

Chapter 2

Comprehensive Primary Health Care for HIV Positive Gay Men

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The Comprehensive Primary Health Care Approach

The concept of primary health care (PHC), as largely practiced within the context of the United States (USA), is understood as a person's first contact with the health care system, which is expected to be nonhospital-based preventative clinical services provided by physicians, nurse practitioners, and physician assistants (Stoeckle, 2009). Research advances in primary health care medicine and the development of evidence-based practice guidelines have provided a robust set of clinical tools to address physiological and psychological needs of patients that prevent severe acute illness events that result in lengthy, expensive, and avoidable hospital admissions (Aberg et al., 2009). Nonetheless, the concept and practice of primary health care does not sufficiently accommodate the complexity of life experiences that impact the health of individuals in the community, including gay-identified men who are living with Human Immunodeficiency Virus (HIV). The disease/illness management focus of the United States' version of primary health care has led health experts to call for it to be more precisely labeled "selective primary health care" (Cueto, 2004; Magnussen, Ehiri, & Jolly, 2004). By contrast, the comprehensive primary health care approach is one that attends to the social, cultural, and political realities of individuals and is well suited as an approach to care for HIV positive gay men who may be experiencing a multitude of social oppressions that impact their health.

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Comprehensive primary health care is a concept that was commissioned by leaders in global health policy and clinical practice who understood that population advances in health could not be achieved without addressing social determinants of health and the inequitable social processes that led to disproportionately poor health outcomes in some groups compared to others (Lynam & Crowley, 2007). This is articulated in the Declaration of Alma Ata—adopted by the World Health Organization in 1978—a policy statement that advanced a holistic definition of health that included social and economic wellness and proposed structural level intervention strategies necessary to achieve “health” for all (International Conference on Primary Health Care, 1978). Initially trumpeted as a solution for resource-limited countries, the comprehensive PHC approach has also been embraced by advanced capitalist societies such as France, Brazil, and Canada—all of whom have outpaced the USA in the gains made in the prevention and management of HIV infection among gay men (Hutchison, Levesque, Strumpf, & Coyle, 2011; Rickets, Naiditch, & Bourgueil, 2012). In this chapter, we move beyond the concept of primary care towards a more serious embrace of comprehensive primary health care considerations for HIV positive gay men. Our objective in writing this chapter is for the reader to gain a core understanding of what is *comprehensive primary health care* and its applicability as an approach to clinical practice with gay-identified men living with HIV.

Principles of Comprehensive Primary Health Care

There are five principles in comprehensive primary health care. These principles are interrelated in that each is a necessary component for maximizing the degree to which an individual’s life is not only disease-free (biomedical and selective primary care models), but also lived to its full potential capacity for social and economic wellness (Magnussen et al., 2004). In order for primary health care to be impactful on the health of individuals and communities there must be a sufficient number of qualified health practitioners trained with the requisite skills to appropriately care for them. The principle of (1) *health care provider capacity development* indicates that health care teams should be composed of personnel (e.g., nurses, physicians, social workers) who are prepared to work together to support individuals in the management of their physical and social wellness needs. The second principle, (2) *community participation*, stipulates that individuals and their communities must be involved in decision-making regarding policies and practices that will ultimately structure how they receive health care as well as the nature and volume of care that will be provided. This is envisioned as a collaborative process actively engaged with individuals and/or communities that lead to greater self-determination for their health and overall wellness. Recognizing that some of the life complexities that accompany an HIV diagnosis are outside the scope of what health care practitioners can address, the principle of (3) *intersectoral collaboration* is proposed as the coordinated assemblage of resources and services from an array of sectors that are relevant to the individual being able to achieve an optimal state of health and

wellness. This goes beyond popular notions of interprofessional or interdisciplinary care, which are typically intrasectoral collaborations across areas such as nursing, pharmacy, social work, and psychology.

The comprehensive PHC principle of intersectoral collaboration calls for coordinating with services outside of the health care sector—for example, housing, criminal justice, employment and education sectors—to more wholly address factors that impact on an individual's health. In order to support individual health maintenance and the prevention of, and recovery from, illness events the (4) *appropriate use of technology* principle stipulates that providers should utilize clinical, social, and behavioral innovations that are not only scientifically sound but also culturally congruent and ones that can be sustained within an individual's and/or communities' economic means. Last, the principle of (5) *accessibility and equity* states that services needed to achieve and sustain optimal states of wellness should be universally accessible to all individuals in a society. Underlying the principles of accessibility is the active and deliberate disruption of institutionalized social processes (such as homophobia, racism, patriarchy) that impede an individual's ability to seek and receive the care at the time and in the quantity and quality that it is needed to achieve optimal wellness (Nelson, Walker, DuBois, & Giwa, 2014).

Evidence-Base for Comprehensive Primary Health Care

Social Determinants of Health

The literature on social determinants of health provides a foundation for grounding a discussion regarding comprehensive primary health care (Baum, 2008; Centers for Disease Control and Prevention, 2010; Rachilis et al., 2016). Research conducted over several years has established that poor health outcomes cluster together with poor social, economic, and political conditions—in particular is the position that marginalization, be it social, cultural, or political (or any combination of the three), negatively impacts the health of those who are the subject of it (Lynam & Crowley, 2007; Navarro & Muntaner, 2004; Nelson et al., 2016). This is particularly the case with HIV infection among many gay men. While there are examples of the mainstreaming of same-gender practices in the USA, gay men remain a socially marginalized group. The marginalization of HIV positive gay men's sexualities is compounded by the intersection of HIV stigma that can occur even within lesbian, gay, bisexual, and transgender communities (Smit et al., 2012). Homophobia, heteronormativity, racism, and HIV/AIDS stigma are all social processes that impact various subcommunities of HIV positive gay men and that comprehensive primary health care approaches can help to mitigate (Courtenay-Quirk, Wolitski, Parsons, & Gomez, 2006; Malebranche & Nelson, 2013; Nelson et al., 2014, 2016).

As mentioned earlier, the comprehensive primary health care approach moves beyond the biomedical management of illness but includes attention to factors that

impact the overall health and well-being of HIV positive gay men. The use of comprehensive primary health care as a public health system strategy for the effective management of HIV among gay men has increased in health systems globally. Communities around the world have made great strides in delaying progression to AIDS and reducing HIV/AIDS mortality among gay men and other men who have sex with other men (Berkman, Garcia, Munoz-Laboy, Paiva, & Parker, 2005; Beyrer et al., 2011; Flowers & Davis, 2012; Galvão, 2005; Helleberg et al., 2012; Parker, 2009; van Griensven & van Wijngaarden, 2010). This is partly accomplished through addressing inequitable social processes and implementing anti-oppression strategies that facilitate engagement in medical care, and ensure equitable access to medical attention (Nelson et al., 2014; Seffner, Garcia, Muñoz-Laboy, & Parker, 2011).

Social Inequities and HIV Outcomes

A number of studies have been conducted that indicate the poor HIV outcomes are not evenly distributed across the entire population of people living with HIV. This is important because HIV positive gay men cross a multitude of socioeconomic spectra. Homophobia and HIV stigma are two important indicators of HIV outcomes (Garcia et al., 2016; Mayer, Bekker, et al., 2012). A study examining the relationship among stigma, medication adherence self-efficacy, and HIV outcomes among 202 HIV positive patients found that HIV stigma mediated the relationship between self-efficacy and quality of life (Li et al., 2011). These results are consistent with other HIV research on stigma and social marginalization (Kinsler, Wong, Sayles, Davis, & Cunningham, 2007; Mahajan et al., 2008; Nelson et al., 2016; Venable, Carey, Blair, & Littlewood, 2006), indicating that anti-stigma and anti-oppression clinic environments optimize wellness outcomes among HIV positive gay men. Nonetheless, HIV/AIDS stigma and other oppressions are not limited to the clinic environment. Even in the communities where they live and socialize, the degree to which HIV positive gay men experience other societal marginalization will impact on their overall quality of life including their experiences of wellness, and vulnerabilities to illness and death (Cole & Omari, 2003; Courtenay-Quirk et al., 2006).

Inequitable Distribution in HIV Care

There have been considerable advancements with the advent of HIV antiretroviral therapies. Unfortunately, these gains are not equally distributed across the entire population of HIV positive gay men and are often tempered by the intersection of social inequities that interfere with the ability of marginalized subgroups of HIV positive gay men to optimize self-management of their therapies (Rachilis et al., 2016). The U.S. Health Resources and Services Administration (HRSA) operates

the Ryan White HIV/AIDS Comprehensive AIDS Resource Emergency (CARE) program that covers health care costs for people living with HIV who do not have sufficient income or insurance coverage to pay for HIV-related services (HRSA, 2010). The program has been in existence since 1990 and serves nearly 900,000 people per year (HRSA, 2010). Even with the additional HIV care capacity created by the Ryan White HIV/AIDS CARE program, inequities exist among gay men and other MSM with regard to enrollment and maintenance in HIV care (Young et al., 2016).

In a 7-city study of 610 marginalized (e.g., substance using, mental illness history, incarceration history) HIV positive people, researchers found that the uninsured, homeless, and those without access to mental health care had less access to HIV primary medical care (Cunningham et al., 2007). Results also showed that these groups were more likely to receive their HIV care in emergency situations. These and other disparities in access to HIV care have been documented in the literature for nearly two decades (Shapiro et al., 1999). Similar inequities exist with regard to young HIV positive gay males. Compared to MSM who acquire HIV infection in adulthood, MSM who sexually acquire HIV during their youth have lower rates of retention in HIV care. Numerous studies indicate that the major challenge for HIV positive adolescents is the risk of being lost-to-care between transitions from pediatric to adult care (Agwu et al., 2012; Chandwani et al., 2012; Dowshen & D'Angelo, 2011; Hussen, Chahroudi, et al., 2015). For example, in a retrospective study of 287 HIV positive youth (age 12–24) enrolled in multisite ($n = 18$) HIV treatment trials aimed at linking them to pediatric HIV/AIDS care between 2002 and 2008, Agwu et al. (2012) found that while two-thirds of youth initiated HAART, one-third of those transferred to adult care discontinued HAART. Researchers in this study also found that 50% of those who discontinued HAART on transition to adult clinical site were not virally suppressed. Further, the only independent predictor of HAART discontinuation identified in their regression analysis was transition to adult HIV care (adjusted hazard ratio: 1.23; 95% CI: 0.80–1.87) (Agwu et al., 2012). This phenomenon disproportionately affects MSM since they represent the majority of adolescent and pediatric cases of HIV (Centers for Disease Control and Prevention, 2015). Progression to AIDS and decreased access to quality HIV primary medical care are also more likely to occur within predominantly poor urban communities than in middle and upper class communities (Heslin, Andersen, Ettner, & Cunningham, 2005; Losina et al., 2009; Miles et al., 2013; Moore, 2011).

Inequities in HIV Outcomes and Care Quality Indicators

Advances in HIV antiretroviral therapy has helped to extend the lifespan of people living with HIV. Health science has developed more sophisticated models for treating HIV as well as managing the patients experience of treatment by such mechanisms as combination formulations which reduce the number of pills that must be taken at once and also formulations that allow for once daily dosing which makes

self-management of HIV antiretroviral therapy drugs more manageable for many HIV positive gay men. Health services research in the areas of patient HIV outcomes also provides evidence of unequal distribution in the quality of HIV care and its associated outcomes (Hall, Byers, Ling, & Espinoza, 2007; Karach, Hall, Tang, Hu, & Mermin, 2015; Laffon et al., 2015; Simard, Fransua, Naishadham, & Jemal, 2012).

For example, a large population study of HIV positive gay- and non-gay-identified MSM was conducted using epidemiologic data from 33 US states on HIV/AIDS cases between 1996 and 2004 to examine inequities in HIV prevalence and progression to AIDS (Hall et al., 2007). Researchers found that, compared to White (25%) MSM, higher percentages of Blacks (33%) and Latino (32%) MSM progressed to AIDS within 3 years of their initial HIV diagnosis (Hall et al., 2007). The researchers also found among the 62,045 MSM with AIDS during 1996–2002, a significantly higher percentage of non-Hispanic Blacks (34%) had severely weakened immune systems (<50 CD4 cells/ μ L) at the time of their AIDS diagnosis than did Hispanics (28%) and non-Hispanic Whites (24%). Furthermore, non-Hispanic Black MSM were significantly more likely than non-Hispanic Whites or Hispanics to have died within 3 years of receiving an AIDS diagnosis (Hall et al., 2007). This specific analysis of Black MSM is important since stress, including the stress of everyday experiences of racism, is known to negatively impact on HIV outcomes such as viral load and CD4 T-cell count (Lesserman, 2008; Oramasionwu et al., 2009).

Reducing disparities in HIV outcomes require more comprehensive approach than that offered by biomedical science and practice alone (Mayer, Bekker, et al., 2012). An interdisciplinary approach to care that more fully accommodates the complexities of the lives of HIV positive gay men is needed in order to regain momentum in the reduction of new infections and increased quality of life. Here, we will specifically outline strategies within a comprehensive primary health care approach for HIV positive gay men—focusing on the five guiding principles of PHC and the ways in which they can be operationalized at the clinical encounter level as well as clinic/institutional policy level.

Applying the Comprehensive Primary Health Care Approach: Health Care Provider Capacity Development

Demonstration of HIV Clinical Excellence

As research in HIV nursing, medicine, and pharmacotherapeutics yield more clinical tools with which to support optimal physiological functioning of HIV positive gay men, health care practitioners will need to be current with regard to how to utilize these advances in the context of the patients' life situations. A number of organizations provide discipline specific continuing education offerings that allow practitioners to attain advanced levels of clinical training in HIV care. The American Academy of HIV Medicine (AAHIV) provides board certification for physicians, nurse practitioners, physician assistants, and pharmacists. Health care providers

who attain this certification have an advanced level of clinical expertise as assessed by their practice experience and a national certification examination (AAHIV, 2013). Registered professional nurses are also able to attain advanced clinical preparation through the HIV/AIDS Nursing Certification Board (HANCb) that offers continuing education to registered nurses leading to the certification as AIDS Care Registered Nurse and Advanced AIDS Care Registered Nurse (HANCb, 2013). The Association of Nurses in AIDS Care (ANAC) and the HIV Medicine Association (HVMA) do not offer certifications, but have published online guidance and links to continuing education resources intended to encourage a high standard of practice for nurses and physicians providing ongoing clinical care to HIV positive gay men and others living with HIV and AIDS (ANAC, 2013; HVMA, 2010). More recently, HRSA announced its intention to invest funding to support the development of graduate education programs aimed at creating nurse practitioner and physician assistant specialists in HIV care (HRSA, 2013). The expansion of the number of health professions graduate programs that train providers to specialize in the care of HIV positive people is consistent with the U.S. National HIV/AIDS Strategy and is a crucial step in building and maintaining a competent HIV health workforce until an effective cure is found.

Multicultural Competencies

Health care practitioners can also improve their level of practice by increasing their capacity to understand patients in the patients' own sociocultural contexts (Nelson et al., 2014). These contexts are multifaceted and include LGBT culture, ethnic culture, and spiritual practice contexts (Hussen, Chahroudi, et al., 2015). Numerous studies indicate that patients rate their clinical experiences more favorably when they perceive that their differences with regard to age, ethnicities, sexualities, and spiritualities are respected and appreciated by their health care providers (Campbell, Ramsay, & Green, 2001; Trevino et al., 2010). Among HIV positive gay men, health care provider cultural competency is also associated with retention in care and self-reported quality of care (Hightow-Weidman, Smith, Valera, Matthews, & Lyons, 2011; Magnus et al., 2010). Opportunities for multicultural competency continuing education exist through HRSA funded AIDS Education & Training Centers (AETCs). The 11 AETCs across the USA routinely offer trainings for practitioners on best practices in providing care to HIV positive gay men and subpopulations (e.g., HIV positive gay men who use illicit substances; HIV positive gay men with mental illness) with unique sociocultural nuances that must be considered when working to develop plans of care (Ciesla & Roberts, 2001; Cunningham et al., 2007; Hatcher, Toldson, Godette, & Richardson, 2009; Shoptaw et al., 2012; Young, Shoptaw, Weiss, Munjas, & Gorbach, 2011; Young et al., 2016). Each AETC is responsible for providing technical assistance and continuing education to specific geographic regions of the country. Information regarding how to participate in continuing education through your regional AETC can be found by visiting their national website at www.aids-ed.org.

Life Stage-Specific Needs

HIV medical care is generally categorized into either pediatric or adult specialty practices. These life stage-specific HIV specialties are important given that there are a host of generational needs that must be attended to involving the physiology, psychology, and social context of HIV positive gay male youth compared to HIV positive adult gay men (Gayles, Kuhns, Kwon, Mustanski, & Garofalo, 2016; Hussen, Harper et al., 2015). Continued attention must be given to addressing the needs of these age groups. Nonetheless, tremendous opportunities remain for health care providers to expand their capacity to address the needs of subpopulations that are often subsumed—and many times made invisible—within the pediatric and adult HIV specialty categories (Young et al., 2016). Here, we will discuss the importance of HIV providers to develop capacities to serve adolescent (pediatric) and older adult (adult) HIV positive gay men.

Adolescents

Based on current national surveillance data, youth ages 20–24 had the highest age-specific number of new HIV infections in the United States (Centers for Disease Control and Prevention, 2015). This age group is considered to be “adolescence” since it is the time of life in which the brain has matured to a point that one has accomplished all the major pediatric developmental milestones but has not yet reached the full stage of adult development (Weinberger, Elvevag, & Giedd, 2005). Adolescents’ specific developmental stage—which is heavily focused on exploration and establishing independence from authority figures—has implications for what are the best strategies to promote retention in HIV medical care, adherence to antiretroviral treatment and preventing onward transmission of HIV (Fielden, Chapman, & Cadell, 2011; Hagan, Shaw, & Duncan, 2008; Leonard, Markham, Bui, Shegog, & Paul, 2010).

There is a growing body of research focused on intervention models that support retention in care and treatment adherence for HIV positive gay adolescent males (Centers for Disease Control and Prevention, 2014; Gayles et al., 2016). Much of this research has yielded evidence regarding specific characteristics that optimize retention of HIV positive adolescent males. These include ensuring that clinic personnel exhibit multicultural competencies in their clinical practice and service delivery (Fortenberry, Martinez, Rudy, & Monte, 2012; Gilliam et al., 2011; Magnus et al., 2010) and that adolescents are provided with coordinated services to address some of their complex psychosocial needs (Bird, LaSaa, Hidalgo, Kuhns, & Garofalo, 2016; Birnbaum, Loundsbury, Eastwood, Palma, & Jo, 2013; Fortenberry et al., 2012; Magnus et al., 2010). Other researchers are conducting research on interventions that take advantage of new technologies and capitalize on their popularity as communication mechanisms to promote treatment adherence (Hirshfield et al., 2016; Shegog, Markham, Leonard, Bul, & Paul, 2012). For example, Shegog et al. (2012) developed and tested a web-based ARV adherence support application for HIV pos-

itive adolescents and found that the intervention program was associated with increased adherence self-efficacy ($p < 0.05$) and increased understanding of the importance of maintaining a regular daily dosage schedule ($p < 0.01$). The utilization of technologies that are most compatible with the communication modes used among HIV positive gay adolescent males is a strategy that is consistent with comprehensive PHC's "*appropriate technology*" principle.

Older Adults

For older adult men, the experience of living with HIV can be complicated by declines in the expansiveness in their social networks or intersecting perceptions of decreased social significance within a LGBT community-context that has historically placed high value on the norms of youth and youthful body images (Grov, Golub, Parsons, Brennan, & Karplak, 2010; Halkitis et al., 2012; Heckman et al., 2002; Lyons, Pitts, Grierson, Thorpe, & Powell, 2010). There is significant research indicating that many HIV positive adult gay men experience depression related to experiences of loneliness, rejection, and HIV-related stigma (Grov et al., 2010). Decreases in perceived sexual desirability may create a situation where older adult HIV positive men are uncomfortable disclosing their HIV status due to the threat of rejection—that may be compounded by the ongoing (even if latent) perceived threat of rejection due to their age (Halkitis, Kapadia, Ompad, & Perez-Figueroa, 2015; Sankar, Nevedal, Neufeld, Berry, & Luborsky, 2011; van Kesteren, Hospers, van Empelen, van Breukelen, & Kok, 2007). A number of interventions have been developed to support interpersonal communication skills development among HIV positive gay men (Eaton, West, Kenny, & Kalichman, 2009; Kalichman et al., 2001). One well-known intervention is Healthy Relationships, an evidence-based group intervention program that promotes self-efficacy and relational skills development for people living with HIV (Kalichman et al., 2001; Kalichman, Rompa, & Cage, 2005). Based on social cognitive theory (Bandura, 1985), Healthy Relationships has a strong emphasis on skill development by having intervention participants first observe and then practice the target behaviors, attitudes, or expectations being modeled (Kalichman et al., 2001, 2005). Other interventions focus specifically on supporting men's decision-making skills regarding the disclosure of their HIV status in various situations (Serovich, Reed, Grafsky, & Andrist, 2009; Serovich, Reed, Grafsky, Hartwell, & Andrist, 2011). These complex life stage-specific needs require serious attention by providers working to increase their capacity to deliver quality care to HIV positive men—young and old alike.

Accessibility and Equity

With decreased access to care and mounting societal discrimination, HIV positive gay men require care that establishes access and longitudinal medical management. Treatment will be most effective only when access to care has been well

established. In order to provide comprehensive primary health care for HIV positive gay men, it is not only necessary to provide a supportive care environment, but also necessary to implement a deliberate anti-racism, anti-oppression framework for practice (Mullaly, 2010; Nelson et al., 2016; Yee, 2005). Due to White supremacy, racism, heteronormativity, and homophobia, White and heterosexual men are granted explicit and implicit social privileges when compared with those who are non-white and/or self-identify as gay (Nelson et al., 2014). Practice frameworks can begin by attending to specific language that supports underlying hegemonic inequities that disenfranchise HIV positive gay men. For example, barriers to access for HIV positive gay men can come in forms as simple as the advertising of your clinic or community-based program. A deliberate anti-oppressive framework requires that health programs do more than “not discriminate” but specifically advertise that their services are inclusive of HIV positive gay men. Additionally, ensuring that program services are advertised at businesses and events that historically target and attract gay men demonstrates a willingness to be visibly associated with gay-identified activities—which is an important anti-oppression strategy (Nelson et al., 2014).

Another area where anti-oppressive practice can be exercised is in the interpersonal communication between the client and the providers. The manner in which health histories, risk assessments, and other clinical data are collected can be experienced as oppressive. For example, if an HIV positive gay man discloses that he has performed anal insertive sex with multiple partners in the past 3 months, an inquiry to him of: “Please, tell me about what motivated your sexual practices with these various partners” is consistent with anti-oppressive practice versus asking for the man to “please tell me the reasons why you were promiscuous and put other peoples lives at risk.” If the patient is exhibiting signs of anxiety or distress, the practitioner may even wish to verbally acknowledge the psycho-emotional difficulties that the patient may be experiencing. In this way, the practitioner does not necessarily normalize the behavior, but makes an inquiry that avoids a moral evaluation of the behavior and reduces the risk of creating an interpersonal environment where the patient may not feel comfortable to further disclose or discuss his needs and concerns. Adopting some of these practices and identifying and incorporating other anti-oppressive practices can help generate environments where comprehensive primary health care can be more equitably accessed.

Community Participation

Health Program Integration

Including HIV positive gay men in the implementation of health programs are common mechanisms by which both clinic and community-based HIV/AIDS service programs achieve their goals for community participation. Health program integration benefits organizations by having individuals, who live the experience of being

a gay man diagnosed with HIV, to help deliver services to others in this population. In addition to integrating HIV positive gay men into health programs, consumer advisory boards are sometimes utilized for generating feedback on how to improve organizational practices on working with HIV positive gay men. The consumer advisory boards can also be useful in identifying emerging social, cultural, and health trends among HIV positive gay men that may stimulate the development of new programs or treatment strategies. Consumer advisory boards are also helpful in ensuring that the clinics and programs are maximally responsive to the interests of HIV positive gay men. This can include interests related to clinic policies that affect the men. For example, a clinic that is contemplating a change in policy that reduces the number of wellness visits that are booked within a 12-month period, for patients who pay a reduced sliding scale fee for clinic services, should include full input from HIV positive gay men since such a decision will impact the care that the men can expect to receive. Consumer advisory boards could also provide input on research targeting HIV positive gay men with the aim of ensuring that the studies are as fair, relevant, and beneficial as possible to the men who will enroll. Health program integration can be achieved in numerous ways. Whichever methods are chosen, token participation should be avoided and full, serious input into program design and implementation must be the goal.

Developing a Client-Centered Treatment Plan

There is increasing attention given to the benefits of developing treatment plans that are centered on the client's sociocultural context and other situational factors that may be occurring at the time of the plan development. Numerous studies indicate that client-centered treatment plans are associated with greater treatment plan adherence by patients (Bogart et al., 2012; Church & Simon, 2010; Farrisi & Dietz, 2013; Gilman, Hidalgo, Thomas, Au, & Hargreaves, 2012). Moreover, health care providers have a moral imperative to ensure that the treatment plans for patients are based on what the patients' believe are in their own best interest (Beauchamp & Childress, 2001). HIV positive gay men who are fully informed about treatment options may decide to exercise options that the treating physician or nurse practitioner may not agree is the best course of action. It is important that the provider's understanding of the clinical situation is reconciled with the patient's understanding of what is the plan that they want for themselves. Nonetheless, it remains that the interests of the health care provider must not be prioritized over the self-expressed interests of the patient—regardless of the outcome implications. Major professional medical organizations have published statements that are consistent with the notion that treatment plans and approaches must be centered on the self-expressed interests of the patients (American Board of Internal Medicine Foundation, American College of Physicians American Society of Internal Medicine Foundation, & European Federation of Internal Medicine, 2002). Additionally, there is an abundance of evidence-based interventions for assisting providers to improve communications

with patients such that the patients' needs and wishes are more likely to result in a plan of care that reflects the patients' interests (Harrington, Noble, & Newman, 2004; Kaymeg, Howard, Clochesy Mitchell, & Suresky, 2010; Rao, Anderson, Inui, & Frankel, 2007; Tennstedt, 2000). Providers can use these and other interventions to better enhance their skills in listening to HIV positive gay men's needs and incorporating them accordingly into their plans of care.

Intersectoral Collaboration

Health and Social Service Sectors

Collaboration between disciplines within health care is necessary to effectively promote physical and social wellness for HIV positive gay male patients. For example, the primary physician, nurse practitioner, or physician assistant should, whenever indicated, work in conjunction with other health providers such as pharmacists, psychologists, social workers, and registered dietitians. Notwithstanding the importance of multidisciplinary collaborations within health care, a comprehensive primary health approach stipulates that multidisciplinary efforts across sectors, outside of the health care domain, are required to fully address the complexities of patients' needs. HIV positive gay men with complex needs may require that health care providers coordinate care with a myriad of sectors for such services as job placement, employment skills training, rehabilitation services, housing, and community-reintegration supportive services for ex-offenders. Partnering with these programs can enhance health care providers' abilities to meet the needs of HIV positive gay men by ensuring that other basic needs receive appropriate attention by the appropriate professionals.

Human Rights Sector

Human rights workers engage in advocacy to increase public awareness of social injustices with their aim of reducing the de facto privileges that are withheld from groups that are marginalized and otherwise made less powerful groups, such as gay men, people of color, and people living with HIV (Oldenburg et al., 2016). Human rights workers have a broad scope of practice and have the capacity to provide advocacy for HIV positive gay men on a range of important issues from marriage equality to demanding accountability from insurance companies whose coverage policies discriminate against HIV positive applicants and enrollees (Barclay, Bernstein, & Marshall, 2009). Many immigrants and refugees, especially those from HIV-endemic countries, may arrive to the USA. Many of these individuals may learn of their HIV status only after arriving in the USA. Those who are gay-identified may find that is unsafe to return to their countries of origin either

because of poor HIV/AIDS care infrastructure or because engaging in HIV/AIDS care will lead to imminent disclosure of their sexual behavioral practice, which could increase their vulnerability to violence and other homophobia-based social marginalizations (Nelson et al., 2015). In these cases, human rights workers can support newcomers to the USA in navigating asylum processes and helping them link with legal professionals who specialize in immigration cases. Human rights workers may also help individuals who are undocumented, link to health service networks that practice multicultural competence and that may provide free clinical services without requiring patient's to authenticate their identities with official government documents such as social security cards, birth certificates, or drivers licenses. Such strategies may reduce fears that engagement in health care systems place them at high-risk for apprehension by police agents and deportation.

Appropriate use of Technology

Advances in ART

Antiretroviral therapy (ART) is the cornerstone of pharmacologic management of HIV. The goals of ART include CD4 count increase, decreased HIV viral load, and delayed progression to AIDS. Studies indicate that early initiation of ART decreases progression to AIDS and HIV mortality by 50% (Marks, Gardner, Craw, & Crepaz, 2010; Mayer, 2011; Zolopa & Katz, 2012). The gold standard of care is to use at least two classes of ART, from which at least three different agents are selected (Aberg et al., 2009; Zolopa & Katz, 2012). ART classes include: nucleoside reverse transcriptase inhibitors (e.g., Retrovir, Videx, Hivid, Zerit, 3TC, Emtriva), nucleoside reverse transcriptase inhibitors (Viread), protease inhibitors (Crixivan, Invirase, Norvir, Viracept, Lexiva, Kaletra, Reyataz, Norvir), non-nucleoside reverse transcriptase inhibitors (Viramune, Rescriptor, Sustiva, Intelence), entry inhibitors (Fuzeon, Selzentry), and integrase inhibitors (Isentress). Each of the drug classes has unique actions against HIV infection. These medications carry complex pharmacokinetic and pharmacodynamic properties, and as such, they should be prescribed and monitored only by experienced HIV clinicians. Most classes of ART drugs also produce side effects that require monitoring and treatment. Patients should receive sufficient education about their medications, side effects, signs/symptoms that necessitate notification of a health provider, and the importance of strict maintenance to the medication regimen. The number of pills that a patient must consume daily ("pill burden"), the patient's ability to adhere to the regimen, costs, and comorbidities and immune status should all receive consideration when working with the patient to develop a treatment plan. All things considered, the treatment plan to which the patient is most willing to commit is the one he is most likely to follow and thus should be the one selected.

Sexual Health

Sexual health promotion is of paramount importance in primary care of HIV positive gay men (Mayer, Bush, et al., 2012). The patient's own views about his sexuality and disease process should be evaluated. Any perceived deficiencies should be addressed through health counseling and education from the appropriate professional. Patients should be educated about their disease process and receive coaching on the various ways that they can express their sexualities that minimize their chances of onward transmission of HIV. Patients should also receive education on what sources of information are reliable when researching their own disease processes and how it may impact aspects of their sexual expression that may include, for some, erection and ejaculation.

Prevention of other sexually transmitted infections (STIs) is critical for HIV positive gay men. HIV positive gay men are at increased risk for coinfection with other sexually transmitted pathogens (Bachmann et al., 2009; Pando et al., 2012; Rice et al., 2016). STIs common in gay HIV positive patients include human papilloma virus (HPV), hepatitis A, B, and C, gonorrhea, syphilis, chlamydia, and herpes 1 and 2 (Zolopa & Katz, 2012). Moreover, treatment of gonorrhea, chlamydia, and syphilis can significantly reduce the amount of HIV virus present at the urethral and anal mucosal sites—consequently decreasing the odds of onward HIV transmission to sexual partners (Modjarrad & Vermund, 2010). An HIV positive gay man should also be offered hepatitis A & B vaccinations if it is determined that he has not been previously vaccinated or if verification—either by patient recollection or chart documentation—is unavailable. The HPV vaccine is now recommended for MSM through age 26, especially for HIV positive MSM. High-intensity behavioral counseling and other evidence-based behavioral interventions should be considered for use in support of STI risk reduction. HIV positive gay men who have serodiscordant sexual partnerships should be considered for pre-exposure prophylaxis (PrEP) for the HIV negative partner along with high-frequency HIV screening for early detection and treatment in the event of seroconversion (Baeten et al., 2012; Grant et al., 2010; Thigpen et al., 2012). Sexual health care for HIV positive gay men is complex, requiring provider-patient collaborations to find strategies for achieving sexual expression and health maintenance goals (Mayer et al., 2016; Weinman, 2010).

Mental Health

Mental health and wellness is an integral and foundational aspect of HIV care for gay men (Batchelder, Safren, Mitchell, Ivardic, & O'Cleirigh, 2017). A comprehensive suicide assessment and screening should be conducted at the first clinical encounter, as HIV positive persons are two times more likely to experience depression and suicidal thoughts than HIV negative persons (Ciesla & Roberts, 2001). The health provider should be sensitive as to how the diagnosis of HIV and other STI

positive results are delivered to gay men, as studies have demonstrated that the manner in which the clinician communicates these results can alter the response and coping ability of the patient (Hult, Maurer, & Moskowitz, 2009). Some HIV positive gay men may also have internalized feelings of homophobia, which may be a contributing or compounding factor to their experiences of depressive symptoms. Internalized homophobia among HIV positive gay men has been linked both to increased risk of depression and to sexual risk behaviors (Ross, Rosser, & Neumaier, 2008). Linkages to psychological counseling services and support groups should be provided, wherever possible, as these have been shown to have beneficial effects on depressive symptoms (White et al., 2012). Pharmacological agents may also be necessary to support the patients' management of depression and anxiety. Given HIV positive gay men's elevated risk for developing depressive symptoms, health care providers should conduct a psychosocial assessment, even if only a brief one, at every clinical encounter and work with patients to develop a mental health plan of care and linkage to care, as appropriate.

E-Technology

As the numbers of uninsured HIV positive gay men increase, the need to treat, monitor, and educate such patients will also increase. Qualified clinicians may not always reside in the geographic location of clinical need. In such situations, clinicians may be able to conduct limited evaluations over the phone, through video conferencing, and through email (Hirshfield et al., 2016). This type of technology is best suited for follow-up evaluations, counseling, needs assessment, triage, prescription refills, and education. E-technology should not serve as an initial point of entry for physical examinations. E-technology may increase, as the numbers of insured may reach historic proportions within the context of the Affordable Health Care Act in the USA. Legal and ethical considerations must be evaluated and resolved as this emerging form of patient evaluation and treatment continues to evolve. E-technology may provide considerable relief for current gaps in access to care for HIV positive gay men across the country.

Directions for Future Research

With the passing of the Affordable Care Act (ACA) and the implementation of the National HIV/AIDS Strategy and HIV Care Continuum Initiative, the USA has begun a new chapter in the organization of health care practice approaches. This reorganization presents an optimal window for the emergence of comprehensive primary health care as an approach to HIV/AIDS care (Beyrer et al., 2012). The utilization of a comprehensive PHC approach will require research and innovation regarding how health care costs are managed (Basinga et al., 2010; Mayer et al.,

2016; Schoen et al., 2009), how health care teams are organized under ACA (Rittenhouse, Shortell, & Fisher, 2009), and the implications of multidisciplinary health care teams on HIV care quality outcomes (Mayer et al., 2016; Poulton and West, 1993; Sherer et al., 2002; Zaller, Gilliani, & Rich, 2007). Additional research should also explore how emerging solutions in data (e.g., electronic charts, local/regional patient information exchanges) and communication (telemedicine) systems can be harnessed to support more time-efficient, cost-effective, accessible, and client-centered health care services and expand access points into HIV care (Hirshfield et al., 2016; Schoen et al., 2012).

Test and treat interventions focus on reducing risk of onward transmission by suppressing the HIV viral load of HIV-infected individuals (Castel et al., 2016; Kalichman et al., 2010; Modjarrad & Vermund, 2010). Additionally, interventions that promote early linkage to and retention in care are needed to support quality outcomes for HIV positive gay men (Marks et al. 2010; Mayer, 2011; Gwadz et al., 2015; Mugavero, Norton, & Saag, 2011; Rachilis et al., 2016). It will also be important for future research to extend beyond clinical and behavioral factors that impact screening, medical care linkage and treatment towards investigating policies that interfere with the effective and efficient linkage to care (Mugavero et al. 2011; Riley et al., 2012). Although gay men generally reduce HIV transmission risk behaviors after receiving an HIV diagnosis, a substantial percentage of HIV positive gay men remain at increased risk for the onward transmission of HIV (Crepaz et al., 2009; Mayer, Bush, et al., 2012). This highlights the need for continued research evaluating innovative strategies for preventing the onward transmission of HIV to others (Safren et al., 2011; Serovich et al., 2009).

Conclusions

The comprehensive primary health care approach is a relevant practice model for working with HIV positive gay men. Within the comprehensive PHC approach, a more holistic engagement with the needs of HIV positive gay men can be accomplished (Beyrer et al., 2012; Bhatia & Rifkin, 2010). Public health practice has a long tradition of advocating for social justice reforms as interventions to improve health and wellness of vulnerable and marginalized populations (Nelson & Morrison-Beedy, 2012); however, increased attention must be given to educating nurses, physicians, and other members of the clinical team to adopt anti-racism, anti-oppression frameworks in their clinical practice (Nelson et al., 2014, 2016). The United States, through the National HIV/AIDS Strategy, has an opportunity to more fully adopt principles of comprehensive primary health care. Many of the priorities in the National HIV/AIDS Strategy are congruent with the comprehensive primary health care approach. These include expanding access to HIV primary care, maximizing the application of technological innovation in the primary and secondary prevention of HIV and the development of community-informed plans for the manner in which HIV prevention and care are organized and delivered within local communities

across the USA. Implementing the principles of comprehensive PHC will require that health care professionals push the boundaries and commit to social justice aims within their clinical practice (Dean & Fenton, 2010; Easley & Allen, 2007; Eliason, Dibble, & DeJoseph, 2010; Nelson et al., 2016) and work with partners outside of the health sector to help HIV positive gay men attain their wellness goals.

References

- Aberg, J. A., Kaplan, J. E., Libman, H., Emmanuel, P., Anderson, J. R., Stone, V. E., ... Gallant, J. E. (2009). Primary care guidelines for the management of persons infected with human immunodeficiency virus: 2009 update by the HIV medicine association of the Infectious Diseases Society of America. *Clinical Infectious Diseases*, 49, 651–681.
- Agwu, A. L., Siberry, G. K., Ellen, J. M., Fleishman, J. A., Rutstein, R., Gaur, A. H., ... Gebo, K. A. (2012). Predictors of highly active antiretroviral therapy utilization for behaviorally HIV-1-infected youth: Impact of adult versus pediatric clinical care site. *Journal of Adolescent Health*, 50, 471–477.
- American Academy of HIV Medicine. (2013). *American Academy of HIV Medicine credentialing information*. Retrieved from <http://www.aahivm.org/about>.
- American Board of Internal Medicine Foundation, American College of Physicians, American Society of Internal Medicine Foundation, & European Federation of Internal Medicine. (2002). Medical professionalism in the new millennium: A physician charter. *Annals of Internal Medicine*, 136, 243–246.
- Association of Nurses in AIDS Care. (2013). *Professional development*. Retrieved from <http://www.nursesinaidscare.org/i4a/pages/index.cfm?pageid=3289>.
- Bachmann, L. H., Grimley, D. M., Chen, H., Aban, I., Hu, J., Zhang, S., ... Hook, E. W., III. (2009). Risk behaviors in HIV positive men who have sex with men participating in an intervention in a primary care setting. *International Journal of STD and AIDS*, 20, 607–612.
- Baeten, J. M., Donnell, D., Ndase, P., Mugo, N. R., Campbell, J. D., Wangisi, J., ... Celum, C. (2012). Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. *New England Journal of Medicine*, 367, 399–410.
- Bandura, A. (1985). *Social foundations of thought and action*. Prentice-Hall, NJ: Englewood Cliffs.
- Barclay, S., Bernstein, M., & Marshall, A. (2009). *Queer mobilizations: LGBT activists confront the law*. New York, New York University Press.
- Basinga, P., Gertler, P. J., Binagwaho, A., Soucat, A. L. B., Sturdy, J. R., & Vermeersch, C. (2010). *Paying primary health care centers for performance in Rwanda* (World Bank Policy Research Working Paper No. 5190). Geneva: World Bank.
- Batchelder, A. W., Safren, S., Mitchell, A. D., Ivardic, I., & O'Cleirigh, C. (2017). Mental health in 2020 for men who have sex with men in the United States. *Sexual Health*. doi:10.1071/SH16083, 14, 59.
- Baum, F. (2008). The commission on the social determinants of health: Reinventing health promotion for the twenty-first century. *Critical Public Health*, 18, 457–466.
- Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics* (5th ed.). New York: Oxford University Press.
- Berkman, A., Garcia, J., Muñoz-Laboy, M., Paiva, V., & Parker, R. (2005). A critical analysis of the Brazilian response to HIV/AIDS: Lessons learned for controlling and mitigating the epidemic in developing countries. *American Journal of Public Health*, 95, 1162–1172.
- Beyrer, C., Sullivan, P. S., Sanchez, J., Dowdy, D., Altman, D., Trapence, G., ... Sidibe, M. (2012). A call to action for comprehensive HIV services for men who have sex with men. *Lancet*, 380, 424–438.
- Beyrer, C., Wirtz, A. L., Valker, D., Johns, B., Sifakis, F., & Baral, S. D. (2011). *The global HIV epidemics among men who have sex with men*. Washington, DC: The World Bank.

- Bhatia, M., & Rifkin, S. (2010). A renewed focus on primary health care: Revitalize or reframe. *Globalization and Health*, 6. doi:10.1186/1744-8603-6-13, 6.
- Bird, J. D., LaSaa, M. C., Hidalgo, M. A., Kuhns, L. M., & Garofalo, R. (2016). "I had to go to the streets to get love": Pathways from parental rejection to HIV risk among young gay and bisexual men. *Journal of Homosexuality*, 19, 1–22.
- Birnbaum, J. M., Loundsbury, D. W., Eastwood, E., Palma, A., & Jo, G. Y. (2013). 128. Use of system dynamics modeling as a tool for evaluation and intervention planning for HIV+ adolescents and their retention in care in an urban adolescent HIV clinic. *Journal of Adolescent Health*, 52, S82–S83.
- Bogart, L. M., Wagner, G. J., Mutchler, M. G., Risley, B., McDavitt, B. W., McKay, T., & Klein, D. J. (2012). Community HIV treatment advocacy programs may support treatment adherence. *AIDS Education and Prevention*, 24, 1–14.
- Campbell, J. L., Ramsay, J., & Green, J. (2001). Age, gender, socioeconomic, and ethnic differences in patients' assessment of primary health care. *Quality Health Care*, 10, 90–95.
- Castel, A. D., Kalmin, M. M., Hart, R. L., Young, H. A., Hays, H., Benator, D., ... Greenberg, A. E. (2016). Disparities in achieving and sustaining viral suppression among a large cohort of HIV-infected persons in care—Washington, DC. *AIDS Care*, 28, 1355–1364.
- Centers for Disease Control and Prevention. (2010). *Establishing a holistic framework to reduce inequities in HIV, viral hepatitis, and tuberculosis in the United States*. Atlanta, GA: U.S. Department of Health and Human Services—Centers for Disease Control and Prevention.
- Centers for Disease Control and Prevention. (2014). Men living with diagnosed HIV who have sex with men: Progress along the continuum of HIC care—United States, 2010. *Morbidity and Mortality Weekly Report*, 63, 829–833.
- Centers for Disease Control and Prevention. (2015). *HIV/AIDS surveillance report: Diagnoses of HIV infection in the United States and dependent areas, 2011*. Retrieved from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>.
- Chandwani, S., Koenig, L. J., Sill, A. M., Abramowitz, S., Conner, L. C., & D'Angelo, L. (2012). Predictors of antiretroviral medication adherence among a diverse cohort of adolescents with HIV. *Journal of Adolescent Health*, 51, 242–251.
- Church, K., & Simon, L. (2010). Delivering integrated services: Time for a client-centered approach to meet the sexual and reproductive health needs of people living with HIV. *AIDS*, 24, 189–193.
- Ciesla, J. A., & Roberts, J. E. (2001). A meta-analysis of the relationship between HIV infection and risk for depressive disorders. *American Journal of Psychiatry*, 158, 725–730.
- Cole, E. R., & Omari, S. R. (2003). Race, class and the dilemmas of upward mobility for African Americans. *Journal of Social Issues*, 59, 785–802.
- Courtenay-Quirk, C., Wolitski, R. J., Parsons, J. T., & Gomez, C. A. (2006). Is HIV/AIDS stigma dividing the gay community? Perceptions of HIV-positive men who have sex with men. *AIDS Education and Prevention*, 18, 56–67.
- Crepaz, N., Marks, G., Liau, A., Mullins, M. M., Aupont, L. W., Marshall, K. J., ... HIV/AIDS Prevention Research Synthesis Team. (2009). Prevalence of unprotected anal intercourse among HIV-diagnosed MSM in the United States: A meta-analysis. *AIDS*, 23, 1617–1629.
- Cueto, M. (2004). The origins of primary health care and selective primary health care. *American Journal of Public Health*, 94, 1864–1874.
- Cunningham, C. O., Sohler, N. L., Wong, M. D., Relf, M., Cunningham, W. E., Drainoni, M., ... Cabral, H. D. (2007). Utilization of health care services in hard-to-reach marginalized HIV-infected individuals. *AIDS Patient Care and STDs*, 21, 177–186.
- Dean, H. D., & Fenton, K. A. (2010). Addressing social determinants of health in the prevention and control of HIV/AIDS, viral hepatitis, sexually transmitted infections, and tuberculosis. *Public Health Reports*, 125, 1–5.
- Dowshen, N., & D'Angelo, L. (2011). Health care transition for youth living with HIV/AIDS. *Pediatrics*, 128, 762–771.
- Easley, C. E., & Allen, C. E. (2007). A critical intersection: Human rights, public health nursing, and nursing ethics. *Advances in Nursing Science*, 30, 367–382.

- Eaton, L. A., West, T. V., Kenny, D. A., & Kalichman, S. C. (2009). HIV transmission risk among HIV seroconcordant and serodiscordant couples: Dyadic processes of partner selection. *AIDS and Behavior*, 13, 185–195.
- Eliason, M. J., Dibble, S., & DeJoseph, J. (2010). Nursing's silence on lesbian, gay, bisexual, and transgender issues: The need for emancipatory efforts. *Advances in Nursing Science*, 33, 206–218.
- Farrisi, D., & Dietz, N. (2013). Patient navigation is a client-centered approach that helps to engage people in HIV care. *HIV Clinician*, 25, 1–3.
- Fielden, S. J., Chapman, G. E., & Cadell, S. (2011). Managing stigma in adolescent HIV: Silence, secrets and sanctioned spaces. *Culture, Health and Sexuality*, 13, 267–281.
- Flowers, P., & Davis, M. M. (2012). Understanding the biopsychosocial aspects of HIV disclosure amongst HIV-positive gay men in Scotland. *Journal of Health Psychology*. doi:[10.1177/1359105312454037](https://doi.org/10.1177/1359105312454037), 18, 711.
- Fortenberry, J. D., Martinez, J., Rudy, B. J., & Monte, D. (2012). Linkage to care for HIV-positive adolescents: A multisite study of the adolescent medicine trials units of the adolescent trials network. *Journal of Adolescent Health*, 51, 551–556.
- Galvão, J. (2005). Brazil and access to HIV/AIDS drugs: A question of human rights and public health. *American Journal of Public Health*, 95, 1110–1116.
- Garcia, J., Parker, C., Parker, R. G., Wilson, P. A., Philbin, M., & Hirsch, J. S. (2016). Psychosocial implications of homophobia and HIV stigma in social support networks: Insight for high-impact HIV prevention among black men who have sex with men. *Health Education and Behavior*, 43, 217–225.
- Gayles, T. A., Kuhns, L. M., Kwon, S., Mustanski, B., & Garofalo, R. (2016). Socioeconomic disconnection as a risk factor for increased HIV infection in young men who have sex with men. *LGBT Health*, 3, 219–224.
- Gilliam, P. P., Ellen, J. M., Leonard, L., Kinsman, S., Jevitt, C. M., & Straub, D. M. (2011). Transition of adolescents with HIV to adult care: Characteristics and current practices of the adolescent trials network for HIV/AIDS interventions. *Journal of the Association of Nurses in AIDS Care*, 22, 283–294.
- Gilman, B., Hidalgo, J., Thomas, C., Au, M., & Hargreaves, M. (2012). Linkages to care for newly diagnosed individuals who test HIV positive in nonprimary care settings. *AIDS Patient Care and STDs*, 26, 132–140.
- Grant, R. M., Lama, J. R., Anderson, P. L., MacMahan, V., Liu, A. Y., Vargas, L., ... Glidden, D. V. (2010). Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *The New England Journal of Medicine*, 363, 2587–2599.
- Grov, C., Golub, S. A., Parsons, J. T., Brennan, M., & Karplak, S. E. (2010). Loneliness and HIV-related stigma explain depression among older HIV-positive adults. *AIDS Care*, 22, 630–639.
- Gwadz, M., Cleland, C. M., Applegate, E., Belkin, M., Gandhi, M., Salomon, N., ... Heart to Heart Collaborative Research Team. (2015). Behavioral intervention improves treatment outcomes among HIV-infected individuals who have delayed, declined, or discontinued antiretroviral therapy: A randomized controlled trial of a novel intervention. *AIDS and Behavior*, 19, 1801–1817.
- Hagan, J. F., Shaw, J. S., & Duncan, P. M. (2008). *Bright futures: Guidelines for health supervision of infants, children, and adolescents* (3rd ed.). Elk Grove Village, IL: American Academy of Pediatrics.
- Halkitis, P. N., Kapadia, F., Ompad, D. C., & Perez-Figueroa, R. (2015). Moving toward a holistic conceptual framework for understanding healthy aging among gay men. *Journal of Homosexuality*, 62, 571–587.
- Halkitis, P. N., Kupprat, S. A., Hampton, M. B., Perez-Figueroa, R., Kingdon, M., Eddy, J. A., Ompad, D. C. (2012). Evidence for a syndemic in aging HIV-positive gay, bisexual, and other MSM: Implications for a holistic approach to prevention and healthcare. *National Resource Model*, 36. doi:[10.1111/napa.12009](https://doi.org/10.1111/napa.12009), 365.
- Hall, H. I., Byers, R. H., Ling, Q., & Espinoza, L. (2007). Racial/ethnic and age disparities in HIV prevalence and disease progression among men who have sex with men in the United States. *American Journal of Public Health*, 97, 1060–1066.

- Harrington, J., Noble, L. M., & Newman, S. P. (2004). Improving patients' communication with doctors: A systematic review of intervention studies. *Patient Education and Counseling*, 52, 7–16.
- Hatcher, S. S., Toldson, I. A., Godette, D. C., & Richardson, J. B. (2009). Mental health, substance abuse, and HIV disparities in correctional settings: Practice and policy implications for African Americans. *Journal of Health Care for the Poor and Underserved*, 20, 6–16.
- Health Resources & Services Administration. (2010). *Going the distance: The Ryan white HIV/AIDS program, 20 years of leadership, a legacy of care*. Rockville, MD: Author.
- Health Resources & Services Administration. (2013). *AETC education for nurse practitioners and physician assistants*. Grant announcement. Retrieved February 28, 2015, from <http://www.hrsa.gov/grants/index.html>.
- Heckman, T. G., Heckman, B. D., Kochman, A., Sikkema, K. J., Suhr, J., & Goodkin, K. (2002). Psychological symptoms among persons 50 years of age and older living with HIV disease. *Aging and Mental Health*, 6, 121–128.
- Helleberg, M., Engsig, F. N., Kronborg, G., Larsen, C. S., Pedersen, G., Pedersen, C., ... Obel, N. (2012). Retention in a public healthcare system with free access to treatment: A Danish nationwide HIV cohort study. *AIDS*, 26, 741–748.
- Heslin, K. C., Andersen, R. M., Ettner, S. L., & Cunningham, W. E. (2005). Racial and ethnic disparities in access to physicians with HIV-related expertise. *Journal of General Internal Medicine*, 20, 283–289.
- Hightow-Weidman, L. B., Smith, J. C., Valera, E., Matthews, D., & Lyons, P. (2011). Keeping them in "STYLE": Finding, linking, and retaining young HIV-positive black and Latino men who sex with men in care. *AIDS Patient Care and STDs*, 25, 37–45.
- Hirshfield, S., Downing, M. J., Jr., Parsons, J. T., Grov, C., Gordon, R. J., Houang, S. T., ... Chaiasson, M. A. (2016). Developing a video-based ehealth intervention for HIV-positive gay, bisexual, and other men who have sex with men: Study protocol for a randomized controlled trial. *JMIR Research Protocol*, 5, e125. doi:10.2196/resprot.5554.
- HIV Medicine Association. (2010). *Qualifications for physicians who manage the longitudinal HIV treatment of patients with HIV*. Arlington, VA: Author.
- HIV/AIDS Nursing Certification Board. (2013). *Certification information*. Retrieved February 1, 2013, from <http://www.hancb.org/certification.htm>.
- Hult, J. R., Maurer, S. A., & Moskowitz, J. T. (2009). "I'm sorry, you're positive": A qualitative study of individual experiences of testing positive for HIV. *AIDS Care*, 21, 185–188.
- Hussen, S. A., Chahroudi, A., Boylan, A., Camacho-Gonzalez, A. F., Hackett, S., & Chakraborty, R. (2015). Transition of youth living with HIV infection pediatric to adult-centered healthcare: A review of the literature. *Future Virology*, 9, 921–929.
- Hussen, S. A., Harper, G. W., Bauermeister, J. A., Hightow-Weidman, L. B., & Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2015). Psychosocial influences on engagement in care among HIV-positive young black gay/bisexual and other men who have sex with men. *AIDS Patient Care and STDs*, 29, 77–85.
- Hutchison, B., Levesque, J. F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: Systems in motion. *Milbank Quarterly*, 89, 256–288.
- International Conference on Primary Health Care. (1978). *Declaration of Alma Ata, USSR, September 6–12, 1978*. Published online by World Health Organization. Retrieved February 8, 2015 from http://www.who.int/publications/almaata_declaration_en.pdf.
- Kalichman, S. C., Cherry, C., Amaral, C. M., Swerzes, C., Eaton, L., Macy, R., ... Kalichman, M. O. (2010). Adherence to antiretroviral therapy and HIV transmission risks: Implications for test-and-treat approaches to HIV prevention. *AIDS Patient Care and STDs*, 24, 271–277.
- Kalichman, S. C., Rompa, D., & Cage, M. (2005). Group intervention to reduce HIV transmission risk behavior among persons living with HIV/AIDS. *Behavior Modification*, 29, 256–285.
- Kalichman, S., Rompa, D., Cage, M., DiFonzo, K., Simpson, D., Austin, J., ... Graham, J. (2001). Effectiveness of an intervention to reduce HIV transmission risks in HIV-positive people. *American Journal of Preventive Medicine*, 21, 84–92.

- Karach, D. L., Hall, H. I., Tang, T., Hu, X., & Mermin, J. (2015). Comparative mortality among people diagnosed with HIV infection or AIDS in the U.S., 2001–2010. *Public Health Reports*, 130, 253–260.
- Kaymeg, K., Howard, V. M., Clochesy, J. M., Mitchell, A. M., & Suresky, J. M. (2010). The impact of high fidelity human simulation on self-efficacy of communication skills. *Issues on Mental Health Nursing*, 31, 315–323.
- Kinsler, J. J., Wong, M. D., Sayles, J. N., Davis, C., & Cunningham, W. E. (2007). The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care and STDs*, 21, 584–592.
- Laffon, B. T., Hall, H. I., Surendera, B. A., Benbow, N., Hu, Y. W., & Urban Areas HIV Surveillance Workgroup. (2015). HIV infection and linkage to HIV-related medical care in large urban areas in the United States, 2009. *Journal of Acquired Immune Deficiency Syndromes*, 69(4), 487–92.
- Leonard, A. D., Markham, C. M., Bui, T., Shegog, R., & Paul, M. E. (2010). Lowering the risk for secondary transmission: Insights from HIV-positive youth and health care providers. *Perspectives on Sexual and Reproductive Health*, 42, 100–116.
- Lesserman, J. (2008). Role of depression, stress, and trauma in HIV disease progression. *Psychosomatic Medicine*, 70, 539–545.
- Li, X., Huang, L., Wang, H., Fennie, K. P., He, G., & Williams, A. B. (2011). Stigma mediates the relationship between self-efficacy, medication adherence, and quality of life among people living with HIV/AIDS in China. *AIDS Patient Care and STDs*, 25, 665–671.
- Losina, E., Schackman, B. R., Sadownik, S. N., Gebo, K. A., Walensky, R. P., Chiosi, J. J., ... Freedberg, K. A. (2009). Racial and sex disparities in life expectancy losses among HIV-infected persons in the United States: Impact of risk behavior, late initiation, and early discontinuation of antiretroviral therapy. *Clinical Infectious Diseases*, 49, 1570–1578.
- Lynam, M. J., & Cowley, S. (2007). Understanding marginalization as a social determinant of health. *Critical Public Health*, 17, 137–149.
- Lyons, A., Pitts, M., Grierson, J., Thorpe, R., & Powell, J. (2010). Ageing with HIV: Health and psychosocial well-being of older gay men. *AIDS Care*, 22, 1236–1244.
- Magnus, M., Jones, K., Phillips, G., Binson, D., Hightow-Weidman, L. B., Richards-Clarke, C., ... Hidalgo, J. (2010). Characteristics associated with retention among African American and Latino adolescent HIV-positive MSM: Results from the outreach, care and prevention to engage HIV-seropositive young MSM of color special project of national significance. *Journal of Acquired Immune Deficiency Syndrome*, 53, 529–536.
- Magnussen, L., Ehiri, J., & Jolly, P. (2004). Comprehensive versus selective primary health care: Lessons for global health policy. *Health Affairs*, 23, 167–176.
- Mahajan, A. P., Sayles, J. N., Patel, V. A., Remien, R. H., Ortiz, D., Szekeres, G., & Coates, T. J. (2008). Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS*, 22, S67–S79.
- Malebranche, D. J., & Nelson, L. E. (2013). Intersections of race, culture, and sexuality. In J. Schneider & V. Silenzio (Eds.), *The gay and lesbian medical association handbook of LGBT health*. Washington, DC: Gay and Lesbian Medical Association.
- Marks, G., Gardner, L. I., Craw, J., & Crepaz, N. (2010). Entry and retention in medical care among HIV-diagnosed persons: A meta-analysis. *AIDS*, 24, 2665–2678.
- Mayer, K. H. (2011). Linkage, engagement, and retention in HIV care: Essential for optimal individual- and community-level outcomes in the era of highly active antiretroviral therapy. *Clinical Infectious Diseases*, 52, S205–S207.
- Mayer, K. H., Bekker, L. G., Stall, R., Grulich, A. E., Colfax, G., & Lama, J. R. (2012). Comprehensive clinical care for men who have sex with men: An integrated approach. *Lancet*, 380, 378–387.
- Mayer, K. H., Bush, T., Henry, K., Overton, E. T., Hammer, J., Richardson, J., ... The SUN Investigators. (2012). Ongoing sexually transmitted disease acquisition and risk-taking behavior among US HIV-infected patients in primary care: Implications for prevention interventions. *Sexually Transmitted Diseases*, 39, 1–7.

- Mayer, K. H., Vanderwarker, R., Grasso, C., & Boswell, S. L. (2016). Emerging models of clinical services for men who have sex with men: Focused versus comprehensive approaches. *Sexual Health*. doi:[10.1071/SH16119](https://doi.org/10.1071/SH16119), 14, 133.
- Miles, I. J., Le, B. C., Wejnert, C., Oster, A., DiNenno, E., & Paz-Bailey, G. (2013). HIV infection among heterosexuals at increased risk—United States, 2010. *MMWR*, 62, 183–188.
- Modjarrad, K., & Vermund, S. H. (2010). Effect of treating co-infections on HIV-1 viral load: A systematic review. *The Lancet*, 10, 455–463.
- Moore, R. (2011). Epidemiology of HIV infection in the United States: Implications for linkage to care. *Clinical Infectious Diseases*, 52, S208–S213.
- Mugavero, M. J., Norton, W. E., & Saag, M. S. (2011). Health care system and policy factors influencing engagement in HIV medical care: Piecing together the fragments of a fractured health care delivery system. *Clinical Infectious Diseases*, 52, S238–S246.
- Mullaly, B. (2010). Oppression: An overview. In B. Mullaly (Ed.), *Challenging oppression and confronting privilege: A critical social work approach* (2nd ed., pp. 34–65). Toronto: Oxford University Press.
- Navarro, V., & Muntaner, C. (2004). Towards an integrated political, economic, and cultural understanding of health inequalities. In V. Navarro & C. Muntaner (Eds.), *Political and economic determinants of population health and well being: Controversies and developments* (pp. 1–6). Amityville, NY: Baywood Publishers.
- Nelson, L. E., & Morrison-Beedy, D. (2012). Conducting intervention research in public health settings. In B. M. Melnyk & D. Morrison-Beedy (Eds.), *Designing, conducting, analyzing and funding intervention research: A practical guide for success* (pp. 247–254). New York: Springer.
- Nelson, L. E., Walker, J. J., DuBois, S. N., & Giwa, S. (2014). Your blues ain't like mine: Considering integrative antiracism in HIV prevention research with black men who have sex with men in Canada and the United States. *Nursing Inquiry*, 21, 270–282.
- Nelson, L. E., Wilton, L., Agyarko-Poku, T., Zhang, N., Alucok, M., Thach, C. T., ... Adu-Sarkodie, Y. (2015). The association of HIV stigma and HIV/STD knowledge with sexual risk behaviors among adolescent and adult men who have sex with men in Ghana, West Africa. *Research in Nursing and Health*, 38, 194–206.
- Nelson, L. E., Wilton, L., Moineddin, R., Zhang, N., Siddiqi, A., Sa, T., ... HPTN 061 Study Team. (2016). Economic, legal and social hardships associated with HIV risk among black men who have sex with men in six US cities. *Journal of Urban Health*, 93, 170–188.
- Oldenburg, C. E., Perez-Brumer, A. G., Reisner, S. L., Mayer, K. H., Mimiaga, M. J., Hatzenbuehler, M. L., & Bärnighausen, T. (2016). Human rights protections and HIV prevalence among MSM who sell sex: Cross-country comparisons from a systematic review and meta-analysis. *Global Public Health*, 15, 1–12.
- Oramasionwu, C. U., Hunter, J. M., Skinner, J., Ryan, L., Lawson, K. A., Brown, C. M., ... Frei, C. R. (2009). Black race as a predictor of poor health outcomes among a national cohort of HIV/AIDS patients admitted to US hospitals: A cohort study. *BMC Infectious Diseases*, 9. doi:[10.1186/1471-2334-9-127](https://doi.org/10.1186/1471-2334-9-127), 9.
- Pando, M. A., Balan, I. C., Marone, R., Dolezal, C., Leu, C., Squiquera, L., ... Avila, M. M. (2012). HIV and other sexually transmitted infections among men who have sex with men recruited by RDS in Buenos Aires, Argentina: High HIV and HPV infection. *PloS One*, 7(6). <http://dx.doi.org/10.1371/journal.pone.0039834>, e39834
- Parker, R. G. (2009). Civil society, political mobilization, and the impact of HIV scale-up on health systems in Brazil. *Journal of Acquired Immune Deficiency Syndrome*, 52, S49–S51.
- Poulton, B. C., & West, M. A. (1993). Effective multidisciplinary teamwork in primary health care. *Journal of Advanced Nursing*, 18, 918–925.
- Rachilis, S., Burchell, A. N., Gardner, S., Light, L., Raboud, J., Antoniou, T., ... Ontario HIV Treatment Network Cohort Study. (2016). Social determinants of health and retention in HIV care in a clinical cohort in Ontario, Canada. *AIDS Care*, 27, 1–10.

- Rao, J., Anderson, L., Thomas, I., & Frankel, R. (2007). Communication interventions make a difference in conversations between physicians and patients: A systematic review of the evidence. *Medical Care*, 45, 340–349.
- Rice, C. E., Maierhofer, C., Fields, K. S., Ervin, M., Lanza, S. T., & Turner, A. N. (2016). Beyond anal sex: Sexual practices of men who have sex with men and associations with HIV and other sexually transmitted infections. *Journal of Sexual Medicine*, 13, 374–382.
- Ricketts, T., Naiditch, M., & Bourgueil, Y. (2012). Advancing primary care in France and the United States. *Journal of Primary Care and Community Health*, 3, 221–225.
- Riley, E. D., Neilands, T. B., Moore, K., Cohen, J., Bangsberg, D. R., & Havlir, D. (2012). Social, structural and behavioral determinants of overall health status in a cohort of homeless and unstably housed HIV-infected men. *PloS One*, 7, e35207. doi:[10.1371/journal.pone.0035207](https://doi.org/10.1371/journal.pone.0035207).
- Rittenhouse, D. R., Shortell, S. M., & Fisher, E. S. (2009). Primary care and accountable care—Two essential elements of delivery-system reform. *New England Journal of Medicine*, 361, 2301–2303.
- Ross, M. W., Rosser, B. R., & Neumaier, E. R. (2008). The relationship of internalized homonegativity to unsafe sexual behavior in HIV-seropositive men who have sex with men. *AIDS Education and Prevention*, 20(6), 547–557.
- Safren, S. A., O’Cleirigh, C., Skeer, M. R., Driskell, J., Goshe, B. M., Covahey, C., & Mayer, K. H. (2011). Demonstration and evaluation of a peer-delivered, individually-tailored, HIV prevention intervention for HIV-infected MSM in their primary care setting. *AIDS and Behavior*, 15, 949–958.
- Sankar, A., Nevedal, A., Neufeld, S., Berry, R., & Luborsky, M. (2011). What do we know about older adults and HIV? A review of social and behavioral literature. *AIDS Care*, 23, 1187–1207.
- Schoen, C., Osborn, R., Doty, M. M., Squires, D., Peugh, J. P., & Applebaum, S. (2009). A survey of primary care physicians in eleven countries, 2009: Perspectives on care, costs, and experiences. *Health Affairs*, 28, 1171–1183.
- Schoen, C., Osborn, R., Squires, D., Doty, M., Rasmussen, P., Pierson, R., & Applebaum, S. (2012). A survey of primary care doctors in ten countries shows progress in use of health information technology, less in other areas. *Health Affairs*, 31, 2805–2816.
- Seffner, F., Garcia, J., Muñoz-Laboy, M., & Parker, R. (2011). A time for dogma, a time for the bible, a time for condoms: Building a Catholic theology of prevention in the face of public health policies at casa Fonte Colombo in Porto Alegre, Brazil. *Global Public Health*, 6, S271–S283.
- Serovich, J. M., Reed, S. J., Graftsky, E. L., & Andrist, D. (2009). An intervention to assist men who have sex with men disclose their serostatus to casual sex partners. *AIDS Education and Prevention*, 21, 207–219.
- Serovich, J. M., Reed, S. J., Graftsky, E. L., Hartwell, E. E., & Andrist, D. W. (2011). An intervention to assist men who have sex with men disclose their serostatus to family members: Results from a pilot study. *AIDS and Behavior*, 15, 1647–1653.
- Shapiro, M. F., Morton, S. C., McCaffrey, D. F., Senterfitt, J. W., Fleishman, J. A., Perlman, J. F., ... Bozzette, M. A. (1999). Variations in the care of HIV-infected adults in the United States: Results from the HIV costs and services utilization study. *JAMA*, 281, 2305–2315.
- Shegog, R., Markham, C. M., Leonard, A. D., Bul, T. C., & Paul, M. E. (2012). “+ CLICK”: Pilot of a web-based training program to enhance ART adherence among HIV-positive youth. *AIDS Care*, 24, 310–318.
- Sherer, R., Stieglitz, K., Narra, J., Jasek, J., Green, L., Moore, B., ... Cohen, M. (2002). HIV multidisciplinary teams work: Support services improve access to and retention in HIV primary care. *AIDS Care*, 14, 31–44.
- Shoptaw, S., Stall, R., Bordon, J., Kao, U., Cox, C., Li, X., ... Plankey, M. W. (2012). Cumulative exposure to stimulants and immune function outcomes among HIV-positive and HIV-negative men in the multicenter AIDS cohort study. *International Journal of STD and AIDS*, 23, 576–580.

- Simard, E. P., Fransua, M., Naishadham, D., & Jemal, A. (2012). The influence of sex, race/ethnicity, and educational attainment on human immunodeficiency virus death rates among adults, 1993–2007. *Archives of Internal Medicine*, 172, 1591–1598.
- Smit, P. J., Brady, M., Carter, M., Fernandes, R., Lamore, L., Meulbroek, M., ... Thompson, M. (2012). HIV-related stigma within communities of gay men: A literature review. *AIDS Care*, 24, 405–412.
- Stoeckle, J. D. (2009). The practice of primary care. In A. H. Goroll & A. G. Mulley's (Eds.), *Primary care medicine: Office evaluation and management of the adult patients* (6th ed., pp. 1–9). Philadelphia, PA: Lippincott, Williams, and Wilkins.
- Tennstedt, S. L. (2000). Empowering older patients to communicate more effectively in the medical encounter. *Clinical Geriatric Medicine*, 16, 61–70.
- Thigpen, M. C., Kebaabetswe, P. M., Paxton, L. A., Smith, D. K., Rose, C. E., Segolodi, T. M., Henderson, F. L., ... Brooks, J. T. (2012). Antiretroviral preexposure prophylaxis for heterosexual HIV transmission in Botswana. *New England Journal of Medicine*, 367, 423–434.
- Trevino, K. M., Pargament, K. I., Cotton, S., Leonard, A. C., Hahn, J., Caprini-Faigin, C. A., & Tsevat, J. (2010). Religious coping and physiological, psychological, social, and spiritual outcomes in patient with HIV/AIDS: Cross-sectional and longitudinal findings. *AIDS and Behavior*, 14, 379–389.
- van Griensven, F., & van Wijngaarden, D. L. V. (2010). A review of the epidemiology of HIV infection and prevention responses among MSM in AIDS. *AIDS*, 24, S30–S40.
- van Kesteren, N. M., Hospers, H. J., van Empelen, P., van Breukelen, G., & Kok, G. (2007). Sexual decision-making in HIV positive men who have sex with men: How moral concerns and sexual motives guide intended condom use with steady and casual partners. *Sexual Behavior*, 36, 437–449.
- Vanable, P. A., Carey, M. P., Blair, D. C., & Littlewood, R. A. (2006). Impact of HIV-related stigma on health behaviors and psychological adjustment among HIV-positive men and women. *AIDS and Behavior*, 10, 473–482.
- Weinberger, D. R., Elvevag, B., & Giedd, J. N. (2005). *The adolescent brain: A work in progress*. Washington, DC: The National Campaign to Prevent Teen Pregnancy.
- Weinman, M. (2010). Living well and sexual self-determination: Expanding human rights discourse about sex and sexuality. *Law, Culture and the Humanities*, 7, 101–120.
- White, W., Grant, J., Pryor, E. R., Keltner, N. L., Vance, D. E., & Raper, J. L. (2012). Do social support, stigma, and social problem-solving skills predict depressive symptoms in people living with HIV: A mediation analysis. *Research and Theory for Nursing Practice*, 26, 182–204.
- Yee, J. (2005). Critical anti-racism praxis in social work: The concept of whiteness implicated. In S. Hick, R. Pozzuto, & J. Fook (Eds.), *Social work: A critical turn* (pp. 87–104). Toronto: Thompson Educational Publishing.
- Young, L. E., Jonas, A. B., Michaels, S., Jackson, J. D., Pierce, M. L., Schneider, J. A., & uConnect Study Team. (2016). Social-structural properties and HIV prevention among young men who have sex with men in the ballroom house and independent gay family communities. *Social Science and Medicine*, 174, 26–34.
- Young, S. D., Shoptaw, S., Weiss, R. E., Munjas, B., & Gorbach, P. M. (2011). Predictors of unrecognized HIV infection among poor and ethnic men who have sex with men in Los Angeles. *AIDS and Behavior*, 15, 643–649.
- Zaller, N., Gilliani, F. S., & Rich, J. D. (2007). A model of integrated primary care for HIV-positive patients with underlying substance use and mental illness. *AIDS Care*, 19, 1128–1133.
- Zolopa, A. R., & Katz, M. H. (2012). HIV infection and AIDS. In S. J. McPhee, M. A. Papadakis, & M. W. Rabow (Eds.), *Current medical diagnosis and treatment, CMDT 2012* (Vol. 31, 51st ed.). New York: McGraw Hill, Lange.

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