survey conducted in 2017. The survey was originally slated to be conducted in April 2020. However, given the ongoing COVID-19 pandemic, we delayed distribution until November 2020.

The survey was programmed into Qualtrics and survey links were distributed via the HPG mailing list and partner organizations. Paper surveys were also delivered to Vista Community Clinic, Family Health Centers of San Diego, San Ysidro Health Center, AIDS Healthcare Foundation (AHF), AHF Pharmacy, Stepping Stone, and University of California San Diego's (UCSD) Owen Clinic. In addition, Harder+Company posted three ads on Grindr between January and February, 2021 and posted flyers around the Uptown neighborhoods. A total of 182 respondents completed at least 50% of the survey, meaning they answered at least half of the questions on the survey. Of those, 164 were completed online and 18 were completed on paper.

In addition, Harder+Company conducted eight virtual focus groups with PLWHA. The purpose of the focus groups was to capture the stories of PLWHA to learn more about their experiences with HIV prevention, care, and treatment. We worked closely with partner organizations to recruit participants from specific communities who are most vulnerable to HIV infection. Participants in the eight groups represented HIV positive Women, including Transwomen, Latina Women, Hispanic/Latinx men who have sex with men (MSM), older HIV positive MSM and Black/African American HIV positive individuals.

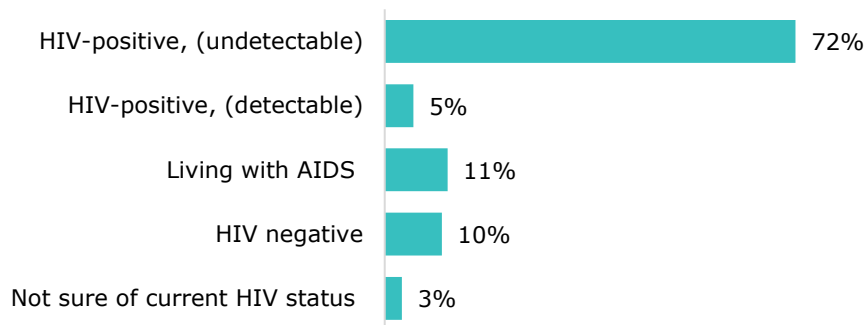
Limitations

Given the ongoing COVID-19 pandemic, Harder+Company was limited to virtual engagements for survey distribution, focus group recruitment, and hosting focus groups. Given these limitations, the number of responses was not as high as previous years. These limitations likely had an impact in the representation of PLWHA who are harder to reach including those experiencing homelessness, transgender youth, and/or undocumented individuals. For instances where there are small n's, it is important to note that the data reported show trends which are not necessarily statistically significant.

Demographics of Needs Assessment Participants

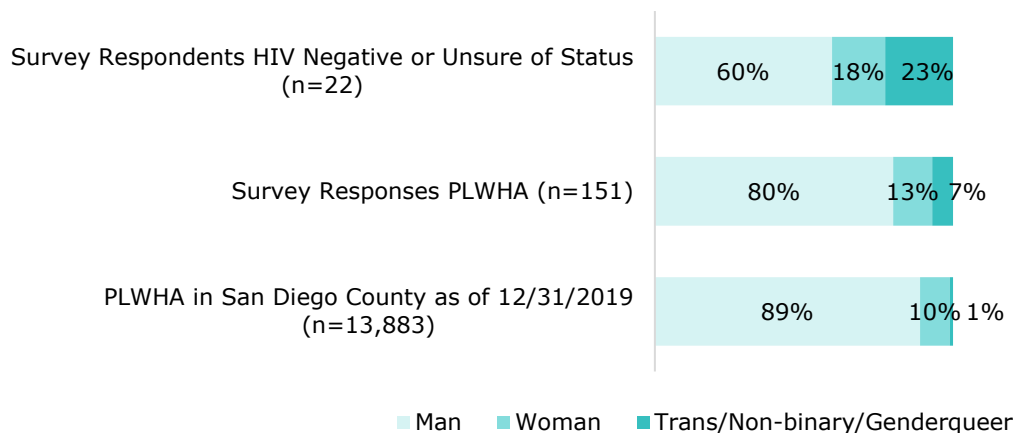
This section provides an overview of responses to the HIV Needs Assessment Survey by key demographics. The survey was intended for residents of San Diego County living with HIV/AIDS, and those who are vulnerable to HIV/AIDS infection, including populations who are disproportionately affected by HIV, which includes Black/African Americans and Hispanic/Latinx, as well as transgender women, injection drug users (IDU), and young adults. In total, 182 individuals completed at least 50% of the HIV Needs Assessment Survey. The majority of respondents are living with HIV/AIDS. More than 70% are HIV positive (undetectable) and another 11% are living with AIDS. About 5% are HIV positive (detectable) and the remaining 13% are HIV negative or unsure of their current HIV status (Exhibit 1).

Exhibit 1. Survey responses by HIV status (n=182)



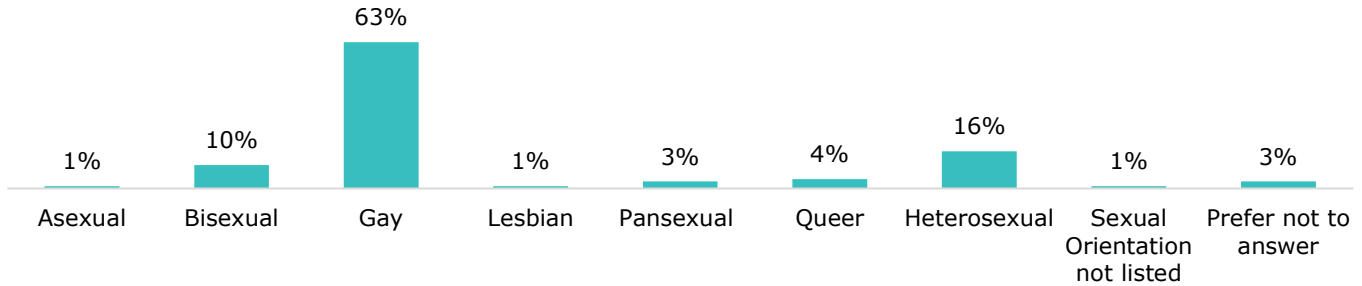
The majority of survey respondents identify as men (77%) followed by women (14%), non-binary (4%), transwomen (2%), genderqueer (1%) and gender not listed (1%). In order to compare survey responses to PLWHA in San Diego County, those who identify as non-binary, transwoman, genderqueer or other were combined into one category. Compared to PLWHA in San Diego County, the survey captured responses from a higher percentage of individuals who identify as women or transwomen/non-binary/genderqueer compared to PLWHA in San Diego County (Exhibit 2).

Exhibit 2. Survey responses by gender identity



The majority of survey respondents identify as gay (63%) followed by heterosexual (16%), bisexual (10%), or queer (4%; Exhibit 3).

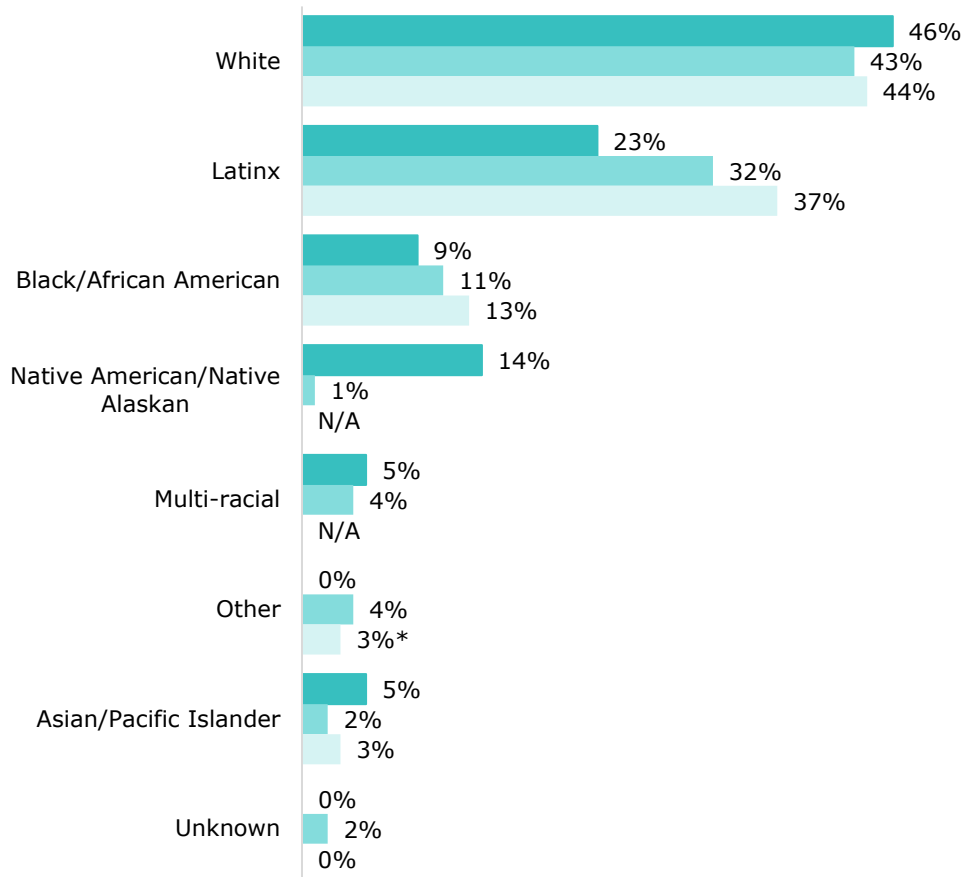
Exhibit 3. Survey responses by sexual orientation (n=179)



Overall, Needs Assessment Survey responses slightly underrepresented the percentage of PLWHA who are Hispanic/Latinx, Black/African American and Asian/Pacific Islander in San Diego County. However, the survey had a slightly higher representation of respondents who are multi-racial or another race/ethnicity not listed on the survey (Exhibit 4).

Exhibit 4. Survey responses by race/ethnicity

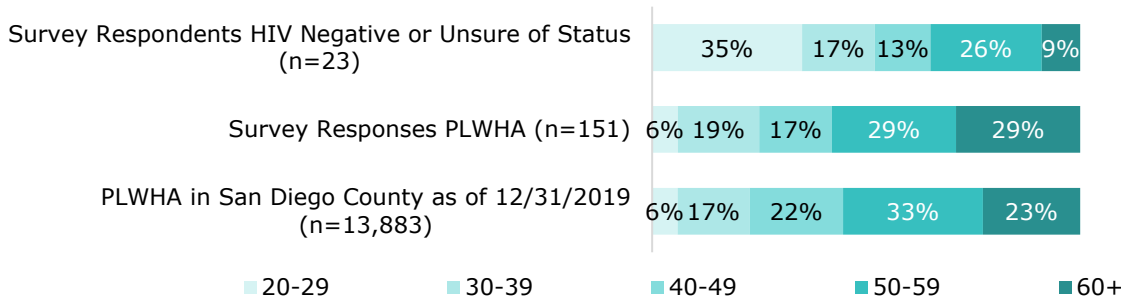
- Percent of Survey Respondents HIV Negative or Unsure of Status (n=22)
- Percent of Survey Responses PLWHA (n=158)
- Percent of PLWHA in San Diego County as of 12/31/2019 (n=13,883)



*For county data, other includes Native American/Native Alaskan, Multi-racial, other and unknown.

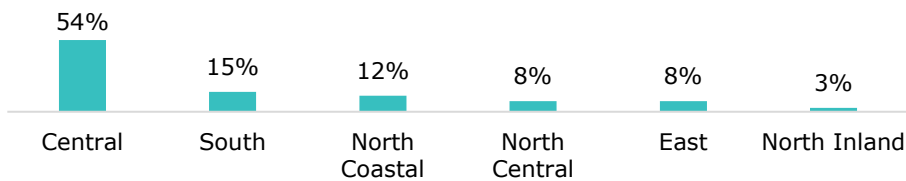
The majority of survey respondents are over the age of 50 (55%). Compared to the percentage of PLWHA in San Diego County, the survey had a slightly higher representation of individuals between the ages 30-39 (19%) and over 60 (27%); Exhibit 5).

Exhibit 5. Survey responses by age



The majority of survey respondents live in the Central region (54%), followed by South region (15%) and North Coastal region (12%); Exhibit 6).

Exhibit 6. Survey responses by county region (n=180)



Focus Group Details

In addition to the full Needs Assessment Survey, Harder+Company trained community members to facilitate focus groups with specific populations of PLWHA in San Diego County. The focus populations were identified based on their underrepresentation in previous efforts and gaps in information about their experiences with prevention, care, and treatment. Exhibit 7 provides an overview of focus groups participants. In addition to focus groups, we also conducted one-on-one interviews with two transwomen. Given the ongoing COVID-19 pandemic, we were limited to conducting virtual focus groups. The number of participants was lower than anticipated due to these challenges.

Exhibit 7. Overview of focus group and interview participants

Population	Number of Focus Groups	Number of Participants
Black/African American HIV positive	2	5
HIV positive Women	1	11
Latina HIV positive Women	1	12
Latinx HIV positive (English and Spanish)	2	4
MSM	1	7
Older (65+) HIV positive	1	3
Total	8	42

Access to Treatment and Care

While there is no known cure for HIV, people diagnosed with HIV who adhere to medical treatment can lead relatively healthy lives.¹ Being connected to a system of support, that includes HIV medical care, HIV case management, and peer support are essential for PLWHA. The following section outlines the results from the HIV Needs Assessment survey and focus groups related to HIV Care and Treatment.

The overarching goals of access to care and treatment for PLWHA include:

- ✓ Connecting newly diagnosed individuals with HIV medical care within a month of disclosure of their positive test results;
- ✓ Ensuring those connected to care retain medical care;
- ✓ Virally suppressing HIV infection;
- ✓ Reducing the experience of homelessness; and
- ✓ Reducing progression to AIDS.

Status and Care

In total, 160 survey respondents are PLWHA. The majority of these individuals report having health coverage through Medicaid (40%) or their employer (17%); 9% reported they do not have health insurance. Of those who reported no health insurance (n=16), 93% identify as men.

Only about half of respondents (53%) report currently having an HIV case manager. White respondents (59%, n=68) were more likely to report not having a case manager compared to Black/African American (17%, n=18) and Hispanic/Latinx (28%, n=50) respondents.

When looking at HIV case manager status by age, 43% of respondents aged 30-39 (n=30), 39% aged 50-59 (n=44) and 67% aged 60+ (n=46) report not having an HIV case manager. Additionally, when looking at case manager status by gender identity, 46% of those who identify as men (n=125) and 46% of those who identify as trans/non-binary or genderqueer (n=11) cite not having an HIV case manager, compared to 14% who identify as women (n=21). Data analyzed by sexual orientation indicated that 47% of those who identify as gay (n=102) do not currently have an HIV case manager, compared to 35% who identify as heterosexual (n=23) and 28% who identify as another sexual orientation (n=25).

Unlike case management, most respondents (98%; n=154) report having an HIV medical care provider, such as a doctor, nurse practitioner, or physician assistant, who provides HIV care and treatment. In addition, across racial and ethnic groups,

¹ National Institutes of Health. (2020, September 24). *HIV Treatment: The Basics*. National Institutes of Health HIV Treatment. <https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-treatment-basics>

most respondents (75%; n=159) had a visit with their HIV medical care provider within the last three months, with the majority (66%, n=158) attending their latest visit in-person. In turn, most respondents also report keeping up with CD4/T-Cell and viral load testing, with 81% (n=157) reporting two or more CD4/T-Cell tests in the past 12 months, which aligns with recommendations to have a CD4-T-Cell test every 3 to 6 months.² In addition, 87% (n=159) report having their viral load measured two or more times in the past 12 months.

While the vast majority of respondents (93%, n=158) report suppressed or undetectable viral loads and 98% report currently taking medication for HIV (i.e., antiretroviral therapy), 33% shared that they have at some point stopped taking HIV medication (n=158). Looking at differences across race/ethnicity, a slightly higher percentage of Hispanic/Latinx respondents (37%, n=51) reported ever stopping their HIV medication compared to 28% of White (n=67) and 24% of Black/African American (n=17) respondents. Additionally, when comparing across sexual orientation, 30% of those who identify as gay (n=103) stopped HIV medication at some point, compared to 61% who identify as other sexual orientation (n=23), and 22% who identify as heterosexual (n=23).

Survey respondents cite various reasons for having stopped taking HIV medication. The top reasons reported are:

- Drug use and drug addiction;
- Forgetting to take the medication; and
- Lack of access to healthcare or resources to get the medication refilled.

These reasons were supported by conversations with HIV positive focus group participants. One person shared that:

"Sometimes I'm out and about and I get home late or something and I lay down and I'm knocked out. And I forget to take it. I'm like, oh, I forgot to take my medication last night."

For those who had stopped their medication for more than 6 months over the past two years, drug use is frequently cited as the cause, although more than half of survey respondents reported they have not had drug or alcohol problems. Additional reasons for stopping HIV medication identified by focus group participants also included:

- Experiences of homelessness;
- Side effects of HIV medication; and
- Experiences of mental health issues, such as depression.

Many focus group participants shared the exhaustion they experience around having to take their HIV medication every day, citing a feeling that they "live to

² Centers for Disease Control and Prevention, Understanding Care (n.d.) Retrieved from <https://www.cdc.gov/hiv/basics/livingwithhiv/understanding-care.html>

take the medication.”

The persistent stigmatization of HIV

Although it has been over 40 years since the first cases of HIV were reported in the United States in 1981³, PLWHA still face perpetual stigma.⁴ During the focus group conversations, stigma was identified by all targeted populations as one of the greatest challenges PLWHA face. Specifically, participants shared that stigma is one of the main reasons for not seeking treatment, testing, or services. While stigma affects all people living with HIV, some groups experience additional layers, driven by family dynamics and cultural beliefs. For example, Black/African American HIV positive men who participated in the focus groups shared that talking about sexual orientation with their families was so impermissible, that they could not imagine having that conversation. Specifically, one participant shared that:

“Just the stigma, fear of just coming out is, in a Black community...just growing up with my Black father and all that stuff just in a family dynamic, it's a very taboo thing to bring up. And no one wants to hear that.”

Similarly, interviews conducted with transwomen revealed the impact of stigma in this community. They shared that stigma is a big challenge for the HIV positive community overall, but especially for transwomen. According to interviewees, HIV is not a topic openly discussed in the trans community, because, as one interviewee shared, “once someone knows your status, they can be so cruel, especially with transwomen.” Most groups agreed that making information about HIV and AIDS more easily accessible to communities can help reduce the stigma around HIV. Similarly, they believe that raising awareness and understanding about HIV would make the community less likely to hold prejudices against PLWHA. Among the older group of PLWHA (i.e., age 65+), however, individuals did not share the same optimism, stating that “stigma is a centuries old problem” that they simply do not see as going away.

For PLWHA who identify as Hispanic/Latinx, stigma is further perpetuated by cultural beliefs. For example, one person shared that in the Hispanic/Latinx community, HIV is often still associated with being gay. Other participants shared that in the Hispanic/Latinx community, similar to what was shared by Black/African American HIV positive focus group participants, talking about or seeking care for HIV is so taboo, that many do not do it to shield themselves from the shame they are made to feel within their own community. For Hispanic/Latinx women who participated in focus groups, the fear of disclosing their status to their partners, especially male partners, feels daunting. Some shared the anxiety around being judged by their partners or families as a reason to delay treatment. Specifically, one person shared that:

“A lot of women just don't want to know...they feel like it's a private situation. I don't want anybody to know. They may judge me. Because, when I first told my family, they wanted to isolate from me. They wanted me to have my own plate. They didn't want me to use their restroom, that whole trip I went with it, but they had to get educated first.”

³ Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (1981). Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/june_5.htm.

⁴ Centers for Disease Control and Prevention. HIV Surveillance Report, 2018 (Updated); vol. 31. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2020. Accessed April 20, 2021.

Barriers to Care and Treatment

Focus group participants who identified as Hispanic/Latinx recognized the importance and benefits of being connected to a case manager. However, they shared that often they find case managers are not consistently supportive of PLWHA. Similarly, they shared that often they have been told they do not need a case manager, indicating that the information being provided for different groups is inconsistent around connecting them to case management services. When asked to describe what characteristics they think a case manager should have, focus group participants consistently shared that case managers should focus on building trust and rapport with clients first, and really understanding their needs and experiences. Interviews with transwomen emphasized the importance of case managers understanding their story to be able to help and connect them to the right services.

A trend that was found from focus group conversations and interviews is that PLWHA are used to having to go through various case managers before they find the right fit. As a result, many encounter barriers that affect access to services. Since the case manager's role often includes assessing and planning actions to meet a client's health and human service needs, it is imperative that PLWHA have access to case management that is trauma informed, welcoming, and non-judgmental from the beginning. Moreover, participants emphasized that, while some PLWHA are more attuned to what services are available to them, many are not; and it becomes more of a challenge for them if there is no one actively trying to reach them and connect them to services. To this point, one focus group participant shared that:

"My biggest thing right now is, during this pandemic, it really, really hindered access and support. And my thing is that I'm pretty fortunate that I'm a go-getter, so I will go and find what I need. But for some people, that's harder and I noticed that if I was someone who was in those shoes, I don't necessarily feel like I had a lot of support and resources and things reaching out to me. And I would think someone who's maybe newer into this situation than I am wouldn't know that those things are available."

This sentiment was supported by survey data, where 31% of respondents report challenges in accessing both health and basic services. Exhibit 8 shows the services respondents most frequently selected as important to them, most of which were related to their HIV care and treatment.

Exhibit 8. Top 6 services survey respondents reported as the most important to them. (n=142)

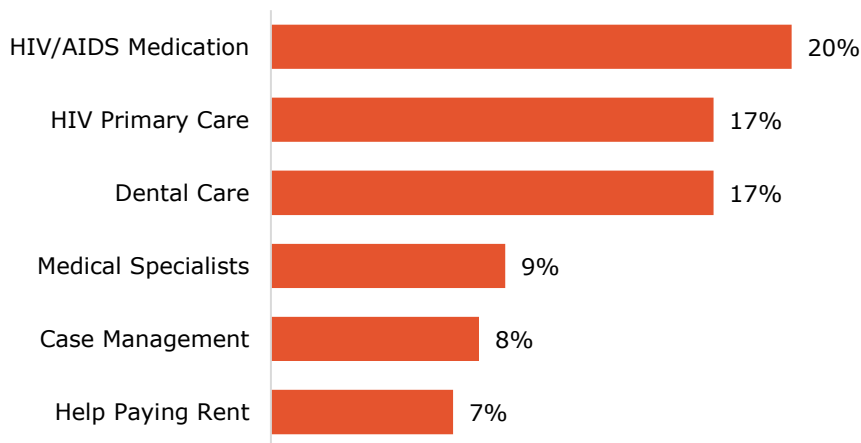
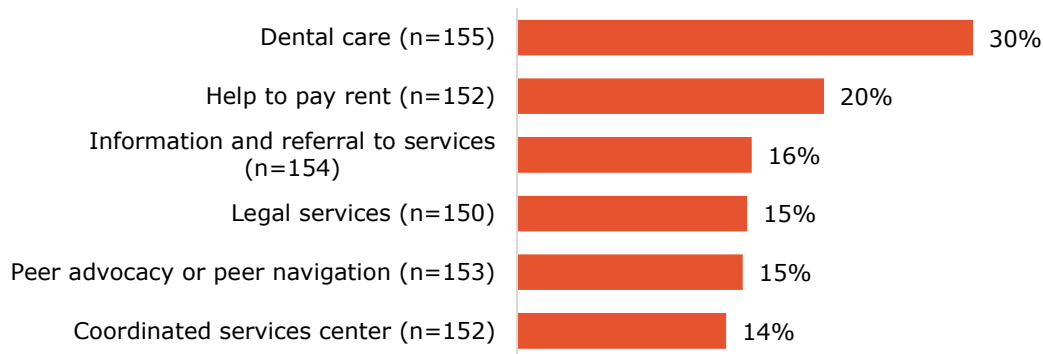


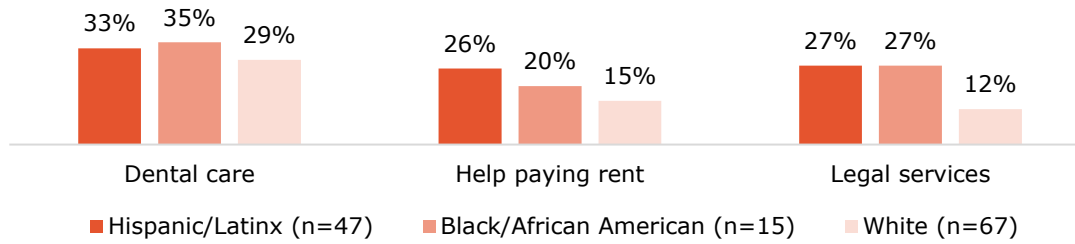
Exhibit 9 highlights the top six services PLWHA report needing but have difficulty accessing or have been unable to access in the past year. Although PLWHA indicated the most important services to them are related to access to HIV treatment and care, other services were more difficult to access.

Exhibit 9. Top 6 services respondents had difficulty accessing or were unable to access in the past year







Respondents who identify as Hispanic/Latinx and Black/African American seem to experience challenges in accessing these services at higher rates. Analysis of the data revealed some demographic findings regarding access. Specifically, these groups report challenges accessing dental care, help paying rent, and legal services (Exhibit 10).

Exhibit 10. Challenges accessing services by race/ethnicity



Not knowing how to find services was one of the top challenges listed across all race and ethnic groups for accessing supportive services.

Respondents in the 30-39 (n=29) age category seem to experience challenges accessing these services at higher rates than other age groups. Specifically, they:

-  report having difficulty accessing or being unable to access help **paying rent** (52%)
-  report difficulty accessing or being unable to access **dental care** (41%)
-  experience challenges accessing **legal services** (31%)
-  report challenges accessing **emergency shelter** (35%)

Other Health Concerns

In addition to accessing care for HIV treatment, the survey explored other health issues that PLWHA experience.

Mental Health

Overall, 20% of PLWHA (n=141) shared having some sort of mental health condition, including bipolar disorder, depression, anxiety, mental illness, PTSD and/or psychological issues.

Counseling/therapy

Of survey respondents, 36% of those who identify as HIV positive (n=132) and 40% of respondents living with AIDS (n=20) have seen a therapist or received counseling within the past year. A slightly higher percentage of respondents (44%; n=23) who identified as HIV negative or are unsure of their status have seen a therapist or received counseling within the past year.

Focus group participants shared current mental health issues they have experienced and witnessed within the HIV community and beyond. They include:

- Lack of preventative mental healthcare;
- Lack of awareness around preventative mental healthcare geared toward youth; and
- Lack of understanding or resources around what to do for mental health or who to turn to for support.

Focus group participants also highlighted the need for more open conversation and transparency around the use of medication to support mental health conditions. As one focus groups participant shared:

"For me, it was the mental health part. Fighting the depression and not knowing what to do or who to turn to or who to talk to. And, although now I know that there are plenty of resources to help with that, that was something that I didn't know in the beginning."

There are significant disparities in access to mental health services as well as a lack of culturally sensitive mental health services for communities of color across the United States. According to the National Alliance on Mental Illness (NAMI), racial and ethnic minority groups are less likely to have access to mental health services in the United States.⁵ These communities are also less likely to receive diagnosis and treatment for their mental illness, less likely to use community mental health services, more likely to receive lower-quality care, and have less overall access to mental health services. Those who do choose to seek treatment often receive inferior care because there tends to be little diversity among mental health providers and decreased understanding about the different mental health needs across minority groups. Even when language translation services are provided, lack of diversity breeds cultural insensitivities that lead to negative health outcomes, such as higher treatment dropout rates. Studies have shown that minorities are

⁵ National Alliance on Mental Illness. (2017, July 31). *Disparities Within Minority Mental Health Care*. <https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care>

less satisfied with the quality of care they receive since they feel that providers simply do not understand their needs. Through the HIV Needs Assessment, several focus group participants brought personal experience that show these national trends are also present in care in San Diego County and highlighting how mental health issues impact PLWHA:

"I tried reaching out for help, for mental help and stuff like that, and it was drug related. So, I got to a drug and abuse counselor who was trying to put me in a program that years later I ended up in. So, I still feel there is a lack of offering the service, if there is one. There's a lack of, 'Hey, these are the services that we have because we notice that you're a Latino, because we noticed that you're going through all of this stuff in your life because you're 19 years old that you just got HIV and there's probably something going on in your mind right now. So let us offer you some mental help.' There was never any of that. For me, it's common sense. If a 19-year-old gets HIV and you're looking at his drug history and you're looking at the fact, all of these factors along with it, like who's taking care of him? Why are we not assigned a case manager when cases are done, or they get like that? I was sure assigned to a County agent when I wasn't taking care of my STDs at the age of 22, because they didn't want me to become like a pandemic on my own. But what about my mental health before that? I'm not justifying by any anything that I've ever done, but just saying what about my mental health in the beginning?"

One participant shared a specific consideration for the Hispanic/Latinx community:

"I feel like mental health is not really popular in the Latino community itself. And with HIV, there comes a lot of stigmas. Even if you don't live in the United States, but in Mexico, it's HIV equals gay, is you're gay, you get HIV. You're gay, you're this, you're gay, you're that. So, it comes with a lot of stigmas. So mental health overall will be another issue that can compare to HIV, that is as big as HIV."

The role of mental health in access to care and treatment

Approximately 13% of PLWHA survey respondents (n=158) reported having dropped out of care for one year or more in the last 10 years, with the top reason reported being drug use (21%), followed by not knowing where to find services (11%), difficulty with health coverage (11%), and experiences of homelessness (11%; n=19).

It is important to highlight the connection between PLWHA's experiences with mental health issues that often lead to dropping out of care. Across conversations with HIV positive Hispanic/Latinx groups (women, including transwomen, and gay, bisexual, and MSM), survey and focus group respondents experienced depression, anxiety, and stress that they shared has often led to drug and alcohol use. While causality between mental health and drug use were not assessed through this study, survey responses show these two things to be prevalent in the HIV positive community. According to the American Addiction Centers, transgender people experience higher rates of depression and mental illness than other communities.⁶ Across the United States, as many as 30% of LGBTQ+ individuals report use of drugs and alcohol, compared with 9% in the general population.⁷ Discrimination and prejudice are drivers of daily stress experienced by this group, which can

⁶ American Addiction Centers. (2020, February 4). *Transgender and Addiction*. <https://americanaddictioncenters.org/transgender>

⁷ Ibid

contribute to higher rates of addiction in this community. Hispanic/Latinx women, including transwomen living with HIV who participated in the HIV Needs Assessment, report negative experiences with care in San Diego. They cite lack of understanding, judgmental attitudes, and lack of empathy from case managers and medical providers, who often seem to have no training in treating HIV positive transwomen, which requires trauma informed approaches.

One focus group participant shared what they described as the biggest disappointment related to their HIV diagnosis:

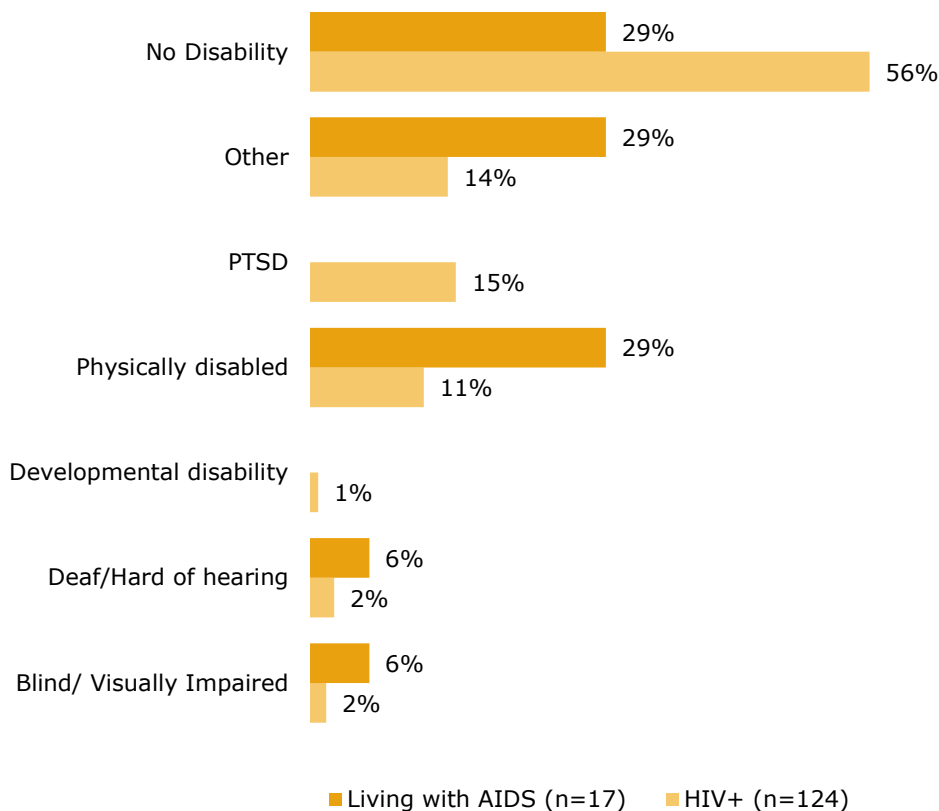
"When my little girl was born, I brought her in for her check-up and the doctor that was supposed to check her passed off her file to other doctors. In that moment I felt like I was this weird thing and thought it would continue to be that way always."

This and similar experiences shared by focus group participants highlight the need for increased cultural competency in case managers and service providers, to support their ability to serve all individuals who are HIV positive, with intentional and sensitive practices tailored to patients' intersectional identities.

Disability

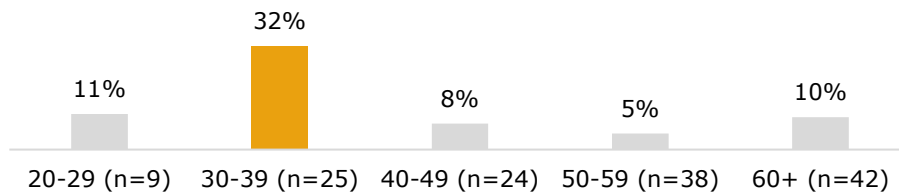
For survey respondents who are HIV positive, 44% indicate they have a disability and 71% who are living with AIDS indicated they have a disability (Exhibit 11). Of those who indicated they had an "other" disability that was not listed (n=21), 43% indicated a mental health issue, 10% indicated cancer, and 10% indicated autism.

Exhibit 11. PLWHA disability status



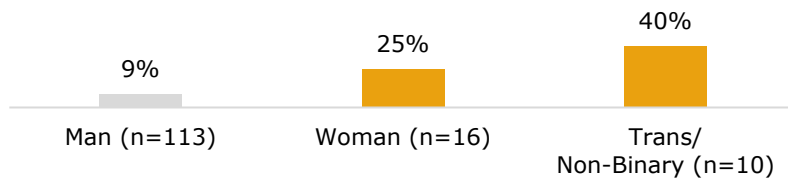
When looking at disability by other characteristics, 32% respondents aged 30-39 (n=24) indicated they had PTSD, compared to 5-11% for other age group (Exhibit 12).

Exhibit 12. PTSD by age for PLWHA



In addition, when looking at disability by gender identity, 25% of those who identify as women and 40% of those who identify as trans, non-binary or genderqueer indicated they suffer from PTSD compared to 9% of those who identify as men (Exhibit 13).

Exhibit 13. PTSD by gender identity



Coinfections

Survey respondents were also asked about whether they had been tested for other sexually transmitted infections (STIs) and if so, if they had been diagnosed with Hepatitis B, Hepatitis C, or Tuberculosis. For survey respondents living with HIV/AIDS (n=152 or 153):

20%

have had **Hepatitis B**

11%

have had **Tuberculosis**

12%

have had **Hepatitis C**

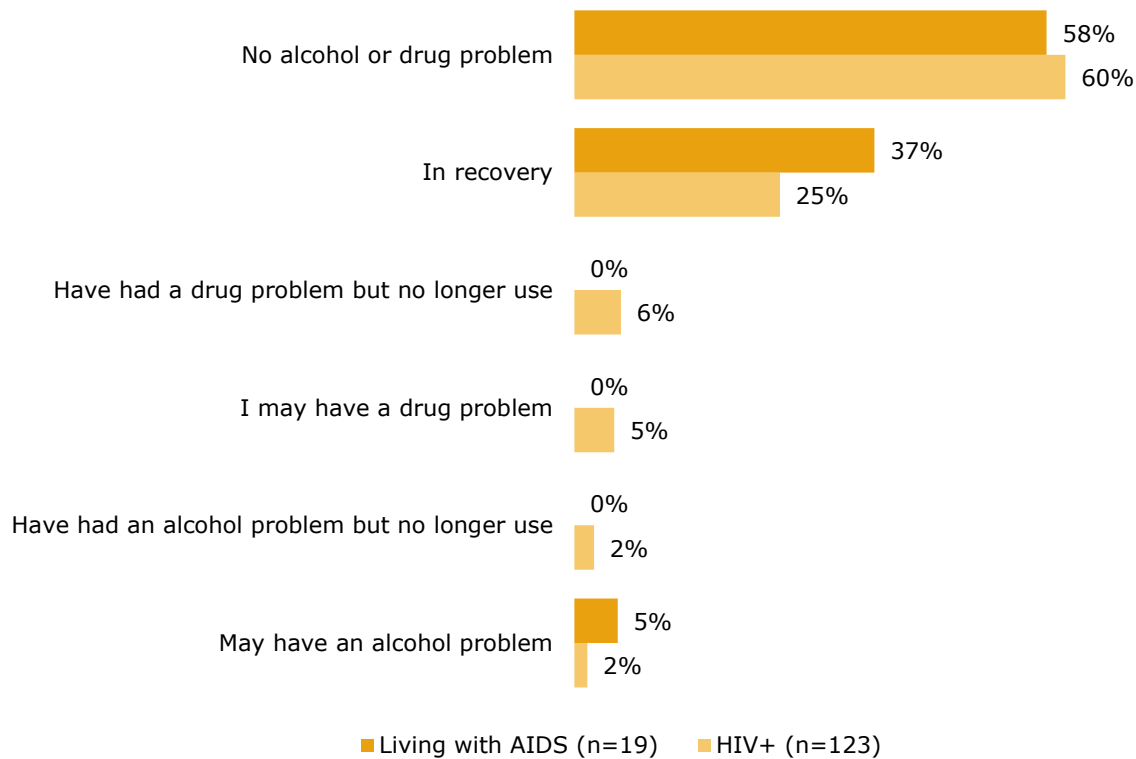
89%

have been **tested for STIs**

Substance Use

The majority of PLWHA respondents shared that they have not had a drug/alcohol problem (58-60%; Exhibit 14). However, when looking at this by race/ethnicity, 63% of Black/African American respondents (n=16) reported a history of drug/alcohol abuse compared to just 36% of White (n=62) and 35% of Hispanic/Latinx respondents (n=43; data not shown).

Exhibit 14. Substance use by HIV status



Of those who identify as HIV negative or are unsure of their status (n=22), 50% have not experienced alcohol or drug issues and 23% had a previous drug problem but are no longer using (data not shown).

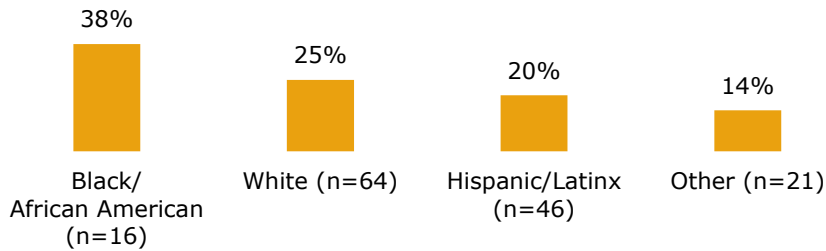
Given the current context of the COVID-19 pandemic, recovery for many has been difficult. In total, 6% of survey respondents living with HIV/AIDS have had trouble accessing alcohol and drug recovery services or have been unable to access them altogether (n=150). Focus group participants who had gone through recovery prior to the COVID-19 pandemic shared some potential opportunities and obstacles for people trying to enter recovery during this time:

"I feel really bad for people that are trying to come into recovery right now, because they don't have that personable experience that is so important when you're trying to follow that path. And there're online meetings 24 hours a day, you can get on a meeting at any time of the day, but it's just trying to get people to do it that is hard. And I honestly, I empathize with that a lot and I feel bad. Mental health, I'm really proud of the mental health being so open to do telephone and teleconference and stuff like that to help people with their mental health. I've seen clinics doing more of it. My doctor does more of it. I mean, so it seems like it's more broader now, because of the pandemic. They're starting to go into those avenues that they didn't do as much before, which I think is great. But it's still hard because it misses that personable piece."

Illicit Drug Use

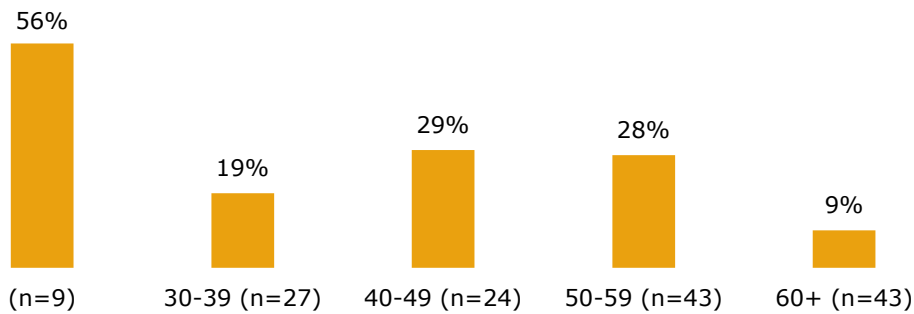
About one-quarter (24%; n=149) of PLWHA survey respondents indicate that they have injected illicit and/or non-prescribed drugs, with some variations by race/ethnicity and age (Exhibits 15 and 16). Black/African American respondents were slightly more likely to indicate they have injected illicit drugs compared other races/ethnicities.

Exhibit 15. PLWHA who have injected illicit drugs by race/ethnicity



More than half of respondents 20-29 years old have injected illicit and/or non-prescribed drugs compared to 10-30% for other age groups.

Exhibit 16. PLWHA who have injected illicit drugs by age



Social Determinants of Health

Social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) as well as the patterns of social engagement, sense of security, and well-being are all affected by where people live.⁸ In the context of HIV risk, social determinants of health can increase vulnerability to HIV infection and impact the care PLWHA receive.⁹ In addition to social determinants of health, it is also important to consider the impact of structural racism as a root cause of disparities as well as a factor that contributes to how PLWHA receive HIV care and treatment services.^{10,11}

Resources that enhance quality of life can have a significant influence on population health outcomes, including reducing risk of HIV infection and supporting PLWHA. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.¹² Addressing social determinants of health is an upstream, communitywide intervention to address the root causes and conditions (e.g., economic instability) that contribute to poor health.¹³

This section highlights findings related to housing, criminal justice, and employment. It is important to consider these factors in identifying supports that PLWHA may need to improve their access to regular treatment and care, adherence to treatment and ability to live healthy lives.

Housing

Focus group participants voiced concern that, despite the ongoing affordable housing crisis, the city continues to shift zoning requirements to fit "*Condos in backyard alleyways...and charging three times [their] rent for those units. [They] can tell you [they feel they are] eventually going to have to move because [they] can't, [they're] not going to be able to afford it.*"

⁸ Social Determinants of Health. (n.d.). Retrieved from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

⁹ Center for HIV Identification, Prevention and Treatment Services and Center for Strengthening Youth Prevention Paradigms. HIV prevention at the structural level: the role of social determinants of health and HIV. Los Angeles, CA; 2012. Retrieved from https://www.chla.org/sites/default/files/atoms/files/SYPP_Social_Determinants_FINAL.pdf.

¹⁰ Yearby, R. (2020). Structural Racism and Health Disparities. *Journal of Law, Medicine & Ethics*, 48(3), 518–526. <https://doi.org/10.1177/1073110520958876>

¹¹ Randolph, S., et al. (2020, Sep-Oct). How Perceived Structural Racism and Discrimination and Medical Mistrust in the Health Systems Influences Participation in HIV Health Services for Black Women Living in the United States South: A Qualitative, Descriptive Study. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/32868634/>.

¹² Yearby, R. (2020). Structural Racism and Health Disparities. *Journal of Law, Medicine & Ethics*, 48(3), 518–526. <https://doi.org/10.1177/1073110520958876>

¹³ Zook, K. G. (2019, October 29). When Talking About Social Determinants, Precision Matters: Health Affairs Blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>

Looking at housing status of survey respondents, 72% of those who identify as HIV positive (n=127) and 61% of those living with AIDS (n=18) rent or own their own home. Comparatively, 84% of the respondents who identified as HIV negative or are unsure of their status (n=19) are renting or own their own home. Additionally, 11% of the respondents living with AIDS (n=18) and the same percentage of those who identify as HIV positive (n=127) live in a treatment facility, supportive living facility, or group home. One person from each of those communities (HIV positive, living with AIDS, and HIV negative or unsure of their status) is currently unhoused.

As shared previously, 20% of survey respondents who are living with HIV/AIDS (n=152) indicated they had challenges accessing services to help with rent payment.

Urgent Housing issues

Survey respondents highlighted various urgent housing issues including lack of accessible housing for the formerly incarcerated, the need to yield more single-family occupancies to families with children, lack of affordable low-income housing for PLWHA near necessary medical services, lack of appropriate transportation, and high move-in costs. One barrier focus group participants highlighted is gatekeeping from system and patient navigators.

"When you go to some of these places, you have some people that will work with you and won't work with you. [...] And they're controlling those that get the first pick at housing vouchers and those that don't kind of thing."

When asked what kind of housing services or assistance are currently available for PLWHA in the San Diego community, focus group participants mentioned Mercy Housing, Partial Assistance Rental Subsidy (PARS), and Housing Opportunities for Persons with AIDS (HOPWA). Participants also expressed how difficult it is to access housing resources, in general. A number of participants highlighted various issues with PARS, and many have not heard anything about HOPWA in several years and would like to see more current information publicly available. One participant shared that the County is supposed to be administering those HOPWA funds and would like to see more transparent information around how frequently the County can apply to the federal government or HOPWA funds. They also wondered if the County asks for increases to those funds when they apply. Several participants expressed frustration and critical feedback around some of the current approaches to addressing the housing crisis in San Diego County. One participant shared that:

"The HIV Planning Council has had conversations with HOPWA representatives in the past and they have admitted that there is no housing in San Diego County that anyone can afford. This was a county-wide issue that the Board of Supervisors expressed the need to tackle several years ago and unfortunately this issue remains present."

Demographic-specific considerations

One focus group participant shared an important consideration for those currently unhoused and seeking housing support:

"For me, in the circles that I ran in, it was housing. Many people that I come in contact with were on the streets, homeless, and having unprotected sex and contracting the disease. And, once you told them that you could get housing, that the county, the state, whatever, would provide

housing if you go get services and to get off the streets, a lot of people would then say, "Yeah. I'll go and get help if you're going to help me that way. If you're going to help get me clean and off the street." Anyway, I would say housing is a resource that would help people, HIV positive, go get care."

For those experiencing houselessness, there are compounding factors that also affect their ability to maintain stable housing.

"It's kind of difficult to maintain, take your meds every day and sleeping on the streets and getting high or drinking and stuff at the same time. You tend to not take medication properly and then... I think that once I got stable housing, then I was able to maintain my regimen and take my medication every day, but it's really difficult when you're homeless."

Another important consideration was brought up for the aging population. Older individuals often look to affordable housing as alternatives to institutional settings like nursing homes or care facilities. When affordable housing opportunities arise, there is often a requirement that individuals live with a roommate. For many older individuals, a roommate situation can be unrealistic, especially for those who have lived on their own for most of their lives.

Criminal Justice

The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that people in prison are on average five times more likely to be living with HIV compared with adults who are not incarcerated.¹⁴ The World Health Organization (WHO) estimates the difference to be even starker, suggesting prisoners are 15 times more likely to be HIV positive than those who are not imprisoned. A systematic evidence review released in 2018 found recent incarceration is associated with an 81% increase in HIV risk.¹⁵

According to survey data, 23% of survey respondents who are PLWHA (n=150) have been convicted of a crime. Of those who were convicted of a crime and experienced incarceration, 26% who are HIV positive (n=23) and 57% of those living with AIDS (n=7), express challenges with getting medical care, housing, and HIV needs upon their release; 40% of those who identified as HIV negative or are unsure of their status (n=5) noted experiencing the same challenges.

Employment

Employment can have a positive impact on PLWHA. According to research, PLWHA who are employed are more likely to achieve optimal antiretroviral adherence compared to those who are unemployed.¹⁶

Overall, 36% of PLWHA are employed, 22% are not working but looking for a job, 21% are unable to work or disabled and 16% are retired (Exhibit 17). Comparatively, 73% of those who identified as HIV negative or unsure of their

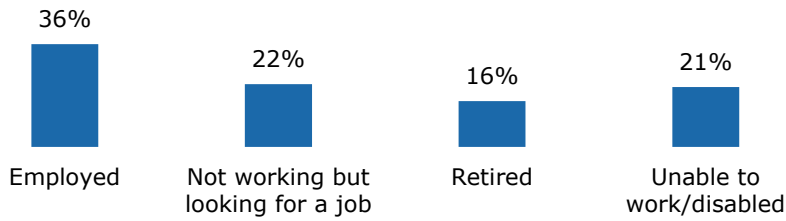
¹⁴ Prisoners, HIV and AIDS. (2019, October 10). Retrieved from <https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/prisoners>.

¹⁵ Prisoners, HIV and AIDS. (2019, October 10). Retrieved from <https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/prisoners>.

¹⁶ National HOPWA Institute, Promoting Employment for People Living with HIV/AIDS Presentation (2017). Retrieved from https://www.dca.ga.gov/sites/default/files/promoting_employment_for_plwha.pdf.

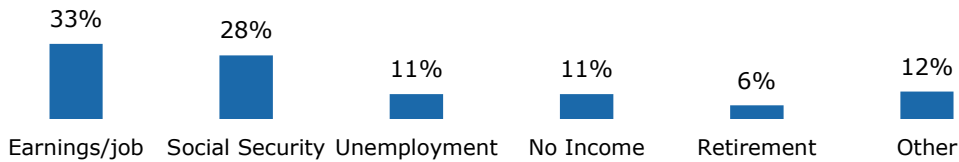
status (n=22; data not shown).

Exhibit 17. Employment status of PLWHA (n=151)



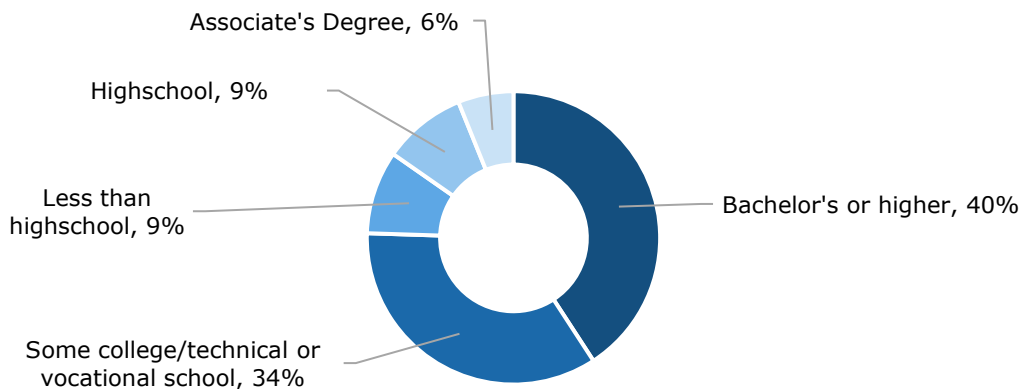
One-third of respondents who are PLWHA have income from their job (33%), Social Security (28%), unemployment (11%), retirement (6%) or other sources such as CalWORKS, general assistance/relief, family/friends (12%; Exhibit 18). The majority (68%) of the 22 survey respondents who identified as HIV-negative or are unsure of their status have income from their jobs as their main sources of income and 23% access Social Security (data not shown).

Exhibit 18. Main source of income for PLWHA (n=151)



Nearly half of PLWHA survey respondents had an associate’s degree or higher (46%) or had some college/technical or vocational school experience (34%; Exhibit 19).

Exhibit 19. PLWHA educational attainment (n=148)



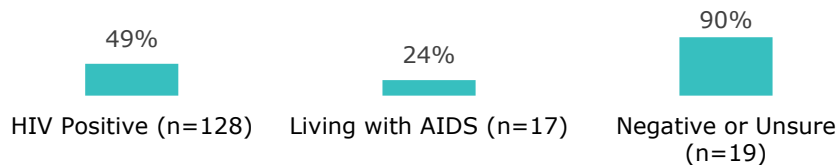
Testing and Prevention

The HIV Needs Assessment Survey also focused on understanding HIV prevention and testing needs in the community.

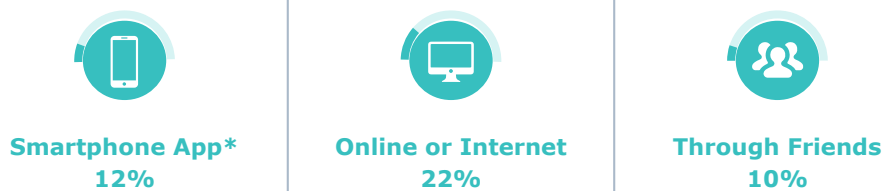
HIV Prevention

Survey respondents were asked about their recent sexual relationships to better understand how respondents are engaging with their partners. Overall, 51% of all respondents indicated they had oral, vaginal, or anal sex within the past three months, with 90% of those who are HIV-negative or unsure of their status indicating they had sex within the past three months (Exhibit 20).

Exhibit 20. Have had sex within the past 3 months by HIV Status



Of those that had sex within the past 3 months (n=82), 27% of all survey respondents had no new sex partners. Of those that did have sex, the most frequent places they met their partners was:



*the most frequently used apps included Grindr (31.9%), Scruff (12.5%) and DNA (29.2%; n=72)

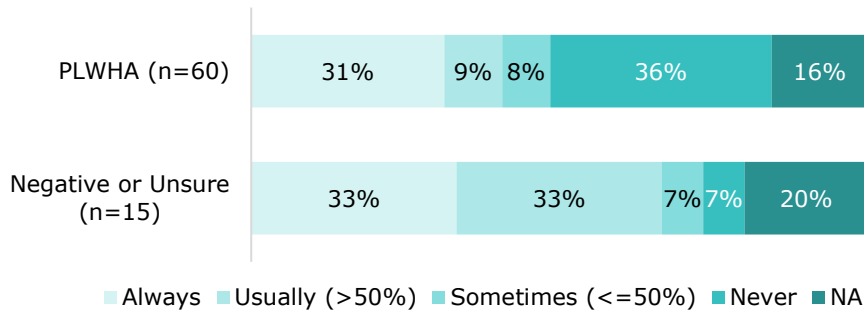
For those who had sex within the past three months, Exhibit 21 provides an overview of their partners' status. Regardless of HIV status, nearly one-third of respondents did not know the status of their sex partner(s) (32%).

Exhibit 21. HIV Status of Sex Partners

HIV Status of Sex Partners	HIV Status of Respondent	
	PLWHA (n=61)	Negative or Unsure (n=15)
Anonymous	7%	7%
HIV Negative on PrEP	13%	7%
MSM	15%	20%
HIV Negative not on PrEP	11%	20%
Accept or received money for drugs	3%	0%
HIV Positive	20%	13%
Unknown HIV Status	31%	33%

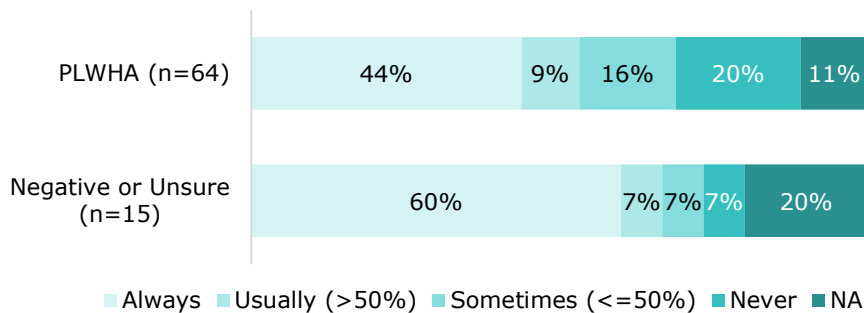
When looking specifically at PLWHA who had sex in the past three months, 36% never ask their partners their status while 31% always do. More than two-thirds of those who are HIV-negative or unsure of their status ask their sex partners their status always or usually (65%; Exhibit 22).

Exhibit 22. Ask sex partners if they know their status?



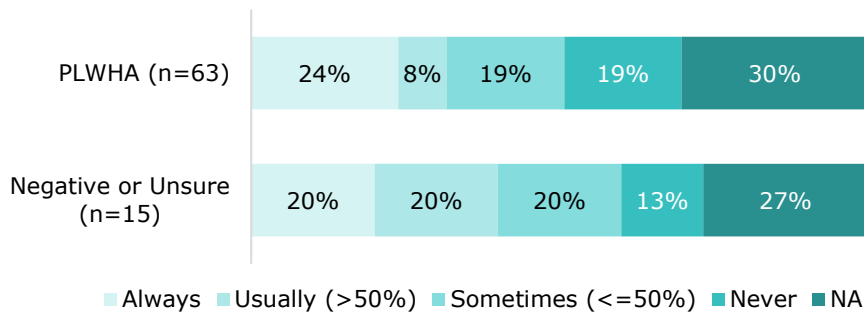
For PLWHA who had sex in the past 3 months, 44% always tell their partners their current status while 20% never do (Exhibit 23).

Exhibit 23. Tell partners your current status?



Nearly 20% of PLWHA also indicated that they never wear condoms even when they didn't share their status with their partners (Exhibit 24).

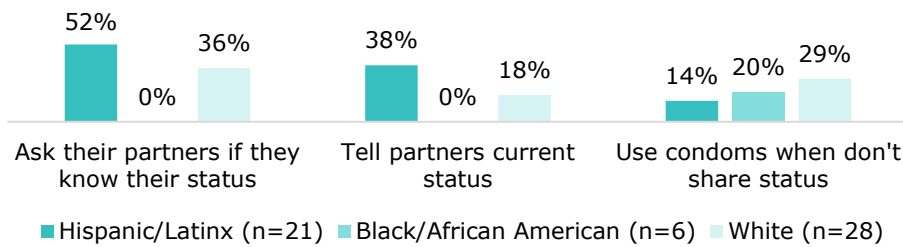
Exhibit 24. Use condoms when didn't share status?



Several focus group participants shared that not using condoms is a health issue for their community. Some shared that people don't like wearing condoms while others indicated that they might forget.

Exhibit 25 displays these data by race/ethnicity for PLWHA. Overall, Hispanic/Latinx respondents were more likely to never ask their partners if they know their status or tell partners their current status compared to White or Black/African American respondents. White respondents were more likely to say they “never” use condoms when they don’t share their status compared to Black/African American and Hispanic/Latinx respondents.

Exhibit 25. Percent of respondents who responded “never” to each question by race/ethnicity



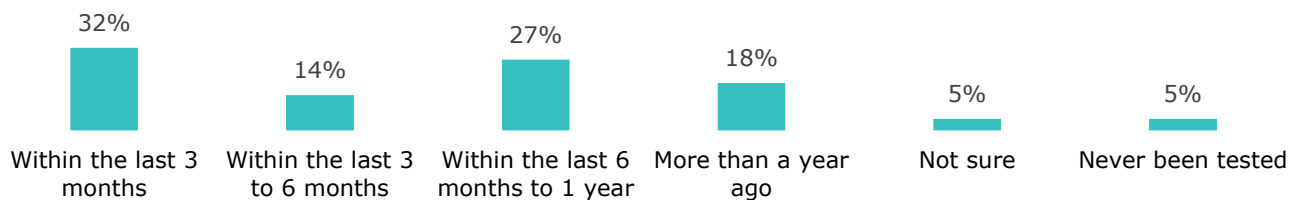
HIV Testing, PrEP and PEP use

The survey also aimed to better understand how those who are vulnerable to HIV infection are engaging in testing and other prevention measures such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis PEP use.

PrEP is a medicine that people who are vulnerable to HIV infection can take to prevent getting HIV from sex or injection drug use¹⁷. PEP is the use of antiretroviral drugs after a single high-risk event to stop HIV seroconversion.¹⁸

The survey looked at testing and PrEP and PEP use for those who are HIV negative or unsure of their status. Overall, 23 respondents indicated they are HIV negative or unsure of their status. Of those, 78% reported they get tested for HIV at least once per year. The majority have been tested for HIV within the past year (73%; Exhibit 26).

Exhibit 26. When was your most frequent HIV test? (n=22)

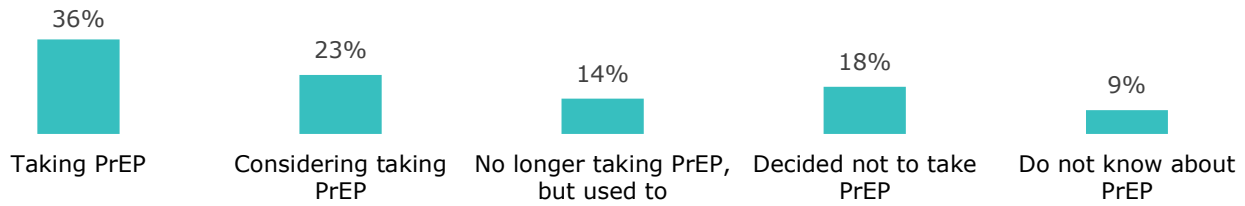


When asked about their use of PrEP, more than one-third (36%) of survey respondents who are HIV-negative or unsure of their status indicated they are taking PrEP (Exhibit 27).

¹⁷ Centers for Disease Control and Prevention (n.d.) What is PrEP? Retrieved from <https://www.cdc.gov/hiv/basics/prep/about-prep.html>

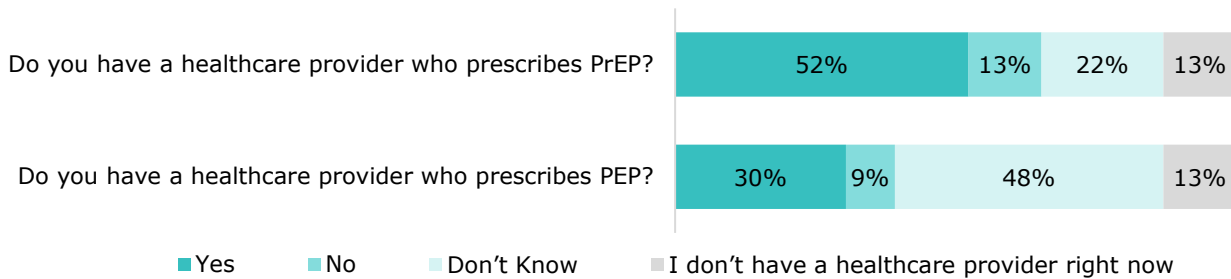
¹⁸ Centers for Disease Control and Prevention (n.d.) Post-Exposure Prophylaxis (PEP) <https://www.cdc.gov/hiv/risk/pep/index.html>

Exhibit 27. PrEP use among those who are HIV negative or unsure of their status (n=22)



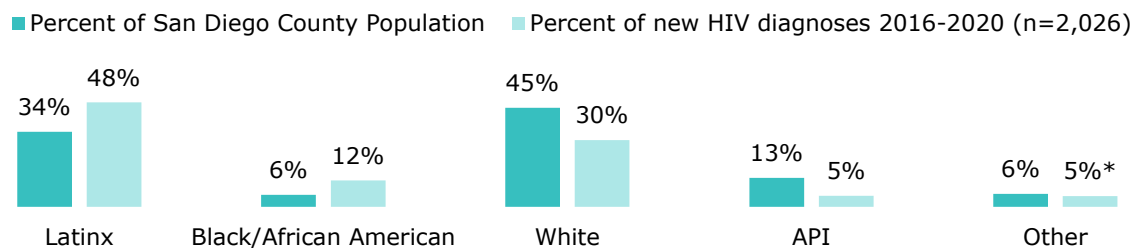
When asked whether they have access to a provider who prescribes PrEP, 35% were unsure or did not currently have access to a provider. A higher percentage (31%) did not know if they had a provider who prescribes PEP or did not currently have a healthcare provider (Exhibit 28).

Exhibit 28. Access to PrEP and PEP (n=23)



According to literature, Black/African American and Hispanic/Latinx MSM were significantly less likely than were White MSM to be aware of PrEP, to have discussed PrEP with a healthcare provider, or to have used PrEP within the past year.¹⁹ In San Diego County, Black/African American and Hispanic/Latinx individuals make up a disproportionate amount of new HIV infections (Exhibit 29).

Exhibit 29. Percent of new HIV diagnoses by race/ethnicity in San Diego County²⁰



¹⁹ Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (2019, September). Racial/Ethnic Disparities in HIV Preexposure Prophylaxis Among Men Who Have Sex with Men- 23 Urbans Areas, 2017. Retrieved from <https://www.cdc.gov/mmwr/volumes/68/wr/mm6837a2.htm>

²⁰ United States Census Bureau QuickFacts. Population Estimates July 2019. Retrieved from: <https://www.census.gov/quickfacts/fact/table/sandiegocountycalifornia,CA/PST045219>

Although only 23 respondents who are HIV negative or vulnerable to HIV infection responded to the survey, it is important to note the disparities that exist in PrEP use.

Barriers to testing

Through focus groups, participants shared several barriers to testing including stigma and fear of finding out they are HIV positive; cost, especially for those who do not have insurance or information about testing; not knowing where to get tested; stigma around getting tested; and PrEP use makes people less concerned about getting tested for HIV. It was noted that transwomen also have challenges in accessing providers who understand their unique needs. For example, interviewees shared that along with stigma, transwomen also have challenges due to inaccurate identity documents, violence experienced by trans people, discrimination, including by healthcare providers, who often do not take the time to get to know and understand the trajectory of a trans person's life and healthcare experiences. Therefore, there is a need for more visibility around safe spaces for transwomen to be tested.

Specific communities also highlighted challenges their peers face in accessing HIV testing. Hispanic/Latinx focus group participants shared that sometimes individuals may cross the border for affordable care. They also shared that there is a belief in the Hispanic/Latinx community that only gay people get HIV. This makes it challenging for Latinx women living with HIV, especially in trying to communicate their status with partners.

Black HIV positive focus group participants shared that having testing centralized in Hillcrest makes it challenging because many Black/African American men do not feel comfortable coming to Hillcrest for testing. A similar sentiment was shared in by Hispanic/Latinx focus group participants. Hillcrest is a neighborhood in San Diego often associated with the LGBTQA+ community, as it is an area lined with gay bars, pride flags, and is host of the annual Pride Parade, which is considered the largest single-day civic event in the region.²¹ For communities where sexual orientation is stigmatized and taboo, such as Hispanic/Latinx and Black/African American communities, going to the Hillcrest area to receive services feels too risky for some. Additionally, some men do not feel comfortable being open about their sexuality and therefore do not want to be associated with providers who do HIV testing.

Across groups, focus group participants shared that there used to be mobile testing clinics, but they see them less. They felt that having these available, especially if discreet, would allow easier access to testing.

²¹ San Diego Pride (2021) Parade. Retrieved from: <https://sdpride.org/parade/>

Recommendations

Based on findings from both the Needs Assessment survey and focus groups with PLWHA, several key recommendations emerged. While the number of respondents for the Needs Assessment survey hinders the ability to test for statistical significance of findings, trends that emerged through focus groups, interviews and the survey are similar to those seen in previous years (2017 and 2014). Given participation in this study was impacted by the ongoing COVID-19 pandemic, we recommend the Needs Assessment survey be revised to a shortened version that prioritizes key questions and is conducted at an interim point between 2021 and 2023, when the next full Needs Assessment would be due. Additionally, we recommend that the outreach for the following HIV Needs Assessment focuses on reaching the underrepresented populations, including Black, Hispanic/Latinx, transgender, women, gender-queer and non-binary. The following are key recommendations based on findings from the Needs Assessment.

Trauma informed care and sensitivity training are imperative for all providers working with the HIV/AIDS community. One need highlighted across the conversations with various groups is that many PLWHA focus group participants feel that providers, including health care providers and case managers, do not fully understand how to support HIV positive individuals. Most often, they cited a lack of understanding of their experiences and culture, especially for minority and marginalized groups (e.g., Hispanic/Latinx people and women, including transwomen). One participant said specifically that:

"In San Diego, there is a need for 'sensitization' of medical personnel; they feel so uncomfortable and don't know how to talk to trans people; trans women show up and, based on their appearance, doctors and nurses don't know how to talk to them, they don't know how to interact with trans people...this has such negative implication for a person's mental health. [...] they need to better understand what are the situations that trans people experience".

Being culturally attuned to a person's experiences supports a more humane and effective delivery of health care and case management services; it is imperative to the dignity of PLWHA to feel not just seen, but understood and respected by everyone in the community, especially providers who play such a fundamental role in their access to care and treatment.

Improving supports for PLWHA experiencing substance use or mental health issues

Survey and focus groups respondents shared past and current experiences dealing with substance use and mental health issues. Given the unique circumstances of PLWHA, it is important that supports exist for PLWHA who are experiencing these issues, to ensure they have access to regular care and treatment and are connected to resources they may need.

Ideal substance use services for PLWHA

According to focus group participants, ideal substance use services would ensure that staff who work at these organizations are trained to support PLWHA who are dealing with substance use issues. Ideally, trainings would be trauma-informed and

healing-centered to best equip staff with the tools and capacity to hold more empathy and remove judgement in their interactions with clients. One focus group participant shared how it would be helpful to have staff who understand that people are experiencing unique challenges.

"I guess to have a person that understands people at different levels. Because you have people who use drugs at different levels. Some are [functional], some can't. Some can hold a job, some can't when they do it."

Services like drop-in centers would be better resourced so that staff have the tools to support clients' whole selves and make sure they feel seen and safe while not perpetuating harmful, policing, or stigmatizing practices. Within the context of the San Diego community, participants see a need to invest in more detox facilities that are rooted in harm reduction and that integrate peer support from workers who have gone through detox themselves. One focus group participant shared their vision for having a drop-in center where they could get the needed support.

"I think something like a monitored drop-in center where someone who's seeking help for substance [use] could come in and get some advice or just be able to speak to somebody... just have a place to drop in and just chat with somebody."

Providing specific mental health support for PLWHA and offering both telehealth and in-person options

According to focus group participants, ideal mental health services would allow individuals to access, either in-person and via telehealth mental health services. The shift to telehealth due to COVID-19 this past year has increased peoples' access to mental health services. Telehealth services also allow people to access care discreetly, with less fear of externalized shame or stigma from friends, family, doctors, or themselves compared to when trying to find in-person mental health support. Telehealth services have also made it much easier for those who do not have accessible transportation and eliminates the cost of travel. One challenge that telehealth services exacerbate, however, is the isolation and loneliness that people can experience without in-person connection and community. This can also have a disproportionate impact on people experiencing mental health issues. Sustaining a hybrid model with both telehealth and in-person services allows more people to access services while still providing opportunity for those looking for more personal connection and co-healing.

Ideal mental health services would also be more comprehensive and preventative. Given the co-occurring nature of mental health issues and HIV infection, participants feel services must be holistic and mental health issues need to be addressed as a systemic public health issue:

"The main problem we're having with our mental health program is that we have a lot of homeless and a lot of those people have, besides mental problems say, it's a mental and a substance abuse problem. And that's something that needs to be tackled. It's a systematic problem in the County itself... These problems have gotten so bad that we really need an overhaul in our whole government. I just don't see any hope for it. I'm sorry. I just don't see how we can sit there and fix it without a major government effort and major overhaul of everything."

To expand on the currently available emergency hotlines where people can call for mental health services or in home supportive services, focus group participants

would like to see mental health hotlines specifically for PLWHA:

"I was having a mental health breakdown and they do have hotlines where you could call for mental health services, just for FYI. You don't have to have any insurance; you just got to call the mental health hotline and reach out or you could call in home supportive services. They're available, come out and get someone to come out and assist you. We are in COVID and a lot of people don't want to come out...but there is some services, you can always call the 1-800 mental health hotline."

"They need [a mental health] hotline for people dealing with HIV."

One participant shared some of their dreams for collective community care:

"I always wondered what it would be like to be able to offer cleaning services to women in our situation. With all the other amounts of things that are going on in a person's life sometimes I know me personally, I will let my house turn into garbage. I just forget to do the dishes, I don't throw out the trash, I don't do the floor, I don't do anything. Especially if I'm caught in deep in my depression. And I was like, 'If we had something that offered something just as simple as that, I'll come help you do some laundry or I'll come help you get the dishes out the sink.' Those kinds of things would not only help with I think someone's mental health, but even their physical wellbeing. And even for those who suffer from neuropathy and different things going on there's days when you just can't get up. And I don't know that was just something I had thought about, but I know it doesn't make any relevance right now during COVID, but just something FYI for the future."

Although there are mental health hotlines and in home supportive services available for people with HIV that do not require insurance in San Diego County, not all focus group participants were aware of these resources. It would be beneficial to PLWHA to ensure these services are more widely accessible within the community.

Expand housing access for PLWHA

Focus group participants shared various suggestions for how to address the housing crisis and increase access for PLWHA to suitable affordable housing in their communities. One suggestion they laid out for themselves and other community members was to continue to advocate for what they need. Another participant suggested to push community developers to move the work of building affordable housing units away from the coast and further toward the East, where there is more land available. One participant expressed frustration that, although builders who take U.S. Department of Urban Development (HUD) funds are required to have a certain number of units set aside for low-income people, because the interest rates are so low, very few builders are taking HUD funds. Participants understand that builders may be less inclined to apply for HUD funds when it means they will have to sacrifice some of their profit. To tackle this issue, participants recommended that either the County change the building codes or ensure that building development is contracted to require it.

Focus group participants laid out the specific need for more money allocated to permanent housing for PLWHA. They touched on the discrepancies between the budgets for emergency housing and the budgets for permanent housing like Partial Assisted Rental Subsidy (PARS).

"I think we need more funding in housing in particular. The fact that we've gone from half a million to 1.3 million in temporary housing and yet PARS only went up \$200,000, I think is a shame, the emergency housing budget used to be half of PARS. Now it's almost three times that, that is crazy."

The hotel voucher is not a permanent solution and focus group participants echoed thoughts around the need for themselves and the community to step in, fix it, and demand for more than band-aid solutions:

"We have to have permanent housing for our people. And we need a better subsidized system. This thing about PARS being a temporary program. The PARS program, we actually do it as a better program than Section 8. The guy literally sat there and stated that they tried to negotiate with people, but, and people are getting those vouchers and not using it. So this is a crazy system. If you get... you have a program in which people are getting the vouchers and they can't find something to use it on, what happens to the money?... That's why there's only 87 people on the HOPWA program. And that should be increased and should have been increased to be increased yearly, I think, but this is all beyond what we can do as an HIV Planning Group."

Addressing social determinants of health to improve outcomes for PLWHA

There is a growing recognition that truly improving the health of our nation requires partnership and breaking down silos among healthcare, public health, and social services, as no single entity is able to tackle the social determinants of health on its own. Traditionally, these entities have operated with distinct and separate missions: public health has been responsible for population health and disease control, the healthcare sector has provided clinical care, and social service agencies have addressed access to the resources and services necessary for healthy living (e.g., housing, education, and transportation). Our nation's growing healthcare [costs](#) and [poor outcomes](#), are evidence that this siloed approach is not working.²² Like many health issues, addressing structural barriers to health, improving daily living conditions, and addressing the inequitable distribution of power, money and resources should all be addressed to improve outcomes for PLWHA and to develop HIV prevention programs.²³

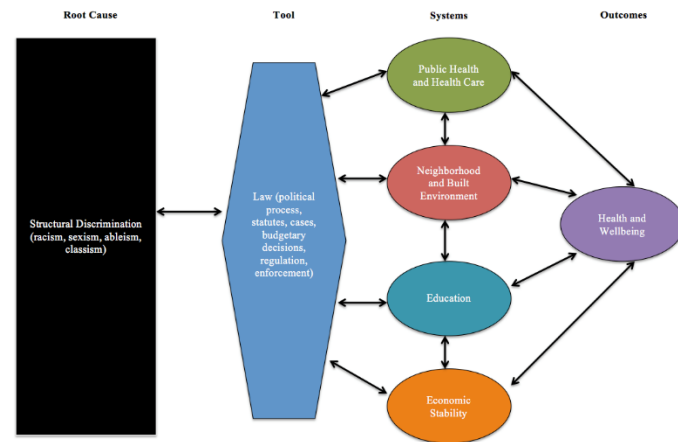
²² Zook, K. G. (2019, October 29). When Talking About Social Determinants, Precision Matters: Health Affairs Blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>.

²³ Dean, H.D. and Fenton, K.A. Addressing social determinants of health in the prevention and control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections and Tuberculosis. Public Health Reports, 2010, 125.

The Root Cause: Structural Racism

In addressing SDOH to develop HIV prevention strategies and to improve outcomes for PLWHA, it is important to acknowledge that structural racism is the root cause of racial health disparities.²⁴ Yearby developed a revised SDOH framework that highlights the connection between structural discrimination, law, systems, and racial health disparities.²⁵

In addition, the SDOH concept is also too often framed with a solely negative connotation. For the purposes of advancing health equity, it is essential to remember that there are social factors that confer health benefits to certain populations and cause harm in others. For example, the Centers for Disease Control and Prevention’s Healthy People 2020 initiative identifies economic stability as one of five SDOH areas. Just as economic stability can confer health benefits, economic instability can create health risks and challenges.²⁶



Revised SDOH Framework created by Raquijah Yearby (2020)

The new model that Yearby developed positions racism as the root cause of the SDOH and centers understanding and addressing structural discrimination in tandem with addressing the social and environmental context in which people live, as prerequisites for improving their health and wellbeing. Therefore, prior to developing interventions to improve the health conditions of San Diego County residents living with or vulnerable to HIV/AIDS, it is crucial to first identify the current status and trends of key social determinants that affect the health of residents. Given that new HIV infections are disproportionately seen among Black/African American and Hispanic/Latinx men in San Diego county, it is important to acknowledge and address how structural racism is the root of this disparity.

²⁴ Yearby, R. (2020). Structural Racism and Health Disparities. *Journal of Law, Medicine & Ethics*, 48(3), 518–526. <https://doi.org/10.1177/1073110520958876>.

²⁵ Yearby, R. (2020). Structural Racism and Health Disparities. *Journal of Law, Medicine & Ethics*, 48(3), 518–526. <https://doi.org/10.1177/1073110520958876>.

²⁶ Zook, K. G. (2019, October 29). When Talking About Social Determinants, Precision Matters: Health Affairs Blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>.

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