HIV: Current Research

Extended Abstract

The efficacy of trauma-informed and structurally-competent models of HIV testing and treatment by healthcare centers in addressing stigma and health disparities within marginalized communities

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Abstract

The high prevalence of trauma and its negative impact on health and health-promoting behaviors among HIV-infected and high-risk HIV-uninfected populations underscore the need for interventions to address trauma and its associated sequelae in order to improve physical and mental well-being and bolster HIV prevention and treatment efforts in these populations. Fortunately, growing global awareness of the intersection of trauma and HIV has resulted in development and testing of interventions to address trauma in the context of HIV treatment, and several recent reviews have highlighted this work [16, 19]. Most recently, Seedat (2012) reviewed interventions to improve psychological functioning and health outcomes of HIV-infected individuals with a history of trauma and found 15 intervention studies published in the 2 years prior [16]. These studies employed various intervention methods (e.g., individual therapy, group therapy, prolonged exposure therapy) and had varying degrees of efficacy across trauma and HIV-related outcomes. However, they were all focused on intervening at the individual level and were almost exclusively conducted in the U.S. Intervention studies among HIV-uninfected individuals have also received attention. Among the trauma-informed HIV primary prevention intervention literature, two recent reviews of interventions in sub-Saharan Africa have nicely summarized this body of intervention research [20, 21]. Combined, they reported on the efficacy of over a dozen prevention interventions addressing the intersection of violence and HIV, predominately focused on youth and women in sub-Saharan Africa, with studies employing various intervention approaches including community-wide, school-based, and individual-level behavioral strategies to address violence and decrease HIV sexual risk behaviors. Notable limitations of the literature on HIV-uninfected populations, however, are the narrow scope of trauma addressed in these programs (e.g., most concentrate on intimate partner violence (IPV)), the nearly exclusive focus on trauma or violence experienced by or directed toward women, as well as the absence of interventions addressing the intersection of trauma and HIV prevention conducted in the U.S.

The national and worldwide system to battle HIV, frequently alluded to as the "90-90-90," means Stigma is a well-documented barrier to health seeking behavior, engagement in care and adherence to treatment across a range of health conditions globally. In order to halt the stigmatization process and mitigate the harmful consequences of health-related stigma (i.e. stigma associated with health conditions), it is critical to have an explicit theoretical framework to guide intervention development, measurement, research, and policy. Existing stigma frameworks typically focus on one health condition in isolation and often concentrate on the psychological pathways occurring among individuals. This tendency has encouraged a siloed approach to research on health-related stigmas, focusing on individuals, impeding both comparisons across stigmatized conditions and research on innovations to reduce health-related stigma and improve health outcomes. We propose the Health Stigma and Discrimination Framework, which is a global, crosscutting framework based on theory, research, and practice, and demonstrate its application to a range of health conditions, including leprosy, epilepsy, mental health, cancer, HIV, and obesity/overweight. We also discuss how stigma related to race, gender, sexual orientation, class, and occupation intersects with health-related stigmas, and examine how the framework can be used to enhance research, programming, and policy efforts. Research and interventions inspired by a common framework will enable the field to identify similarities and differences in stigma processes across diseases and will amplify our collective ability to respond effectively and at-scale to a major driver of poor health outcomes globally. It has been more than a long time since the beginning of the HIV and AIDS plague, and the social and conduct sciences have made significant commitments to HIV anticipation and care since the commencement of the pestilence. For instance, the Centers for Disease Control and Prevention records various "compelling conduct intercessions" that have been created by social researchers and are as often as possible utilized or adjusted by network based associations and clinical settings to forestall HIV contamination, advance HIV testing among populaces at high danger of contamination, or draw in those living with HIV into care.1 Although we have made significant progress, we despite everything have work to do. All the more explicitly, wellbeing abberations have become the

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dominant focal point with the end goal that HIV is as yet a significant issue among especially powerless populaces. The national and worldwide HIV avoidance and care targets, regularly alluded to as "90-90-90," center around the objectives of diagnosing 90% of individuals living with HIV, getting 90% of those analyzed onto antiretroviral treatment (ART), and accomplishing viral concealment in 90% of those on ART.2 The staying "10-10-10" speaks to those people living with HIV who will stay undiscovered, not on ART, and not virally stifled, in any event, when we arrive at our 90-90-90 objectives. The 10-10-10 likely incorporates the people living with HIV who are generally powerless (eg, the more socially underestimated, including men who have intercourse with men or transgender ladies, individuals who are destitute or temperamentally housed, infusion medicate clients, and racial minorities) and are unfavorably influenced by incongruities identified with social determinants of wellbeing. These social determinants of wellbeing can be comprehended as the conditions in the earth in which individuals live, work, learn, and play that can influence their wellbeing results legitimately or by implication through expanded (or diminished) hazard factors.3,4 These conditions in the earth incorporate, yet are not constrained to, destitution, absence of access to human services, having an underestimated social character, having (or coming up short on) a feeling of network, examples of segregation and imprisonment, or encountering a lopsided measure of wrongdoing and violence.3,4 what's more, the 10-10-10 may not be handily reached by HIV anticipation and treatment endeavors that don't explicitly distinguish and react to their novel needs.

Social researchers occupied with HIV-related research, with their inclination to concentrate on social determinants of wellbeing, are prepared to help arrive at the 10-10-10. Biomedical methodologies profit by coordinated efforts with the social sciences,5 and there are numerous manners by which social researchers can team up to propel the science and control the pestilence. For HIV science to keep on gaining ground in arriving at our objectives, we need a solid sociology educated research plan to manage us forward, and coordinated effort is integral to acknowledging such a plan. Poundstone6 (ie, socioepidemiological system of HIV) and Krieger7,8 (ie, the ecosocial way to deal with wellbeing) have explained staggered structures that can assist with controlling the cognizant advancement of interdisciplinary and synergistic ways to deal with arriving at the 10-10-10. Figure 1, adjusted from Poundstone,6 represents one manner by which multidisciplinary approaches could be consolidated across individual, social, and basic degrees of study and intercession. Teaming up over the rungs of an environmental, staggered structure can enable social researchers to enhance and supplement the qualities of each control. This is particularly obvious against a background of restricted assets for look into, which should be boosted for sway.