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Facilitators and Barriers to Effective Scale-up of Evidence-Based Nonprofit-Level HIV Prevention and Treatment Interventions Among Black Men who have Sex with Men (MSM)

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CHANGE THE WORLD FROM HERE

Facilitators and Barriers to Effective Scale-up of Evidence-Based Nonprofit-Level HIV Prevention and Treatment Interventions Among Black Men who have Sex with Men (MSM)

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Capstone Research Report Submitted in Partial Fulfillment
of the Requirements for the
Master of Nonprofit Administration Degree
in the School of Management
directed by Dr. Richard Greggory Johnson III

San Francisco, California
Spring 2023

Abstract

Since the scale-up of HIV/AIDS prevention evidence-based interventions (EBIs) has not been simple in nonprofit settings, it is crucial to examine processes that occur in the translation of the EBIs into practice that affect successful implementation through the lens of nonprofit principles and practices. This paper examines the facilitators and barriers to effective scale-up of evidence-based HIV prevention and treatment services for nonprofit health organizations that serve Black men who have sex with men (MSM). I interviewed nonprofit health organizations (n = 4) engaged in the global response to end the HIV epidemic, specifically those who provide HIV prevention and treatment services for Black MSM between the ages of 18 and 50. The expert interviews assessed facilitators and barriers to HIV prevention and the perceived importance of ending the HIV/AIDS epidemic in the Black community as a public health threat by 2030 as part of the Sustainable Development Goal. Based on the findings, I advocate and recommend creating a new model for an improved nonprofit structure that supports partnership, learning collaboratives, and best practices and research for Black MSM.

Keywords: HIV/AIDS, Black MSM, Prevention Services, Evidence-Based Interventions, Sustainable Development Goal

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I want to thank my family, friends, and all my professors in the Master of Nonprofit Administration program. I owe a debt of gratitude to my advisor, Dr. Richard Greggory Johnson III, for his academic encouragement and guidance, advice on research design, and thought-provoking recommendations on this project. In addition, I wish to express a heartfelt thank you to my mentor, Dr. Bisola Ojikutu, for her scholarship, mentorship, and friendship.

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Section 1. Introduction

HIV persists as a serious public health challenge in the U.S. Last year, the number of new HIV infections in the U.S. rose by 16% (CDC, 2022). Black Americans are the most affected racial or ethnic group, with a lifetime HIV risk of 1 in 20 for men (compared to 1 in 132 for whites) and 1 in 48 for women (compared to 1 in 880 for whites). Among Black Americans, Black MSM continue to be most affected by the HIV epidemic in the U.S. (CDC, 2022). If current HIV diagnosis rates persist, about 1 in 2 Black MSM will be diagnosed with HIV during their lifetime (CDC, 2022). These estimates are a sobering reminder that Black MSM face an unacceptably high risk for HIV and if we don't scale up HIV prevention efforts in this community now, hundreds of thousands will be diagnosed with HIV in their lifetime.

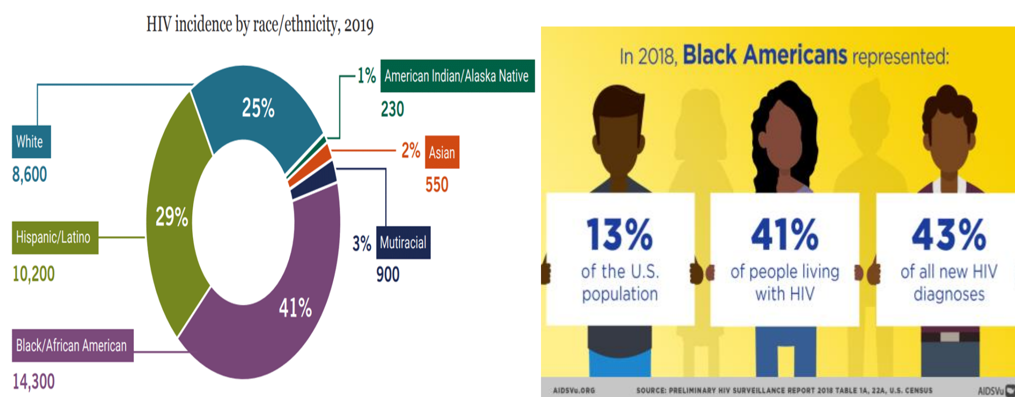

Figure 1: Source: CDC, HIV incidence and prevalence in the U.S., 2015–2019, HIV Surveillance Supplemental Report.

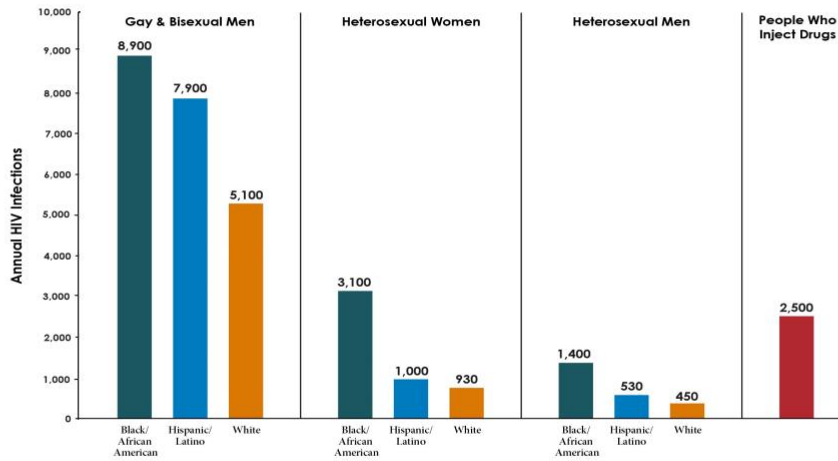

Figure 2: Source: CDC, New HIV Infections by Race and Transmission Group

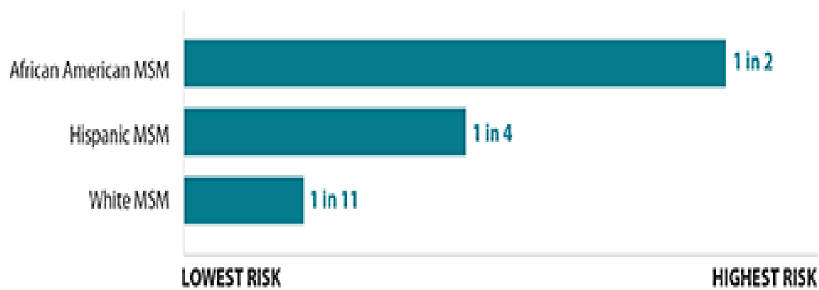

Figure 3: Source: CDC, Lifetime Risk of HIV Diagnosis among MSM by Race/Ethnicity

The extremely high risk of HIV infection for Black MSM portends further devastation unless prevention efforts among this population become much more successful. There is a need for community-level risk-reduction interventions with proven efficacy among this population. However, few such interventions have been developed or adapted for Black MSM. In addition, there are salient contextual factors in the lives of Black MSM—especially racism and sexual prejudice—that can diminish their access to resources needed to protect them from HIV transmission, thus presenting formidable barriers to prevention (Zamboni & Crawford, 2007). These barriers have not been well described in the literature because HIV prevention research has typically not focused on minority men within the general MSM population (Zamboni & Crawford, 2007).

A comprehensive and practical approach to understanding and addressing these challenges is needed to better understand the health status and health education needs and guide the development of effective HIV prevention and treatment programs for Black MSM. Nonprofit organizations promise to be an effective treatment and prevention model to reach this key population adequately. Studies have shown that when nonprofit health organizations are empowered to identify the challenges to designing and implementing effective prevention and intervention strategies, they have a greater willingness to accept and implement interventions than those imposed strictly by upper management resulting in greater sustainability and community impact (Kegeles et al., 2015).

Research Question and Outcomes

To help design an approach, I wanted to conduct open-ended expert interviews with nonprofit leaders and staff centered around perceived facilitators and barriers to implementing HIV prevention and treatment programs and their commitment to ending the HIV epidemic in the Black community as a public health threat by 2030 as part of the Sustainable Development Goal. My research question was, "what are the facilitators and barriers to effective scale-up of evidence-based nonprofit-level HIV prevention and treatment services in Black MSM?" I then hypothesize that nonprofit health organizations who identify their own challenges and barriers to designing and implementing effective HIV prevention and intervention strategies have a greater willingness to accept and implement interventions than those imposed strictly by upper management.

This paper expands on previous studies to better understand these challenges and develop effective organizational development plans to help nonprofit health organizations work together to meet the needs of Black MSM and also create a new model for an improved nonprofit structure that supports partnership, learning collaboratives, and best practices and research among this population.

Section 2: Literature Review

The homophobic stigma present in the U.S. has a pervasive impact on Black MSM (Montgomery et al., 2003). Despite evidence that Black and White American

heterosexuals report similar levels of homophobic sentiments, Black MSM have been reported to exhibit higher levels of internalized homophobia and less frequently disclose their gay orientation than MSM of other racial groups (Stokes & Peterson, 1998). Black MSM are more likely than White MSM to report having sex with women, to think that their friends and neighbors are against homosexuality, and to self-identify as straight.

One of the reasons why Black men have higher levels of internalized homophobia may be due to the pervasive impact of organized religion in their life (Woodyard et al., 2000). Similar to White religious organizations, Black churches tend to oppose homosexual activity. Nevertheless, Black MSM tend to be more involved in religious communities than White MSM, which causes them to be more secretive about their same-sex behavior (O'Leary et al., 2007). Moreover, homophobic teachings received in churches cause Black MSM psychological pain, likely worsening their already-present experiences of internalized homophobia (Woodyard et al., 2000).

Evidence suggests that internalized homophobia challenges community-based HIV prevention and treatment efforts. Greater internalized homophobia is associated with lower awareness of HIV prevention services and fewer changes in the perception of one's ability to use condoms (Huebner et al., 2002). Among Black MSM, higher degrees of psychosocial distress and gay identity are connected to higher levels of sexual risk-taking (Crawford et al., 2002). Similarly, Black MSM report greater frequency and severity of daily hassle associated with their gay identity than their White counterparts

(*Ethnic-Racial Differences in Psychological Stress Related to Gay Lifestyle among HIV-Positive Men - PubMed*, n.d.).

Black MSM and bisexual men have been reported to have significant mental health issues that are related to their sexual orientation (Richardson et al., 1999). The rates of depressive distress among Black MSM were reported to be higher than those found in previous studies of gay male populations that were mostly White (Cochran & Mays, 1994). In addition, loneliness, despair, rage, anxiety, and other negative health effects have all been linked to rejection in ethnic minority MSM (Greene, 1994).

Evidence shows how racism affects the quality of life of Black MSM. In a study of 2645 participants (nearly 60% of whom were men) at Black gay pride events in nine US cities, the type of discrimination reported most commonly by men was based on racial/ethnic identity (57%), especially within the mainstream (mainly White) gay community (Pastrana, 2016). Also, Black MSM have complained about encountering prejudice at gay bars, clubs, and social gatherings (Icard, 1986). The study also found that Black MSM's lifetime experiences with racial discrimination are highly connected with sexual problems such as maintaining affection for a partner, issues with sexual stimulation, orgasm, and premature ejaculation (Zamboni & Crawford, 2007).

Despite these pervasive negative experiences, some research findings suggest that resiliency factors help buffer the impact of homophobia and societal racism on Black MSM. Studies have found counterintuitive associations between social support on the one hand and mental health and sexual risk for Black MSM on the other. For

example, a small pilot study found that Black MSM who reported lower levels of social support also reported fewer HIV-risk behaviors (Ostrow et al., 1991). Among White MSM, on the other hand, low social support was linked to increased HIV-risk behaviors. The surprising finding for Black MSM was attributed to racial differences in social-support systems and to the possibility that the measures of social support were less culturally relevant for Black men (Ostrow et al., 1991).

Similar findings were found in a small comparative study of White and Black MSM, which discovered significant negative relationships between Black men's mental health and social support from family and friends but strong positive relationships for White men. The negative impacts of social and physical stressors (such as health symptoms, everyday problems, and life events) on depressive mood, on the other hand, were buffered by psychosocial resources, according to research of a community sample of Black gay, bisexual, and heterosexual men. Other evidence suggests that racial and sexual identity are crucial factors in the emotional health of Black MSM. Black MSM reported greater self-worth, greater HIV prevention self-efficacy, and stronger social support when they had a positive sexual and racial identity.

Barriers to health care access and use constitute systemic disadvantages that pose severe problems for Black MSM. Blacks are less likely than other HIV-positive MSM to have access to private clinics, to discuss HIV-related health concerns with their doctors, to use outpatient health services, to report satisfaction with medical staff in outpatient settings, to report the absence of nondiscriminatory practices among

medical staff, to believe that outpatient medical services are of high quality and competence, to have access to medications, and to trust their doctors (Halkitis et al., 2003).

Nonetheless, HIV-positive Black MSM are just as likely as HIV-positive White MSM to report having health insurance, using inpatient services, or having been recently hospitalized (Jacobson et al., 2001). Given that there is a significant correlation between Black racial identity and poverty, the link between poverty and socioeconomically associated health disparities may help explain why Black MSM have less access to healthcare (Krieger et al., 2005). Poor health outcomes, such as lack of health coverage and poor care quality, have been linked to poverty (Reif et al., 2005).

Furthermore, incarceration represents a further significant structural factor related to HIV risk for Black MSM (Jones et al., 2008). Jones et al. discovered that recently incarcerated men were noticeably more likely to report unprotected anal sex in a study of Black MSM between the ages of 18 and 30. In contrast, other studies found that within their sample of Black MSM, HIV status was not related to incarceration and that reports of anal sex among incarcerated participants tended to be higher outside of jail than during incarceration (Wohl et al., 2000). Another study also found that a majority of the incarcerated men in the study population contracted HIV before incarceration(CDC, 2006).

Section 3: Methods and Approaches

Methods: The data collection for this project focused on how nonprofit organizations implement HIV prevention and treatment programs and their commitment to ending the HIV epidemic. It focused on open-ended expert interviews with nonprofit leaders and key staff about their perceived facilitators and barriers to implementing HIV prevention and treatment programs in Black MSM.

Sampling Selection: I chose four nonprofit organizations, namely Fenway Health, The National LGBTQIA+ Education Center, AIDS Action Committee, and Multicultural AIDS Coalition, because they are committed to improving the health and well-being of LGBTQIA+ people and BIPOC individuals, particularly Black MSM through access to the highest quality health care, education, research, and advocacy. Their leadership and staff maintain values that collectively express their principles, support their mission, and are the standards to which they hold themselves and their actions accountable: Diversity, Equity, Inclusivity, Community, and Compassion.

Collection: To begin this research, I recruited the nonprofits (N=4) by word-of-mouth and flyers from local community-based organizations and events. Interviews were conducted at community-based settings and assessed each organization's ability to deliver effective HIV/STIs community-based prevention interventions based on the following guiding principles: evidence-based activities, demonstrated effectiveness, compliance, transparency, collaborations and partnerships, quality assurance, quality improvement, and accessibility.

Interviews: I conducted four interviews, which were semi-structured to help me understand the landscape of HIV care disparities in the nonprofit sector and provide additional information and examples for my overall research. A semi-structured interview process was used to keep some level of consistency and to help keep the focus on specific issues from their perspectives.

From the interviews, I was able to glean new information that supported my research, findings, discussion, and areas for future research. A common theme emerged from the interviews: All the nonprofit organizations faced a variety of issues due to a slow recovery from COVID, including staff shortage and turnover, adapting back to fully in-person programming, providing community support for disparities in access to financial assistance and healthcare, and limited opportunities to collaborate with community-based organizations in the same capacity pre-pandemic. However, they are learning and adapting from the previous years, not allowing these challenges to deter their efforts from serving their communities, particularly those persons most vulnerable. While recognizing the challenges ahead, each interviewee maintained that their organization is doing its best to ensure that Black MSM and those at risk of HIV infection have access, either directly or via referral, to HIV/STI testing and counseling, outpatient mental health programs, harm reduction services and substance abuse treatment, nutritional services, and specialty medical care.

Section 4. Data Analysis

All four participating organizations reported their biggest challenge as high staff turnover and shortage caused by the COVID-19 pandemic (see table 1 below). They identified inadequate staff training and a lack of standardized sexual health navigation and training as well as community empowerment training, as reasons why new hires lack training and technical know-how on how to run HIV prevention and treatment programs effectively. Three participants reported a need for formal plans to support orientation and transfer of duties during staff transitions. One participant agrees that developing jurisdiction-level standardized health navigation and training programs would help address this challenge.

Despite recent recommendations that nonprofit funders should allow flexibility with their funding and make accommodations for HIV testing and retention in care incentives (Saint-Cyr et al., 2022), all four participants reported a lack of funding flexibility in incentive provisions for HIV testing and treatment as another challenge. Traditionally, economic hardship and lower socioeconomic status are known barriers to HIV testing and retention in care (Krieger et al., 2005). A recent study by Dr. Miguel Reina Ortiz, a University of South Florida College of Public Health (COPH) associate professor, and Neielle Saint-Cyr, on how incentive-based interventions can promote HIV testing and care showed positive results—meaning the incentives showed uptake in HIV care (Saint-Cyr et al., 2022). “Incentives caused people to be more consistent with HIV testing, taking their medication if diagnosed with HIV and meeting with their health care

providers. I believe incentives work because they help motivate people and may help provide access to care for some individuals," Saint-Cyr noted. For people who are unable to travel to providers to receive care, incentives (which can sometimes be cash, gift cards, and bus passes) may help them pay for travel expenses. Incentives may also help those who are unable to purchase food. Saint-Cyr et al recommend using incentives to promote HIV testing and care, particularly among Black MSM living in the U.S. There is a need for federal, state, local, and individual funders to allow flexibility with their funding and make accommodations for HIV testing and retention in care incentives.

Other challenges brought up by the participants during the interviews include:

1. Small workspaces: Three participants expressed a need for a larger, more dedicated program space for in-person work and outreach activities to accommodate their growing programs and the ever-changing needs of the communities they serve, particularly Black MSM.
2. Emergency financial assistance: Two participants expressed that emergency financial assistance for struggling individuals/families and housing/rental assistance (e.g., Airbnb/hotel stays) not tied to HIV interventions should be an option. Again, this calls for funders to be flexible with their funding requirements and allowing provisions for HIV testing and retention in care incentives.

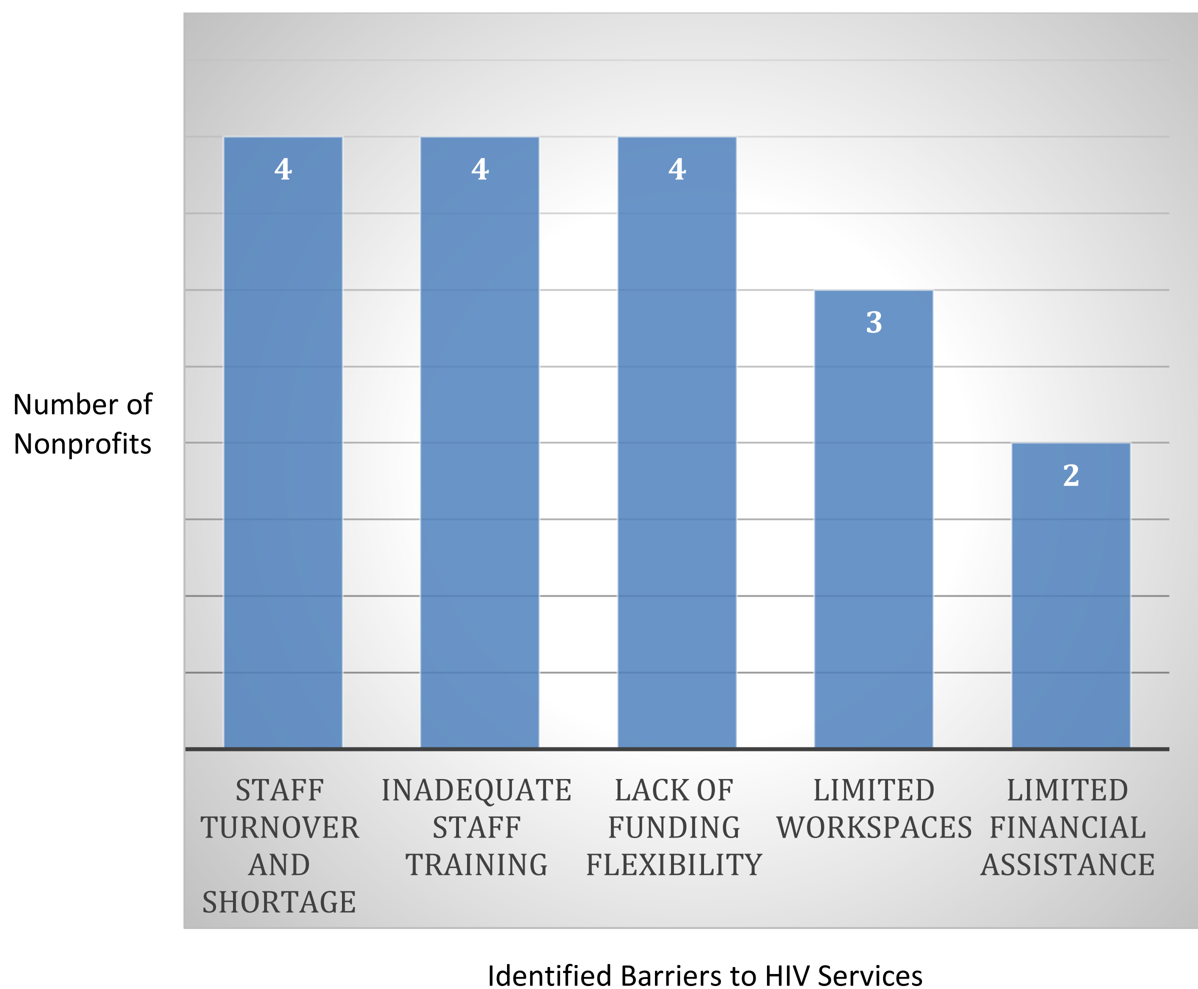

Table 1: Identified Barriers to HIV Prevention and Treatment Services

Some of the facilitators to effective scale-up of an evidence-based nonprofit-Level HIV prevention intervention the participants identified during the interviews include:

1. Already established trusting relationships between the nonprofits and their communities and target populations.
2. Experience and knowledge of the nonprofits in relation to HIV intervention programs and services delivery.

3. Compatibility of their programs and intervention services with the community's needs.
4. Community perceived benefits of the intervention services and the need to maintain health status.
5. Accessibility, friendliness, and inclusive work culture of their organizations
6. Use of participatory and mixed HIV intervention methods such as community-level, group-level, and individual-level interventions.
7. Integration of HIV intervention services with other social services such as housing, mental health programs, harm reduction services, and use of same-age, same-sex, or peer navigators and implementers.
8. Collaboration with different agencies and stakeholders in designing and delivering the intervention.

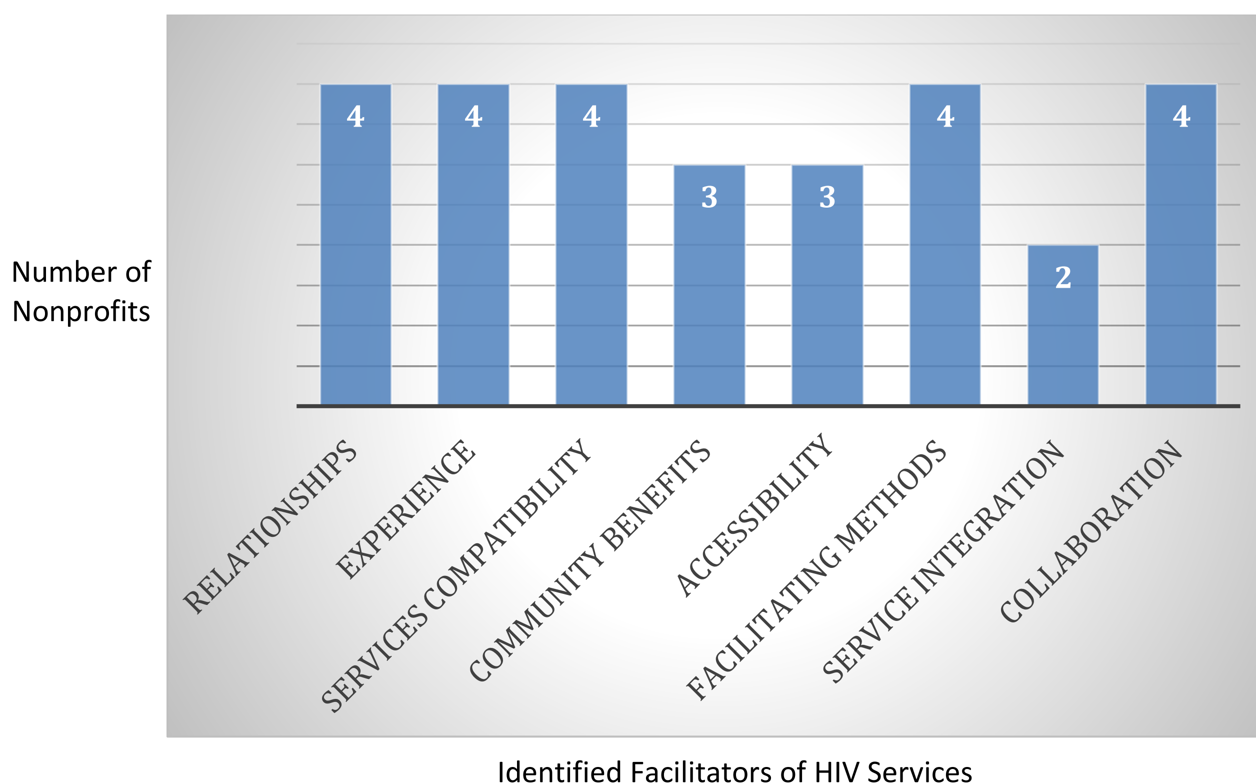

Table 2: Identified Facilitators of HIV Prevention and Treatment Services

Section 5: Implications and Recommendations

This project highlighted the many challenges nonprofit organizations face with scaling up evidence-based HIV prevention and treatment services for Black MSM. Based on these findings, I advocate and recommend a new model for an improved nonprofit structure that supports partnership, learning collaboratives, and best practices and research in this key population. The plan will include the following strategies and recommendations:

1. Advocate for flexible federal, state, and community-based HIV prevention funding and initiatives to help nonprofits support Black MSM living with HIV or at risk of HIV to receive medical care, medication assistance, and essential support social services to stay in care; reduce HIV-related stigma and discrimination, disparities, and health inequities; and achieve integrated and coordinated efforts that address the HIV epidemic among all partners of Black MSM.
2. Support an increase in the number of nonprofits that receive cultural competence and humility training in HIV prevention and care to help move nonprofit organizations past cultural stereotypes and biases (e.g., based on race, sexual orientation, and gender identity) to offer client-centered services with cultural humility. This provides an excellent opportunity for nonprofit organizations to have a better understanding of how to address population-specific emerging issues in HIV prevention, such as homophobia, structural racism, and mistrust in the healthcare system.
3. Recruit at least 20 nonprofit participants every year and conduct at least four learning collaboratives to help them develop a curriculum, identify and share innovative and evidence-based programs, adapt programs for Black MSM, and begin planning implementation.
4. Provide a national distance learning series of at least three webinars to increase the capacity of nonprofits to provide HIV and PrEP services to new

and existing patients. Topics will include, but not be limited to: identifying Black MSM at risk for HIV using validated screening tools; establishing and maintaining strong relationships with outside partners to identify those in need of services; evidence-based and promising care models for delivering testing and PrEP (e.g., primary care, STI screening and treatment programs, substance use disorder treatment programs, and TelePrEP); increasing PrEP adherence and persistence; PrEP for communities of color; PrEP for people experiencing homelessness; PrEP for injection drug users; and PrEP for transgender people.

5. Deliver tailored training sessions in person and virtually on HIV prevention and PrEP for nonprofits located in priority jurisdictions per the Ending the HIV Epidemic initiative. Training and technical assistance will include a combination of train-the-trainer sessions, workshops, panels, and/or presentations to individuals and groups of health centers.
6. Develop succession plans for key roles with detailed and program-specific orientation plans for newly hired staff. Succession planning helps provide continuity of critical services and transfer of institutional memory during periods of staff changes. A formalized orientation and training process ensures consistent onboarding for new staff. A training plan over several months will provide new employees opportunities to meet with other staff in

related program areas to understand their relationship within the framework of their funders' strategy and expectations.

7. Support partnership and collaboration across other nonprofit agencies to leverage resources, learning collaboratives, and best practices.

Section 6: Conclusions

HIV persists as a serious public health challenge in the U.S., particularly among Black MSM, who continue to bear the highest burden of the HIV/AIDS epidemic (CDC, 2000). HIV interventions for Black MSM should seek to reduce the causes of racial disparities in HIV infection rates between Black and White MSM. Homophobia, structural racism, mistrust in the healthcare system, limited access to HIV testing and treatment, and higher rates of sexually transmitted infections among Black MSM may be strong predictors of a greater risk of HIV infection in this population. Therefore, there is a need to support nonprofit organizations in their ongoing efforts to mitigate stigma and discrimination, increase HIV testing and PrEP uptake, facilitate the rapid start of HIV treatment among those diagnosed, and support adherence in care among Black MSM. Future research should build upon this project to explore other structural and community-level challenges needed to better understand the health status and the development of effective HIV intervention programs for Black MSM.

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Appendix A: Title of Appendix

Semi-Structured Interviews

1. Tell me a bit more about your organization.
2. What does ending the HIV epidemic mean to your organization and the communities you serve?
3. What types of HIV prevention and treatment services do you provide?
4. What target population(s) do you serve?
5. How has the COVID-19 pandemic impacted your work and service delivery?
6. Do you receive federal, state, city, foundation and/or individual funding to support your work? If yes, from who and how much per year?
7. How important are these funding streams to ending HIV in Black MSM?
8. What are the facilitators and barriers you face to scaling-up up evidence-based HIV prevention and treatment services in this population?
9. In your opinion, how can these challenges be addressed, and how should this first be implemented?
10. Are we close to ending the HIV epidemic in the U.S.?
11. Anything else you would like to share?

Note. By participating in this interview, you agree to have your name cited in the research as personal communication unless you express wishes to remain anonymous.

Author's Bio

Ugochukwu "Ugo" Uzoeghelu is a collaborative and enthusiastic nonprofit leader and healthcare professional offering over ten years of experience in HIV prevention, treatment, and research. Originally from Johannesburg, South Africa, Ugo received his bachelor's degree in medical sciences at Nnamdi Azikiwe University College of Medicine in Nigeria and MSc in Clinical Investigation from Harvard Medical School. Over the years, he has dedicated his career to achieving health equity in the prevention, treatment, and care of HIV and other infectious diseases. Ugo's work focuses on applying technical expertise and clinical research findings to support the design and implementation of strategies to reduce HIV risk and vulnerability and to maximize uptake of retention in, and adherence to key HIV interventions in communities disproportionately affected by the HIV epidemic in the U.S. He is currently a Program Manager at Boston Public Health Commission where he supports nonprofit efforts and projects on HIV/STI/Hepatitis prevention and service delivery.

Ugo's professional work experience in nonprofit began as an HIV/AIDS Activist Academy Fellow for Fenway Health, a Boston-based nonprofit whose mission is to improve the health and well-being of LGBTQIA+ people and BIPOC individuals through access to the highest quality health care, education, research, and advocacy. Since then, Ugo has worked with various nonprofit organizations offering training and technical assistance on nonprofit leadership and governance, program analysis and evaluation, and needs assessment.

Intent on continuing to grow to be of the best service to his community, Ugo enrolled in the Master of Nonprofit Administration program at the University of San Francisco, where he learned practical skills and critical competencies that have supported him in his current role and with the nonprofits he serves. His mission statement is: To advocate and support individual and community projects and initiatives that make life healthier and safer for members of our community. Ugo is committed to continually evolving to become an inspiring and transformational nonprofit leader.

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