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SEARCH STRATEGY

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S1	american journal of public health	Ebook Central, Public Health Database, Publicly Available Content Database	595043*

* Duplicates are removed from your search, but included in your result count.

Monitoring Intersectional Stigma: A Key Strategy to Ending the HIV Epidemic in the United States

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ABSTRACT (ENGLISH)

Barriers to HIV prevention and treatment in the United States persist. Although the Ending the HIV Epidemic (EHE) initiative holds promise, the success of the program may be stymied by inadequate frameworks and tools for monitoring intersectional stigma. Originating from a Black feminist critique of the consequences of treating race and gender as mutually exclusive categories,¹ intersectionality is a theoretical framework that examines how intersecting and mutually interdependent forms of power and oppression (e.g., racism, classism, cisgenderism, ableism) drive health inequities.²

Given that populations most affected by HIV are often impacted by stigma related to multiple axes of marginalization (e.g., race, socioeconomic position, sexual orientation), intersectionality is a valuable framework to understanding HIV inequities in the United States, and monitoring for intersectional stigma should be a key component of EHE activities because it allows for assessing health status and relevant behaviors over time to better determine intervention needs. We view monitoring expansively as ongoing, systematic processes to collect, analyze, disseminate, and utilize information regarding precursors, mechanisms, and outcomes of intersectional stigma within multilevel spheres of influence (e.g., within both academic research and public health practice). In this article, we discuss (1) current data sources and opportunities for monitoring intersectional stigma in public health practice, (2) key gaps within intersectional stigma research, and (3) implementation strategies for successful monitoring, which we believe will lead to more comprehensive, equitable, and ethical EHE interventions in the United States.

FULL TEXT

Barriers to HIV prevention and treatment in the United States persist. Although the Ending the HIV Epidemic (EHE) initiative holds promise, the success of the program may be stymied by inadequate frameworks and tools for monitoring intersectional stigma. Originating from a Black feminist critique of the consequences of treating race and gender as mutually exclusive categories,¹ intersectionality is a theoretical framework that examines how intersecting and mutually interdependent forms of power and oppression (e.g., racism, classism, cisgenderism, ableism) drive health inequities.²

Given that populations most affected by HIV are often impacted by stigma related to multiple axes of marginalization (e.g., race, socioeconomic position, sexual orientation), intersectionality is a valuable framework to understanding HIV inequities in the United States, and monitoring for intersectional stigma should be a key component of EHE activities because it allows for assessing health status and relevant behaviors over time to better determine intervention needs. We view monitoring expansively as ongoing, systematic processes to collect, analyze,

disseminate, and utilize information regarding precursors, mechanisms, and outcomes of intersectional stigma within multilevel spheres of influence (e.g., within both academic research and public health practice). In this article, we discuss (1) current data sources and opportunities for monitoring intersectional stigma in public health practice, (2) key gaps within intersectional stigma research, and (3) implementation strategies for successful monitoring, which we believe will lead to more comprehensive, equitable, and ethical EHE interventions in the United States.

INTERSECTIONAL STIGMA IN PUBLIC HEALTH PRACTICE

This section describes how select data sources can better address intersectional stigma at multiple levels of public health practice (federal, state, local, and community levels), pointing to actionable steps that can be taken now. More detailed information is provided in Appendix A (available as a supplement to the online version of this article at <http://www.ajph.org>).

At the federal level, EHE aims (pillars) are biomedical, and funding opportunities lack intersectional stigma-related monitoring and regulatory frameworks.³ As one example, the EHE data visualization Web site, AHEAD,⁴ excludes structural determinants of health such as intersectional stigma, filters combining multiple demographics for national-level data, and any stratifications for data on local jurisdictions, despite demographics being present in the source data. AHEAD and other data visualization Web sites such as AIDSvu⁵ would be improved by including a broader diversity of data sources that reflect intersectional stigma (e.g., surveys, laws, geographical indicators, court and prison records). By contrast to EHE, the 2022-2025 National HIV/AIDS Strategy for the US⁶ addresses intersectional stigma through its focus on racism as a public health threat, quality of life, integrated responses to intersecting health conditions, leadership for people living with HIV, structural determinants of health, reforming HIV criminalization laws, and intersectional priority populations (e.g., Black women).

At the state and local levels, health departments serve important monitoring and technical assistance functions. Jurisdictional EHE plans⁷ could add intersectional stigma pillars related to implementing programs for priority populations and utilizing an expansive array of data sources for metrics beyond HIV surveillance data. For example, administrative databases like Medicaid are prime opportunities for collection of intersectional stigma-related data and reporting EHE metrics. Similarly, health department funding contracts could stipulate collection of intersectional stigma-relevant data, including service utilization, client demographics, and organizational characteristics. Population-specific surveys that already include validated HIV stigma measures (e.g., Medical Monitoring Project) could be expanded to assess other types of stigma.

At the community level, embedding intersectional stigma measurement within routine engagement in HIV services could improve service quality and determine whether interventions reduce intersectional stigma. Examples of collectable data include assessment of trauma and resilience, stigmatization by providers, or whether policies and physical spaces are welcoming. Funders' focus on biomedical person-level or program-level outcomes (e.g., HIV care continuum),⁸ can preclude dedication of resources or personnel to stigma-mitigation activities. Therefore, framing intersectional stigma as a quality-of-care issue and establishing clear plans and agreements for how these data will be used are strategies that may accelerate provider buy-in.⁹ Providers may need valid measures and training on collecting intersectional stigma-related data, such as how to report on communities that are smaller in number and thus potentially more easily identifiable from reported data (e.g., Black transgender women and Latino gay men).

By virtue of lived experience, marginalized communities are quite familiar with the harmful consequences of intersecting systems of oppression, and, yet, they are often ostracized from decision-making roles. People who have personal experience with the stigma-related constructs in question should have positions of leadership in research activities, public health practice, and organizational development.¹⁰⁻¹³ It behooves us to adopt language used by communities (e.g., "whole-person approach") to demystify the concept of "monitoring" into concrete steps, measures, and best practices and to tailor intersectionality research for community partners. Partnerships must be equitable and characterized by shared leadership¹⁴ where all partners have the power to address their priorities and grievances and receive technical support and funding to participate in monitoring.

THEORETICAL AND MEASUREMENT CHALLENGES

Monitoring must be intersectional from conceptualization, design, analysis, and through to data interpretation and dissemination to prevent from rendering invisible the experiences of oppressed groups.¹⁵ Nonholistic approaches include relying upon additive notions of identity and experience, focusing on demographic variables devoid of their socio-historical contexts rather than more conceptually meaningful measures of inequity, and allowing intersectional stigma to remain implicit when opportunities arise to make it explicit.¹⁶ In this section, we discuss some conceptual, methodological, policy-related, and procedural gaps challenging integration of intersectional stigma within monitoring efforts.

Conceptual Gaps

Focusing solely on demographic characteristics and presenting data stripped of their structural, social, cultural, and historical origins poses problems for monitoring health inequities. These include (1) reductive attribution of outcomes to individual behavior or deficits within communities rather than systems and structures that ignore or exacerbate intersectional stigma, (2) reliance by decision-makers (e.g., policymakers, organizational leadership) on their own insufficient theoretical understandings or limited direct experiences with intersectional stigma processes when interpreting the significance of disparities, and (3) hyperfocus on the multiple intersecting social categories that comprise people's identities (i.e., "flattening" of intersectionality).¹⁷ The latter may perpetuate a false belief that disparities are somehow intrinsic to communities and intractable, rather than emphasizing actionable solutions and resiliencies within these populations. A myopic view of inequities that focuses exclusively on identity-related demographic differences is unjustifiable when more conceptually meaningful variables exist (e.g., socioeconomic status, food insecurity, trauma).

The 2022-2025 National HIV/AIDS Strategy's⁶ goal of achieving a 50% reduction in HIV stigma among people living with HIV ignores other forms of stigma (e.g., racism, sexism) that are based upon systems of inequality and power, consequently rendering them less visible in funding, monitoring, and programming. Because stigmas are interdependent and mutually constitutive, EHE must incorporate a more holistic view regarding reduction of intersectional stigma.

Methodological Gaps

Appropriate measurement. There are several existing approaches to examining stigma intersectionally.^{18,19} One approach is to independently assess different types of stigma by using either parallel questions (i.e., adapting the same stigma measure) or conditionspecific measures (e.g., experiences of racism and HIV stigma). Two important limitations of this approach are that a priori defined categories may not always be relevant or comprehensive and that asking questions about separate types of stigma requires participants to think independently about their identities, which goes against one of intersectionality's core tenets that social identities are multiple and intersecting, rather than unidimensional and independent.^{2,18}

A second approach is to compare HIV stigma across groups at different intersections (e.g., Black heterosexual women vs White bisexual men). Solely focusing on HIV stigma limits our ability to capture other types of discrimination, hampers understanding of which interventions to test first with certain populations or communities versus others, overly relies on demographic characteristics rather than larger structural factors, and may prevent examination of interaction effects in data analyses, which often requires large samples. This approach also requires a priori decisions regarding how many and which social categories to include, and proper categorization to identify intersectional groups.¹⁸

A third approach is to use attributionfree measures, such as the Intersectional Discrimination Index.¹⁸ This index is composed of three subscales that assess anticipated, day-to-day, and major discrimination. Participants are prompted to think about experiences they have had "because of who you are," thus, not priming specific attributional bases. This approach may overcome many of the challenges of the former, although more research and investment are needed to explore its utility within practice settings.

Qualitative and mixed-method research approaches can provide contextualized insight into the unique manifestations of intersectional stigma within certain populations and yield greater clarity regarding how intersectional stigma influences service utilization. Accordingly, such approaches may elucidate challenges to

achieving EHE outcomes. However, even mixed-method assessments of intersectional stigma require vigilance about integrating an intersectional approach, such as eschewing additive questions (e.g., How would you describe your experience as a Black person? Woman? Lesbian?) and avoiding asking respondents to rank their identities or discrimination experiences.¹⁶ Ultimately, effective development and use of intersectional stigma measures requires a primary focus on interlocking systems of oppression (not on identities) and meaningful engagement and empowerment of communities disproportionately affected by HIV.

Focus on individual-level factors. Efforts to study and monitor stigma generally focus on experiences of stigmatized individuals, often excluding interpersonal and structural processes in clinical settings and communities. EHE monitoring efforts must identify social and structural determinants that fuel intersectional stigma in these domains. If, for instance, we neglect how laws that criminalize HIV exposure, drug use, or sex work drive people to avoid services, then a focus solely on individual-level factors will lead to selection bias when we are evaluating progress toward EHE benchmarks. EHE monitoring needs to connect culture, policies, and laws to individual outcomes to elucidate change targets situated farther upstream from individual behavior.

Lack of inclusion of strength-based approaches. Assessment tends to focus on negative experiences and overlooks opportunities for assessing strengths and multilevel resilience, such as social support, coping, and collective action and advocacy.²⁰ It remains unclear which measures are most appropriate for monitoring strengths, but this approach can provide new avenues for intervention that resonate with affected populations and individuals and more closely align with how they view themselves.

Policy and Procedural Gaps

There are currently no widely accepted policies or procedures, nor a national strategy, to identify individual-, community-, or population-level impacts of intersectional stigma or to track intersectional stigma trends to ensure federal and state resources are quickly directed to meet the needs of affected populations. Public health information systems lack regulatory frameworks and scientific guidelines necessary to integrate intersectional stigma into monitoring. Limitations of existing data systems include a lack of validated measures, chronic underfunding for robust stigma data collection, limited reporting of who is receiving services and their health outcomes, siloed and duplicative data systems, and data monitoring requirements that are burdensome or may be too strenuous for smaller organizations. Institutions may lack capacity or procedures to effectively address unique needs of marginalized populations—such as ethics protocols to implement when stigma is reported by recipients of services—or may utilize systems that inadequately capture critical information necessary to do so, such as those that conflate gender identity and sexual orientation. For example, monitoring systems that only assess people's sex assigned at birth or that inadequately assess present gender identity²¹ may result in gender-diverse populations being either misclassified in analyses or misgendered, risking failure to monitor and address their unique health needs.

INTERSECTIONALITY PRACTICES FOR HIV PUBLIC HEALTH GOALS

To advance the public health goals of EHE, we propose three priorities for intersectional implementation of EHE monitoring activities: (1) ensuring access to validated stigma measures and supporting their use aligned with the core tenants of intersectionality, (2) motivating use of such measures via policy and data feedback loops, and (3) establishing equitable community partnerships.

Access

A measurement toolkit is needed to streamline access and dissemination by cataloguing current and future psychometrically validated measures and qualitative instruments and by providing written guidance on their adaptation to meet diverse needs. The National Institutes of Health-funded PhenX Toolkit²² is an aspirational format for an intersectional stigma toolkit because its protocols detail how to integrate a catalog of measures across studies, thereby increasing continuity and statistical power. Stakeholders need capacity building to monitor intersectional stigma in ways that do not perpetuate stigma. Capacity-building agencies that are adept at providing linkages between community, health care, academics, and health departments, such as AIDS Education and Training Centers, could provide training on monitoring that is aligned with principles of intersectionality.

Motivation

Reaching policy goals requires interagency coordination and regulatory frameworks for screening, identifying, and addressing intersectional stigma, whereby data are quickly returned to public health stakeholders who have opportunities to address stigma. In addition to explicitly adding intersectional stigma metrics to jurisdictional EHE plans and data dashboards, federal agencies should convene a national HIV-related intersectional stigma strategy working group to establish new policies, guidelines, and funding mechanisms for monitoring intersectional stigma, building upon the 2020 HIV-Related Intersectional Stigma Research Advances and Opportunities Workshop.²³ Tracking intersectional stigma trends can help ensure expedient distribution of resources to interventions that meet the needs of communities. One priority implementation strategy is development of national and local surveillance to monitor stigma indicators and outcomes. Current data-to-care programs signal health departments to re-engage clients lost to care, and data on intersectional stigma could likewise function as a sentinel event to prioritize the deployment of intervention specialists to mitigate stigma when it deters service engagement and, through a feedback loop, to quickly relay information to entities engaged in monitoring intersectional stigma. These data could be integrated into existing surveillance activities and dashboards and used to optimize processes for quality improvement within organizations.

Partnerships

Achieving EHE goals while attending to intersectional stigma requires participatory praxis that disrupts current inequitable power dynamics and improves opportunities for leadership and professional development among individuals from stigmatized communities.¹⁴ By its nature, intersectional stigma engenders feelings of mistrust, fosters disengagement, and makes people hesitant to disclose sensitive information.²⁴ Equitable approaches to ending the HIV epidemic necessitate rebuilding trust that has been historically broken by ensuring unencumbered access to expertise that exists across all partners. Ongoing engagement of community leaders, people living with HIV, and marginalized and historically underrepresented communities through entities such as the Centers for AIDS Research and the Federal AIDS Policy Partnership is critical to EHE implementation and comprehensive assessment of intersectional stigma.^{11,13,25} Partnerships must be mutually beneficial to all parties, interdisciplinary, and aligned with the core tenets of intersectionality, and must utilize ethical and empowering methods such as community-based participatory research.

CONCLUSIONS

Intersectional stigma provides a lens to examine how social and structural processes produce or exacerbate HIV-related health inequities. Although conceptual, methodological, and procedural gaps remain, the various data sources currently available in the United States are promising for monitoring intersectional stigma, and there are ample opportunities to improve monitoring as we work toward ending the HIV epidemic. The COVID-19 pandemic has further reinforced how crucial an intersectional approach is to monitoring effects of interlocking systems of oppression, not only toward ending the HIV epidemic but also ultimately toward dismantling the very systems that perpetuate health inequities. We propose that achieving these goals hinges upon increased access to and support for measurement of intersectional stigma and requires policies that motivate the use of intersectional measures with proper feedback loops, as well as equitable community partnerships. /AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts to declare.

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DETAILS

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Structural HIV Stigmatization and Discrimination Among Latina/x/o Immigrants: Intersections With Heterosexism, Ageism, and Transprejudice

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ABSTRACT (ENGLISH)

HIV stigmatization and discrimination (S&D) remain global health concerns for people at risk for or living with HIV. However, few studies have examined Latina/x/os' health in the context of multiple systems of oppression targeting their identities, including anti-immigrant prejudice.

Despite evidence that Latina/x/o immigrants in the United States have better health outcomes than non-Latina/x/o Whites, advantages are lost over time. HIV S&D generate barriers to accessing services along the HIV care continuum for Latina/x/os.¹ Undocumented Latina/ x/o immigrants experience unique factors that shape their health before, during, and after migration,² including S&D and sociopolitical marginalization (e.g., state-sanctioned discrimination, condemnation as criminals, underpayment for work) as well as structural barriers to accessing HIV services (e.g., denial of care, cultural/language incompetency). Unsurprisingly, undocumented Latina/x/o people living with HIV enter care with more advanced disease than documented individuals.³

Intersectional frameworks are needed to illuminate and alter or eliminate interlocking systems of oppression. These systems include sexism (assumption that men are superior to women), classism (belief that social or economic status determines a person's value), ableism (belief that able-bodied individuals are superior to individuals with disabilities), racism (belief that Whites are superior to those of other races/ethnicities), colorism (belief that a lighter skin tone is superior to a darker skin tone), heterosexism (assumption that heterosexuality is the only normal and natural expression of sexuality), ageism (belief that younger people are superior to older people), and transprejudice (negative valuing and stereotyping of individuals whose appearance or identity does not conform to social expectations or conventional conceptions of gender). Here we focus on heterosexism, ageism, and transprejudice to exemplify ways in which intersectional S&D affect Latina/ x/o immigrants.

FULL TEXT

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Despite evidence that Latina/x/o immigrants in the United States have better health outcomes than non-Latina/x/o Whites, advantages are lost over time. HIV S&D generate barriers to accessing services along the HIV care continuum for Latina/x/os.¹ Undocumented Latina/ x/o immigrants experience unique factors that shape their health before, during, and after migration,² including S&D and sociopolitical marginalization (e.g., state-sanctioned discrimination, condemnation as criminals, underpayment for work) as well as structural barriers to accessing HIV services (e.g., denial of care, cultural/language incompetency). Unsurprisingly, undocumented Latina/x/o people living with HIV enter care with more advanced disease than documented individuals.³

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HETEROSEXISM

Gay, bisexual, and other men who have sex with men (GBMSM) carry a disproportionately high HIV burden; in 2018, their risk of HIV acquisition was 22 times higher than among all adult men, and they accounted for 17% of new

HIV infections globally, including 40% in Latin America. HIV prevalence and incidence are higher among younger cohorts.⁴ New HIV diagnoses increased 6% between 2009 and 2018 among Latino GBMSM. Differences among Latinos by race and geography require further investigation. HIV and other health concerns (e.g., social isolation, psychological distress, suicidality) are associated with interlocking S&D, including racism and heterosexism toward Latino GBMSM.⁵

Despite advancements in HIV prevention and treatment, Latino GBMSM have limited access to HIV services. Barriers to HIV service access and use include heterosexist S&D and discrimination on the part of health providers,⁶ both of which are distinctively associated with HIV acquisition among Latino GBMSM after they have immigrated to the United States.¹ For example, criminalization of undocumented Latino immigrants contributes to their delayed diagnosis and presentation to care as well as to shorter HIV to AIDS intervals.³

Intersectionality invites more nuanced understandings of S&D. Intersectional racist-heterosexist microaggressions (e.g., "Latino gay men are hot in bed") are associated with anxiety and social isolation.⁷ Importantly, colorism, a bias toward lighter skin rooted in White supremacy, increases the complexity of intersectional S&D in that Black and darker-skinned Latino GBMSM contend with unique forms of S&D such as racial slurs, microaggressions (e.g., skin tone-based nicknames), and rejection, including by Latina/x/os.

Nonetheless, community engagement (e.g., volunteering and activism) and peer-led programs mitigate the negative effects of interlocking S&D. Intersectionality frameworks call for innovative approaches (e.g., community-based participatory research, community systems strengthening) that uncover how systems of oppression interact to produce conditions that block or advance the well-being of Latino immigrant GBMSM.

AGEISM

More than half of people with HIV are older than 50 years, with higher proportions among GBMSM. They face not only HIV and heterosexist S&D but ageism, racism, and colorism. Observed racial/ethnic inequities in younger cohorts are exacerbated in older age⁸ as a result of increased poverty, social isolation, and S&D. This is amplified by the intersection of racism, colorism, and sexism in the case of Latino GBMSM. Yet, older Latino GBMSM remain invisible in the literature,⁸ suggesting that the inequities described here are intensified in this group, especially among those with HIV. Research is urgently needed to answer basic epidemiological questions that can inform programs and interventions among the growing, diverse group of aging Latino GBMSM.

TRANSPREJUDICE

Thirty-five percent of immigrant Latina transgender women (ILTW) are living with HIV.⁹ ILTW are often targeted by S&D stemming from transprejudice, sexism, racism, ethnocentrism, classism, and anti-immigrant policies. Two large surveys conducted by community-based transgender organizations indicate that about half live in extreme poverty, and the majority suffer physical violence and threats.^{2,3} Most transgender individuals murdered in the United States are Black and Latina transgender women, reflecting the lethal intersection of transprejudice and racism. Deterrents to health care access among ILTW include inaccessible health insurance, lack of transgender health knowledge on the part of providers, microaggressions on the part of clinic staff, and fears of deportation among those who are undocumented. These factors interact to severely limit HIV care access among ILTW and contribute to poor physical and mental health outcomes.¹⁰

Sources of ILTW resilience that mitigate the effects of S&D and discriminatory behaviors include social support from transgender peers and involvement in community organizations advocating for transgender rights. Qualitative studies and community-based participatory research suggest that community health clinics with opportunities for social support from other ILTW and community involvement to advocate for transgender rights result in increased health care use and improved health outcomes.¹¹ Increasing transgender knowledge and cultural competence among providers and clinic staff also improves care access and health outcomes.

PUBLIC HEALTH IMPLICATIONS

Innovative, multimethod, and community-based participatory research approaches are necessary to capture the unique vulnerabilities and resiliencies of the interlocking identities associated with sustained social networks, cultural practices, and Latina/x/os' countries of origin (e.g., Cuban Americans benefit from policies that other Latina/x/os do

not benefit from). Epidemiological data are needed to disentangle effects related to place, social class, race/ethnicity, and economic status.

Research on Latina/x/o immigrants should be community engaged and participatory and should incorporate interdisciplinary approaches and intersectional frameworks. An intersectional praxis requires approaches that support local, grassroots, community-led movements that confront the ways in which trauma, immigration enforcement, disruptions of social networks, and anti-immigrant discrimination affect the mental and physical health of Latina/x/o immigrants.

Beyond research, advocacy aimed at decriminalization of undocumented immigrants could diminish S&D and improve health care access among Latina/x/os. Institutionally, hospital policies explicitly prohibiting S&D and promoting training of health providers to reduce discriminatory practices would improve access to, use of, and retention in services along the HIV care continuum. At the community level, fostering avenues for engagement would ameliorate the social isolation and psychological distress associated with rejection while mobilizing resistance to systems of oppression. In addition, much can be gleaned from examining the health implications of living in sanctuary regions for immigrant Latina/x/os with different intersectionalities.¹²

The US border with Latin America is a geographical boundary Latina/x/os cross pursuing safety and economic opportunity. Many Latino GBMSM and transgender women cross the border fleeing violence and other forms of persecution related to sexuality and gender only to encounter metaphorical walls plastered with exclusion messages. In addition to myriad insults, slights, and stares exhorting Latina/x/os, whether immigrant or US born, to go home, othering messages are most profoundly (and almost invisibly) delivered through interlocking structural forms of S&D.

As Bowleg affirms, "intersectionality is fundamentally a resistance project."¹³(p89) Addressing the intersectional vulnerabilities facing Latina/x/os requires a radical, multidisciplinary, inclusive praxis that challenges conventional approaches to health care and tackles interlocking structural obstacles while strengthening sources of resilience. Hermanos de Luna y Sol in San Francisco, CA, born of community-based participatory research, offers an example of an intersectional praxis.

Hermanos de Luna y Sol addresses the sexual health concerns of Latino GBMSM and transgender women. It is a theoretically derived, communitybased, peer-led program providing experiences of social support and social belonging, promoting critical awareness of the social and cultural forces shaping participants' social and sexual lives, and facilitating community building and activism against oppressive social forces. Using the space made available for them to gather and learn from each other, participants navigate obstacles, produce knowledge, change systems of oppression, and, in the process, teach us that it is only to the extent that Latina/x/os belong that we all belong.

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CONTRIBUTORS

S. Arreola led the overall development and conceptualization and the sections on heterosexism and public health implications. J. Ramirez-Valles contributed to the overall conceptualization and led the ageism section. R. M. Diaz contributed to the overall conceptualization and led the transprejudice section.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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DETAILS

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Intersectional Resilience Among Black Gay, Bisexual, and Other Men Who Have Sex With Men, Wisconsin and Ohio, 2019

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ABSTRACT (ENGLISH)

Objectives. To investigate resilience strategies used by Black gay, bisexual, and other men who have sex with men (MSM) to navigate racism and heterosexism. **Methods.** In 2019, we conducted in-depth interviews with 46 Black MSM in Milwaukee, Wisconsin, and Cleveland, Ohio. Thematic analysis, informed by intersectionality, was used to identify intersectional resilience within the context of participants' lives. **Results.** Our analyses revealed ways in which Black MSM respond to stigma and oppression. We identified the following themes that capture these experiences: pride in intersectional identities, perseverance, community advocacy, and social support. Our analyses reveal how men draw on these assets and resources to positively adapt despite experiences of racism and heterosexism. **Conclusions.** Intersectional resilience can support Black MSM in navigating racism and heterosexism. However, public health interventions at the institutional and system levels are needed to directly target the root causes of oppression and support resources that facilitate intersectional resilience. (Am J Public Health. 2022;112(S4):S405-S412. <https://doi.org/10.2105/AJPH.2021.306677>)

FULL TEXT

Headnote

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Methods. In 2019, we conducted in-depth interviews with 46 Black MSM in Milwaukee, Wisconsin, and Cleveland, Ohio. Thematic analysis, informed by intersectionality, was used to identify intersectional resilience within the context of participants' lives.

Results. Our analyses revealed ways in which Black MSM respond to stigma and oppression. We identified the following themes that capture these experiences: pride in intersectional identities, perseverance, community advocacy, and social support. Our analyses reveal how men draw on these assets and resources to positively adapt despite experiences of racism and heterosexism.

Conclusions. Intersectional resilience can support Black MSM in navigating racism and heterosexism. However, public health interventions at the institutional and system levels are needed to directly target the root causes of oppression and support resources that facilitate intersectional resilience. (Am J Public Health. 2022;112(S4):S405-S412. <https://doi.org/10.2105/AJPH.2021.306677>)

An increasing body of literature has demonstrated that Black gay, bisexual, and other men who have sex with men

(MSM) contend with intersectional stigma and discrimination.^{1,2} Intersectionality is a framework rooted in Black feminist scholarship and activism that highlights how social conceptualizations of race, class, sexuality, gender, and other social categories are interconnected and shape access to power, resources, and opportunity.^{3,4} With social justice roots,³ intersectionality has shed light on the intersecting structural dimensions of oppression and privilege. Intersectional stigma⁵ refers to the process by which some individuals are exposed to multiple forms of oppression, prejudice, and discrimination. Social processes, structures, and power dynamics privilege and marginalize historically disadvantaged people,⁶ contributing to disparate health outcomes.⁷ The intersection of race- and sexuality-based discrimination is linked to myriad negative health outcomes for Black MSM, including negative psychological and substance use outcomes⁸ and limited access to HIV prevention services.²

However, research on intersectional stigma is often deficit focused, losing sight of empowerment, resistance, and resilience within marginalized communities, a concept foundational to intersectionality.⁹ Resilience is most frequently defined through a White, Western lens that focuses on the process by which individuals positively adapt, recover, or cope within the context of adversity.¹⁰ More recently, researchers have expanded the framework to examine the systems and structures that support or threaten resilience and the positive adaptations individuals make despite oppression.¹¹

In this study, we examined intersectional resilience. Intersectional resilience recognizes that individuals with multiple marginalized statuses possess unique strengths that may confer a protective effect and focuses on how individuals navigate systems that engender adversity or promote wellness. The same factors that make people targets of intersectional stigma and discrimination can also act as resources and strengths. Furthermore, intersectional resilience considers the structural, cultural, and political contexts that shape adversity and resilience to understand how some individuals thrive in oppressive environments.

Research has started to examine the relationship between intersectional stigma and resilience. Foreexample, race- and sexuality-related stigma have been identified as sources of resilience and psychological growth. Research has shown that racial pride helped Black men cope with discrimination and negative stereotypes.^{12,13} Similarly, LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) people of color have described how adversity and hardship validated their experiences and promoted a sense of collective identity and belonging.¹⁴

We examined intersectional resilience among Black MSM, including the strategies men use to navigate racism and heterosexism. Although individuals may be exposed to other types of stigma (e.g., stigma related to HIV status), we focused on racism and heterosexism given their prominence among Black MSM.^{8,15} It is important to note that intersectional resilience is not a binary construct. That is, we did not categorize men as being or not being resilient. Rather, our aim was to examine various aspects of intersectional resilience in the lives of study participants.

METHODS

In 2019, we interviewed Black or African American cisgender men who were 18 years or older; identified as gay, bisexual, or otherwise having sex with men; reported negative or unknown HIV status; and resided in Cleveland, Ohio, or Milwaukee, Wisconsin. Interviews were conducted by a Black gay man in Milwaukee and by a Black gay man and Blacktrans woman in Cleveland. Interviews were done as part of a larger study examining the influence of social networks on uptake of preexposure prophylaxis.

We recruited a purposive sample through partnerships with LGBTQ service organizations and health care providers. Community recruitment strategies (e.g., recruiting participants at barber shops) and paid social media advertising were used to recruit individuals not affiliated with LGBTQ groups. Interviews lasted 30 to 90 minutes, and participants were compensated \$50.

A semistructured guide covered topics including health care, HIV prevention, and family and social life. The flexibility of the interview guide allowed the research team to probe for additional information about participants' experiences and follow their lead in discussions. This approach was useful in examining unanticipated or underexplored conceptualizations of intersectional stigma and resilience.

Interviews were audio-recorded and transcribed verbatim. To code data, we used MAXQDA qualitative data analysis software and a team-based analytic coding strategy. Initially, transcripts were coded with participants' characteristics

(e.g., age, study city). We then used inductive coding to generate a codebook. Three coders independently read 3 transcripts and generated lists of potential codes. These lists were refined and combined to create a single codebook that was applied to additional transcripts for further refinement and assessment of fit. Finally, axial coding was used to identify dominant concepts, group related codes, and draw connections among codes.¹⁶

We coded all interviews twice to ensure adequate application of the codebook. Coded transcripts were then analyzed via thematic analysis,¹⁷ focusing on oppression, resilience, and responses to stigma and marginalization. An intersectional lens was used throughout the analysis, with participants' experiences being examined in the context of their social positions as Black MSM. The following research question guided our analysis: How is intersectional resilience present in the lives of Black MSM?

RESULTS

The sample consisted of 46 Black MSM. The characteristics of the sample are presented in Table 1. Our results are organized around 4 themes: (1) pride in intersectional identities, (2) perseverance and navigation of masculinity expectations, (3) advocacy and leadership, and (4) social relationships. Excerpts from interviews are used to illustrate these themes. Pseudonyms are used throughout. Additional illustrative quotes are provided in Box 1.

Pride in Intersectional Identities

Throughout the interviews, men discussed experiencing racism and heterosexism throughout their lives. In reflecting on their experiences, several participants expressed pride in their identities and described overcoming stigma and oppression to get to a place of self-acceptance. As one participant noted, "I was trying to hide it. And being in the closet, I was not happy. And now that I am being myself, being a Black, gay, African American male, I am completely happy."

Similarly, another participant stated:

I take pride in being a Black gay man, 'cause being Black in society, you are already supposed to be bottom of the totem pole. Being gay on top of that, you really struck down. But I use my smarts, my education, my wits, my everything that I learned and achieved over the years to define me, not my race, not my sexuality, 'cause that has nothing to do with me . . . being a gay Black man, you should be proud of it. -Mark (22-year-old gay man, Cleveland)

This participant's reflection highlights the complexity of intersectionality and the difficulty of centering pride in the context of oppression. Mark expressed pride in being a Black gay man yet also noted that his race and sexuality had "nothing to do with me." These seemingly contradictory statements may reflect how he viewed himself as more than a Black gay man, despite society using those characteristics to determine his worth. Living in a racist and heterosexist environment has dictated his social position at the "bottom of the totem pole," and as a result he may see his education and accomplishments as important in defining himself in an environment that devalues other aspects of his identity.

Participants' affirmation and celebration of their marginalized identities as Black gay men reflect 1 aspect of intersectional resilience. Several individuals attributed some of their best personality traits to their gay identities: Being gay is what makes me. I wonder if I would be as clever, as witty, as intelligent you know, if I wasn't gay. It makes me think on my feet. It's made me had to be street smart. . . . I've never looked at it as a negative thing. The only negative thing is the way society views it. -Daniel (37-year-old gay man, Cleveland)

Similarly, another participant described how he coped with discrimination:

You just kind of cope with [racism and heterosexism] by knowing that you are the perfect version of yourself. You are a masterpiece in whatever, like, version of it is. . . . You are perfect, and you just can't let how other people perceive you affect that. -Johnny (20-year-old queer man, Milwaukee)

In this excerpt, Johnny is referencing "Masterpiece" by Jazmine Sullivan, a "self-love" song about being able to accept and love all things about oneself. He went on to describe the importance of self-love for himself and other Black gay men in coping with challenges associated with stigma: "No matter the adversity I go through, I keep moving forward. I refuse to be held down . . . what's attractive is going through true adversity, making it out on the other end with a smile on your face."

Perseverance and Navigation of Masculinity Expectations

Throughout their narratives, participants described perseverance in response to adversity and an internal motivation to "keep going" and not give up despite the challenges they faced. Several participants attributed these characteristics to their identities as Black men. For example, according to one participant:

I'm proud to be a Black man. Being a Black man is overcoming odds, to me, because people think that you can't do certain stuff or that you won't be successful because of the stigma. If you overcome it as a Black man, then that's good to me. That's what I want to do: overcome the stigma, be something. -Shawn (19-year-old gay man, Cleveland)

In articulating their experiences with intersectional stigma, nearly all of the participants expressed a desire to persevere and "overcome the stigma" and negative stereotypes they faced. Yet, there was a shared understanding that they were individually responsible for coping with and overcoming oppression.

You already coming with the Black strike against you. Now you have the gay strike against you. It's incredibly tough and you have to have a thick skin. And going back to the whole masculinity thing, that's where the whole confidence or belief in yourself has to come into play ... to be resilient, it means to be strong, that you're a fighter. -Daniel (37-year-old gay man, Cleveland)

In this excerpt, Daniel defines resilience as being "strong" and "a fighter," a perception that was common among men in this study. When considering the intersection of racism and heterosexism, more than half of the study participants described masculinity norms and expectations. There was a shared sense that, as Black men, they were expected to be strong, hide their emotions, "be dominant," and "carry yourself like a straight man would." Conforming to masculinity norms was perceived as essential to navigating and surviving daily life and avoiding intersectional stigma. For example, one participant described how his masculinity helped him "to blend in" to avoid heterosexism. Individuals also noted that these expectations reflected an image of masculinity that was often at odds with how they were perceived as gay and bisexual men. As one participant stated, "[Being gay] doesn't coincide with that ideal image of masculinity in this world."

Advocacy and Leadership

Engaging in advocacy and challenging societal norms and stigma were important components of intersectional resilience for study participants. Men described their exclusion and lack of representation in predominantly White or heteronormative spaces. For example, participants in both Cleveland and Milwaukee noted a lack of predominantly Black bars and clubs for gay and bisexual men and described systematic ways in which they were excluded from White gay bars, with one participant noting that "they did their best to keep Black people from coming." Participants described bars that "don't wanna play any type of Black music" and clubs that began to "up the price of drinks" in an attempt to exclude Black men. In response, some participants found meaning in becoming advocates and leaders in their communities, creating their own spaces and relationships that celebrated Black gay men. For example, one participant described how he sought to combat stigma facing the Black gay community:

I think a lot of the stigma that they had about the gay lifestyle I broke. I get tested regularly, I advocate for my community when I can and whatever I can help out I volunteer. I've done work with the [sexually transmitted infection] clinic and did testing with them. I've shown them a positive part of the gay lifestyle. -TJ (29-year-old gay man, Milwaukee)

Advocacy and volunteer work provided opportunities for participants to support their communities and cope with or resist oppression. This was particularly evident when individuals described their informal work in HIV prevention advocacy and sexual education within the community. One participant noted that "I try to make sure I'm servicing my community.... I try my best to just be an advocate and lower the stigma whenever I can." Another individual described his HIV prevention advocacy and education work with Black gay men, noting that "I continue to fight the good fight."

In addition, several participants talked about their role in advocacy and social change. Some described themselves as community leaders and influencers who were well respected in their communities. One participant noted that his friends lovingly referred to him as "the preacher" because of his regular informal advocacy around HIV prevention. Others noted that they were a source of inspiration for other Black gay and bisexual men. For example:

I'm so amazed when people tell me that I have such a big influence, and people listen to me and you know, they look up to you, and I'm like "Holy shit! I am a big piece of work." -James (25-year-old bisexual man, Milwaukee)

Men who described themselves as leaders talked about the positive feelings they experienced with respect to being "inspiring" or having a big influence, as well as their desire to use that influence to better their community. One participant in Cleveland described heterosexism in Black communities, noting that "I think progress is happening, and that's why I say we're pioneers. Because that was a really tough wall to break down in our own communities, in our own acceptance of one another."

Social Relationships

Data from this study reveal the complexity of social support as a component of intersectional resilience. Although some individuals described rejection, heterosexism, and anxiety around coming out to their families, others noted the importance of their families in helping them cope with oppression, particularly racism. One individual described his experiences with racism in school:

I had a good balance of family and I always realized that not everybody had that. So, when the community and the world said what they wanted to say, I came back to my family and I got to heal, and talk about that, and feel that out so I didn't carry that with me or believe the things that people said. -Randall (35-year-old gay man, Cleveland)

Even when individuals' experiences with intersectional stigma threatened their sense of self, many drew on social relationships that supported their identities. Families were often described as important sources of support and resilience in combating racism and developing resilience.

Approximately half of the study participants described the importance of the support they received from other Black MSM. These relationships were particularly important in helping individuals cope with discrimination and stigma. I am surrounded with people. I still have cousins and my mother and my grandfather and my father and people around me that just love me genuinely. But if it's a gay issue and I want somebody that can relate, then I've got 3 gay Black men in my life that can usually relate to what I'm going through, so I got really good guides. And that's kind of how I cope with it. -Ned (30-year-old bisexual man, Milwaukee)

Even for individuals who had strong relationships with their families of origin, there was a need for support from other Black MSM who could relate to their experiences and help them cope with intersectional stigma. Creating relationships and community with people of the same intersecting identities was an important way men developed pride in their identities.

DISCUSSION

Our examination of intersectional resilience among Black MSM highlights how these individuals thrive not despite their oppression and marginalized identities but because of them. Applying an intersectional lens to resilience brings awareness of the power and agency of intersectionally marginalized communities and turns attention toward systems and structures that contribute to marginalization or promote resilience.¹¹ Although men in this study often conceptualized resilience as an individual attribute, their experiences also reflect how systems and environments shape oppression and resilience.

Typically, intersectional stigma research with Black MSM focuses on the negative forces that increase risks for HIV or contribute to disparate health outcomes.^{8,18} However, men in this study described their marginalized identities as a source of pride and used their social positions to support other Black MSM. For example, young Black MSM may harness intersectional resilience through community leadership and having a visible, positive impact in their communities to help them combat the social degradation caused by oppression and marginalization. This aligns with previous research in which LGBTQ people of color have articulated narratives of "positive intersectionality" wherein they create a culture of acceptance and empowerment around their identities, increasing resilience and well-being.¹⁹

In addition, researchers have found that members of Black sexual minority groups report experiencing positive intersectional events (those associated with being both Black and LGBTQ) at a rate nearly 3 times that of negative events. These positive, identity-supportive experiences are associated with positive affect.²⁰

Men's descriptions of resilience, namely as being "strong" or "a fighter," may reflect masculinity norms placed on

Black men. Such norms are rooted in historical racialized contexts²¹ and often conflate masculinity and heterosexuality, making it difficult for Black MSM to achieve societally prescribed masculine expectations.^{15,22} Furthermore, participants' experiences of masculinity reflect the simultaneous racism and heterosexism they experience, creating pressures around masculinity in ways that are especially acute. Our findings align with those of prior research in highlighting the challenges Black MSM face in navigating masculine expectations and the consequences of those expectations for self-perception and health behaviors.²³

Relatedly, men often located the responsibility of overcoming adversity within themselves, which may reflect social narratives around resilience such as pulling oneself up by the bootstraps and bouncing back from challenges. Black MSM may internalize or draw on these expectations to navigate and survive the systemic racism and heterosexism they encounter.²⁴ However, the weight of these expectations and efforts to overcome unrelenting oppression may have negative long-term consequences. For example, John Henryism²⁵ is a phenomenon among African Americans in which active coping against persistent social oppression can result in negative health outcomes. That is, Black MSM may be surviving the intersectional stigma they encounter but not without a physical or psychological toll.

Men in this study described how they mobilized to become community advocates and leaders and expressed a desire to improve their communities and the experiences of Black MSM. In doing so, they were able to exert agency and make efforts to intentionally resist oppression. As advocates, men recognized that they were not powerless in their lives or communities. This mirrors research with Black MSM demonstrating their desire to engage in social action and act as community leaders.^{26,27} The cultivation of Black MSM as community leaders and role models may be an essential aspect of intersectional resilience, as it can help change societal norms and create more inclusive and resilient spaces and communities.

The intersecting stigmas facing Black MSM often meant that they had to navigate multiple spaces and group memberships, requiring skilled navigation. Several men struggled to find sources of support and belonging in their communities and described challenges in navigating their families of origin or their involvement in largely White LGBTQ spaces. In line with previous research,²⁸⁻³⁰ participants described the importance of support from other Black gay men in facilitating belongingness and coping with intersectional stigma. Belongingness and community can serve to validate individuals' experiences of oppression and facilitate opportunities for marginalized individuals to create their own spaces to interrogate and resist oppression.¹⁴

Limitations

The interview guide for this study did not promote conversations on the social and political environments in which resilience occurs. Thus, our data provide little context on participants' social environments and how these environments may have supported or constrained resilience. In addition, outcomes research is needed to understand how intersectional resilience influences HIV risk, mental health, and other health outcomes, including the potential psychological toll of resilience.

Conclusions

Intersectional resilience makes way for interventions that create safe and affirming environments for Black MSM harmed by intersectional stigma, advocacy and social change efforts led by and targeting Black MSM, and structural change to address racism and heteronormativity. Collective action is an active form of community participation wherein individuals work to resist oppression and improve the political and social conditions of their communities.³¹ Collective action is associated with increases in empowerment and well-being³² and with lower levels of internalized stigma³¹ and minority stress.³³ For example, engagement in the Black Lives Matter movement can instill an individual sense of racial pride while simultaneously combating societal racism and contributing to community change.³⁴ Such interventions can work to dismantle intersectional oppression and celebrate Black MSM. Intersectional resilience may protect Black MSM from negative health consequences, including those associated with experiencing racism and heterosexism. As is evident from our results, pride in intersectional identities, perseverance, activism, and social support networks may be key to supporting power, agency, and intersectional resilience among Black MSM. However, regardless of one's individual-level resilience resources, societal oppression

shapes access to resources and power and engenders adversity. Public health interventions should aim to dismantle oppressive institutions and systems rather than calling on marginalized communities to be resilient to systemic oppression. /AJPH

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K. G. Quinn oversaw qualitative data collection, led the data analysis, and drafted the article. J. Dickson-Gomez assisted in the qualitative data analysis and the writing of the article. B. Pearson conducted the interviews and assisted with interpretation of results. E. Marion assisted in writing and analysis. Y. Amirkhanian provided feedback on the article. J.A. Kelly provided extensive feedback on the article and the analysis.

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The authors have no conflicts of interest to disclose.

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All procedures were reviewed and approved by the institutional review board at the Medical College of Wisconsin. Participants provided informed consent.

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Intersecting Stigmas: Being Black African, Immigrant, and Living With HIV in the United States

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ABSTRACT (ENGLISH)

Nationally, HIV incidence among African immigrants is six times higher than in the general population and nearly twice that of US-born Black individuals.^{1,2} The precise number of African immigrants living with HIV (ALWH) in the United States is unknown, because of the lack of disaggregated HIV surveillance data on Blacks or African Americans by country of birth. Compared with the HIV epidemiological profile for US-born Black people, among ALWH there are higher rates of heterosexual transmission and higher rates among women. Although some ALWH may have acquired HIV prior to migration, a significant proportion acquire HIV after migration.² HIV risk after migration is due to complex sociocultural, psychosocial, and structural conditions, such as xenophobia and racism. African immigrants are less likely to test for HIV and often present late to care.^{3,4} HIV-related stigma is higher among African immigrants than among other groups, further exacerbating risk factors and systemic barriers.³ As this population grows, it is critical to understand their unique experiences with HIV-related stigma and address intersecting stigmas associated with race, nativity, immigration status, ethnicity, language, and HIV status.

FULL TEXT

Nationally, HIV incidence among African immigrants is six times higher than in the general population and nearly twice that of US-born Black individuals.^{1,2} The precise number of African immigrants living with HIV (ALWH) in the United States is unknown, because of the lack of disaggregated HIV surveillance data on Blacks or African Americans by country of birth. Compared with the HIV epidemiological profile for US-born Black people, among ALWH there are higher rates of heterosexual transmission and higher rates among women. Although some ALWH may have acquired HIV prior to migration, a significant proportion acquire HIV after migration.² HIV risk after migration is due to complex sociocultural, psychosocial, and structural conditions, such as xenophobia and racism. African immigrants are less likely to test for HIV and often present late to care.^{3,4} HIV-related stigma is higher among African immigrants than among other groups, further exacerbating risk factors and systemic barriers.³ As this population grows, it is critical to understand their unique experiences with HIV-related stigma and address intersecting stigmas associated with race, nativity, immigration status, ethnicity, language, and HIV status.

SOCIOCULTURAL CONTEXT OF HIV-RELATED STIGMA

Cultural values and norms determine perceptions about the causes of diseases, influence behaviors, and shape prevention and care decisions. Stigmatizing attitudes about HIV need to be understood within the context of African cultural values and norms that migrated with African immigrants from their home countries to the United States.⁴ HIV continues to be seen as a "death sentence" and aligned with behaviors that are considered deviant and immoral, such as having multiple partners, homosexuality, and premarital or extramarital sex.⁵ Hence, merely going to get tested is sufficient to elicit stigma. In some African societies, HIV is understood as a divine punishment for a sin or a spiritual curse.⁵ African immigrants living with HIV often experience distancing, gossiping, and shunning from family, friends, and the community. This leads to denial, social isolation, nondisclosure, and fear of integration into the larger US community. Given the collectivist culture of African communities, the impact of HIV stigma extends to the whole family, bringing dishonor and harming the family's reputation.⁴ Consequently, ALWH would rather hide their diagnosis from family and community members in the United States, as well as in Africa, and not seek care than face censure and shame.⁵ Gender biases within some African cultures limit women's sexual and reproductive autonomy, prevent communication about sexual health with partner(s), and fuel intimate partner violence.⁶ Concurrently, African masculinity stigmatizes men's willingness to engage with HIV testing and care. Across the continent of Africa, anti-homosexuality bills are criminalizing lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual (LGBTQIA+) individuals, which multiplies the stigma and shame experienced by these

communities.

INTERSECTIONAL STIGMA AMONG AFRICAN IMMIGRANTS

While navigating the challenges of HIV-related stigma, African immigrants in the United States are also socially marginalized because of multiple identities based on race, nativity, immigration status, ethnicity, and language (Table 1). Stigmas associated with African immigrants' intersecting identities (e.g., being Black, foreign-born, and a non-English speaker) compound their vulnerability to HIV and discrimination based on their HIV status.

Although there are similarities in terms of anti-Black interactions with US systems, the experiences of African immigrants in the United States differ from those of US-born Black people because of converging socially oppressed identities related to being an immigrant. As noted by Castañeda et al.,

being an immigrant limits behavioral choices and, indeed, often directly impacts and significantly alters the effects of other social positioning, such as race/ethnicity, gender, or socioeconomic status, because it places individuals in ambiguous and often hostile relationships to the state and its institutions, including health services.⁷(p378)

Being Black

African immigrants are subjected to anti-Black racism and related injustices and health disparities experienced by US-born Black people. State-sanctioned violence, for example, is a reality underscored by the murders of Amadou Diallo, Alfred Olango, Ousmane Zongo, and other African immigrants unjustly killed by the police. Health disparities among African immigrants are a consequence of living longer in the United States, adopting local behaviors, and having racialized experiences that affect health outcomes, similar to their US-born counterparts.

Being Black and an African Immigrant

Despite the growing efforts of national movements, such as #ImmigrationIsABlackIssue (a social media mantra coined by UndocuBlack Network), Africans are often excluded from the US immigration narrative. Stigmatizing beliefs and stereotypes toward racialized immigrants, including African immigrants, are reflected in anti-immigrant rhetoric and policies,⁸ making African immigrants more vulnerable because of their Blackness as well as their status as foreigners. Racist rhetoric, such as a US president referring to African nations as "shithole" countries, fuels existing stereotypes about Africans being lazy, poor, dirty, and constantly seeking aid. Examples of harmful policies that specifically stigmatized African immigrants include the 2017 travel bans preventing nationals of selected African countries from entering the United States, and the fluctuating authorization of Deferred Enforced Departure and Temporary Protected Status for individuals from Liberia, Sierra Leone, Somalia, Sudan, and Guinea. African immigrants are targeted and criminalized by both local law enforcement and immigration enforcement, thus facing arrest, detention, and deportation at disproportionate rates.⁹ Anti-immigrant stigma leads to worse health outcomes by targeting distinct racial/ethnic populations and limiting health resources, including HIV services, to immigrants with specific statuses.⁷ Overall, restricted access to health insurance, uncertainty regarding eligibility for health services based on immigration status, and fears of rejection of one's citizenship request or deportation if one tests HIV positive impede engagement in HIV testing, treatment, and prevention efforts.¹⁰ Often, immigrants living with HIV who are detained or in deportation proceedings live in unhygienic conditions, are denied interpreters and access to their medical records, and receive subpar treatment, with no access to HIV specialists.¹¹

Being Black, an African Immigrant, and Multilingual

Language is used to reinforce existing oppressions and reiterate the differential status of immigrants in the United States. Being able to speak American English like a native speaker and not having a foreign accent is tied to career mobility, higher income, and ease of navigating US institutions, including the health care system. African immigrants tend to be multilingual-including colonial and native languages-and prefer to speak dialects that are not considered mainstream in the United States. Linguistic discordance with health care providers, inadequate interpreter and translation services, and lack of linguistically appropriate health materials contribute to delays in engagement in care, late initiation of antiretroviral therapy, and increased risk of onward HIV transmission for African immigrants.

CONCLUSION

Explicit efforts to illuminate and address the nuances of HIV-related stigma and interlocking systems affecting the lives of African immigrants are needed. Specifically centering African immigrants requires examining intersecting

stigmas based on race, nationality, ethnicity, immigration status, and language that influence their uptake of HIV services and overall well-being. This has implications for HIV surveillance, research, and practice. It is critically important for national and local HIV data sets to disaggregate race and ethnicity data by "country of birth." This will provide a more accurate account of the national epidemic in the United States, and document the HIV epidemiological profile of African immigrants to support targeted interventions. More research is needed to understand immigration as a social determinant of health, which influences access and utilization of HIV services. Various immigration-related factors are relevant for HIV research, such as immigration status, length of time in the country, age at time of migration, preferred language, and English language proficiency. Moreover, interventions addressing HIV stigma among African immigrants are limited. Much of the effort to address HIV stigma among African immigrants has been developed locally, led by or in partnership with communities. Strategies incorporate cultural activities, storytelling and media, and bundling HIV testing with other health screenings to maximize prevention while destigmatizing HIV services.¹² HIV stigma-reducing interventions need to be culturally and linguistically tailored, multilevel, and conducted in partnership with the community. More specifically, direct funding to community-based organizations is needed to evaluate and scale up community-defined HIV interventions to reduce HIV stigma.

Failure to recognize the widespread issue of HIV among African immigrants has resulted in a lack of HIV prevention and care initiatives for this growing US population. An intersectionality framework can serve as a useful tool to improve documentation and understanding of the HIV epidemic among African immigrants, implement targeted solutions, and create policies that directly address their unique positioning in the United States. ÂfPU

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DETAILS

Subject:	Domestic violence; Stigma; Health disparities; Racism; Black people; Medical tests; Acquired immune deficiency syndrome--AIDS; Surveillance; Race; Country of birth; Language; Cultural values; Community; Ethnicity; Immigration policy; Human immunodeficiency virus--HIV; Deportation; Migration; Immigrants; Prevention; Stereotypes; Multilingualism; Multiculturalism & pluralism; Health services; Minority & ethnic groups; Epidemiology; Sociocultural factors; Risk analysis; Immigration; African cultural groups; Risk factors; Health risks; Heterosexuality; Discrimination; Demographic change; African Americans; Xenophobia
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HIV-Related Intersectional Stigma and Discrimination Measurement: State of the Science

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[ProQuest document link](https://www.proquest.com/scholarly-journals/intersecting-stigmas-being-black-african/docview/2717342344/se-2?accountid=211160)

ABSTRACT (ENGLISH)

Background. Across settings, individuals from populations that are multiply stigmatized are at increased risk of HIV and experience worse HIV treatment outcomes. As evidence expands on how intersecting stigmatized identities and conditions influence HIV outcomes, researchers have used diverse quantitative approaches to measure HIV-related intersectional stigma and discrimination. To date, no clear consensus exists regarding how to best quantitatively measure and analyze intersectional stigma and discrimination. **Objectives.** To review and document existing quantitative measures of HIV-related intersectional stigma and discrimination to inform research, programmatic, and policy efforts. **Search Methods.** We searched 5 electronic databases for relevant studies. References of included articles were screened for possible inclusion. Additional articles were screened on the basis of consultations with

experts in the field. **Selection Criteria.** We included peer-reviewed studies published between January 1, 2010, and May 12, 2021, that were HIV related and presented 1 or more quantitative measures of stigma and discrimination using an intersectional lens in measure design or analysis. **Data Collection and Analysis.** Systematic methods were used to screen citations and abstract data via a standardized coding form. Data were analyzed by coding categories stratified according to 2 subgroups: (1) studies incorporating a single intersectional measure and (2) studies that examined intersectional stigma through analytical approaches combining multiple measures. **Main Results.** Sixteen articles met the inclusion criteria, 7 of which explicitly referenced intersectionality. Ten studies were from the United States. All of the studies included participants living with HIV. Among the 4 studies incorporating a single intersectional stigma measure, 3 explored race and gender stigma and 1 explored gender and HIV stigma. Studies involving analytic approaches ($n = 12$) mostly examined intersectional stigma via interaction terms in multivariate regression models. Three studies employed structural equation modeling to examine interactive effects or latent constructs of intersectional stigma. **Conclusions.** Research on the measurement of HIV-related intersectional stigma and discrimination is currently concentrated in high-income settings and generally focuses on the intersection of 2 identities (e.g., race and gender). Efforts are needed to expand appropriate application of intersectionality in the development, adaptation, and use of measures of HIV-related intersectional stigma and discrimination. The use of context-, identity-, or condition-adaptable measures should be considered. Researchers should also carefully consider how to meaningfully engage communities in the process of measurement development. **Public Health Implications.** The measures and analytic approaches presented could significantly enhance public health efforts in assessing the impact of HIV-related intersectional stigma and discrimination on critical health outcomes. (Am J Public Health. 2022;112(S4):S420-S432. <https://doi.org/10.2105/AJPH.2021.306639>)

FULL TEXT

Headnote

Background. Across settings, individuals from populations that are multiply stigmatized are at increased risk of HIV and experience worse HIV treatment outcomes. As evidence expands on how intersecting stigmatized identities and conditions influence HIV outcomes, researchers have used diverse quantitative approaches to measure HIV-related intersectional stigma and discrimination. To date, no clear consensus exists regarding how to best quantitatively measure and analyze intersectional stigma and discrimination.

Objectives. To review and document existing quantitative measures of HIV-related intersectional stigma and discrimination to inform research, programmatic, and policy efforts.

Search Methods. We searched 5 electronic databases for relevant studies. References of included articles were screened for possible inclusion. Additional articles were screened on the basis of consultations with experts in the field.

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Main Results. Sixteen articles met the inclusion criteria, 7 of which explicitly referenced intersectionality. Ten studies were from the United States. All of the studies included participants living with HIV. Among the 4 studies incorporating a single intersectional stigma measure, 3 explored race and gender stigma and 1 explored gender and HIV stigma. Studies involving analytic approaches ($n = 12$) mostly examined intersectional stigma via interaction terms in multivariate regression models. Three studies employed structural equation modeling to examine interactive effects or latent constructs of intersectional stigma.

Conclusions. Research on the measurement of HIV-related intersectional stigma and discrimination is currently concentrated in high-income settings and generally focuses on the intersection of 2 identities (e.g., race and

gender). Efforts are needed to expand appropriate application of intersectionality in the development, adaptation, and use of measures of HIV-related intersectional stigma and discrimination. The use of context-, identity-, or condition-adaptable measures should be considered. Researchers should also carefully consider how to meaningfully engage communities in the process of measurement development.

Public Health Implications. The measures and analytic approaches presented could significantly enhance public health efforts in assessing the impact of HIV-related intersectional stigma and discrimination on critical health outcomes. (Am J Public Health. 2022;112(S4):S420-S432. <https://doi.org/10.2105/AJPH.2021.306639>)

PLAIN-LANGUAGE SUMMARY

We conducted a systematic review of peer-reviewed studies to document existing quantitative measures of HIV-related intersectional stigma and discrimination as a means of informing research, programmatic, and policy efforts. We included studies published between January 1, 2010, and May 12, 2021, that were HIV related, incorporated 1 or more quantitative measures of stigma and discrimination, and involved the use of an intersectional lens in measurement design or analysis. A total of 16 articles met the inclusion criteria. Among these, 7 studies explicitly referenced intersectionality, 10 were conducted in the United States, and all included participants living with HIV. Most studies examined intersectional stigma through analytic approaches ($n = 12$), with the majority exploring stigma via interaction terms in multivariate regression models. Only 4 studies examined intersectional stigma via a single, intersectional measure. Our results indicate that measurement of HIV-related intersectional stigma and discrimination is concentrated in high-income settings and generally focuses on the intersection of 2 identities (e.g., race and gender). Efforts are needed to expand appropriate application of intersectionality in quantitative HIV research, including intersectional stigma related to more than 2 identities, statuses, or conditions. Careful consideration should be given to how we engage communities and honor the principles of intersectionality when adapting measures for intersectional HIV research.

More than 20 years ago, African American feminist legal scholar Kimberlé Crenshaw used the term "intersectionality" to describe how multiple forms of inequalities, mainly due to race and gender, were embedded in the United States legal system and often intersected to create distinct barriers for marginalized individuals and groups.¹ Through her work describing the unique experiences of discrimination and violence among African American women in the United States, she argued that individuals' specific social realities are based on their affiliation to multiple marginalized identities and social positions.^{1,2} In coining the term intersectionality, Crenshaw drew on the work of previous Black feminists^{3,4} and argued that Black women's experiences were more than the sum of their parts (e.g., being both Black and women), instead converging from interdependent systems of power and oppression.^{1,5}

Over the past decade, interest in applying intersectionality as a theoretical lens and orientation to study health inequities—including in relation to HIV prevention, treatment, and care—has grown exponentially.² The groups at highest risk for acquiring HIV in the United States and globally are those whose identities encompass multiple socially stigmatized populations, such as marginalized groups at the intersections of racial/ethnic, gender, and sexual minority status. Possible examples of groups at these unique intersections include young Latinx and Black men who have sex with men in the United States,^{6,7} Black and Latina transgender women living in the United States,⁸ and young Black women and girls in South Africa.⁹

Studies have also shown that people living with HIV who are members of multiply stigmatized population groups experience worse HIV treatment and care outcomes than those who are not members of such groups.^{10,11} For example, female sex workers living with HIV have been found to have lower rates of antiretroviral therapy adherence and viral suppression than women living with HIV who are not sex workers.¹² Given this, HIV researchers have increasingly sought to understand the role of intersecting marginalized identities and conditions in shaping HIV outcomes.¹³⁻¹⁷

Understanding the complex relationships between intersectional stigmatized identities, socially marginalized positions, and HIV outcomes warrants nuanced methodological approaches.¹⁸⁻²⁰ In recent years, scholars have increasingly used quantitative approaches to document and measure HIV-related intersectional stigmas and

discrimination to appropriately intervene and address these challenges. However, to date, there is no clear consensus within the field regarding how to best quantitatively measure and analyze intersectional stigma and discrimination,¹⁸ including as it relates to HIV stigma. Of particular debate is whether and how intersections can be captured within a given measure or scale or be reflected through examinations of the interplay between measures of distinct types of stigma.^{18,20,21} Also, there is significant variation in how researchers analyze that interplay, for instance whether it is modeled via additive or multiplicative approaches.^{18,20,21}

Given the critical need to investigate the effects of intersectional stigma on HIV-related outcomes and ongoing methodological questions, we sought to examine the state of the evidence regarding measurement of HIV-related intersectional stigma and discrimination by conducting a systematic review of peer-reviewed literature published over the past 10 years. We were motivated by a conceptualization of intersectional stigma that acknowledges the interplay of stigmas either through measurement itself or through intersectional analytic approaches. Through this review, we aim to document HIV-related intersectional stigma and discrimination measures that can serve as a key reference for researchers, practitioners, and community members to use in future research, programmatic, and policy efforts.

METHODS

Guided by previous work,^{5,22} we defined intersectional stigma as internalized, perceived, anticipated, or enacted stigma (the latter also referred to here as discrimination^{23,24}) related to the unique intersection of multiple marginalized identities, statuses, or conditions. Using this definition, we explored measures and analytic models related to intersectional stigma, focusing on any 2 or more intersections of social stigmas (e.g., substance use, sex work) or interlocking systems of oppression (e.g., race, gender, class) relevant for understanding HIV-related risks and outcomes.

Inclusion Criteria

We included studies in the review if they met the following criteria:

1. They presented work relevant to HIV risk and outcomes. Examples of these studies are those that (a) included people living with HIV, (b) compared populations of people living with HIV with those not living with HIV, or (c) assessed an HIV-related outcome (e.g., HIV stigma, HIV prevention, or HIV care and treatment outcomes).
2. They presented information on stigma measures using an intersectional lens. This included (a) single measures (i.e., scales, indices, or indicators) that considered stigma experiences at unique intersections (e.g., one scale measuring the specific stigma experiences of Black women living with HIV) and (b) multiple measures that considered the intersectional nature of multiple forms of stigma (e.g., one measure of HIV stigma and a separate measure of racism). If multiple measures were used, we required authors to explore their intersectional effects through analytic approaches (e.g., interaction terms, latent variable models combining multiple stigma measures).
3. They presented quantitative data.
4. They were published in a peer-reviewed journal between January 1, 2010, and May 12, 2021.

Exclusion Criteria

We excluded studies if they met any of the following criteria:

1. They did not examine intersectional stigma or discrimination. This includes studies that measured one form of stigma (e.g., HIV stigma, sex work stigma) among vulnerable populations but did not consider the other unique identities, statuses, or conditions of those populations.
2. They used exclusively additive analytic approaches to explore intersectional stigma or discrimination. This includes studies combining multiple indexes or measures to yield a single sum score capturing intersectional stigma or discrimination. Such approaches assume that each stigmatized identity, social status, or condition is independent from the others,^{20,25} which does not align with our conceptualization of intersectional stigma.
3. They included multiple stigma measures but did not bring them together analytically (e.g., studies that entered multiple stigma scales independently in a regression model but did not use interaction terms to explore their intersecting effects).
4. They presented research on perpetration of stigma rather than experiences of stigma.

5. They were conference abstracts, commentaries or editorials, protocol papers, or exclusively qualitative studies. We did not restrict studies according to design, geographic location, subgroups, or language.

Search Strategy and Terms

We searched 5 electronic databases (PubMed, PsycINFO, the Cumulative Index to Nursing and Allied Health Literature, EMBASE, and the Cochrane Library) for relevant studies. Our search terms included (1) HIV or AIDS; (2) stigma, discrimination, and other relevant terms; and (3) intersectional, interlocking, layered, and other relevant terms (full search terms are available from the authors upon request). We also reviewed secondary references of included articles for possible inclusion of other relevant work. Finally, we consulted with 2 key experts in the field to identify any additional studies.

Screening

After deduplicating our search results, we screened articles for inclusion. Screening occurred in 3 phases. First, 1 trained study member screened the titles, abstracts, and citation information of all records and removed irrelevant articles. Second, resulting titles and abstracts were screened in duplicate by 2 trained study members working independently. Third, studies were pulled for full-text reviews on the basis of consensus between the 2 reviewers, with referral to senior study members as needed. Any article for which no consensus regarding inclusion was reached was included in a full-text review. Finally, we obtained full-text articles of all selected abstracts, and 2 members of the team independently assessed these articles to determine final study selection. During each phase, we retained excluded articles that were relevant and could serve as background material for our review.

Data Abstraction

Two trained study members completed the data abstraction of all included articles. Data abstraction was conducted in duplicate for the first 10 articles, with differences resolved through consensus and referral to a senior study team member when necessary. Two reviewers independently conducted the remaining abstraction. A standardized coding form was used to gather the following information from each included study: study identification (authors and year of publication), study description (study design and setting, period of study, sample size, and relevant study population characteristics), authors' conceptualization of intersectionality, types of intersectional stigma assessed, form and level of stigma, information on measures (e.g., description, rigor), relevant intersectional stigma results, study limitations, source of funding, and references for secondary screening.

We classified forms of stigma as internalized (feelings of inferiority or of deserved negative outcomes owing to one's affiliation to a marginalized identity, status, or condition), perceived (perceptions of stigmatizing attitudes by the public toward one's affiliated group), anticipated (expectations of poor treatment or outcomes owing to one's affiliation to a marginalized identity, status, or condition), and enacted (unjust treatment due to one's affiliation to a marginalized identity, status, or condition).^{26,27} Furthermore, we classified levels of stigma as individual (stigma held within individuals), interpersonal (stigma occurring between individuals), societal (stigma exhibited by members of communities), and structural (stigma within institutions and structures of power).

Data Analysis

All data were analyzed through coding of categories. We stratified analyses by 2 subgroups: (1) studies that incorporated a single intersectional measure (e.g., stigma toward women living with HIV) and (2) studies that examined intersectional stigma through the use of analytical approaches bringing together multiple stigma measures (e.g., interactive effects of HIV and gender stigmas). Given the heterogeneity in populations, study designs, measures, types of stigma, and outcomes, we did not conduct a meta-analysis of the data and instead present the synthesized data narratively.

RESULTS

A total of 1415 published citations were identified through our initial search, and 10 additional citations were identified from consultation with 2 key experts (Figure 1). After removal of duplicates, 801 citations were part of the first-level title and abstract screening, with 713 records excluded during this phase. In addition, 88 citations were part of the second-level title and abstract screening, resulting in the further exclusion of 52 citations.

The remaining 36 citations were included in the full-text review.^{21,28-62} Of these 36 citations, 20 were excluded

because they did not explore intersectional stigma through either a single measure or a combined analytic approach,^{21,28-33} they examined intersectional stigma through an additive approach,³⁴⁻³⁹ they were insufficiently HIV related,⁴⁰⁻⁴³ they measured stigma perpetration rather than experiences of stigma,^{44,45} or their description of stigma measures or analyses was insufficient, precluding our ability to understand the authors' assessment of intersectional stigma.⁴⁶ This resulted in 16 articles meeting the inclusion criteria for our review.

Study Descriptions

Table 1 presents a description of the 16 included studies.⁴⁷⁻⁶² Of these studies, 10 were conducted in the United States, 2 in Russia, 1 in Botswana, 1 in Canada, 1 in China, and 1 in the Dominican Republic. Some studies collected data in multiple languages (data not shown), including 3 studies in the United States^{53,56,60} conducted among English- and Spanish-speaking participants, 1 study in Canada⁵⁹ conducted among English- and French-speaking participants, and 1 study in Botswana⁵⁰ conducted among Setswana- and English-speaking participants. All of the included studies involved people living with HIV, with most exploring outcomes among male-identifying members of sexual minority groups^{51-53,57,58,60,62} and cisgender women.^{48-50,59} Three studies explored individuals who injected drugs^{54,61} or who reported use of illicit drugs, misuse of prescription drugs, or use of alcohol.⁵⁶ One study explored cisgender female sex workers,⁵⁵ and another explored transgender women.⁴⁷ The majority of studies employed a cross-sectional design (n = 11). Among the investigated outcomes, most related to mental health and well-being^{48,50,52,56,60,62} or HIV treatment and care.^{47,49,51,53,54,59}

Intersectionality and Forms and Levels of Stigma

Among the included studies, 7 explicitly referenced intersectionality theory or frameworks in their work,^{54,56-61} reflecting on the interdependence of socially marginalized identities, conditions, or statuses in influencing health outcomes (Table 2). Although the remainder of the studies did not explicitly reference intersectionality theory or frameworks, they indicated the "intersectional,"^{48,49} "overlapping,"⁴⁷ "layered,"⁵⁵ "synergistic,"⁶² "simultaneous,"⁵¹ "concurrent,"⁵³ or "combined"⁵² effects of multiple identities, conditions, or statuses on the health of socially marginalized groups. Among the 16 included studies, 4 explored intersectional stigma through a single measure,⁴⁷⁻⁵⁰ whereas 12 employed analytic approaches to bring together multiple stigma measures.⁵¹⁻⁶² Most studies explored the intersection of 2 types of stigma (n = 11), with the remaining studies exploring the intersection of 3 types (n = 5). Studies explored different forms of stigma, including enacted (n = 11), internalized (n = 8), perceived (n = 3), and anticipated (n = 2) stigma. In addition, studies examined intersectional stigma at the individual (n = 8), interpersonal (n = 10), structural (n = 6), and societal (n = 1) levels.

Intersectional Stigma Via Single Measures

Appendix A (available as a supplement to the online version of this article at <http://www.ajph.org>) presents the measurement descriptions of studies exploring intersectional stigma through a single measure.⁴⁷⁻⁵⁰ In all 4 studies, a single scale was used to measure intersectional stigma.

Two of the 4 included studies, both conducted by Dale et al.,^{48,49} were based on the same sample and employed the same intersectional stigma measure to estimate the effects of gendered racial microaggressions among Black women living with HIV in a large urban city in the southeastern United States. These studies, although involving the same measure, analyzed the measure differently by using sum⁴⁸ or average⁴⁹ scores from a validated scale⁶³ to explore the frequency and appraisal of gendered racial microaggressions. Both studies, which employed regression models to explore the effects of intersectional gender and race stigma on posttraumatic stress disorder symptoms or conditions⁴⁸ and barriers to HIV-related care,⁴⁹ reported good internal consistency (Cronbach α > 0.90 for each subscale).

In a separate study, Baguso et al.⁴⁷ adapted an existing scale⁶⁴ to explore enacted stigma due to gender identity or presentation and race among transgender women living with HIV in San Francisco, California. In this study, the authors measured intersectional stigma by asking respondents about experiences of discrimination, followed by a question attributing such experiences to their race, gender identity or presentation, or both.⁴⁷ The authors reported an internal consistency (Cronbach α) of 0.76 for their measure. The measure was dichotomized, and respondents who attributed experiences of discrimination to both gender identity or presentation and race were classified as

experiencing intersectional gender and race stigma. The authors used logistic regression to explore the relationship between intersectional gender and race stigma and HIV treatment and care outcomes.⁴⁷

Finally, only 1 measure was developed to focus on the intersectional stigma experiences of people living with HIV. In their study, Yang et al.⁵⁰ examined intersectional (HIV and gender) stigma experiences among women living with HIV in Botswana. The authors developed the Cultural Factors Shape Stigma subscale, which the authors determined to have strong content validity, good internal consistency (Cronbach's α 0.90), and high test-retest reliability ($P = .92$).⁵⁰ Construct validity assessments revealed a positive, marginally significant correlation with the validated Berger HIV Internalized Stigma Scale²⁶ ($p = 0.24$; $P = .095$) and a strong correlation with the validated Center for Epidemiologic Studies Depression Scale⁶⁵ ($p = 0.39$; $P = .005$).⁵⁰

Intersectional Stigma Via Multiple Measures

Appendix A also presents the analytic approaches of 12 studies assessing intersectional stigma through multiple stigma measures.⁵¹⁻⁶² In most studies, authors generated a sum or average score for each stigma measure and subsequently explored 2- or 3-way interactions via multivariable logistic or linear regression models.^{51-54,56'57'60-62}

In addition to exploring interactive effects through regression analyses, 2 studies (Vetrova and colleagues' exploration of substance use and HIV stigma⁶¹ and Yang and colleagues' examination of HIV and sexual orientation stigma⁶²) developed 4-level group categorizations of intersectional stigma. These stigma groups (classified as "high-high," "high-low," "low-high," and "low-low") were used in comparisons of the outcomes of interest.^{61'62}

Three studies employed structural equation modeling to explore the effects of intersectional stigma through multiple stigma measures.^{55'58'59} The first study explored the influences of latent sex work and HIV internalized stigma constructs on social cohesion and consistent condom use among cisgender female sex workers living with HIV in the Dominican Republic.⁵⁵ In this study, Carrasco et al.⁵⁵ assessed 4 mediation models, including a model testing the interactive effects of latent constructs of HIV and sex work internalized stigmas.⁵⁵

In a second study, English et al.⁵⁸ examined the interactive effects of the latent constructs of racial discrimination and internalized sexual orientation stigma among sexual minority men living in New York City. In this study, the authors used longitudinal structural equation modeling to explore the interactive effects of baseline stigma related to race (enacted) and sexual orientation (internalized) on substance use at a 12-month follow-up, mediated by emotional regulation at baseline and internalizing symptoms at a 6-month follow-up.⁵⁸

The third study, conducted by Logie et al.,⁵⁹ was based on a sample of women living with HIV from marginalized communities in Ontario, Quebec, and British Columbia, Canada. In this study, the authors used structural equation modeling to examine the impact of a latent intersectional stigma construct (indicated by latent constructs of internalized HIV stigma, racial discrimination, and gender discrimination) on HIV outcomes (antiretroviral therapy adherence, CD4 count, viral load) via social support, depression, resilience, and drug use.⁵⁹

DISCUSSION

We identified 16 studies from 6 countries assessing the effects of intersectional stigma on health-related outcomes, including HIV-related, mental health, and substance use outcomes. Of these 16 studies, only 4 employed a single intersectional stigma scale; the remaining 12 used multiple stigma scales or indices, which were then combined analytically. All 16 studies were conducted among people living with HIV, with several ($n = 7$) conducted among male-identifying members of sexual minority groups.

Just under half of the included studies ($n = 7$) made explicit reference to intersectionality as a motivating theory, framework, or perspective. Most of the remaining studies either did not acknowledge intersectionality or referred briefly to "intersectional stigma" but did not situate their work within the intersectionality literature or define intersectionality. Furthermore, several of the included studies applied intersectionality during post hoc analyses but did not consider intersectionality during study design or implementation. A recent review by Bauer et al.⁶⁶ revealed a parallel trend in the broader literature.

As such, given the recent proliferation of quantitative intersectional HIV research, we encourage scholars to think critically about their conceptualization of intersectionality from the outset. This will help shape how intersectional

stigma is measured and whether the selected measurement approach aligns with conceptual underpinnings. Logie et al. exemplified this notion by using intersectionality theory to guide their analytic approach when assessing intersectional HIV, race, and gender stigma.⁵⁹

Others have pointed out the importance of studying intersectional stigma from a multilevel perspective.²³ The studies included in our review were most likely to measure intersectional stigma at the individual and interpersonal levels. We did not identify any studies of community or organizational intersectional stigma, suggesting a need for additional research in these areas. However, the fact that 6 studies measured structural stigma is promising, given the structural nature and embeddedness of intersectional stigma, discrimination, and oppression.

Most studies included in our review did not measure intersectional stigma through a single scale or index but, instead, combined new and existing measures of stigma to quantitatively estimate the effects of intersectional stigma. This is consistent with Mena and colleagues' finding that most intersectionality-based analyses in other health fields rely on combining multiple stigma scales analytically.⁶⁷ We caution researchers using these approaches to carefully consider their assumptions and motivations, particularly when applying measures not intended to be used intersectionally.⁶⁶

We did not include in our review studies measuring intersectional stigma by combining multiple stigma scales through additive approaches (e.g., by yielding a sum score) because they did not align with our conceptualization of intersectionality^{20,25} and how the interdependence of multiple identities, social conditions, or statuses affects health outcomes. Rather, represented in this review were analyses that examined intersectionality beyond these additive approaches. This aligns with recent calls to employ moderation approaches, multilevel modeling, and latent variable models to model intersectional experiences when using multiple existing scales.¹⁸

Among those studies that incorporated dedicated intersectional stigma measures ($n = 4$), only 1 was specifically developed for the study population of interest (Batswana women living with HIV).⁵⁰ Others were adaptations or reapplications of existing scales, none of which reported substantial community involvement. Our findings suggest that it is feasible to adapt or tailor existing measures for intersectional HIV-related research. Given the time and resources required to develop scales tailored toward unique intersectional experiences among marginalized communities, scholars should consider using context-, identity-, or condition-adaptable measures when possible. When adapting measures for intersectional HIV research, scholars should carefully consider how to meaningfully engage communities and honor the principles of intersectionality throughout their approach.

Although not an intersectional stigma measure, Kerrigan et al.⁶⁸ provided an example of how to develop a scale in conjunction with the community for whom the scale is intended. In their work, the authors used in-depth and cognitive interviews to define measure domains and items and then assessed the content validity of a sex work stigma scale among cisgender female sex workers living in the Dominican Republic and Tanzania while also assessing the construct validity of the scale against other existing measures. Similar methods could be employed when approaching the development of intersectional stigma measures.

Furthermore, although our inclusion criteria covered studies that examined HIV stigma or other HIV-related outcomes among both people living with HIV and other populations, we identified studies of intersectional stigma conducted only among people living with HIV. This suggests an opportunity for additional quantitative intersectional stigma research in the field of HIV prevention, which is of particular importance given that the qualitative literature suggests that intersectional stigma and discrimination play an important role in access to and uptake of HIV testing and prevention interventions (e.g., preexposure prophylaxis).⁶⁹⁻⁷² Also, the majority of studies we included considered intersectional stigmas related to HIV and only 1 or 2 additional identities or conditions. Additional efforts are needed to understand the more complex effects of large numbers of intersectional identities.⁶⁶

Finally, although there is a growing body of qualitative literature around intersectional stigma and HIV in low-income settings,⁷³⁻⁷⁵ we found no corresponding quantitative studies. Indeed, most of our studies ($n = 11$) were conducted in high-income settings; the remainder ($n = 5$) were conducted in upper-middle-income settings. Given the growing concentration of HIV epidemics among multiply marginalized communities worldwide, additional intersectional stigma research in low-income settings is warranted. Such studies would provide a more nuanced description of how

intersecting identities are experienced in more marginalized communities, allowing for transnational and multilevel analyses to be conducted. Also, as reflected in some of the studies wherein data were collected in multiple languages ($n = 5$), using culturally and linguistically congruent measures to examine intersectional stigma and discrimination is advantageous because these measures allow for more in-depth exploration of intersecting realities across diverse groups.

Limitations

Our review involved some limitations. For example, we included studies that did not explicitly reference intersectionality as a motivating theory or framework. This may have resulted in the inclusion of studies that did not set out to do intersectional research. We also excluded non-peer-reviewed articles and conference abstracts. This exclusion, although made in an effort to allow for included articles to have undergone more thorough quality checks through the peer-review process and to present more complete information, could have led to disregard of relevant work related to intersectional stigma measurement. Despite these limitations, the results of our review of HIV-related intersectional stigma and discrimination measures and analytic approaches can serve as a key reference for researchers, practitioners, and community members in future research, programmatic, and policy efforts.

Conclusions

There is a growing body of quantitative research examining HIV-related intersectional stigma and discrimination, although current research is concentrated in high-income settings and involves people living with HIV and members of sexual minority groups. In this review, we have identified gaps in the development and adaptation of tailored, multidimensional measures of intersectional stigma and discrimination. Further efforts are required to ensure that intersectionality is appropriately defined and applied in quantitative research from the outset and to explore the potential of more complex analytic and measurement approaches for studying intersectional stigma as it relates to HIV. High-quality, innovative approaches to quantitatively measuring and analyzing HIV-related intersectional stigma have great potential to improve the HIV response and increase equity in HIV testing, treatment, and prevention outcomes by allowing for a more nuanced understanding of the effects of individuals' intersecting realities on their health trajectories.

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T. S. Karver, K. Atkins, C. E. Kennedy, and D. Kerrigan led the writing of the review. T. S. Karver and K. Atkins conducted the search and data abstraction. C. E. Kennedy and D. Kerrigan provided expertise on the final application of the methodology. T. S. Karver led the project administration. All of the authors contributed to the conceptualization, review protocol, methodology, and editing of the review.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this research because secondary data were used.

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DETAILS

Subject:	Research; Public health; Data collection; Mathematical analysis; Ethnic identity; Criteria; Intersectionality; Regression analysis; Regression models; Gender; Human immunodeficiency virus--HIV; Stigma; Race; Disease prevention; Sex industry; Coding; Clinical outcomes; Data analysis; Oppression; Discrimination; Black people; Subgroups; Medical treatment; Multivariate statistical analysis; Systematic review; Health risks

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Engaging in Intersectional Liberation for Every(Black)Body Impacted by Anti-Blackness and HIV-Related Stigma

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ABSTRACT (ENGLISH)

Despite the availability of effective medications for HIV treatment and prevention, Black people continue to experience a disproportionate burden of the disease. In 2019, more than 40% of people living with HIV in the United States were Black, and they had lower rates of viral suppression than members of other racial and ethnic communities.¹ This epidemiological pattern has persisted since the beginning of the HIV epidemic.² Recent literature indicates that the same underlying socioeconomic structural issues that give rise to negative health outcomes among Black people also impact how HIV is both experienced and addressed within Black communities.^{3,4}

Underlying these health outcomes is the pervasive impact of anti-Black racism, which is prejudice, attitudes, beliefs, stereotyping, or discrimination that explicitly or implicitly reflects the view that people of African descent are inferior to those in other racial groups. Anti-Black racism prohibits Blackness from being valued and systematically marginalizes people perceived to be of African descent. Simultaneously, Black people hold intersectional, socially stratified identities based on ethnicity, nationality, sexuality, gender, and other characteristics. Interlocking systems of oppression which target overlapping identities (e.g., Black, gay, immigrant) compound the experience of oppression, amplifying vulnerability to HIV for specific Black communities.

Intersectional HIV stigma is the manifestation of oppressive policies and practices within systems that result in prejudice and discrimination directed at people living with HIV or people perceived to be at greater risk of HIV acquisition. Stigma enacts a psychological toll and directly impacts health-seeking behaviors of people living with HIV and others from marginalized populations, such as lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+) communities; people who use drugs; sex workers; and immigrants. HIV-related stigma can be interpersonal, institutional, or internalized and occurs in personal, work, and health care settings. Addressing intersectional HIV stigma and its impact on Black communities is complex, given the paramount challenges posed by anti-Black racism, nativism, heterosexism, and other systems of oppression. It requires an intentional approach that centers the voices and leadership of Black people.

FULL TEXT

BLACK COMMUNITIES AND HIV

Despite the availability of effective medications for HIV treatment and prevention, Black people continue to experience a disproportionate burden of the disease. In 2019, more than 40% of people living with HIV in the United States were Black, and they had lower rates of viral suppression than members of other racial and ethnic communities.¹ This epidemiological pattern has persisted since the beginning of the HIV epidemic.² Recent literature indicates that the same underlying socioeconomic structural issues that give rise to negative health outcomes among Black people also impact how HIV is both experienced and addressed within Black communities.^{3,4}

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BLACK LEADERSHIP AND HIV

Black HIV activism has been a pillar of the HIV response from the beginning of the epidemic.^{5,6} Although this rich history has often gone unrecognized, it has contributed to important gains in HIV policy, resource allocation, and community mobilization for Black people overall, as well as other impacted communities. However, Black communities have not mounted a fully successful response to HIV. This is due in part to the perception of HIV as a "cross-cutting issue." As described by Cohen, "cross-cutting" issues are those that primarily impact the most marginal groups within an already marginalized group.⁶ This "secondary marginalization" occurs when a majority within a stigmatized group does not view some of its members as worthy of the collective's resources.

People most impacted by HIV in Black communities experience marginalization at the intersection of multiple social categories. These include sexual orientation (e.g., gay and bisexual men), gender identity (e.g., transgender people), substance use (e.g., people who inject drugs), occupation (e.g., sex workers), or immigration status (e.g., undocumented people). Black people who hold these identities are devalued not only by others in the Black community but also in society at large on the basis of their identities being seen as immoral or their societal roles viewed as inferior.^{5,7} This sentiment showed up in various ways earlier in the epidemic, including mainstream Black institutions' unwillingness to acknowledge HIV as a problem that needed to be addressed nationally. Consequently, the Black community's response to HIV has often been less robust than would be expected if HIV severely affected Black community members who are held in higher social regard based on class, sexuality, citizenship, or gender. In addition to internal dynamics, external factors fueled by anti-Black racism block Black people from gaining the position, power, and resources needed to lead response efforts. This includes insufficient funding to Black-led HIV organizations, limited social capital wielded by Black leaders, and inadequate as well as often stigmatizing media focused on the HIV epidemic in Black communities.

THE BEGINNING OF UNITED WE RISE

In the summer of 2019, three Black-led HIV organizations envisioned a national convening to address the inadequate response to the HIV crisis in Black communities. They assembled a 35-member planning committee. Members were intentionally selected, representing community and academic stakeholders, geographic and demographic diversity, and a range of knowledge and skills.

Three in-person planning meetings were organized to cultivate space for critical thinking about internal and external barriers and reflecting on individual and collective experiences. During these meetings, participatory exercises resulted in significant changes to the direction of the work. As originally envisioned, 300 Black individuals from diverse disciplines would attend a threeday conference with traditional plenaries and breakout sessions. The goal was to develop policy recommendations that could be shared with decision-makers at various levels of government

and public health organizations. This original concept evolved into the creation of a collective of Black people living with HIV, activists, researchers, and health providers, all of whom focused on the question, "What would the response to HIV look like if it were led by Black people?" Work groups were established to implement key operations and planning activities, such as a communications strategy and ongoing community engagement. The committee named the initiative United We Rise (UWR), aiming to break oppressive cycles and develop strategies that attend to the structural conditions underlying inequities in HIV and other health conditions in US Black communities. The participatory exercises were the genesis of a commitment to centering Blackness, liberation, and intersectionality—ultimately generating our mantra: Every(Black)Body.

Every(Black)Body embodies collective liberation from systems that do not value Black people and the internal struggles that result from this devaluation. Addressing HIV within Black communities is seen as both an internal and an external process requiring Every(Black)Body to be heard and engaged. It demands that we honor the history and diversity of the Black diaspora and value the range of unique, intersectional lived experiences of Black people. Blackness is defined as honoring our beginning as people of African descent, understanding our shared history with oppressive colonial systems and their generational impact, uplifting commonalities and practices across Black cultures, and thriving in one's Black skin. Across the diaspora, Blackness is both a communal and an individual experience. The concept of intersectionality recognizes the dynamic interplay between multiple social identities that Black people hold, their positionality within social hierarchies, and the myriad social issues that are linked to HIV. UWR's approach to applying intersectionality to the HIV response is closer to its Black feminist roots than what is often found in public health research.⁸

In "Theory as Liberatory Practice," bell hooks acknowledged,

When our lived experience of theorizing is fundamentally linked to processes of self-recovery, of collective liberation, no gap exists between theory and practice. Indeed, what such experience makes more evident is the bond between the two— that ultimately reciprocal process wherein one enables the other.⁹

Planning committee members engaged in more relational, reflective exercises during planning meetings, allowing for a departure from traditional processes and accepted narratives about ending the HIV epidemic. This created space for elevating liberation as a core concept and practice. Both the arc of the planning process and the intended outcomes for the initiative were redirected from their original intent. Emphasis was placed on promoting dialogue within the Black community to name and address the sometimes-harmful realities of our relationships with each other and the necessity of using an intersectional lens to define needed action.

After establishing the principles that shape our collective vision, the planning committee was deliberate in seeking direction from a broad crosssection of Black community members in the United States. UWR developed a Web-based survey using an adapted Delphi process and disseminated it nationally.¹⁰ This led to the development of five focus areas deemed fundamental to advancing Black liberation in the context of forging an effective response to HIV in the US Black diaspora (Table 1).

In December 2020, UWR held a 3-day virtual convening to build internal solidarity across identities and energize HIV community mobilization in a manner that intersects with broader justice efforts. The five focus areas guided the content for the convening. Two hundred twenty-five individuals participated in "couch conversations" (informal discussions with researchers, health providers, activists, and policymakers) and "kitchen conversations" (intimate dialogues about who we are, our values, and ways our communities have intentionally or unintentionally harmed each other). Each day included small-group working sessions engaging participants to identify values essential to intersectional solidarity, values needed for Black-principled leadership, and action areas to ensure that the Black response to HIV is intersectional. Outcomes provided structure to UWR's ongoing mobilization efforts and work within the five focus areas.¹¹

LESSONS LEARNED

Willingness to "do something different" brought inherent challenges for UWR leadership and overall planning and implementation. Selecting a diverse planning committee required conveners to bridge disagreements on inclusion criteria and expand the pool of potential attendees beyond conveners' social and professional networks. Leadership

struggled with the tension between having an innovative process and defaulting to traditional planning and community engagement practices. Generally, committing to a participatory planning process requires time and resources. Because of the COVID-19 pandemic, the planning phase became longer, which led to some participation fatigue and frustration. Staff time, capacity for effective facilitation, and funding were needed to support ongoing engagement. Some challenges were overcome by shifting the responsibility for the direction of the project to the planning committee and creating space for an organic process dependent on what developed overtime. Committee members co-led workgroups, cofacilitated full planning meetings, served as influencers, and coproduced social media live shows.¹² An unmet goal was adequately building connections to other social movements, such as criminal justice, immigrant rights, reproductive justice, and drug decriminalization, and engaging them with UWR. However, this is a priority for UWR's future growth to ensure that the HIV response is intersectional and improves the overall wellness of Black communities.

CONCLUSION

Ending the HIV epidemic in the United States requires identifying and dismantling anti-Black racism and the ways Black people are marginalized by intersecting systems of oppression. The work of UWR builds on a tradition in the Black community of intersectional organizing, including HIV efforts in the 1990s. The HIV response during this era was mostly grassroots-led.

As the HIV response has become more professionalized and biomedically focused, resource allocation to community-led HIV strategies has declined. A substantial shift in the direction of the HIV response in the United States is needed, requiring bold new leadership and innovative, nonhierarchical strategies that reimagine collaboration, decision-making, and resource allocation. As a Black-led, intersectional approach rooted in a liberator/praxis, UWR offers a vision for firmly centering the needs of Black communities most impacted by HIV. With sustained energy from Black communities, investment in Black visions to end HIV and other health inequities, longer-term resourcing of Black-led agencies, and strong collaboration between Black and allied organizations, there can be transformative progress in the fight to end HIV for Every(Black)Body and other impacted communities. *AjPU*

Sidebar

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A Case for Strengths- Based Approaches to Addressing Intersectional Stigma in HIV Research

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ABSTRACT (ENGLISH)

Stigma reduction is essential for reaching global goals for ending the HIV epidemic, and HIV researchers have paid increasing attention to the intersectional nature of stigma. In *Workable Sisterhood*, Berger first defined intersectional stigma as the relationship between interlocking forms of oppression (i.e., intersectionality) and the ways in which people become socially defined as "other" (i.e., stigma).¹ She illustrates how HIV stigma compounds structural inequities along axes of race, class, and gender for marginalized women living with HIV. She also demonstrates how experiences of intersectional stigma can expose the structural roots of oppression and inspire mobilization of internal (e.g., faith) and external (e.g., peer support) resources to challenge oppressive structures. This conceptualization of intersectional stigma is grounded in empowerment to transform inequitable power systems. Yet, subsequent HIV-related intersectional stigma research has largely focused on deficit-based outcomes. A scoping review of quantitative intersectional stigma research revealed that a minority of studies (13 of 32) explored empowerment-based factors in conjunction with intersecting stigma.² Although intersectional stigma research often focuses on the harms of stigma to argue for social and structural change, this approach has limitations.

FULL TEXT

Stigma reduction is essential for reaching global goals for ending the HIV epidemic, and HIV researchers have paid increasing attention to the intersectional nature of stigma. In *Workable Sisterhood*, Berger first defined intersectional stigma as the relationship between interlocking forms of oppression (i.e., intersectionality) and the ways in which people become socially defined as "other" (i.e., stigma).¹ She illustrates how HIV stigma compounds structural inequities along axes of race, class, and gender for marginalized women living with HIV. She also demonstrates how experiences of intersectional stigma can expose the structural roots of oppression and inspire mobilization of internal (e.g., faith) and external (e.g., peer support) resources to challenge oppressive structures. This conceptualization of intersectional stigma is grounded in empowerment to transform inequitable power systems. Yet, subsequent HIV-related intersectional stigma research has largely focused on deficit-based outcomes. A scoping review of quantitative intersectional stigma research revealed that a minority of studies (13 of 32) explored empowerment-based factors in conjunction with intersecting stigma.² Although intersectional stigma research often focuses on the harms of stigma to argue for social and structural change, this approach has limitations.

LIMITATIONS OF DEFICITBASED HIV RESEARCH

A deficits perspective in HIV-related intersectional stigma research can overlook the skills, knowledge, and collective resources within marginalized communities. For example, HIV prevention efforts may be more effective if they incorporate existing resiliencies rather than primarily intervening to address vulnerabilities. Consistent with this assertion, a study of sexual practices among a sample of multiracial, multiethnic gay and bisexual men found that adding psychosocial strengths (e.g., social support) to a multivariable model of risk rendered the relationship between psychosocial problems (e.g., substance use) and condomless sex no longer significant.³ This suggests that a sole focus on challenges may miss existing health-promoting community resources. Deficit-based research may also inadvertently pathologize communities as being inherently damaged or in need of external intervention. This, in turn, can exacerbate stigma and contribute to hopelessness. For example, Tuck has described the ways that "damage-centered research" with Indigenous communities can lead to lasting consequences in which communities come to see themselves as broken.⁴

BENEFITS OF STRENGTHSBASED HIV RESEARCH

Strengths-based research can identify and build on existing health-promoting resources that mitigate the impact of intersectional stigma. For example, a study with African American gay and bisexual men in House and Ball communities found that participation in these communities was associated with resiliency factors such as social support and volunteerism.⁵ Strengths-based research may also identify the mechanisms of action underlying

protective factors. For instance, types of social relationships may be more important for health than general concepts of social support. One study found that who young people choose as support persons when deciding to get an HIV test may vary based on relationship dynamics with families and intimate partners.⁶ Thus, studies focused on uncovering how strengths can mitigate intersectional stigma may reveal unexamined assumptions and generate novel approaches. Some disciplines within mental and behavioral health have long used an asset-based lens for intervention development. Intervention research focused on strengths may be more appealing to participants than risk-focused studies, thereby increasing engagement. By leveraging existing community resources, strengths-based interventions are inherently more sustainable than time-limited, externally driven, individual-focused behavior change interventions. This sustainability addresses concerns about leaving participants with nothing when an external intervention ends.

CONCEPTUALIZING STRENGTHS-BASED RESEARCH

Strengths-based approaches have been conceptualized in a variety of ways. Dulin et al. identified social-ecological levels to resilience in HIV research, including individual (e.g., coping), interpersonal (e.g., social support), community (e.g., collective efficacy), and structural (e.g., activism).⁷ Their review found that resilience resources were largely associated with antiretroviral adherence but noted that most studies focused on individual and interpersonal resilience rather than the community or structural levels. Resilience-based interventions require a collectivist understanding of agency to affect interlocking structural systems that may undermine that agency. For instance, work with displaced women in Haiti drew attention to multilevel, incremental, and nonlinear dimensions of agency—intrapersonal, interpersonal, relational, and collective—that were enacted even in contexts of structural constraints.⁸ In another example, Walton and Oyewuwo-Gassikia developed the #BlackGirlMagic framework that (1) gives Black women the space and authority to assert their greatness; (2) allows Black women to move beyond the limitations imposed on them by systems of oppression, namely, racism, sexism, and misogyny; (3) acknowledges a more just understanding about the lived reality of Black women from a strengths-based perspective; and (4) recognizes the aspects of Black women's social identities as inextricable from one another.⁹(p466)

This framework simultaneously considers community strengths alongside the realities of intersecting inequities. However, when applied at the individual rather than structural level, concepts like resilience and #BlackGirlMagic can inadvertently deflect responsibility for inequities away from systems of power and unintentionally blame groups who experience intersectional stigma for not having enough resilience, agency, or magic.¹⁰ A scoping review found that most strengths-based quantitative intersectional stigma research focused on individual and interpersonal factors, signaling a need for greater research attention to community- and structural-level resources available to resist intersectional stigma.²

Njeze et al. offer one example of this approach. They developed an "intersectionality of resilience" framework that conceptualizes Indigenous youth resilience as strengthening cultural identity—including engaging in cultural activities, pride in Indigenous heritage, connecting with social groups that serve the community, and arts-based practices and positive decision-making to produce desired changes.¹¹ As they describe it,

This strengths-based reframing of intersectionality, then, also connects with aspects of a "political intersectionality" insofar as it explores and uncovers the systemic forces that shape subjects as well as the multi-axes modes of resistance for contesting and reclaiming power that informs and underlies many political struggles.¹¹(p2015)

APPROACHES TO STRENGTHS-BASED RESEARCH

When implementing strengths-based approaches to intersectional stigma research in HIV, it is important to employ methods that are aligned with this framing. Rather than simply reverse-coding deficit-based variables to produce strength-based variables, researchers must employ constructs consistent with frameworks like the intersectionality of resistance. For example, Shaw et al. recommend viewing resilience as a multifaceted, multilevel construct and using analytic approaches that can support examination of such a construct, including community-based participatory research, social network analysis, and multilevel modeling.¹⁰

Practical steps for researchers include integrating strengths-focused factors in study design, including the research foci, data collection tools and methods, and analytic frameworks. Although examination of resilience and social

support is important, stigma researchers should also examine structural and community-level strengths such as collective efficacy, agency, and empowerment; resistance and advocacy; solidarity; and community mobilization and transformation. Intersectional stigma intervention research can also elicit critical hope and solidarity in shared struggles of oppression, including through providing spaces for building connection and solidarity.¹²

CONCLUSION

Addressing intersectional stigma is essential to efforts to end the HIV epidemic. HIV research that uses a strengths-based intersectional lens at social and structural levels provides opportunities to highlight community resources, identify mechanisms that support community resilience and resistance, and leverage existing, sustainable assets. Doing so can generate strategies to challenge intersectional stigma and effect positive change. These strength-based approaches must be led by or, at a minimum, meaningfully engage community members to create solutions that can transform the social and structural environments that drive HIV inequities. 4P»

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An Expanded Definition of Intersectional Stigma for Public Health Research and Praxis

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ABSTRACT (ENGLISH)

Intersectionality-an analytic tool that enables researchers and historically marginalized communities to investigate how "intersecting power relations influence social relations across diverse societies as well as individual experiences

in everyday life"¹(p2)-is becoming a prominent lens through which to conduct social and behavioral science research, particularly within the field of public health.¹⁻³ Intersectionality is now recognized as critical to ending the HIV epidemic, as well as addressing other public health priorities.^{2,4} Stigma researchers are applying an intersectional lens to understand and address health inequities among groups at the most marginalized intersectional positions, as stigma reduction cannot be fully achieved without centering the structures and systems that drive stigma and discrimination.^{2,5,6} For example, without understanding how racism and homophobia mutually shape the experiences and opportunities of sexual minority people of color, we cannot fully understand or address the stigma and discrimination they experience.

To realize its full potential for improving health equity, a closer look at the concept of intersectional stigma and how it is operationalized in research and practice is warranted. Berger defined intersectional stigma as the "total synchronistic influence of various forms of oppression which combine and overlap to form a distinct positionality."⁷(p24) Logie et al. defined intersectional stigma as the "interdependent and mutually constitutive relationship between social identities and structural inequities."⁵(p9) Considering these definitions, the next logical step in understanding and addressing public health inequities is to deliberately integrate intersectional stigma frameworks into interventions to improve health outcomes.

To address intersectional stigma and its sequelae, it is important to consider what it means for a stigma reduction intervention to be "intersectional." We recommend that an intersectional stigma reduction intervention should hold the following principles: (1) recognize and name how systems of power, privilege, and oppression intersect to affect individual experiences and fuel stigma; (2) aim to dismantle systems of power, privilege, and oppression, and mitigate the harms caused by those systems; (3) ensure community leadership and meaningful engagement; and (4) support collective action, cohesion, and resistance to address the intersecting axes of inequities. We explore these principles to guide progress toward achieving health equity.

FULL TEXT

Intersectionality-an analytic tool that enables researchers and historically marginalized communities to investigate how "intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life"¹(p2)-is becoming a prominent lens through which to conduct social and behavioral science research, particularly within the field of public health.¹⁻³ Intersectionality is now recognized as critical to ending the HIV epidemic, as well as addressing other public health priorities.^{2,4} Stigma researchers are applying an intersectional lens to understand and address health inequities among groups at the most marginalized intersectional positions, as stigma reduction cannot be fully achieved without centering the structures and systems that drive stigma and discrimination.^{2,5,6} For example, without understanding how racism and homophobia mutually shape the experiences and opportunities of sexual minority people of color, we cannot fully understand or address the stigma and discrimination they experience.

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(1) Recognize and name how systems of power, privilege, and oppression intersect to impact individual experiences and fuel stigma

Within this burgeoning area of public health praxis, it is important for researchers and community practitioners to be explicit about how an intervention is informed by the concept of intersectionality and how it will address intersectional stigma. Systems of power perpetuate intersectional stigma^{5,7}; therefore, the conceptual underpinnings of intersectional stigma interventions and subsequent phases of development, implementation, and dissemination should clearly name systems of power and oppression and clarify their role in perpetuating oppression.⁸ For example, this can be accomplished through statements of purpose and conceptual models that explicitly note which systems of oppression are being addressed and how.

Stigma reduction interventions that simply consider co-occurring stigmas are not truly intersectional without recognizing the contexts that drive and mutually shape these stigmas. This is upheld by Rao et al., who note in their editorial on HIV stigma among Black women in the United States, "[o]ur understanding of the factors that have an impact on the health of Black women is limited when we regard these categories as distinct or static identities and add or subtract them from concepts of interest."⁹(pp446-447) The authors go on to convey how understanding the experiences of Black women as "mutually constructed and fluid, continually shaping and shaped by dynamics of power"⁹(p447) offered insights to inform impactful intervention-in this case, to explore resilience strategies as an intervention to reduce internalized stigma.⁹

(2) Aim to dismantle systems of power, privilege, and oppression, and mitigate the harms caused by those systems
Intersectional stigma interventions must expand beyond an emphasis on individual attributes (i.e., stigmatized identities or health conditions) by including components that both (a) seek to dismantle the systems of privilege and power that drive intersectional stigma and (b) mitigate the harms caused by those systems. For example, the Manas por Manas intervention in Brazil is designed to mitigate the harms of intersectional stigma experienced by transgender women while navigating stigmatizing health care and other social service environments. Working with peer navigators, transgender women acquire critical skills and tools to manage and address anticipated and enacted stigma experienced when seeking services (e.g., using role play to navigate situations where their correct pronouns or chosen name are not used).¹⁰

Additionally, structural solutions that address the factors underpinning interlocking systems of oppression are needed to affect long-term, systemic change and prevent intersectional stigma from moving forward. For example, the aforementioned Manas por Manas study also advocates for and supports transgender women to step into positions of power, visibility, and influence within universities, clinics, and communities.¹⁰ Ensuring that transgender women are visible in staff positions and leadership roles within the organizations that serve these communities- and have a voice in shaping the policies and practices of these organizations- is an initial step toward dismantling some of the structural barriers and stigma that perpetuate health inequities.

(3) Ensure community leadership and meaningful engagement

Communities experiencing intersectional stigma are uniquely positioned to identify and facilitate effective interventions to address intersectional stigma. As such, the development and implementation of interventions to address intersectional stigma should include leadership and engagement of communities experiencing the type of intersectional stigma addressed by the intervention. Community leadership and engagement should go beyond community members simply serving on a community advisory board or serving as "gatekeepers." Community members must be recognized and engaged as codevelopers, coimplementers, and coevaluators wherever possible. Depending on the community and context, the form of community leadership and engagement may vary, ranging from community organizations leading efforts, to community organizations and public health researchers and practitioners connecting and forming mutual partnerships, to public health researchers and practitioners leveraging their resources and skills to bolster the infrastructure and capacity of a community organization if needed. Furthermore, an often overlooked but critical factor for ensuring community leadership is the availability of core funding to support the infrastructure of community organizations, not just funding for activities or services they provide as part of a research study. For example, in the Encontros intervention, local sex workers worked to

establish their own organization to support local HIV prevention efforts through community building, integration, and social cohesion. The research team and national network of sex workers partnered to secure a training for the nascent sex worker advocacy group that addressed how to establish an association, write an organizational charter, and manage grants and finances.¹¹⁻¹³ Organizational support is a means to ensure that community organizations can engage as equal or lead partners without relying on university structures to receive donor funds, which inherently contributes to a power imbalance.

(4) Support collective action, cohesion, and resistance to address the intersecting axes of inequities

Public health researchers and practitioners who focus on stigma must move away from emphasizing deficits in communities, as has been the tendency. Crenshaw, who first coined the term "intersectionality" in 1989, maintains that intersectionality does not problematize social identities; rather, it recognizes the power of collective action, cohesion, and resistance that exists in the face of oppression: "The social power in delineating difference need not be the power of domination; it can instead be the source of social empowerment and reconstruction."¹⁴(p1242) Furthermore, Logie et al. assert that intersectional stigma research and praxis would benefit from greater focus on the radical potential of intersectionality to leverage collective efficacy, solidarity, and liberation in efforts to dismantle systems of oppression.³

There has long been debate about intersectionality's focus on inequity and empowerment; as Davis inquired more than a decade ago, "Should it be deployed primarily for uncovering vulnerabilities or exclusions or should we be examining it as a resource, a source of empowerment?"¹⁵(p75) Empowerment, in this context, should not be interpreted as the paternalistic conferral of power, but rather the inherent resilience of communities facing intersectional stigma that leads to action, such as coalition building, community mobilization, and political activism.¹⁶ As such, public health researchers and practitioners should not simply document these strengths and assets, but become part of the solution by working alongside and joining the ongoing, collective action of communities experiencing intersectional stigma to advance social and health equity.

INTERSECTIONAL STIGMA REDUCTION INTERVENTIONS

We offer four additional examples of intersectional stigma reduction interventions that reflect the principles outlined in this editorial.

* The Karnataka Health Promotion Trust developed a series of integrated structural interventions in collaboration with female sex workers, policymakers, and other stakeholders "to address context-specific factors (social inequity, violence and harassment, and stigma and discrimination) contributing to HIV vulnerability"¹⁷ in South India. This program simultaneously worked to mitigate harms and risk for female sex workers, as well as the structural drivers of stigma. The community-level activities were observed to increase female sex worker's membership in community-based organizations and support referrals to social benefits and redressal of violence and harassment.¹⁷

* Project Advocacy and Other Community Tactics (ACT) was designed to "eliminate barriers to HIV care for gay and bisexual men and transgender women in five African and two Caribbean countries."¹⁸(p2251) This project entailed a "coordinated set of community-led advocacy initiatives targeting structural changes,"¹⁸(p2251) including community mobilization and sensitization workshops.¹⁸ Project ACT was observed to improve access and availability of affirming care and resources, and highlighted "the vital role community-led advocacy plays in addressing stigma and discrimination as structural barriers to HIV care."¹⁸(p2251)

* Sheroes was a community-driven, group-level HIV intervention for transgender women in the United States; it entailed five weekly, peerled group sessions and sought to decrease risk for HIV acquisition and transmission as well as increase access to gender affirmation.¹⁹ Sheroes centered the voices of transgender women, through collaboration and engagement with transgender community members and stakeholders. Sheroes also fostered "alliances between transgender women through community building and empowering relationships via creation of a 'sisterhood' of transgender women who had completed the intervention."¹⁹ The pilot indicated an increase in such social support and a reduction in sexual risk behavior, as compared with the control group.¹⁹

* Positively Trans is a Transgender Law Center program led by trans women of color living with HIV in the United States. Through "community-driven research, leadership development, and storytelling,"²⁰ Positively Trans makes

the case that "trans voices, needs, and leadership must be centered in [the HIV] response, and that the HIV response is a key strategy for trans health and liberation."²⁰ This program serves as an important reminder that within community settings there are existing, effective community-led efforts to reduce and mitigate the harms of intersectional stigma.

IMPLICATIONS FOR IMPLEMENTATION AND EVALUATION

To inform the development of interventions in line with the principles that we have outlined, and to assess the impact of these interventions on health outcomes relevant to populations affected by intersectional stigma, the concept of "evidence" needs to be broadened. At present, funders and peer-reviewed journals tend to have a narrow conceptualization of evidence. Randomized controlled trials (RCTs) are considered the gold standard of evaluation, and biomedical outcomes are often prioritized over socio-structural and community-level outcomes valued by communities. In addition, intervention implementation typically must accommodate three- to five-year funding cycles, thereby constraining the outcomes an intervention can reasonably affect in such a short time. Current standards constrain our ability to maximize impacts that reflect community priorities, evaluate the success of interventions, and study the reduction of intersectional stigma over time. In addition, narrow conceptualizations of evidence limit the potential for community-derived solutions to be optimally evaluated and scaled.

Study Design

When evaluating intersectional stigma reduction interventions, evidence from programmatic efforts using real-world implementation strategies and designs should be valued alongside RCTs. RCTs are limited in their ability to assess social and structural change. For example, employing an RCT design to evaluate an intersectional stigma intervention is often impractical, as it would likely require randomizing communities to social or community change interventions, which would be expensive and could take much longer to evaluate than the typical five-year funding cycle allows. We must support study designs without experimental assignments, such as rigorous observational research and implementation science methods. Furthermore, we need to acknowledge the value of qualitative and mixed methods for evaluation research.

Outcomes

To effectively evaluate intersectional stigma reduction interventions, it is necessary to employ a wider range of proximal markers (e.g., mobilization and solidarity), implementation outcome measures (e.g., acceptability, feasibility), and structural outcome measures (e.g., changes in laws and policies, community representation) alongside clinical outcomes. Existing measures have been validated for this purpose (e.g., cohesion,^{21,22} community mobilization²³). Where needed, measures may be adapted or additional measures developed and validated to capture other latent constructs to support the generalizability of findings.²⁴

Timelines

Extended evaluation timelines can allow more meaningful observation and assessment of the impact of intersectional stigma interventions that seek to effect systemic change. For example, traditional National Institutes of Health R01 grants could be extended from five to seven years for interventions that address structural drivers of stigma. Similarly, funders could release calls for supplemental grants to allow for additional data collection two years after the intervention ends to assess longer-term changes and policy-level effects. Such extended timelines are necessary, as policy and institutional-level changes often do not manifest within traditional study timelines.

Structural Interventions

Beyond study design, outcomes, and timelines, there is a need for greater development, implementation, and evaluation of structural interventions, which work by altering the societal, legal, and economic contexts that influence individual, community, and societal health outcomes. For example, legalizing and making widely available needle exchange programs at a state or country level is an example of a structural intervention to minimize harms, such as HIV and hepatitis C exposure, for people who inject drugs. At present, few intersectional stigma interventions have included structural components to dismantle systems of power, privilege, and oppression.

Research Coordination

Recognizing that multiple interventions across levels are necessary to dismantle systems of power, coordinated

approaches that create opportunities to build on prior and ongoing research and praxis are needed. For example, alongside the provision of harm reduction services for people who use drugs, legal changes, such as decriminalizing possession of multiple syringes, are required so programs can operate safely and legally.²⁵ Such coordination may occur among public health researchers and practitioners, community organizations and members, or local officials. This may also be accomplished through the creation of dedicated research consortiums. Supporting the dissemination of intersectional stigma reduction efforts also supports opportunities for continued or complementary interventions by other study teams.

This editorial offers a close look at the implications of intersectional stigma from an intervention standpoint as well as more broadly within public health. Employing an intersectional lens and approach to stigma reduction is critical to advancing public health and achieving health equity. To fully realize this goal, public health communities must support and facilitate action to dismantle and mitigate the interlocking power dynamics that drive health inequities. To meaningfully do so, we must expand our approaches and reassess values placed on various modalities of intersectional research and praxis.

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J.E. Pachankis receives royalties from Oxford University Press for books related to stigma-focused mental health interventions.

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Stronger Together: Coalitions as Interventions Against Intersectional Stigma

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ABSTRACT (ENGLISH)

HIV continues to disproportionately impact key populations- gay and bisexual men, transgender people, people who use drugs, and sex workers-worldwide, especially those who are financially poor and those who are Black and Brown. In 2020, according to UNAIDS, key populations represented 65% of new HIV infections globally- far beyond the proportion of the general population.1 Governments legislate against key populations: 70 countries outlaw gay sex, most countries criminalize drug use, and nearly all countries have laws against sex work.2 Forty years after the

first cases of AIDS were published, intersectional stigma continues to push key populations to the margins of society. The problems of stigma, discrimination, violence, and criminalization cannot be treated away with antiretroviral medications; yet, because the mainstream HIV response has become ever more reliant on biomedical solutions, it struggles with addressing these systemic and endemic problems. Service organizations, advocacy groups, and governments do not often use intersectional stigma as a lens through which to be developing health care policies and practices, addressing laws and policies, and even in organizing convenings. Indeed, the level of attention and resources devoted to redressing intersectional stigma, discrimination, violence, and criminalization remain incommensurately small in comparison with the scale of the problem and its impacts.

Intersectional stigma describes how interlocking forms of social oppression impact people with multiple stigmatized identities (e.g., the effects of racism, transphobia, criminalization of sex work, and HIV-related stigma on a Black transgender sex worker living with HIV).³ Key populations are overlapping communities that share common experiences of exclusion, pathologization, discrimination, and dismissal. Stigma marks gay and bisexual men, people who use drugs, sex workers, and transgender people as sick, immoral, deviant, and, in many contexts, criminal. Key populations are often scapegoated for social and political ills and are often delegated to the role of helpless, passive recipients of services or objects of research.^{4,5} The global HIV response has not been able to provide clear enough pathways toward solutions and instead has at times contributed to the problem.

FULL TEXT

HIV continues to disproportionately impact key populations- gay and bisexual men, transgender people, people who use drugs, and sex workers-worldwide, especially those who are financially poor and those who are Black and Brown. In 2020, according to UNAIDS, key populations represented 65% of new HIV infections globally- far beyond the proportion of the general population.¹ Governments legislate against key populations: 70 countries outlaw gay sex, most countries criminalize drug use, and nearly all countries have laws against sex work.² Forty years after the first cases of AIDS were published, intersectional stigma continues to push key populations to the margins of society. The problems of stigma, discrimination, violence, and criminalization cannot be treated away with antiretroviral medications; yet, because the mainstream HIV response has become ever more reliant on biomedical solutions, it struggles with addressing these systemic and endemic problems. Service organizations, advocacy groups, and governments do not often use intersectional stigma as a lens through which to be developing health care policies and practices, addressing laws and policies, and even in organizing convenings. Indeed, the level of attention and resources devoted to redressing intersectional stigma, discrimination, violence, and criminalization remain incommensurately small in comparison with the scale of the problem and its impacts.

Intersectional stigma describes how interlocking forms of social oppression impact people with multiple stigmatized identities (e.g., the effects of racism, transphobia, criminalization of sex work, and HIV-related stigma on a Black transgender sex worker living with HIV).³ Key populations are overlapping communities that share common experiences of exclusion, pathologization, discrimination, and dismissal. Stigma marks gay and bisexual men, people who use drugs, sex workers, and transgender people as sick, immoral, deviant, and, in many contexts, criminal. Key populations are often scapegoated for social and political ills and are often delegated to the role of helpless, passive recipients of services or objects of research.^{4,5} The global HIV response has not been able to provide clear enough pathways toward solutions and instead has at times contributed to the problem.

HIV2020: COMMUNITY RECLAIMING THE GLOBAL RESPONSE

After the International AIDS Society's (IAS's) decision in 2018 to hold the AIDS2020 conference in the United States, global key population-led networks came together in protest, given the discriminatory travel restrictions against sex workers and people who use drugs, as well as people from 11 Muslim countries. In addition, the Trump administration was overtly hostile toward refugees; migrants; Black, Brown, and Indigenous people; cisgender women; trans and gender-diverse people; and financially poor people.⁶ Because of these issues, key population-led networks argued the United States was an inappropriate place to hold the conference. Plans to hold AIDS2020 in the United States nevertheless proceeded. The organizers only had one requirement: that there be no travel bans against people living with HIV. Other kinds of stigma associated with identity were not considered.

In response and in a show of solidarity, global community-led networks- MPact Global Action for Gay Men's Health, the Global Network of People Living with HIV, the International Network of People Who Use Drugs, Global Action for Trans Equality, and the Global Network of Sex Work Projects- joined forces to cocreate HIV2020, the first alternative, community-led global HIV conference.⁷ Although most HIV conferences have narrowed their focus to treatment, clinical care, and other biomedical solutions, HIV2020 articulated a vision for and by key population communities. The global networks envisioned a conference that welcomed both empirical science and the beautifully complicated and sometimes messy work of coalition building. HIV2020 elevated necessary blunt discussions about sex and drug use from the points of view of communities engaged in these practices rather than encasing them in public health discourse, which can often be focused on disease and risk rather than identities and pleasure.⁸ The community-led conference endeavored to create a radically different global gathering in which intersectional coalitions and solidarity movements could be envisioned and formed to counter divisive agendas.

The HIV2020 conference committee was composed of global, regional, and national advocates from key population groups, which, over many months, designed a program that embodied community voices, agendas, and priorities. This was a rare occasion during which radical envisioning was the norm, intersectional stigma was explicitly articulated, and solutions were given shape and meaning by people living with and disproportionately affected by HIV. Organizing committee meetings were spaces where partners discussed how to be in coalition and put those politics into practice. In negotiating with Mexico City government officials as the prospective host, HIV2020 organizers asked for several conditions: that city police not arrest sex workers for the duration of the conference, that drug replacement regimens be provided, and that a local sex worker rights activist cases be reviewed. The conference organizers insisted on centering diverse voices who could speak about shared issues faced by key populations. All sessions were designed to be delivered in person via a variety of formats and methodologies. Then the COVID-19 pandemic hit. Despite the disruption caused by COVID-19, the conference organizers reimaged and flexibly adapted to the times, moving HIV2020 online. In fact, this was the first major conference to have done so, demonstrating yet again ingenuity and flexibility. Key populations are and have always been on the front lines and at the forefront of innovation. The IAS followed two weeks later with an announcement that they would hold AIDS2020 virtually.

Between July 2020 and October 2020, a total of 7397 participants from 131 countries joined HIV2020 to listen, watch, and interact across 33 sessions. HIV2020 sessions unapologetically addressed community agendas on research, community mobilization, advocacy, programs, and funding. HIV2020 sessions spoke directly to the issues of greatest concern among key population communities. Sessions focused on bodily autonomy, grassroots organizing, movement building, harm reduction, sex, and pleasure. The conference held fast to shared principles about staying strength based and sex positive. All sessions were offered in five languages to maximize accessibility and participation. Sessions were spread over four months, making it easier for community members to schedule their participation. HIV2020 concluded with a plenary celebration on December 1, 2020, World AIDS Day 2020, during which a set of strategic demands were made to the IAS challenging the community relevance of large, multimillion-dollar conferences in the face of shrinking global investments and persistent barriers to HIV services. HIV2020 was a demonstration of unity as diverse communities across gender, sexual orientations, race and ethnicity, age, and geography banded together to create a common platform. People living with HIV, gay and bisexual men, people who use drugs, sex workers, and transgender people united in open recognition of the overlap between their communities and a common understanding about the synergistic and compounding effects of stigma faced by individuals with multiple community memberships and identities. Convenings that are free from industry trappings can lead to creative and common solutions to challenges facing key populations. Such gatherings are also important because they allow mutual support, affirmation, and a sense of belonging, each of which is critical to the work of resisting and recovering from intersectional stigma.

As the conference went on, it was difficult not to draw parallels between the HIV and COVID-19 pandemics. COVID-19, like HIV, highlights the synergistic and compounding effects of intersectional stigma impacting key populations. How people congregate, the work they do, where they live, and how they move around in the world all came under

heavy scrutiny during the COVID-19 public health mitigation efforts.⁹ Although the lockdowns affected everyone, the COVID-19 pandemic was especially hard on key populations.¹⁰ Access to health care and HIV services became more complicated and challenging, and the ability to work and to socialize was diminished as venues were shut down. Key population-led organizations and networks remained left out of most conversations about prevention, testing, vaccinations, and other lifesaving tools.¹¹

LESSONS LEARNED

The primary themes and lessons learned from HIV2020 led organizers to develop a set of strategic recommendations for strengthening and expanding the meaningful engagement of key populations. They include increased investments in key population-led programs and organizations; stronger and more targeted efforts to decriminalize HIV, gender identity, same-sex sexuality, sex work, and drug use; strengthening sustained support for advocacy through funding; supporting flexible and unconventional approaches led by key populations to reach, inform, gather, and support their peers; and equal partnership in all planning and funding spaces.¹² Although not new, these recommendations are more urgent now than ever because intersectional stigma continues to marginalize key populations in public health responses, whether to HIV or to COVID-19.

To address HIV intersectional stigma, community-led responses from those most impacted must be supported and institutionalized. The organizers of AIDS2020 dismissed the needs and concerns of networks of key population groups and went forward with their US-based event. Their narrow view of stigma prevented them from acknowledging how key populations would be challenged, face problems, and be made vulnerable at AIDS2020—from visa applications, to experiences in travel, to facing discriminatory laws, attitudes, and media. Rather than compromising and putting their constituents in potential harm, the key population networks organized an alternative convening where a larger range of conversations and interventions could occur.

Ultimately, HIV2020 proved to be a transformational moment in which communities of gay and bisexual men, people who use drugs, sex workers, and trans and gender-diverse people demonstrated what intersectional, coalitionbuilding work looks like in practice as it was made real and undeniably visible. Globally, HIV2020 affirmed that we, as criminalized and stigmatized communities, are very much stronger together when it comes to challenging intersectional stigma. The global showcase of solidarity that was HIV2020 holds important lessons and implications for future critical, intersectional praxis. ÂfPU

Sidebar

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CONFLICTS OF INTEREST

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Intersectional Stigma and HIV Continuum Outcomes Among Sexual Minority Men in Sub-Saharan Africa: A Conceptual Framework

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ABSTRACT (ENGLISH)

Sexual minority men (SMM)-which we define as cisgender and transgender men who are romantically attracted, sexually attracted, or both to other cisgender and transgender individuals-in sub-Saharan Africa are at heightened risk for HIV infection and have a higher HIV prevalence and incidence compared with the general population. This disparity has been largely attributed to the stigma and discrimination-on the basis of sexual orientation or gender identity-to which SMM in sub-Saharan Africa are subjected. Recently, there has been a stronger emphasis on investigating how different patterns of intersectional stigma contribute to health inequities among marginalized communities. Intersectional stigma, a term coined by Michele Tracy Berger in her book *Workable Sisterhood*,¹ refers to the confluence of multiple stigmatized identities and how they interact with structural context and factors (e.g., cultural norms and practices, social policy) to have an impact on health outcomes. Sexual orientation, HIV status, and socioeconomic status may each affect the health of SMM in sub-Saharan Africa.

A systematic review published in *The Lancet* in 2019 found that while 67% of SMM in sub-Saharan Africa had ever tested for HIV, among SMM living with HIV, only 24% were currently on antiretroviral therapy, and 25% of them had achieved viral load suppression.² While it is increasingly recognized that intersectional stigma-related to HIV status and sexual minority identity-affects HIV prevention and care outcomes, there are notable gaps in the literature, with no existing model to frame the mechanisms through which experiences of intersectional stigma affect HIV prevention and care outcomes among SMM in sub-Saharan Africa. Understanding these mechanisms has important implications for future HIV intervention development and policymaking.

FULL TEXT

Sexual minority men (SMM)-which we define as cisgender and transgender men who are romantically attracted, sexually attracted, or both to other cisgender and transgender individuals-in sub-Saharan Africa are at heightened risk for HIV infection and have a higher HIV prevalence and incidence compared with the general population. This disparity has been largely attributed to the stigma and discrimination-on the basis of sexual orientation or gender identity-to which SMM in sub-Saharan Africa are subjected. Recently, there has been a stronger emphasis on investigating how different patterns of intersectional stigma contribute to health inequities among marginalized communities. Intersectional stigma, a term coined by Michele Tracy Berger in her book *Workable Sisterhood*,¹ refers to the confluence of multiple stigmatized identities and how they interact with structural context and factors (e.g., cultural norms and practices, social policy) to have an impact on health outcomes. Sexual orientation, HIV status, and socioeconomic status may each affect the health of SMM in sub-Saharan Africa.

A systematic review published in *The Lancet* in 2019 found that while 67% of SMM in sub-Saharan Africa had ever tested for HIV, among SMM living with HIV, only 24% were currently on antiretroviral therapy, and 25% of them had achieved viral load suppression.² While it is increasingly recognized that intersectional stigma-related to HIV status and sexual minority identity-affects HIV prevention and care outcomes, there are notable gaps in the literature, with no existing model to frame the mechanisms through which experiences of intersectional stigma affect HIV prevention and care outcomes among SMM in sub-Saharan Africa. Understanding these mechanisms has important implications for future HIV intervention development and policymaking.

CONCEPTUAL FRAMEWORK

Drawing from the socioecological model, our conceptual framework (Figure 1) proposes that SMM in sub-Saharan Africa experience interconnected systems of stigma (structural, community, interpersonal, and individual) that collectively and uniquely undermine their ability to gain access to and engage with HIV prevention and health care services.

STRUCTURAL STIGMA

Structural stigma refers to the "societal-level conditions, cultural norms, and institutional practices that constrain the opportunities, resources, and wellbeing of the stigmatized."³(p743) We propose that the most salient sources of structural stigma to which SMM in sub-Saharan Africa are subjected are anti-lesbian, gay, bisexual, transgender,

and queer (LGBTQ)-oriented legislation, police brutality; arrests; extortion; economic disenfranchisement; and discrimination in health care settings. SubSaharan Africa accounts for nearly half of the countries worldwide where homosexuality is outlawed, which has implications for access to HIV-related health services.

A study of 28 African countries found that SMM living in countries with the most severe anti-LGBTQ legislation were less likely to be tested for HIV and to be aware of their serostatus compared with those in countries with the least severe legislation.² Anti-LGBTQ laws both discriminate against sexual minority communities and embolden state actors (e.g., police and law enforcement) to "enforce" these laws and ordinances-all to the detriment of already marginalized groups. In a study of SMM living with HIV in Eswatini, participants described experiences of violence from police officers and lack of protection because of their sexuality.⁴

Another study of SMM in Jamaica found that SMM living with HIV were more likely to report experiencing police harassment,⁵ which has implications for their engagement in HIV care services. While no known studies have specifically examined anti-LGBTQ police harassment and violence and its effects on HIV care engagement among SMM in sub-Saharan Africa, related literature has linked, for example, US immigration enforcement activity and health care-seeking behavior among Latinx immigrants.⁶ Similarly, stigma because of sexual orientation and HIV status as grounds for denial or termination of employment might result in economic disenfranchisement, which may limit access to HIV prevention and care services. In South Africa, SMM living with HIV have reported experiences of discrimination and isolation, including loss of employment and housing, because of their HIV serostatus.⁷ Lack of adequate employment is also associated with sexual practices that might elevate exposure to HIV such as transactional sex and condomless anal sex.⁸ Another source of structural stigma is discrimination and prejudice in health care settings. Denial of health care services, lack of confidentiality, and negative health care worker attitudes because of sexual orientation or HIV status may lead African SMM to avoid engaging in health care. Interventions designed to address health care provider stigma toward SMM in sub-Saharan Africa have shown promising results, but more work in this area is needed.

COMMUNITY AND INTERPERSONAL STIGMA

We define community and interpersonal (enacted) stigma as discriminatory attitudes and behaviors perpetuated by friends, intimate partners, family, health care providers, and other community members. Even where this stigma is not directly experienced by stigmatized individuals, it may affect their behavior given the expected negative sequelae should their stigmatized identities become known (anticipated stigma).⁹ A study of SMM in seven western and southern African countries found a high prevalence (7%-40%) of enacted stigma because of perceived sexual orientation, ranging in severity from family exclusion and gossip to blackmail, physical violence, and rape.¹⁰ It is plausible that SMM who experience stigma from family and friends may be at heightened risk for HIV infection and more hesitant to seek HIV-related health care services. A study of SMM across eight African countries found that experiences of interpersonal stigma, specifically exclusion from family events and rejection by friends,¹¹ was associated with HIV seropositivity, providing further evidence of how further marginalization of SMM living with HIV by individuals that would ideally be a source of social support had dire implications for health and well-being.

INDIVIDUAL STIGMA

Perceptions, experiences, or anticipation of stigma can lead to internalized stigma, whereby the stigmatized individuals absorb and believe the stigmatizing messages embedded in the nonaffirming culture.⁹ We conceptualize individual stigma factors as the attitudes, beliefs, and trauma that are derived and informed by stigma and the impact of experiences of stigma on the health and well-being of the stigmatized individual, including internalized stigma (absorption of negative messages or stereotypes about stigmatized identity), substance use, and psychosocial health. Studies have documented high levels of internalized HIV stigma among SMM in sub-Saharan Africa, and constant experiences of stigma may lead SMM to engage in substance use as a coping mechanism. Lastly, the negative psychosocial effects of stigma cannot be underemphasized among SMM in sub-Saharan Africa. Various studies have documented a strong association between experiences of stigma and reports of depressive symptoms, anxiety, loneliness, and suicidality in this population.¹²

INTERVENTION AND POLICY IMPLICATIONS

In spite of discrimination and violence, SMM in sub-Saharan Africa remain resilient and continue to build a collective agency. Consistent with this proposed framework, interventions and policies should be developed to address the intersectional nature of the stigma experienced by SMM in sub-Saharan Africa and to block the mechanisms through which this stigma exacerbates HIV disparities. Most existing HIV prevention and care interventions focus solely on changing individual-level behavior, ignoring the larger nonaffirming contexts in which SMM are forced to exist and thrive. Future interventions should address the multilevel systems that propagate stigma and inhibit SMM from easily accessing quality and affirming HIV health services. Possible interventions include sensitization trainings for community members, religious leaders, and health care providers; leveraging mobile technology to connect marginalized communities directly to affirming health care services; repealing of anti-LGBTQ laws; and economic strengthening programs. >4JPH

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DETAILS

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Punishing Vulnerability Through HIV Criminalization

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ABSTRACT (ENGLISH)

HIV criminalization" refers to the unjust application of criminal law to people living with HIV for nonmalicious HIV transmission, perceived or potential HIV exposure, or nondisclosure of known HIV-positive status. Although many HIV-specific criminal statutes were misguidedly enacted with the primary purpose of protecting public health, it has been extensively documented that HIV criminalization in fact poses a barrier to HIV prevention, care, and treatment and negatively affects the quality of life of those affected by HIV.¹⁻⁴ As a result, HIV criminalization is an important issue for policymakers, public health practitioners, and health care providers, in addition to people living with HIV and justice advocates.

Obtaining accurate information on how HIV criminalization laws are applied is challenging, given the lack, or inadequacy, of systems to track them in most jurisdictions. At the HIVJustice Network, we monitor HIV-related criminal laws and cases in real time, based primarily on media reports. These are collated and classified according to alleged crime, known demographics, and disposition in our searchable Global HIVCriminalisation Database.⁵ Our analysis based on these reports strongly suggests that people living with HIV often receive unjust treatment in the legal system. Moreover, we observe that HIV criminalization serves as a proxy for discrimination based on class, ethnicity, gender identity, migrant status, race, sex, sexual orientation, and other markers of social vulnerability. The

most aggressive push to criminalize people living with HIV tends to occur at the intersection of several stigmatized identities.

FULL TEXT

HIV criminalization" refers to the unjust application of criminal law to people living with HIV for nonmalicious HIV transmission, perceived or potential HIV exposure, or nondisclosure of known HIV-positive status. Although many HIV-specific criminal statutes were misguidedly enacted with the primary purpose of protecting public health, it has been extensively documented that HIV criminalization in fact poses a barrier to HIV prevention, care, and treatment and negatively affects the quality of life of those affected by HIV.¹⁻⁴ As a result, HIV criminalization is an important issue for policymakers, public health practitioners, and health care providers, in addition to people living with HIV and justice advocates.

Obtaining accurate information on how HIV criminalization laws are applied is challenging, given the lack, or inadequacy, of systems to track them in most jurisdictions. At the HIVJustice Network, we monitor HIV-related criminal laws and cases in real time, based primarily on media reports. These are collated and classified according to alleged crime, known demographics, and disposition in our searchable Global HIVCriminalisation Database.⁵ Our analysis based on these reports strongly suggests that people living with HIV often receive unjust treatment in the legal system. Moreover, we observe that HIV criminalization serves as a proxy for discrimination based on class, ethnicity, gender identity, migrant status, race, sex, sexual orientation, and other markers of social vulnerability. The most aggressive push to criminalize people living with HIV tends to occur at the intersection of several stigmatized identities.

Our most recent analysis indicates that 130 countries have unjustly criminalized people living with HIV over the course of the epidemic-either under HIV-specific statutes or through the application of a wide range of general criminal laws (e.g., sexual assault, bodily harm, attempted murder). We are aware of 50 countries that are actively prosecuting individuals under these laws for sexual acts that may or may not risk transmission, as well as for spitting, biting, and even breastfeeding. Another 60 countries have HIV-specific criminal laws without active enforcement but hanging like the Sword of Damocles over people living with HIV.

From the early days of the AIDS epidemic, HIV has been especially associated with negative attitudes toward gay men. That legacy continues even today, with multiple intersections between homophobia, transphobia, and HIV criminalization. For example, mass arrests of gay men in Egypt, Uganda, and Senegal have been linked to fear of HIV, and the religious right has posited that HIV is a punishment for the same-sex sexual activities or alternative gender expression that they deem immoral.

The facts that HIV is primarily transmitted and acquired through sex and drugs and that the virus tracks poverty and marginalization make HIV criminalization laws prime candidates for discriminatory application. When the stigmatized status of being HIV positive intersects with other stigmatized statuses (e.g., gay man, transgender person, sex worker, immigrant), a distinct and amplified risk of being criminalized arises. However, selectively and arbitrarily targeting behaviors relating to taboo (to the dominant culture) forms of work, intimacy, or pleasure can obscure the discrimination driving prosecutions, making it seem like the charges are based solely on an individual's wrongdoing and deserve punishment.

HIV criminalization makes it appear as if the state is solving the problem of new HIV transmissions and acquisitions by punishing the "bad actors" who are supposedly responsible for spreading the virus. However, because HIV exposure or transmission is seldom the result of malicious intent, criminalization not only provides a false sense of security but also scapegoats individuals for systemic failures of society and government.

We see a trend of criminal charges being disproportionately brought against people who are not of the dominant ethnic/racial group in many countries rather than the charges being evenly distributed across the population of people living with HIV. As has been documented previously in Australia, New Zealand, Canada, and Europe, those charged are primarily migrant heterosexual men from countries where HIV is endemic. In the United States and Canada, we see men of color-including gay men of color-being disproportionately prosecuted.^{6,7} Discriminatory

attitudes toward, and assumptions about, the sexual behavior of different groups has clearly played into such cases, including erroneous ideas that people from high-prevalence countries bring HIV into high-income countries; that Black men have insatiable sexual appetites; and that Indigenous women- another marginalized group disproportionately criminalized in Canada-are sexually available and irresponsible.⁸⁻¹⁰ Racial minorities are also less likely to go to the police for protection or to have access to legal information and advice. Newcomers and racial minorities often reside in poor neighborhoods and have more interactions with police, less access to health care and social services, and higher rates of HIV. All of these factors intersect, increasing the likelihood of racism manifesting in HIV criminalization.

In tracking the cases, we also notice that the majority of those facing prosecution are in positions of less power than their accusers, often because of intersecting stigmatized identities, behaviors, and practices. This is not surprising, as HIV is a disease of poverty and stigma, and those with more power are better able to access services and lawyers and more readily turn to the police for protection. Women, notably in sub-Saharan Africa, Eastern Europe, and Central Asia, are particularly vulnerable to prosecution because they are often the first in a relationship to know their status, because of routine antenatal HIV testing, and less likely to be able to safely disclose their HIV-positive status to sexual partners or negotiate condom use, because of inequality in power relations, economic dependence, and high levels of gender-based violence. Many women living with HIV also face coercion and control over reproductive health and pregnancy.

We believe, therefore, that HIV criminalization is not only a manifestation of state-sponsored HIV stigma but also a proxy for other forms of stigma and discrimination. Exacerbated by heavy-handed policing and vitriolic media coverage enabled by unjust laws that fly in the face of science and human rights, HIV criminalization thrives at the intersection of social vulnerabilities. It further exacerbates stigma, impeding service accessibility and reducing the effectiveness of HIV-related funding and programs. Indeed, the Joint United Nations Programme on HIV and AIDS Global AIDS strategy explicitly recognizes inequality and HIV criminalization as barriers to ending HIV as a public health threat by 2030.¹¹

There is no one-size-fits-all approach to challenging HIV criminalization. HIV-specific criminal laws have been "modernized" in several US states based on arguments that they were not based on up-to-date science on HIV-related risk or harm. In other countries, human rights-based arguments have led to HIV-specific criminal laws being suspended or repealed: Colombia's law was found to be unconstitutional in 2019 because it violated the right to equality, and one of two Kenyan laws used for HIV criminalization was found to be unconstitutional in 2015 because it did not meet the standards for a justifiable limitation of the constitutional right to privacy.¹²

However, modernizing or repealing HIV-specific laws alone will be insufficient to address the full complexity of the intersecting stigmas behind both misguided attempts to protect people from HIV infection and intentional criminalization of groups of people (e.g., based on sexual or gender identity, sex work, or drug use). As with other manifestations of discrimination, the ultimate solution lies in equality and empowerment. >4JPH

Sidebar

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DETAILS

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The Public Health Crisis Is Planetary-and Nursing Is Crucial to Addressing It

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ABSTRACT (ENGLISH)

If the Earth were our client, her status would be multisystem failure. She is not ready for hospice, but she does need intensive care to survive. Signs and symptoms include catastrophic wildfires, unprecedented and extended periods of severe heat, climate-related disasters of historic proportions, massive biodiversity loss, deforestation and desertification of the land, emerging infectious and zoonotic diseases including COVID-19, severe air pollution, and changes in water quality and availability. Each of these changes profoundly impacts the health of humans and often impacts structurally vulnerable populations disproportionately.

In September 2021, more than 200 global nursing, medical, pharmacy, dental, and public health journals issued a joint statement titled, "Call for Emergency Action to Limit Global Temperature Increases, Restore Biodiversity, and Protect Health." Its authors wrote:

As health professionals, we must do all we can to aid the transition to a sustainable, fairer, resilient, and healthier world. Alongside acting to reduce the harm from the environmental crisis, we should proactively contribute to global prevention of further damage and action on the root causes of the crisis.¹(p1135)

FULL TEXT

If the Earth were our client, her status would be multisystem failure. She is not ready for hospice, but she does need intensive care to survive. Signs and symptoms include catastrophic wildfires, unprecedented and extended periods of severe heat, climate-related disasters of historic proportions, massive biodiversity loss, deforestation and desertification of the land, emerging infectious and zoonotic diseases including COVID-19, severe air pollution, and changes in water quality and availability. Each of these changes profoundly impacts the health of humans and often impacts structurally vulnerable populations disproportionately.

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PLANETARY HEALTH

To accomplish these goals, we must work collaboratively to redesign our current model, shifting from illness care to health care based on principles of planetary health.

"Planetary health is a solutions-oriented, transdisciplinary field and social movement focused on analyzing and addressing the impacts of human disruptions to Earth's natural systems on human health and all life on Earth."² The planetary health movement calls for a great transition of all human sectors. Public health nurses are perfectly positioned to lead this transition because they have always addressed sources of harm, promoted strategies to protect our nation's most vulnerable citizens, and advocated for policies that protect our water, air, and land. Now the planetary health paradigm connects the knowledge and skills of public health nursing to a global movement for change.

Appreciation for the broader context in which people live, work, commune, and connect has been a foundational feature of all nursing from Florence Nightingale and Lillian Wald onward, as is working with individuals, communities, and populations collaboratively to prevent poor health outcomes, enhance wellness, and advocate for more equitable health outcomes for all. This framework of nursing—now the most trusted profession in the United States for the 20th year in a row³—is a powerful force to guide the contribution of public health-focused nurses and health professionals to address what is the greatest public health crisis of our time. Nurses and other health workers are needed not only to ensure that public health and health care delivery is made more environmentally sound (given

that the health sector contributes approximately 8% of all US greenhouse gasses, a proportion that has increased⁴) but also to help reduce the need for the volume of health care delivery itself. Prevention of illness, thus reducing health care service use,⁵ is a cardinal goal of public health nursing that will bring even further benefit in the Anthropocene era. The National Academy of Medicine, among others, has called for decarbonizing the health sector,⁶ which will contribute to global goals as well as bring health cobenefits to populations.⁷

PUBLIC HEALTH AND THE GREAT TRANSITION

Public health and health care delivery systems likewise must do a better job of adapting to the multiple health impacts that are ensuing from planetary health stresses, including the COVID-19 crisis. Needs include improved surveillance and data systems, as well as best practices in communicating the climate crisis and how it affects people locally. Annual surveys show that most of the American public now believes that the climate crisis is already affecting their health and the health of their communities. This recognition must be leveraged in advocating to enhance public health infrastructure. The Centers for Disease Control and Prevention's BRACE (Building Resilience Against Climate Effects) framework should be funded at a level that is more commensurate with the urgent crisis. Representing a key portion of the global health workforce, nurses form the backbone of public health and health care delivery systems. Planetary health concepts must become part of the curriculum for preparation and continuing professional development of the nursing workforce. This has been recognized in the American Association of Colleges of Nursing's competencies for nursing, which include a call for planetary health content (see additional resources in the Appendix, available as a supplement to the online version of this article at <https://ajph.org>). Curricular elements of such a planetary health approach have been identified, and alliances including the Global Consortium on Climate and Health Education are working to ensure uptake in clinical schools.

An agenda for public health and nursing in the Anthropocene must include addressing mitigation and adaptation strategies at every level, emphasizing prevention and including a laser focus on equity. This can begin with education as health professionals, which could be enhanced by credentialing and licensing board inclusion of planetary health content. For nurses, this includes a continuation of the shifting emphasis from acute care or "illness care" to broader population health using a "planetary health care" framing. As trusted messengers, nurses can provide anticipatory guidance to patients and communities. Higher engagement of health departments in this work can leverage the BRACE framework, and public health nurses can be engaged in developing green offices with best practices to support community sustainability. Regional planning should be better supported and integrated across public health and health care systems. Workforce resilience must be addressed, including mental health services. Finally, reversal of the decline in public health spending must occur, now more than ever.

CALL TO ACTION

Global nursing organizations have called for significant action on climate change and other issues that threaten planetary health. Some organizations are leading the way with practical ways for nurses to get involved. For example, the Alliance of Nurses for Healthy Environments sponsors Nurses Drawdown (see additional resources in the Appendix), which offers tangible steps that all nurses, including public health nurses, can take to draw down greenhouse gases and improve the health of humans and the planet. In addition, the American Nurses Association has launched an innovation committee on planetary and global health to support nurses who are taking action on planetary health.

We must take bold action to eliminate the causes of our current crisis, including challenging continued use of fossil fuels that impact air quality and contribute to climate change. We must work to adequately protect structurally vulnerable populations. The nation's public health infrastructure needs a massive investment of federal and state funding. Public health must be universally recognized as the first line of defense if we are to have a sustainable health care system. Policies need to ensure equitable access to knowledge and resources to protect structurally vulnerable populations in a world undergoing climate change. Public health nurses can be part of redesigning our cities and communities to ensure access to clean air, water, green space, and healthy foods for all people. Finally, public health messaging must convey a sense of urgency and preparedness. We need to take mitigation steps now while also promoting adaptation and resilience to the changes already in play. At the same time, public health

nurses and all health professionals must convey hope that if we work together across disciplines and political parties, we can build a healthy future for humans and all life on Earth. Jfpu

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Black Sexual Minority Male HIV Researchers, Clinic Administrators, and Activists Call for the Advancement of an Intersectionality Approach to Address HIV Stigma

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[ProQuest document link](#)

ABSTRACT (ENGLISH)

HIV-related research that focuses on Black sexual minority men (SMM) often treats that particular community as monolithic. The research often focuses on the disparate rates of HIV infection while offering little insight into the social, cultural, political, and economic dynamics shaping the lives of Black SMM that impact decision-making and behavior or access to health care or public health systems. We postulate that these insufficient and often uninformed hypotheses are due to the lack of queer Black people living with HIV in HIV-related public health leadership, clinical research, health care delivery, and academia. This dynamic expressly exacerbates instead of reduces the experienced external and internal stigmas. We are happy to see articles in this special supplement of AJPH addressing the Black diaspora of SMM and raising the need for more investment in understanding intersectionality and an intersectional lens to build future research.

Recent research uses an intersectional framework to explain HIV prevention and treatment inequities. For Black SMM, links are found between lived experiences of racism and queerphobia¹ and reduced HIV-related health-seeking behaviors (e.g., poorer medication adherence, less frequent HIV screening).² These articles in this special supplement highlight the systemic racism within academia while also showcasing that these "isms" are only a small portion of the many enacted stigmas that impact Black SMM.

FULL TEXT

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DIVING DEEPER INTO DRIVERS OF INTERSECTIONAL STIGMA

While reviewing the special supplement, the lack of Black SMM as first authors on each journal article except for one ("Intersectional Stigma and HIV Continuum Outcomes Among Sexual Minority Men in Sub-Saharan Africa: A Conceptual Framework") was duly noted. Meaningful engagement of Black SMM must occur at all levels of academia, research, and health care delivery if we expect to see an improved and more community-responsive approach. Black SMM leadership is vital to success.

It has also been shown that other enacted stigmas may directly affect Black SMM (e.g., sizeism, colorism, racial fetishization, and ageism). Quinn et al. (p. S285) discuss how these enacted stigmas deserve special attention and investigation, examining their relationship with HIV-related outcomes among Black SMM. Indeed, this argument is

strengthened by the fact that prior research examining HIV-related outcomes among Black SMM has found evidence that the elevated rate of HIV prevalence among Black SMM compared with SMM of other races is due in part to Black SMM participating in smaller, more racially homophilous sexual networks than their White and Latino counterparts.³ Although many Black SMM likely consciously choose Black sexual partners because of an affinity for cultural familiarity and love of Blackness, other Black SMM may desire to participate in a less racially homophilous sexual network but find their ability to do so is restricted by anti-Black structural racism. These pathways to health-seeking behavior, partner selection, and safer sex practices were rightly reinforced by Friedman et al. (p. S332). In addition, research has primarily and problematically conflated race with ethnicity and country of origin, so much so that the extant literature addressing Black race-related HIV outcomes among SMM often uses the terms "Black" and "African American" interchangeably or even groups together Black people of varying Black diasporic backgrounds (e.g., Africans, Caribbean people, and African Americans) in analyses without regard for their cultural differences. Black people are not monolithic. Ogunbajo et al. (p. S254) reinforced the challenges researchers have in segmenting vastly different cultures by inferring that in-country African SMM's experiences may be similar even across varied geopolitical environments, sociopolitical legacies from colonization, and current alignment with pervading religiosity and evangelical influences. Grouping Black people solely by racial group, without attention to ethnic differences, could produce less meaningful or less generalizable results and could have limited utility for intervention. It would be wise for future intersectional stigma research in the field to consider ethnicity and culture and to assess how inter- and intracultural dynamics could influence HIV-related health outcomes among Black SMM. We concur that the field must still examine its cisnormative approach to examining HIV-related outcomes among Black SMM. Much of the reviewed literature has focused on the health behaviors of cisgender Black SMM, although Black SMM include transgender and nonbinary persons. Their experiences deserve to be accurately accounted for in the research literature. As Black cisgender queer men, our HIV health-seeking behaviors and HIV serostatuses reflect much of our lived experiences and responses to stigma and discrimination faced and at times internalized. We are a small subset of Black SMM still yearning to slow down HIV incidence in our community.

ADDRESSING SYSTEMIC RACISM AND HETEROSEXISM

We eagerly anticipate improved HIV-related health outcomes for Black SMM delivered by public health institutions. Historically, HIV public health solutions have not aligned with HIV biomedical advancements. This is clear with the disparate awareness and uptake of oral preexposure prophylaxis for Black SMM compared with White SMM.⁴ Moreover, this disparate uptake is already expected for injectable options for both preexposure prophylaxis and HIV treatment without minimal proactive interventions to improve health equity. Therefore, we do not have to wait for modelers to tell us that slower uptake will exacerbate the disparity in health outcomes for Black SMM compared with those for White peers.

The answer to these and other challenges in the inequitable HIV response must be rooted in Blackness and queerness. Black SMM community investment requires a better normative standard of the meaningful involvement of affected persons and the community. It is the only answer to move forward. There is an implicit ambiguity around the phrase "nothing about us without us." That ambiguity must be removed. Health justice for Black SMM requires intentional segmentation to avoid characterization of the expression "all lives matter" when what is needed is a sustained public health response highlighting that Black Lives Matter.

Collectively, the articles that we reviewed for this supplement have the potential to help develop and further long-term sustainable investments to build pipelines to support Black queer people living with and impacted by HIV to become funded principal investigators. Intentional diversification of research teams should be modeled from successful Black-led and Black-centered organizations such as The Bros in Convo (Orlando, FL),⁵ THRIVE Support Services (Atlanta, GA),⁶ and The Normal Anomaly (Houston, TX).⁷

Investment in systemic approaches, not only to dismantle intersectional stigmas that Black SMM experience, will not accomplish our collective goals. Wright et al. (p. S313) and Taggart et al. (p. S251) explicitly focused on the spatial impact that the physical built environment has on its inhabitants, especially marginalized populations such as Black SMM. The metrics are now being developed to evaluate how intersectional stigma impacts particular subpopulations

at individual, community, and systemic levels.

The White-dominated HIV public health and academic sectors are finally, and thankfully, taking note that review of these structures has also been inherently racist as interventions and subsequent responses are rooted in comparison of Black SMM with White peers. Addressing the dynamics among Black SMM and HIV public health leaders must be laid bare if collective action is expected to lead to better prohealth-seeking behaviors and ultimately improved HIV-related health outcomes. Â1Pii

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CONTRIBUTORS

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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DETAILS

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Neighborhood Characteristics, Intersectional Discrimination, Mental Health, and HIV Outcomes Among Black Women Living With HIV, Southeastern United States, 2019–2020

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ABSTRACT (ENGLISH)

Objectives. To examine the effects of within-neighborhood and neighboring characteristics on discrimination, stigma, mental health, and HIV outcomes among Black women living with HIV (BWLWH). **Methods.** A total of 151 BWLWH in a southeastern US city provided baseline data (October 2019-January 2020) on experienced microaggressions and discrimination (race-, gender-, sexual orientation-, or HIV-related), mental health (e.g., depression, posttraumatic stress disorder), and HIV outcomes (e.g., viral load, antiretroviral therapy adherence). Neighborhood characteristics by census tract were gathered from the American Community Survey and the National Center for Charitable Statistics. Spatial econometrics guided the identification strategy, and we used the maximum likelihood technique to estimate relationships between a number of predictors and outcomes. **Results.** Within-neighborhood and neighboring characteristics (employment, education, crime, income, number of religious organizations, and low-income housing) were significantly related to intersectional stigma, discrimination, mental health, HIV viral load, and medication adherence. **Conclusions.** Policy, research, and interventions for BWLWH need to address the role of neighborhood characteristics to improve quality of life and HIV outcomes.

FULL TEXT

Headnote

Objectives. To examine the effects of within-neighborhood and neighboring characteristics on discrimination, stigma, mental health, and HIV outcomes among Black women living with HIV (BWLWH).

Methods. A total of 151 BWLWH in a southeastern US city provided baseline data (October 2019-January 2020) on experienced microaggressions and discrimination (race-, gender-, sexual orientation-, or HIV-related), mental health (e.g., depression, posttraumatic stress disorder), and HIV outcomes (e.g., viral load, antiretroviral therapy adherence). Neighborhood characteristics by census tract were gathered from the American Community Survey and the National Center for Charitable Statistics. Spatial econometrics guided the identification strategy, and we used the maximum likelihood technique to estimate relationships between a number of predictors and outcomes.

Results. Within-neighborhood and neighboring characteristics (employment, education, crime, income, number of religious organizations, and low-income housing) were significantly related to intersectional stigma, discrimination, mental health, HIV viral load, and medication adherence.

Conclusions. Policy, research, and interventions for BWLWH need to address the role of neighborhood characteristics to improve quality of life and HIV outcomes. (AmJ Public Health. 2022;112(S4):S433-S443.

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(ProQuest: ... denotes formulae omitted.)

Black women living with HIV (BWLWH) are disproportionately affected by HIV and accounted for 64% of all new HIV diagnoses in 2018.¹ In addition, Black or African Americans represented 43% of all deaths among people living with HIV (PLWH) in the United States in 2018.¹ This may be attributable to intersectional systems of oppression that manifest at the neighborhood (e.g., employment rates, housing), interpersonal (e.g., discrimination), and individual (e.g., mental health, health behaviors) levels to have an adverse impact on the lived experiences of BWLWH.²⁻⁵ However, few scholars have used an intersectional lens incorporating neighborhood factors to improve our understanding among BWLWH. Spatial analyses provide an opportunity to examine the potential influence of factors of neighboring areas in addition to withinneighborhood factors.⁶

The theory of intersectionality⁷ states that interwoven systems act in concert to perpetuate discrimination and oppression and postulates that discrimination and oppression are best understood in the context of multiple marginalized identities and manifest differently based on the nature of this intersectionality. Furthermore, Berger conceptualized "intersectional stigma" specifically among women of color living with HIV as a process through which they face structural oppression and barriers to political participation including racism, sexism, and classism, and stigmatization of drug use, sex work, and HIV status.^{8,9} In addition, the social-ecological model of health promotion posits that HIV health promotion, via increased retention and engagement in care, is affected by the complex interplay of individual-level (e.g., housing and spirituality), interpersonal-level (e.g., experiences of discrimination, microaggressions, and trauma), and community-level factors (e.g., neighborhood deprivation and poverty).¹⁰ Neighborhood context (e.g., poverty and crime rates) has been negatively associated with adverse mental and physical health outcomes (e.g., HIV viral load [VL] and depression) among PLWH.¹¹⁻¹³ Poverty prevents access to basic needs (e.g., food, shelter) and medical care, and chronic stress from crime and poverty may make it difficult to prioritize medication adherence, which may compromise immune functioning.¹² In addition, neighborhood factors related to housing reflect a legacy of structural racism—for example, through gentrification, "White flight," the disproportionate burden of evictions on Black women, and the intentional use of public housing to segregate Black Americans historically.^{14,15} Housing may be a resilience resource; for instance, in the United States, programs such as the Housing Choice Voucher Program (Section 8) are prominent for their ability to provide affordable and safe housing in the private market. Religious congregations (e.g., churches) have also been a source of resilience within Black communities, and religion and spirituality have been positively associated with physical and mental health-related quality of life among PLWH.¹⁶ Nonetheless, the direct associations between neighborhood factors and intersectional discrimination, mental health, and HIV-related outcomes among BWLWH is unknown.

Intersectional stigma,⁸ discrimination, and microaggressions (which are defined as subtle acts of discrimination) based on race, gender, and HIV status significantly compromise the mental and physical health of BWLWH. HIV stigma and discrimination have been positively associated with poor viral suppression, and, among BWLWH, depression and posttraumatic stress disorder (PTSD) symptoms have been linked to gendered racial microaggressions and racial-, gender-, and HIV-related discrimination.^{4,5} In addition, PTSD and depression are associated with increased HIV disease progression.¹⁷ However, the relationship between neighborhood-level factors and microaggressions and discrimination aimed at multiple identity axes for BWLWH has yet to be explored. Spatial econometrics is a theoretical and empirical methodology that is designed to encapsulate the effects of potential geographic dependencies and their influences.⁶ Over the past 2 decades, spatial econometric methods have become increasingly important in the applications to social science, although rarely in the context of HIV and mental health. Neighborhoods influence each other, and spatial econometrics is able to incorporate these

interdependencies, which are missing from previous work among BWLWH. Missing from the health literature is that the characteristics of neighboring communities (in addition to within-neighborhood factors) may be important in explaining variation in health outcomes. Accounting for these neighboring effects will help to create policies that will reduce health disparities within and across vulnerable communities.

CURRENT STUDY

Given the dearth of studies examining the impact of characteristics of withinneighborhood and neighboring areas on intersectional discrimination and stigma, mental health, and HIV outcomes among BWLWH, we used spatial econometrics techniques to examine neighborhood characteristics in relation to discrimination, microaggressions, mental health, and HIV outcomes. Findings have the potential to inform future research and multilevel interventions addressing intersectional discrimination and stigma and the health of BWLWH.

METHODS

BWLWH residing in South Florida were recruited between October 2019 and January 2020. Recruitment included sharing flyers and posters at community health clinics and centers, hospitals, and community events. Potential participants who expressed interest completed a phone screen to determine their eligibility. Eligible participants were scheduled for an in-person baseline visit and enrolled in the study if they met the following inclusion criteria:

1. aged 18 years and older;
2. English speaking;
3. identifying as Black (racial identity), African American (racial-ethnic identity), or both;
4. cis-gender female;
5. living with HIV;
6. owning a cell phone with text messaging and Internet capability; and
7. capable of understanding and completing the informed consent process and procedures.

During the baseline visit, participants completed (1) informed consent, (2) questionnaires using the Research Electronic Data Capture, and (3) a semistructured clinical interview. Participants received a \$75 stipend for the visit.

Measures

Self-report demographic information included the participants' age, ethnicity, sexual orientation, relationship status, education level, employment status, and annual household income.

Intersectional Discrimination and Oppression

We used the Gendered Racial Microaggressions Scale for Black Women,¹⁸ a 26-item measure assessing the lifetime frequency and stress appraisal (level of stress resulting from each experience) of microaggressions encountered by Black women (e.g., "Someone accused me of being angry when I was speaking in a calm manner"). Internal reliability estimates (frequency $\alpha = 0.92$; appraisal $\alpha = 0.95$) for the scale have been good among samples of BWLWH.⁵

We used the HIV Microaggression Scale,¹⁹ a 14-item instrument measuring experiences (in past 3 months) of subtle insults stemming from HIV-related stigma (e.g., "You heard someone say, 'I'm HIV negative; I'm clean'"). The internal reliability ($\alpha = 0.83$) for the HIV Microaggression Scale has been good among community-based samples of PLWH.

We used the LGBT (lesbian, gay, bisexual, and transgender) People of Color Microaggression Scale,²⁰ an 18-item instrument assessing microaggressions experienced (in the past 3 months) on the basis of being both a person of color and a sexual or gender minority (e.g., "Being rejected by potential dating or sexual partners because of your race/ethnicity"). The scale has shown good internal reliability ($\alpha = 0.89$) among racially/ethnically diverse LGBT individuals.²⁰

We used the Multiple Discrimination Scale²¹ to capture discrimination (in the past year) on the basis of race, sexual orientation, and living with HIV, and it was adapted to capture gender. We used 13 items to assess each type of discrimination with a total of 56 items (e.g., "In the past year, were you denied a job or did you lose a job because you are a woman?"). The scale has shown good construct validity and reliability (α for race subscale = 0.83; α for sexualorientation subscale = 0.86; α for HIV subscale = 0.85).²¹

Trauma and Mental Health Outcomes

We used the 17-item Life Events Checklist²² to assess exposure to traumatic events involving actual or threatened death, serious injury, and violence. The checklist has shown good internal reliability ($\alpha = 0.78$) among women living with HIV.

The 20-item PTSD Checklist²³ assessed the severity of PTSD symptoms. Participants were asked to endorse symptomology (in the past month) related to their worst or most distressing traumatic event. The checklist has shown great internal reliability ($\alpha = 0.97$) among PLWH.

We used the 20-item self-report Center for Epidemiological Studies Depression Scale²⁴ to assess depressive symptoms (e.g., "I had crying spells"). The scale has shown great reliability ($\alpha = 0.88-0.98$) and validity in studies focused on women living with HIV.⁵

We used the Mini-International Neuropsychiatric Interview for DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition),²⁵ a widely used semistructured clinical interview, to assess current major depressive disorder, PTSD, suicidality, alcohol use disorder, and substance use disorder.

HIV Outcomes

At the baseline visit, blood was collected to assay for HIV viral load by using the Roche COBAS AmpliPrep/ COBAS TaqMan HIV-1 Test, v2.0. A VL cutoff of less than 200 copies per milliliter was used in our analyses for viral suppression and a cutoff of less than 20 was defined as undetectable.

To capture self-reported HIV medication adherence for the past 4 weeks, we used a pre-existing item²⁶: "Thinking about the past 4 weeks, how would you rate your ability to take all your medications as your doctor prescribed them?" Responses ranged from 1 = "very poor" to 6 = "excellent" on a 6-point Likert scale.

Neighborhood Factors

To gather characteristics of each participant's neighborhood, we utilized the open-access Web sites of the American Community Survey (ACS)²⁷ and the National Center for Charitable Statistics (NCCS) Data Archive.²⁸ The ACS is administered by the US Census Bureau more frequently (monthly and annually) than the US Census.²⁷

Neighborhood characteristics (e.g., employment rate, median income, education) were collected by census tract from the 2019 ACS (5-year estimates).

The NCCS collects information filed with the Internal Revenue Service (IRS) by tax-exempt nonprofit organizations. The IRS Business Master File contains descriptive information on each of these organizations, and the 2020 file²⁸ was used to collect variables of interest (e.g., number of Christian religious institutions, number of low-income and subsidized rental housing).

Participant addresses were geocoded to latitudes and longitudes and census tract using the US Census Bureau²⁷ Geocoder service. For each participant, the ACS and NCCS data were merged by census tract. The organizations in the IRS business file were geocoded to census tracts. To estimate the availability of potential nonprofit services for each participant, for each census tract, the number of each type of charitable entity in the NCCS data set was merged with the participant data.

Women's responses to the National Crime Victimization Survey²⁹ were also used as a proxy for neighborhood crime given barriers to reporting and underreporting.³⁰ This survey assesses experiences of 7 major types of crime victimization—assault (aggravated and simple), burglary, robbery, identity theft, motor vehicle theft, rape, and sexual assault. Participants indicated if they had experienced situations related to each type of crime in the past 12 months. If a participant experienced crime victimization in the past 12 months, they were asked to indicate the frequency of the crime(s).

Statistical Analyses

Maximum likelihood techniques (via Stata version 16.1; StataCorp LLC, College Station, TX) estimated all models, and we used the Wald test (χ^2 distributed) to assess if the spatial correlation parameters were jointly significant. For dichotomous outcomes (e.g., diagnoses of depression, PTSD), we used the spatial probit models and assumed the spatial interactions were in the covariates and not the error terms. If spatial dependence is in the error terms for the probit model, then the multivariate normal cumulative distribution function has "n" integrals because of correlation

across space and, hence, the likelihood function does not have a closed form solution-this is computationally infeasible because the number of integrals grows with the sample size.⁶ The unit of observation was participant nested within census tract. Participants' longitude and latitude values (computed from addresses) were used to compute the physical distance within and across census tracts.

The spatial Durbin Error model (see Elhorst³¹), is given as

(1) ...

(2) ...

for ...

The variable h_i represents the dependent variable for the i th individual's outcome (e.g., discrimination, stigma, mental health, VL); x_{ik} is the k th covariate or regressor that is used to explain variations in the outcomes of the i th person. The term $X^{-1} \sum_{j=1}^n S_{ij} x_{jk}$ represents the weighted average of neighboring communities' observations for the respective characteristics that is used to capture interdependencies among the n observations in the covariates between neighbor i and j (for $i \neq j$). This term represents another source of exogenous variations that explain variations in the outcome variable. The term ε_i is an error term, and ... captures the spatial dependence in the error term-the assumption of independence is violated. This is used to capture latent variables that explain variations in outcomes via neighboring communities. Additional details are provided in Appendix A (available as a supplement to the online version of this article at <http://www.ajph.org>).

RESULTS

Among the 151 BWLWH participants, mean age was 53.5 years (range = 21-69); 64.8% had a high-school diploma or above; 85.4% identified as heterosexual; 73.5% had an annual household income of \$1 1 999 or less; and 82.8% identified with a Christian denomination. Table 1 provides additional descriptive information on sociodemographics, intersectional discrimination, mental health, HIV outcomes, and neighborhood factors.

Covariates, Discrimination, and Outcomes

Older age was associated with lower HIV microaggressions ($b = -0.195$; $P < .05$), depressive symptoms ($b = -0.311$; $P < .01$), PTSD symptoms ($b = -0.479$; $P < .01$), posttraumatic cognitions ($b = -0.806$; $P < .05$), and lower likelihood of diagnoses of suicidality ($b = -0.0443$; $P < .01$), PTSD ($b = -0.0298$; $P < .05$), and alcohol use disorder ($b = -0.0309$; $P < .01$; Tables 2-4). Women's annual household income was not associated with microaggression, discrimination, or mental health; however, higher household income was associated with higher likelihood of having HIV viral suppression ($b = 0.214$; $P < .01$) or an undetectable VL ($b = 0.263$; $P < .05$).

Neighborhood Factors and Discrimination

Higher crime was associated with higher gendered racial microaggression (GRM) frequency (0.000652 ; $P < .05$) and appraisal ($b = 0.000726$; $P < .05$; Table 2). Higher employment was associated with lower HIV microaggressions ($b = -0.171$; $P < .05$) and lower HIV-related discrimination ($b = -0.0510$; $P < .05$). Similarly, higher number of low-income and subsidized rental housing was associated with lower HIV microaggressions ($b = -11.90$; $P < .05$). Conversely, higher neighborhood median income was associated with higher HIV microaggressions ($b = 0.129$; $P < .05$) and higher sexual orientation-related discrimination ($b = 0.0478$; $P < .01$).

Higher education in neighboring areas was associated with lower GRM appraisal ($b = -0.0918$; $P < .05$). However, higher neighboring median income was associated with higher GRM appraisal ($b = 0.00153$; $P < .05$).

Neighborhood Factors and Mental Health

Higher crime was associated with higher depressive symptoms ($b = 0.00733$; $P < .05$) and posttraumatic cognitions ($b = 0.0344$; $P < .01$; Tables 3 and 4). Also, higher crime was associated with higher likelihood of diagnoses of PTSD ($b = 0.00131$; $P < .01$) and substance use disorder ($b = 0.00126$; $P < .01$). Higher employment was related to lower PTSD symptoms ($b = -0.420$; $P < .05$) and lower likelihood of alcohol use disorder ($b = -0.0329$; $P < .05$). Higher education was associated with lower likelihood of suicidality ($b = -7.160$; $P < .05$). In addition, higher number of Christian organizations was associated with lower posttraumatic cognitions ($b = -11.60$; $P < .05$) and lower likelihood of depression diagnosis ($b = -0.604$; $P < .01$).

Higher education in neighboring areas was associated with a lower number of traumas ($b = -0.429$; $P < .01$), lower

depressive symptoms ($b = -0.806$; $P < .05$), lower PTSD symptoms ($b = -2.299$; $P < .01$), and lower likelihood of depression diagnosis ($b = -0.177$; $P < .01$). Higher neighboring employment was associated with higher traumas ($b = 0.00241$; $P < .01$), higher PTSD symptoms ($b = 0.0138$; $P < .01$), and higher likelihood of depression diagnosis ($b = 0.00119$; $P < .01$). Higher neighboring median income was also associated with higher traumas ($b = 0.00515$; $P < .05$).

Neighborhood Factors and HIV Outcomes

Higher crime was associated with lower medication adherence within the past month ($b = -0.000866$; $P < .05$) and higher VL log ($b = 0.000591$; $P < .05$; Tables 3 and 4). Conversely, higher education was associated with lower VL log ($b = -4.715$; $P < .05$) and higher likelihood of HIV viral suppression ($b = 6.844$; $P < .05$) and undetectable VL ($b = 6.814$; $P < .05$). Similarly, higher employment was associated with higher likelihood of undetectable VL ($b = 0.0296$; $P < .05$). However, higher median income was associated with lower likelihood of HIV viral suppression ($b = -0.0253$; $P < .05$) and undetectable VL ($b = -0.0224$; $P < .05$).

Contrary to the direction for within-neighborhood, neighboring higher median income was associated with higher likelihood of undetectable VL ($b = 0.00324$; $P < .01$).

Spatial Error

Analyses indicated that there was significant variation in the spatial distribution of GRM frequency ($b = -0.00743$; $P < .05$) and appraisal ($b = -0.00775$; $P < .05$), suggesting that, in addition to the neighborhood variables mentioned previously, some unknown latent characteristics of neighboring areas may influence GRM.

DISCUSSION

To our knowledge, this is the first study among BWLWH to examine how within-neighborhood and neighboring characteristics relate to intersectional discrimination and stigma, mental health, and HIV outcomes among BWLWH using spatial econometrics techniques. We present novel findings as well as results consistent with existing literature. Higher crime victimization (used as a proxy for neighborhood crime) was associated with higher GRM frequency and appraisal, suggesting that women who are facing more crime are also subjected to more GRM. In addition, higher neighborhood employment was associated with lower HIV microaggressions and HIV-related discrimination, and access to affordable housing was associated with lower HIV microaggressions. This suggests that access to jobs and housing may serve as protective factors and is consistent with literature linking unstable housing and HIV-related stigma.³²

Similarly, higher education in neighboring areas was associated with lower GRM appraisal, suggesting that when people in neighboring communities are more educated, BWLWH are less distressed by GRM. However, higher within-neighborhood median income was associated with higher HIV microaggressions and higher sexual orientation-related discrimination, and higher median income in neighboring areas was associated with higher GRM appraisal. These findings align with a recent study reporting that higher within-neighborhood median income was linked to higher internalized HIV stigma and HIV-related discrimination in health care settings.³³ Higher median income may indicate income disparity, and if BWLWH have low income in a higher-income neighborhood, this may result in BWLWH facing more microaggressions. Together, these novel results suggest that socioeconomic characteristics both within neighborhoods and in neighboring areas may have an impact on microaggressions and discrimination Black women face across multiple axes of identities (HIV status, race, gender, and sexual orientation). This further echoes that individual-level experiences of discrimination are directly related to intersecting systems of oppression that manifest in the form of disparities in income and socioeconomic status.⁸

In addition to being associated with higher GRM, crime victimization was also associated with worse mental health (PTSD, substance use disorder, depressive symptoms) and HIV outcomes (lower medication adherence and higher VL). Consistent with existing literature,¹¹ this indicates that higher crime exposure has negative impacts on BWLWH's mental health and may adversely affect women's ability to adhere to antiretroviral therapy and consequentially result in higher VL.¹²

However, across mental health and HIV outcomes, beneficial within-neighborhood characteristics for BWLWH were higher education, employment, and religious organizations. Higher education was associated with lower likelihood of suicidality, lower VL,¹² and higher likelihood of HIV viral suppression and undetectable VL, suggesting that higher

education within neighborhood may be a protective health factor, perhaps as an indication of awareness of health services. Higher within-neighborhood employment was related to lower PTSD symptoms, lower likelihood of alcohol-use disorder, and higher likelihood of undetectable VL. Higher employment within their neighborhood may serve as a buffer in 2 ways: (1) individuals are behaviorally activated (linked to better mental health) through work, and (2) work may provide access to a support system, mental health and HIV care, and resources (e.g., food, housing, car).² In addition, a higher number of Christian organizations was associated with lower posttraumatic cognitions and likelihood of a depression diagnosis, which is consistent with literature indicating the positive effects of religious affiliation.¹⁶

In contrast to the benefits of withinneighborhood education and employment, neighborhood income was adversely associated with HIV outcomes (HIV viral suppression and undetectable VL), echoing that neighborhood-level income (perhaps in the midst of high neighborhood income disparity), may have adverse impacts on BWLWH who may have lower income. In fact, BWLWH's own household income was associated with higher likelihood of having HIV viral suppression and undetectable VL, indicating that what matters most is higher household income for BWLWH.³ Neighboring characteristics also related to mental health and HIV outcomes in interesting ways. Higher employment and income in neighboring areas related to more mental health symptoms and diagnoses (number of traumas, PTSD symptoms, depression) and may be a proxy for income disparity that may expose BWLWH to more traumas, or a proxy for congestion or gentrification, which may have negative implications for BWLWH's mental health.³⁴ This reiterates the negative psychosocial implications of structural inequities in the form of housing policies.⁸ However, higher neighboring income related to undetectable VL may suggest proximity to services such as pharmacies.

Limitations

This study presents novel findings on neighborhood factors, intersectional discrimination, and health among BWLWH; however, a few limitations need to be acknowledged. First, the cross-sectional data and sample size prevents causal and definitive conclusions. Second, our sample consisted of BWLWH in the southeastern United States and, thereby, findings may not generalize to other geographic areas. Third, women's response to questions from the National Crime Victimization Survey were used as a proxy for their neighborhood crime; however, their self-report may be better than official statistics given barriers to reporting to police such as a history of ineffectual, uncompassionate, and sometimes deadly responses by police officers when called to serve Black individuals.²⁹ Despite these limitations, findings presented may have important public health implications.

Public Health Implications

BWLWH bear the brunt of the HIV epidemic, and efforts should be directed to ameliorate the burden by addressing structural inequities (e.g., housing, income, and crime rates), intersectional discrimination and stigma, and mental health, and improve HIV outcomes. The HIV literature has yet to adequately examine how characteristics of withinneighborhood and neighboring areas may be associated with these factors. Our novel findings suggest that policies are needed to (1) improve the rates of neighborhood education and employment, availability of low-income housing, and access to religious organizations and (2) decrease crime. In addition, policies are needed to increase the household income of BWLWH and minimize income disparities, and human rights legislation is needed to improve their quality of life and reduce structural inequities.

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CONTRIBUTORS

S.K. Dale, the study's principal investigator, developed the study hypotheses and procedures for data collection, oversaw the study team, helped to draft the article, and worked closely with I. A. Wright on the analyses. I. A. Wright (co-investigator) co-developed the study hypotheses, contributed spatial econometrics expertise, ran all analyses, and helped to draft the article. R. Reid, N. Shahid, and A. Ponce helped with data collection and with drafting some sections of the article. C. M. Nelson assisted with data organization and management and with drafting a section of the article. J. Sanders, N. Gardner, and E. Simmons helped with data collection and provided feedback on the article. J. Liu and Y. Pan assisted with data organization and management and reviewed the article. A. Phillips was instrumental in participant recruitment and retention and reviewed the article. A. Rodriguez provided medical consultation during data collection and reviewed the article. G. Ironson, S.A. Safren, D.J. Feaster, and M. L. Alcaide are co-investigators who provided insights on the project and feedback on the article.

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CONFLICTS OF INTEREST

The authors declare that they do not have conflicts of interest.

HUMAN PARTICIPANT PROTECTION

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Procedures were approved by the University of Miami institutional review board and informed consent was obtained from all individual participants included in the study.

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DETAILS

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Addressing Intersectional Stigma in Programs Focused on Ending the HIV Epidemic

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[ProQuest document link](https://www.proquest.com/scholarly-journals/neighborhood-characteristics-intersectional/docview/2717341984/se-2?accountid=211160)

ABSTRACT (ENGLISH)

Stigma is defined as a process by which individuals or groups are devalued because of attributes or behaviors deemed "deeply discrediting."¹ HIV stigma, the social discrediting of people living with HIV, often intersects with other forms of social marginalization. Intersectionality is a framework that considers how interlocking social systems of privilege and oppression (racism, sexism, transphobia, heterosexism, classism, xenophobia) condition (at a microlevel) the experiences of people with intersecting, often marginalized social identities (e.g., race, gender identity, sexual orientation, socioeconomic status, country of origin, health status).^{2,3} In the HIV context, an intersectional stigma lens recognizes that multiple marginalized social positions, processes, and identities are "mutually constituted" and that disparities cannot be effectively addressed if racial, gender, and sexual minority status among people living with HIV are treated separately.⁴

An intersectional approach becomes particularly relevant given the social groups most affected by HIV in the United States. In 2019, HIV incidence was higher among Black (45.0 per 100 000), Latinx (21.5 per 100 000), and multiracial (18.8 per 100 000) individuals than among White individuals (5.3 per 100 000).⁵ In addition, 70% of transmissions were attributed to male-to-male sexual contact, as compared with 23% by sexual contact between cisgender men and cisgender women.⁵ Black women account for more than half of new HIV cases among women overall,⁵ and rates of heterosexual HIV transmission among Black women are considerably higher than rates among Black men.⁵ From 2015 to 2019, the only gender categories for which HIV incidence increased were transgender women and transgender men. Black gay and bisexual men and transgender women demonstrate the lowest preexposure prophylaxis use, HIV diagnosis rates, linkage to and retention in care, and viral suppression rates of all racial and gender groups.

FULL TEXT

Stigma is defined as a process by which individuals or groups are devalued because of attributes or behaviors deemed "deeply discrediting."¹ HIV stigma, the social discrediting of people living with HIV, often intersects with other forms of social marginalization. Intersectionality is a framework that considers how interlocking social systems of privilege and oppression (racism, sexism, transphobia, heterosexism, classism, xenophobia) condition (at a microlevel) the experiences of people with intersecting, often marginalized social identities (e.g., race, gender identity, sexual orientation, socioeconomic status, country of origin, health status).^{2,3} In the HIV context, an intersectional stigma lens recognizes that multiple marginalized social positions, processes, and identities are "mutually constituted" and that disparities cannot be effectively addressed if racial, gender, and sexual minority status among people living with HIV are treated separately.⁴

An intersectional approach becomes particularly relevant given the social groups most affected by HIV in the United States. In 2019, HIV incidence was higher among Black (45.0 per 100 000), Latinx (21.5 per 100 000), and multiracial (18.8 per 100 000) individuals than among White individuals (5.3 per 100 000).⁵ In addition, 70% of transmissions were attributed to male-to-male sexual contact, as compared with 23% by sexual contact between cisgender men and cisgender women.⁵ Black women account for more than half of new HIV cases among women overall,⁵ and rates of heterosexual HIV transmission among Black women are considerably higher than rates among Black men.⁵ From 2015 to 2019, the only gender categories for which HIV incidence increased were transgender women and transgender men. Black gay and bisexual men and transgender women demonstrate the lowest preexposure prophylaxis use, HIV diagnosis rates, linkage to and retention in care, and viral suppression rates of all racial and gender groups.⁶

People living with HIV and other individuals affected by HIV stigma contend with the negative synergistic impact of intersectional stigma^{2-4,7,8} on health, manifested at institutional (health care access and competence), interpersonal (rejection and victimization), and individual (internalized stigma and associated poor mental health) levels. Varying stigmas often act in concert^{4,7,8} to increase stress among people with HIV, reduce their likelihood of engaging in healthpromoting behavior (e.g., seeking HIV testing or care), and undermine their resilience (e.g., well-

being, optimism, medication adherence). Although these represent major challenges, the agency, efficacy, resilience, and resistance of individuals who experience intersectional stigma are strengths that can be harnessed to improve health and well-being. Along with this, individuals who are most marginalized experience a disproportionate share of stigma related to HIV.⁹

Intersectional stigma, a primary driving factor of health inequities and a barrier to health care in the United States, has been undertargeted in interventions despite the fact that its effects might be modifiable at several socioecological levels. Existing interventions have been limited in scope and have yet to be tested with respect to their large-scale efficacy. The scope and nature of programmatic work to reduce intersectional stigma and improve HIV-related outcomes, as well as the effects of multilevel Interventions, remain unknown. Here we draw upon the expertise and experience of staff at the National Institutes of Health (NIH), scientific investigators conducting intersectional stigma research, and community service providers who implement programs to improve HIV outcomes in the context of intersectional stigma to inform recommendations to address HIV.

INCREASING AND ENHANCING THE IMPACT OF INTERVENTIONS

There are few interventions explicitly designed to address intersectional stigma. Thus, there is a paucity of research demonstrating the efficacy of intersectional stigma interventions incorporating traditional scientific designs and standards. Other efficacious interventions adopting anti- intersectional stigma approaches may exist, but they may not be labeled and disseminated as such. Nevertheless, work conducted to date offers instructive innovative approaches to optimize HIV-related interventions in the context of intersectional stigma (e.g., comprehensive sex education, programs to optimize coping among clients). As the impact of intersectional stigma on HIV prevention and treatment is increasingly acknowledged in HIV research and the need for more interventions to address this challenge is recognized, more guidance will be needed to ensure optimal effectiveness of anti-stigma efforts. Thus, we developed recommendations to enhance the impact of interventions designed to reduce HIV-related stigma and other intersecting stigmas in implementation settings (Table 1).

Recommendation 1

Our first recommendation is to prioritize community ownership, engagement, and connectedness, which are critical for successful stigma reduction intervention implementation. Researchers should incorporate context- and community-driven approaches to understand types of intersectional stigmas, how they operate, and how to address them. Communities need to be recognized as equal partners given their important and complementary strengths.¹⁰ Researchers must recognize and value the unique skills and expertise that partnerships promote. This can mean ensuring that community members have leadership and decision-making roles in research teams, developing memorandums of agreement emphasizing equitable sharing of budget resources, sharing decision-making authority, and including capacity-building activities in research projects. Communities are often relegated to limited roles, included only for their ability to recruit participants into studies (e.g., via focus groups or in-depth interviews) or to provide feedback on intervention content once developed (e.g., through timelimited advisory boards).

Novel approaches amplifying community voices and involvement are needed so that interventions are dynamic and responsive to emerging challenges and stigmas. Researchers should consider nontraditional, community-driven, participatory methodologies (e.g., human-centered design,¹¹ digital storytelling,¹² a modified Delphi process,¹³ photovoice¹⁴) and support organizations in such work even without research funding.

It is time to move away from reliance on tokenistic community advisory boards with minimal input and move toward engaging community members in conceptualizing and carrying out interventions and research studies, starting with writing funding proposals. Partnered research should include equitable arrangements in terms of finances, decision making, and capacity building. Communities must be centered in such work, as this vantage point allows true intervention tailoring to community and stakeholder priorities. Finally, the field needs more research led by scientists whose identities and lived experiences mirror the communities under study.

Recommendation 2

Our second recommendation is to incorporate the perceptions and experiences of front-line service providers as a means of improving intervention approaches within communities. Service providers are typically underrecognized

and undersupported in efforts addressing intersectional stigma. Thus, although many service providers work to address intersectional stigma (even if they do not label it as such) as part of their day-to-day work, we know little about the content and impact of those efforts. Even if researchers develop the most rigorous and multilayered content-based intervention, it will fail if the experiences and perspectives of service providers on the ground are not incorporated. Their input, beginning with the development stage, is critical. It should be noted that service providers, at times, have been identified as a source of stigma among clients.¹⁵⁻¹⁷ Thus, although service provider perspectives may be valuable for informing interventions, this does not negate the need for the implementation of strategies to address stigma within this population.

Recommendation 3

The third recommendation is to conduct more expansive intersectional stigma interventions and evaluations. Intersectional stigma interventions require attention to multiple levels (e.g., individual, interpersonal, community, structural), types of stigma (e.g., internalized, anticipated, enacted), and stigmatizing and discriminating forces (e.g., racism, sexism, sexual minority status). They also should address systems of privilege and oppression and intervene on these systems or their manifestations.¹⁸ Finally, intersectional interventions should acknowledge the complexity of intersecting identities and systems, give attention to the contexts in which HIV and other stigmas occur, and incorporate the strength and solidarity that can emerge when people with shared identities convene. Given these considerations, we need novel, wide-ranging ways of evaluating intersectional stigma interventions beyond efficacy and effectiveness in terms of HIV-related behaviors and health outcomes. Researchers and funders should consider more use of implementation science study designs (including hybrid implementation and efficacy trial designs)^{19,20} to evaluate community-based interventions and services. Implementation science research can include evaluation of community-based interventions, use of mechanisms such as academic-community partnerships, and local health department-community-federal partnerships. This is critical as approaches to intersectional stigma have effects at both the individual level (by building strengths and resilience to resist stigma) and the structural level (by working with leadership at all levels on sustainable policy change). These types of studies should be conducted in equal collaboration with community partners, and attention should be directed to inner organizational (e.g., organizational culture, structure, and leadership) and outer system (e.g., legislation) contexts.²¹ Researchers and funders should consider how to balance innovation with proven-effective strategies to bring programmatic public health impact to scale. The lack of validated measures assessing the effects of interventions on outcomes beyond HIV indicators (e.g., resilience, empowerment, stigma reduction) may partially explain the limited evidence for intersectional stigma interventions.

Recommendation 4

Our fourth recommendation is to create an accessible, living, and open compendium or database of research and community efforts to address intersectional stigma. Community efforts addressing intersectional stigma cataloged within local health department strategies and end the HIV epidemic plans could be collated with peer-reviewed academic research. The compendium could be modeled after the Centers for Disease Control and Prevention (CDC) compendium of evidence-based interventions with a more flexible approach. According to the CDC, if adapted interventions do not have all of the core components of the original evidence-based interventions, they are not "evidence based."

However, rigid evidence-based intervention guidelines can result in an inability to grow and expand core intervention components in different settings and in alignment with community priorities. Rather than beginning with interventions showing efficacy or effectiveness, we suggest prioritizing core intervention characteristics (e.g., the aspects of an intervention that are most applicable to a given setting) for adaptation, implementation, and testing. In addition, we must develop other open and accessible forums for sharing and disseminating promising programs, best practices, or evidence-informed programming.

Recommendation 5

The final recommendation is to address the role funding priorities play in our ability to address intersectional stigma. We need to broaden the scope of priority HIV research and programmatic outcomes to include stigma reduction and

community empowerment. Funders' prioritization of biomedical outcomes over stigma reduction can be detrimental to program implementation and harmful to participants. This "misalignment" of success metrics-what the funders value versus what communities need-poses a barrier to testing and adoption of effective intersectional stigma-related interventions. Also, the biomedical endpoints demanded by funders often hamper holistic responses to clients' needs. Lastly, the siloed nature of funding prevents the formation of meaningful collaborations among researchers, providers, and communities.

CONCLUSIONS

In this editorial, we have addressed the emergence, potential, key challenges, and future directions of implementation research and practice targeting intersectional stigma within the field of HIV. NIH staff, investigators conducting intersectional stigma research, and community service providers who implement programs to improve HIV outcomes identified critical gaps in funded research, intervention approaches, and teams. These gaps result from suboptimal participation on the part of communities affected by intersectional stigma and those who support them (e.g., health care and social service providers). A common thread that runs across our recommendations is the need to intentionally elevate the focus on intersectional stigma in HIV-related implementation science. Namely, there is a need to reconfigure the unilateral investigator-driven research model by incorporating an equivalent presence of community partners from conceptualization to funding and implementation.

There are benefits in this paradigm shift. First, it may help researchers understand operating mechanisms of intersectional stigmas and assist in developing commensurate interventions and policy-level strategies that combat stigmas and their effects. Second, multilevel, multicomponent hybrid interventions may have more powerful and long-lasting effects than single-focus, single-level approaches.^{18,22} Integration of individual and structural stigma reduction interventions is yet to be optimized and tested in study designs. Findings from emerging interventions conducted by research-community collaborations will be informative with respect to the feasibility and efficacy of interventions targeting both stigma and support among affected individuals. In addition, implementation research related to intersectional stigma around HIV continuums of prevention and care that is conducted in equal collaboration with community partners is more likely to increase validity, buy-in, and sustainability.

Critical steps must be taken to develop true research-community partnerships addressing intersectional stigma. This requires modifying research funding approaches, including creating funding mechanisms prioritizing stigma measurement and eradication as primary outcomes. In addition, grant review models that include community members may help ensure that community values and interests are represented in decisions regarding funding. Moreover, funders can facilitate more authentic research-community partnerships by mandating scientific and community co-leadership on grants and requiring budgets that ensure significant resource disbursement within community-based organizations.

Lastly, governmental-academic-community partnerships can establish an infrastructure for grassroots reporting and cataloguing of ongoing substantial community and service provider efforts addressing intersectional stigma. Creating a "living," centralized platform with project or study descriptions of existing funded and unfunded local and national projects would be beneficial for potential cross collaborations and accelerated timelines to achieve sustained effects on intersectional stigma.

Addressing intersectional stigma can have significant returns with respect to ending the HIV epidemic. However, to obtain these benefits, researchers, funders, and service providers must reconceptualize how efforts to combat intersectional stigma are understood, evaluated, and delivered. Approaches that emphasize authentic community partnerships, build on individual and community strengths, increase the knowledge base regarding intersectional stigma measurement and interventions, and reconfigure funding models are critical in this process. >4JPH

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Stigmatizing Spaces and Places as Axes of Intersectional Stigma Among Sexual Minority Men in HIV Prevention Research

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FULL TEXT

Conceptualizations of intersectional stigma in HIV prevention research are limited and almost exclusively individualistic.^{1,2} Even when stigma is conceptualized as a social process, individuals are typically the focus, as is the case with internalized, anticipated, and enacted stigma. Because constructs are often inseparably tied to their

level of measurement, studies of stigma as both individual and social phenomena reify stigma as a behavioral phenomenon and obfuscate the origin of stigma in oppressive systems and structures.

We advocate an expansion of intersectional stigma to include place as a level of measurement in HIV prevention research for sexual minority men (SMM) at marginalized intersectional positions, such as racial or ethnic minority status, socioeconomic position, and gender expression. Understanding the spatial manifestations of intersectional stigma in social-structural contexts has the potential to expand behavioral understandings of stigma and highlight new avenues for intervention to mitigate the perpetuation of stigma in and through social structures, systems, and institutions.^{3,4} We posit that place is important and understudied as an analytical unit in HIV prevention research on intersectional stigma. Our stance is informed by burgeoning public health literature on spatial stigma and place as a social determinant of health and our research on intersectional stigma and HIV prevention among SMM.^{3,5,6} Place is often conceptualized as a geographic area (e.g., neighborhoods) that both shapes and is constructed by the lived experiences, interactions, practices, and identities of those who inhabit and navigate in a space.⁷ Social-structural factors in health-restrictive environments (places) heighten the risk associated with HIV-related behaviors and obstruct engagement in HIV prevention and care. Places characterized by violence, poverty, unemployment, social disorder, and lower social capital and social cohesion are associated with heightened HIV vulnerability among SMM at marginalized intersectional positions.⁸ Although the study of place has had a resurgence in public health (e.g., place-based interventions to create health-promoting environments), its inclusion in the axes of intersectional stigma remains limited.

Spatial stigma posits that negative representations of marginalized communities can be deleterious to the health of their residents and widen health inequities. Spatial stigma may affect health by limiting access to employment and educational opportunities, restricting available coping resources, limiting access to and engagement with health care, and constricting identity formation and management.⁴ Multidisciplinary research has used the concept of spatial stigma to examine links between geographic boundaries, social institutions and practices, and policy and legal aspects of place and health inequities. Through this lens, intersectional stigma connects to and is reproduced by characteristics of a place—both as an internal process by which social-structural factors perpetuate stigma and from a top-down or external process involving laws, policies, and practices that reinforce oppressive systems.

Structural racism is one of the mechanisms that produces health-restrictive environments and links place to health inequities.⁸ Structural racism is often expressed in the form of stigmatizing laws and criminal justice-related factors and is compounded by unequal enforcement of laws, which has implications for intersectional stigma and HIV prevention among SMM.⁵ Laws that criminalize HIV exposure are also structurally racist insofar as they are more likely to be enforced against Black SMM than SMM of other races, do not reflect advances in HIV prevention and treatment, and stigmatize people with HIV. Structural racism is also linked to practices that promote the overpolicing of places frequented by Black and Latino SMM as well as the increased surveillance of individuals and institutions (e.g., medical and educational systems), which further restricts social and structural resources from these groups.⁹ Overpolicing operates in tandem with gentrification to displace individuals and disrupt community support systems that protect against acquiring HIV.^{9,10} Gentrification-related displacement and replacement also affects access to HIV prevention and care through NIMBY (not in my backyard)-based opposition to establishing and expanding place-based services for marginalized populations.¹⁰ The availability of affordable and safe housing is yet another example of intersectional stigma operating through place. Although the Fair Housing Act (1968; Pub L No. 90-284) protects against discrimination based on single axes of identity (e.g., race/ethnicity, disability), it has limited impacts on transforming institutional practices that reduce access to affordable and safe housing for SMM.

The level of inclusivity and safety of a place further limits the ability of SMM at marginalized intersectional positions to navigate or travel in a place without experiencing stigma.¹¹ Moreover, not having to self-monitor to avoid stigma or consider whether one belongs or is safe in a place is a form of social privilege that becomes increasingly less common among SMM. Place-based stigma may also cause SMM to internalize negative stereotypes about a place. For example, from our work with Black and Latino SMM living in low-income urban neighborhoods, we observed that

SMM internalized spatial stigma, which further constrained access to HIV prevention services in other settings. Understanding manifestations of intersectional stigma in place has the potential to contextualize behavioral understandings of stigma and shift focus to the structures and systems of its origin; redirect intervention efforts from individuals to modifiable social-structural factors that systematically reinforce power imbalances and constrain opportunities; illuminate critical information on how spatial, institutional practices, and policies disproportionately heighten vulnerability to acquiring HIV; and provide guidance on the embodiment of spatial stigma to affect health even when an individual is removed from the devalued environment.^{6,12} We caution that the omission of place from intersectional stigma and HIV prevention research will hinder efforts to abolish spaces that systematically oppress and contribute to persistent HIV inequities. Omission of spaces and places as axes of intersectional stigma also perpetuates a hyperfocus on individual behaviors and prevention techniques, with insufficient attention to the social-structural forces that constrain the availability and effectiveness of HIV prevention.

To fully assess the role of intersectional stigma as a driver of health inequities among SMM, future research and interventions must attend to the social-structural processes in, and external to, places that drive these inequities. Inherent to intersectionality is the goal of deconstructing and uprooting systems of power and privilege.¹² We believe the following objectives must be actualized to achieve this goal:

1. Conceptualize space as a modifiable driver of intersectional stigma and partner with communities to develop multilevel solutions to increase access to and engagement with HIV prevention, including maintaining existing safe and trusted places for HIV prevention that use identity-affirming practices and prioritize holistic wellness, investigating the social and health-related impacts of affirming places in communities, and prioritizing community resilience and community-driven development as key programmatic elements in HIV prevention.
2. Use place-based methodological approaches that provide information on the interlocking systems and structures that require intervention. Integrating qualitative methods with spatial analyses to capture how SMM define place and broader social-structural boundaries (e.g., community-led approaches like participatory photomapping) may better inform the use of administratively defined (e.g., census tracts and zip codes) place-based data in future intersectional stigma research.

3. Invest in collaborative, place-based and systems-focused approaches to address HIV inequities.

Interdisciplinary approaches are needed to conceptualize and intervene in the social-structural factors, policies, and institutions that drive place and spatial stigma, including geographers, transportation experts, policymakers, and public health practitioners to abolish stigmatizing spatial structures.

Attending to place and space as axes of intersectional stigma in HIV prevention research is critical to addressing the social-structural factors that drive HIV inequities and achieving the goals of Ending the HIV Epidemic.

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Integrating Intersectional and Syndemic Frameworks for Ending the US HIV Epidemic

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ABSTRACT (ENGLISH)

In the US HIV epidemic, intersectional stigma research illustrates how multiple interlocking systems of oppression (e.g., classism, racism, misogyny, drug use stigma) amplify HIV vulnerability and related health inequities.¹ Michele Tracey Berger¹ first coined the term intersectional HIV stigma, grounding the core of this intersectional approach in Black feminist theory to articulate individual and collective experiences of status-based oppression and to advance liberation.^{2,3} To date, intersectional HIV-related stigma research has focused largely on understanding how stigma is experienced among populations with multiple interlocking stigmatized statuses in relation to a single health condition, HIV.⁴ In contrast, the past decade of HIV research has leveraged the theory of syndemics to understand how the co-occurrence of multiple health conditions (and their interactions) amplifies HIV vulnerability and related health inequities.⁵

Integrating the foci of these frameworks can better target efforts to end the HIV epidemic (EHE) in the United States. Recently, HIV scholars have explored the usefulness of coapplying intersectionality and syndemic analytic frameworks.⁶⁻⁸ We briefly review each framework's theoretical foundations to provide an integrated understanding of the sociostructural processes through which US HIV disparities are amplified. Finally, we explore community-led efforts to disrupt the paths through which intersectional stigma cultivates domestic HIV-related syndemics.

FULL TEXT

In the US HIV epidemic, intersectional stigma research illustrates how multiple interlocking systems of oppression (e.g., classism, racism, misogyny, drug use stigma) amplify HIV vulnerability and related health inequities.¹ Michele Tracey Berger¹ first coined the term intersectional HIV stigma, grounding the core of this intersectional approach in Black feminist theory to articulate individual and collective experiences of status-based oppression and to advance liberation.^{2,3} To date, intersectional HIV-related stigma research has focused largely on understanding how stigma is experienced among populations with multiple interlocking stigmatized statuses in relation to a single health condition, HIV.⁴ In contrast, the past decade of HIV research has leveraged the theory of syndemics to understand how the co-occurrence of multiple health conditions (and their interactions) amplifies HIV vulnerability and related health inequities.⁵

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INTERSECTIONALITY

Through its formal articulation in legal and sociological studies by Crenshaw and Collins, respectively,^{2,3} the concept of intersectionality was developed to specify how systems of power and privilege are experienced through multiple interlocking social statuses in ways that reinforce inequalities.⁹ Intersectionality is articulated as an analytical lens and as a praxis of social justice that calls for the redistribution of power and liberation to be rooted in marginalized communities.¹⁰

Intersectional researchers have encouraged scholars to consider how health disparities, including HIV vulnerability,

are shaped by systems of power (e.g., racial segregation, carceral systems, poverty, criminalization of drug use and sex work) that are grounded in anti-Blackness, racism, classism, and various manifestations of misogyny (e.g., sexism, transphobia, homonegativity).^{4,9} An intersectional lens can further challenge the dominant stigma paradigm, which siloes experiences of stigma within distinct social positions, to address the interconnected nature of stigmas and elevate the agency of groups of people who experience intersectional stigmas (i.e., resilience and resistance).¹⁰

SYNDEMICS

The theory of syndemics reflects on larger sociostructural environmental contexts (e.g., poverty, urbanicity) in which multiple health and social conditions (e.g., sexual violence, drug use, HIV) interact synergistically to amplify disease burden in a population. Singer emphasized that this interrelationship of "complex health and social crises"^{5(p99)} emerges among high-risk groups "because they are subject to social discrimination, stigmatization, and subordination."^{11(p39)}

The empirical foundations of syndemic theory rest largely on associations between cumulative exposure to individual psychosocial (e.g., depression, violence) and behavioral health conditions (e.g., substance use, sexual compulsivity) and poor individual health outcomes.¹² Stigma, when accounted for, is articulated as an additional syndemic exposure.¹² Such analyses pushed HIV intervention science to acknowledge and address co-occurring conditions that affect vulnerability to HIV acquisition and poorer health outcomes among people living with HIV. Still, future work must address the core theoretical tenet of syndemics (i.e., the synergistic interactions between epidemics driven by sociostructural contexts).¹²

INTEGRATING SOCIOSTRUCTURAL PROCESSES

In brief, intersectionality specifies how interlocking systems of power and privilege produce the sociostructural environmental contexts that promote syndemic conditions. These processes not only amplify disease burden but also restrict access to effective interventions and attenuate treatment efficacy when care is accessed. Box 1 outlines examples of how these sociostructural processes synergistically interact to amplify HIV inequities in the United States and can inform intersectional HIV-related stigma research. Applying an intersectional lens to syndemics draws attention to these systems to illustrate how the "same syndemic exposures" (e.g., drug use stigma, misogyny, police violence) reflect heterogeneity in interconnected health inequities across interlocking social positions (e.g., age, race, gender).⁷ When an individual-level focus is applied, syndemic research reflects the by-product of this sociostructural process (i.e., exposure to social and health conditions), and applications of intersectionality risk simply enumerating "multiple" identities (versus specifying socially structured positions of power or disadvantage) of populations most impacted by this process.^{10,12} Such siloed applications ignore the underlying power dynamics that produce intersectional HIV-related stigma and discrimination and codify health inequities.¹ It is a fallacy to believe that research grounded in either theory can produce a meaningful end to the HIV epidemic by ignoring the sociostructural systems upholding US HIV disparities in exchange for an easier operationalization of complex phenomena (e.g., cumulative conditions or identities that explain enough variance in HIV outcomes). Rather, we echo previous calls for research to inform how to change these sociostructural processes when applying either framework or both of them.^{9,12}

AMPLIFYING SOCIOSTRUCTURAL RESPONSES

Attaining EHE endpoints will require sociostructural change within existing health care, carceral, and community environments, among others.¹⁰ Increasing the availability of condoms and biomedical interventions will fail to achieve the desired public health impact if interlocking systemic oppression and syndemic health inequities remain unaddressed. This final section illustrates how EHE efforts dovetail with ongoing social justice movements led by and for affected communities.^{1,10} Although not an exhaustive list, we highlight organizations working to disrupt the paths through which intersectional stigma cultivates domestic HIV-related syndemics among communities inequitably served 40 years into the US epidemic.

Accounting for Medical Injustice

Past (and ongoing) medical injustices sought to control and exploit the sexual and reproductive lives of Black women

in the United States. Groups such as SisterLove Inc. and the Black Women's Health Imperative are forging paths to destigmatize and empower Black women's sexual and reproductive health. They have developed multidimensional strategies via health policy, research, health education, and leadership development initiatives that integrate HIV prevention and treatment into the broader context of sexual and reproductive autonomy and liberation. Bringing these strategies to scale via implementation science could advance the dissemination and impact of effective biomedical interventions among Black women within EHE jurisdictions.

Decriminalization and Deservingness

Policing and immigration systems reinforce interlocking inequities by chronically destabilizing family, social, economic, and housing environments along axes of race, class, and gender. Access to lifesaving treatment and life-stabilizing services largely requires passing measures of "deservingness" (e.g., drug screening, background checks). Criminalization of drug use, sex work, and gender-affirming care further concentrates these harms within specific subpopulations. Efforts led by the Black Harm Reduction Network and Sex Workers Outreach Project USA to legalize or decriminalize drug use and sex work can help to mitigate the direct harms of these power structures, affording members of these affected populations greater stability to engage in evidence-based HIV interventions and treatment.

Overcoming Misogyny and its Sequelae

Many social syndemic exposures (e.g., trauma, violence, mental illness, substance use) are rooted in racialized manifestations of misogyny, reinforcing social norms that promote or permit physical and sexual violence toward LGBTQAI+ communities of color. Black and Latinx-led groups such as the Counter Narrative Project and the TransLatin@ Coalition are working to dismantle these norms and shift power structures toward liberation by making visible authentic Black and Brown expressions of love, self-care, sexuality, and gender expression. Empowerment and other resilience-based intervention strategies might build on this work to promote and sustain preexposure prophylaxis and antiretroviral therapy adherence within LGBTQAI+ communities of color (see related readings in Appendix A, available as a supplement to the online version of this article at <http://www.ajph.org>).

CONCLUSION

To better inform sociostructural change and paths toward liberation, HIV researchers and health disparity scholars and interventionists more broadly must account for how mutually reinforcing systems of oppression interact to produce and reinforce overlapping HIV-related syndemic health crises.

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Becoming in the Face of Intersectional Stigma-Black, Gay, Woman, and Living With HIV

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ABSTRACT (ENGLISH)

My name is Ms. Arnetta Phillips. When I was young, the schools were segregated. White students went to White schools, and Black students went to Black schools. We had different drinking fountains, and buses had yellow lines going through the middle- separating us by race. These memories I have as a little Black girl still linger to this day. Growing up, Sunday school at church helped to uplift me. I loved Sunday school because we talked about "loving thy neighbor" and learned that it did not matter where you came from or the color of your skin. However, during regular service, the pastor berated the LGBTQ + (lesbian, gay, bisexual, transgender, queer) community, which frightened me because I knew at an early age that I liked girls.

For many years I prayed to God to "take the gay away," forced myself to have relationships with men, and tried to be someone I was not. When I was diagnosed with HIV, I then prayed for God to take the HIV away. Many days, I cried and crawled on the floor praying for my diagnosis to change. The stigma I faced and the sadness that came from not accepting my sexuality and my HIV status took me down the path of addiction. With drugs, I did not have to think, feel, or deal, and it was a way to escape the realities of my life. However, when my father died in my arms from a massive heart attack, I was determined to fulfill his wishes for my sobriety. Once I accepted my drug problem and that I was living with HIV, my life began to change. Twenty years after my initial diagnosis, I visited the pharmacy to get my HIV medication for the first time, and then I sat in the car and cried. I cried because I was finally ready to take charge of my health but also because every day these pills would serve as a reminder that HIV is alive within me. What I did not know that day is that my lived experiences would become a source of empowerment for others.

FULL TEXT

My name is Ms. Arnetta Phillips. When I was young, the schools were segregated. White students went to White schools, and Black students went to Black schools. We had different drinking fountains, and buses had yellow lines going through the middle- separating us by race. These memories I have as a little Black girl still linger to this day. Growing up, Sunday school at church helped to uplift me. I loved Sunday school because we talked about "loving thy neighbor" and learned that it did not matter where you came from or the color of your skin. However, during regular service, the pastor berated the LGBTQ + (lesbian, gay, bisexual, transgender, queer) community, which frightened me because I knew at an early age that I liked girls.

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massive heart attack, I was determined to fulfill his wishes for my sobriety. Once I accepted my drug problem and that I was living with HIV, my life began to change. Twenty years after my initial diagnosis, I visited the pharmacy to get my HIV medication for the first time, and then I sat in the car and cried. I cried because I was finally ready to take charge of my health but also because every day these pills would serve as a reminder that HIV is alive within me. What I did not know that day is that my lived experiences would become a source of empowerment for others.

MAKING AN IMPACT WITH LIVED EXPERIENCES

I have been living with HIV for 28 years, I have been sober for 27 years, and for the past 26 years I have been working at the University of Miami. Through my work with more than 20 research studies as a research coordinator and certified addiction counselor, I have positively affected diverse individuals living with HIV or placed at risk for HIV. My life experiences as a Black woman living with HIV and in recovery from substance use have been fundamental in connecting with my research participants. We often share a deeper connection because of our similar experiences with stigma, discrimination, and shame. As people living with HIV (PLWH), we sometimes find that other people may look, speak, and act differently around us, as well as make assumptions about our lives. Careers, relationships, and typically normal interactions become anxiety inducing because of the judgment. Even now, living with HIV for more than 28 years, facing stigma is still difficult.

In addition, the struggle we face as PLWH is only one of the battles we fight each day. Many Black participants have shared stories of the racial prejudice and bigotry we witness every day. Personally and professionally, I have also witnessed the stigma of being gay, and especially of being Black and gay. Participants have come to me with scars and marks all over their bodies, beaten and raped because of their sexuality. There are still places today where I am not comfortable walking openly as a lesbian because people may stare, frown, and say, "You're going to hell; it's an abomination." To deal with the pain that comes with facing these realities, many participants (like me) turn to drugs as a way to cope. Individuals then make additional inaccurate and hurtful generalizations ("We are weak minded") about us as people who use substances.

LESSONS LEARNED

HIV stigma, like racism and homophobia, unfortunately, is going to be here for a long time to come. Because of this, I have done the work within myself as an individual facing these intersecting stigmas, and I encourage my participants to do the same. You need to be in complete acceptance of yourself.

You need to be able to think, "I'm Black, I'm gay, I'm HIV positive and I'm good." A strong network of support can help during this process. It is so easy to slip back into feeling bad about who you are, feeling like you're worthless, feeling like there is no future for you. If you can connect to a support group or a mental health therapist, or if you have family or close friends who you can talk to, these individuals can help you rise out of that darkness.

I believe it is my life's purpose to give back, encourage others, and bring hope by sharing my story with other PLWH and those struggling with substance use. I am fortunate to have had the support of my family and friends. The loving, open arms of these individuals have been the greatest gifts I could have gotten during this journey. They have learned alongside me and have helped me to accept every part of myself. I hope to do the same for others living with HIV. By disclosing my status to others and being open about the struggles I have faced, I have been able to touch them, pray with them, provide information, counsel them, and give them hope for the future. This has been a blessing and I am grateful to have this opportunity.

RECOMMENDATIONS

From my experience, I have come to believe that there is much that can be done to make the world more just for individuals facing intersectional stigma and discrimination. Better laws, policies, and practices are needed to protect the full humanity and rights of Black individuals, LGBTQ+ persons, women, and PLWH. First, we need to create and enforce laws that protect us from the horrible violence and discrimination resulting from oppression and isms (e.g., racism and homophobia). We also need to remove stigmatizing and outdated laws that criminalize HIV and disproportionately target Black people.

Second, PLWH should have access to essential resources, such as housing, food, mental and physical care, and employment. In any given week in my role as a research coordinator, I have encountered PLWH who lack these

resources; not having these resources often leads to unhealthy behaviors (e.g., substance use) to escape. We need housing, food, and health programs to meet PLWH in the community (without discrimination and judgment) and provide easy access without the barriers created by excessive paperwork and steps. Furthermore, programs are needed to provide PLWH with job training and skills to secure employment. There also needs to be a change in employment policies that exclude PLWH based on histories of sex work, substance use, or incarceration; and there needs to be reentry programs for PLWH with incarceration histories. I have known many people who wanted to work, but employers would refuse to hire them because of their criminal records. As a result, they ended up living on the streets (in a tent, under a bridge) and engaging in sex work or selling drugs to survive.

Third, it is essential that health care workers are competent, compassionate, and adequately trained to engage with clients about HIV, sexuality, substance use, racism, and other aspects of people's lives. I can usually tell by a provider's body language if they are uncomfortable with these aspects, and nobody wants to continue receiving care from a provider who is unwelcoming or judgmental. Aspiring health care workers must decide for themselves if this field suits them and if they are willing to treat all patients with dignity, because biases and stigma have no place in delivering good care. Education and continued training on these topics must then be implemented and prioritized for health care workers so that patients can receive quality, affirming care. PLWH who have experienced intersectional stigma are experts on this subject and are well equipped to provide such training. I, for example, have been a guest speaker in courses and trainings for college students, medical students, and various health care providers.

Fourth, a key strategy to combat discrimination and stigma is hiring staff who are PLWH, have shared lived experiences with PLWH, and have a strong commitment to serving PLWH. Individuals like me, a Black lesbian woman living with HIV, should be meaningfully involved in HIV efforts whenever possible, be it research, practice, or policy, to ensure that our voices and lived experiences inform change.

Lastly, researchers should center the needs of PLWH in all research practices, including training, hiring, and implementation. Many personal questions are asked during research studies, and participants often share deep and difficult experiences. Researchers, therefore, need to be cognizant of participants' emotions and be trained and qualified to address situations that arise and provide resources or referrals to participants as needed. We need to be treated as human beings, not as a subject or as a number.

With these suggested changes, I hope we can work toward a society that is far more accepting and supportive, so that PLWH face less stigma and discrimination and are empowered to get the care they deserve. The dream I've always had is to be able to walk freely and openly, without fear, rejection, or shame, in a world where people do not discriminate because of what you look like, who you love, who you are, and the health condition you have. >4jPH

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The authors declare that they do not have any conflicts of interest.

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Change Is Incremental but Worth Fighting for: Breaking the Silence About HIV Intersectional Stigma

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FULL TEXT

In 1996, Rafael Diaz, PhD, received his first research project grant from the National Institutes of Health (NIH) to study the social and cultural predictors of HIV risk among Latino gay men living in New York, New York; Los Angeles, California; and Miami, Florida. It took Rafael two years to convince NIH reviewers that studying homophobia, racism, and financial hardship was an important endeavor to pursue. I was working in New York when he called to invite me to direct the study.

In the early and mid-1990s, a vibrant national network of Black, Latinx, Asian, Pacific Islander, and Native American gay and bisexual men formed to address HIV. Some of us were community organizers and advocates, others were artists and researchers. We came together across race/ethnicity, sexual orientation, and class lines to exchange information and engage in comradeship.

Together we were building community while quilting beautifully complicated and sometimes messy coalitions. This was because as queer men of color we needed each other for support, belongingness, and healing. When in community, we could free up mind space and physical energy that we otherwise would have used in the constant grind of having to battle institutional oppression and justify or disentangle our layered and integrated selves. We did not call it intersectionality in the early 1990s, even though many of us were publicly out as feminists, having been students of intersectionality's foremothers such as Gloria Anzaldúa, Cherrie Moraga, Pat Parker, Audre Lorde, Toni Cade Bambara, Chrystos, Mitsuye Yamada, Cheryl Clark, Merle Woo, Barbara Smith, and Naomi Littlebear Morena. From their teachings, we understood that economic disenfranchisement, racism, heterosexism, and, for some of us, gender discrimination and ableism were interlocked and always at play whenever we entered a room.

Rafael and I often crossed paths in professional spaces. I admirably witnessed him lift the importance of community as the tsunami of HIV (and ignorance) swept over us. I respected him for his courage and tenacity. Getting proposals through NIH review processes has typically been difficult to say the least, and this is particularly the case for out and proud gay men of color. The challenge was especially painful in the mid-1990s. HIV had and continues to have a predictable social shape. It concentrates in populations bearing the brunt of multiple, mixed forms of oppression. Rafael and other trailblazing HIV social scientists such as the late John Peterson understood this. But Rafael soldiered on in the polite but inhospitable world of NIH funding. He felt he had to, given the deafening silence in academic spaces about the devastation HIV wreaked on sexual minority men of color.

More than 20 years after Rafael's first published article in AJPH reporting findings from his seminal study, I find myself in yet another privileged position: as a guest editor of this special Issue on HIV intersectional stigma sponsored by NIH and the National Institute of Mental Health. As I reviewed the articles, I was both let down and excited, the former because intersectionality remains an enigma for many researchers working in the HIV space. Many contributors to the Issue followed the mainstream propensity to situate Intersectional stigma at the individual level (i.e., Identity) or to propose measures of Intersectional discrimination that attempt to distill its individual components. A few authors had to be directed back to the seminal works of Michele Tracy Berger and Kimberlé Crenshaw to be reminded about the core tenets of Intersectionality. Conversely, I was excited because I knew that for as difficult as it was 21 years ago to break the silence, it led to this place where there is now a growing body of critical work flourishing around and grappling with HIV intersectional social oppression, finally signifying its legitimacy and importance. Change is indeed incremental but worth fighting for.

[For further reading, please see the Appendix, available as a supplement to the online version of this article at <https://www.ajph.org>.]

George Ayala PsyD

Guest Editor

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The Problem With Intersectional Stigma and HIV Equity Research

Bowleg, Lisa, PhD MA¹ ¹ Department of Psychological and Brain Sciences, The George Washington University, Washington, DC, and is the Founder and President of the Intersectionality Training Institute, Philadelphia, PA

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ABSTRACT (ENGLISH)

I commence with a confession. As compelling as I find the argument that stigma is a fundamental cause of health inequities,¹ and as much as I believe (obviously) that intersectionality is an indispensable critical lens for health equity research,²¹ I am not convinced that intersectional stigma is the right concept to advance more equitable HIV treatment and prevention outcomes. The incongruity of this confession is not lost on me. In addition to my role as a guest editor of this special supplement of AJPH, I am also a principal investigator of an intersectional stigma project funded by the same National Institute of Mental Health (NIMH)³ initiative that sourced this supplement. My primary opposition is that intersectional stigma, at least as currently conceptualized, obscures interlocking oppressive social-structural systems such as structural racism, sexism, and heterosexism (to name some) that more accurately explain why, four decades into the HIV/AIDS epidemic in the United States, we can foresee the end of the epidemic for relatively more privileged groups such as White sexual minority men but not Black and Latino sexual minority men or cisgender and transgender women.

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PROBLEM 1: STIGMA OR DISCRIMINATION?

In 2018, the NIMH's Division of AIDS Research parenthetically defined intersectional stigma as "multiple stigmatized identities" when it "cleared" the concept,³ paving the way for funding for many of the projects in this supplement. Alas, there are at least three problems with this individualistically focused definition. Problem 1 concerns the use of the term "stigma" rather than discrimination. In an insightful 1998 article, British disability activist Liz Sayce deftly articulated the problem:

Different conceptual models point to different understandings of where responsibility lies for the "problem" and different prescriptions for action. For instance, by using the term "racism" we focus our attention on collective and individual perpetrators of discrimination. If instead, we construe the problem in terms of the stigma of being black, our attention shifts to the self-image and perceptions of the black individual⁴(p332)

To its credit, NIMH's Division of AIDS Research now uses intersectional discrimination as well as stigma (see Goodenow and Rausch, p. S273). Nonetheless, intersectional stigma still implicitly directs attention to "multiple stigmatized individuals"- those marginalized at multiple intersections of racial/ethnic and sexual and gender minority status-as if the intersections themselves, not the historical legacy of interlocking structural oppression based on those intersections, were the fundamental cause of HIV inequities.

PROBLEM 2: STIGMA WITHOUT STIGMATIZERS

A second problem is that fixating on "multiple stigmatized identities" reifies and privileges the passive vantage point of stigmatizers, a hallmark of White supremacy. Thus, there are stigmatized people, but alas no people, systems, or structures, enacting the stigma or being held accountable for doing so. Reminiscent of the book *Racism Without Racists*,⁵ this nonagentic worldview has implications for HIV research and intervention. People with the power to stigmatize, such as health care providers who fail to prescribe preexposure prophylaxis (PrEP) to people of color, are rarely a focus of HIV intersectional stigma research, nor are the effects of stigmatizing structures such as criminal HIV exposure laws that disproportionately affect Black sexual minority men, for example. As a case in point, most of the articles in this supplement focus almost exclusively on intersectional stigma from the target's perspective, not the enactor's. Consequently, there is a sizable knowledge gap about structural and interpersonal intersectional stigma to inform interventions to stop intersectional stigma and discrimination at the source.

PROBLEM 3: OBSCURING SOCIAL-STRUCTURAL SYSTEMS

Third, although centering the experiences of people marginalized by intersectional discrimination is foundational to critical frameworks such as intersectionality and critical race theory, focusing squarely on "multiple stigmatized identities" absent the structures that perpetuate the stigmatization reifies Erving Goffman's notion of stigma as "an attribute that is deeply discrediting."⁶(p3) In this formulation, stigma is a birthright, an immutable stain that defies time, geography, and social and political intervention. There is nothing intrinsically wrong with being a Black or Latino cisgender woman and/or a sexual or gender minority person. People historically marginalized at specific minoritized intersections are not a problem in need of intervention; the policies, laws, and interpersonal practices

that discriminate against them, however, are. Emphasizing "multiple stigmatized identities" over the structures that stigmatize functions to "reinforce the intractability of inequity, albeit in a more detailed or nuanced way."⁷(p12) Consider the problem documented in recent national surveillance data that HIV has decreased for White sexual minority men but not for their Black and Latino counterparts,⁸ or consider empirical evidence that, despite health insurance, Black and Latino sexual minority men were significantly less likely than their White counterparts to be aware of, have access to, or use PrEP⁹ These problems are not solely rooted in Black and Latino sexual minority men's internalized stigma, the precursor of which is still structurally racist, heterosexist, and classist policies, laws, and practices. In the context of HIV prevention, more pragmatic concerns supersede. Take again the example of PrEP. You don't buy PrEP over the counter like aspirin; PrEP must be prescribed. Neither the source of nor the solution to the problem of PrEP access resides primarily in the individual's internalized intersectional racism and heterosexism. Multilevel solutions, such as training and enforcement of policies that require health care providers to provide the same level and quality of HIV prevention care provided to White patients to all patients, and structural interventions, such as Medicaid expansion to cover PrEP, provide a more promising and equitable route to ending the HIV epidemic than conventional individualistic approaches, no matter how nuanced.

Exclusively individualistic conceptualizations of intersectional stigma miss a vital opportunity to leverage intersectionality for what it is, a social justice project,¹⁰ not simply a tool for innovative research and scholarship. Like studying how fire burns rather than extinguishing it when it does burn, implicitly rooting intersectional stigma within individuals, rather than in oppressive social structures and processes that seed the stigma in the first place, will not advance the knowledge most needed to inform interventions for problems that are foundationally social-structural. Seismic gaps in knowledge exist about structural stigma,^{1,11} particularly intersectional structural stigma-knowledge that is desperately needed to inform effective multilevel (e.g., interpersonal, community, structural) interventions to eliminate inequitable HIV outcomes.

BERGER'S COINAGE AND CITING BLACK WOMEN

Michele Tracey Berger, the Black feminist scholar who coined the term "intersectional stigma" based on her research with women of color living with HIV, conceptualized intersectional stigma to describe how HIV stigma aligned with the "structural realities of race, class, and gender."¹²(p24) Notably, identity was not a focus of Berger's definition. It is telling that until this special supplement, Berger's groundbreaking work was absent from most of the discourse and research on the topic. This invisibility is part and parcel of the history of Black women's intellectual contributions, one that has birthed campaigns such as CiteBlackWomen (<https://www.citeblackwomencollective.org>). Had the HIV field initially listened to (and cited) Berger's work with its attention to structural intersectionality and commitment to intersectionality as critical praxis, we might be closer to achieving HIV equity than we now find ourselves. Albeit more nuanced, intersectional stigma work that implicitly locates the problem within "multiply stigmatized individuals," not the oppressive social structures that create and maintain intersectional stigma and discrimination in the first place, will help end the US HIV epidemic for White people, such as those with class privilege or those who do not inject drugs, but not racialized people at diverse intersections, those for whom, 40 years into the HIV/AIDS epidemic, equitable HIV prevention and treatment outcomes remain elusive. >4JPH

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DETAILS

Subject: Intervention; Gender; Stigma; Health disparities; Social structure; Racism; Oppression; Minority & ethnic groups; Black people; Public health; Mental health; Acquired immune deficiency syndrome--AIDS; Race; Intersectionality; Disease prevention; Human immunodeficiency virus--HIV; Confession; Health research; Epidemics; Inequality; Sexism; Transgender persons; Social systems; Discrimination; Prevention; Medical treatment; Heterosexism; Sexually transmitted diseases--STD; Systemic racism

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Biopsychosocial Health Outcomes and Experienced Intersectional Stigma in a Mixed HIV Serostatus



Longitudinal Cohort of Aging Sexual Minority Men, United States, 2008–2019

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ABSTRACT (ENGLISH)

Objectives. To determine whether intersectional stigma is longitudinally associated with biopsychosocial outcomes. **Methods.** We measured experienced intersectional stigma (EIS; ≥ 2 identity-related attributions) among sexual minority men (SMM) in the United States participating in the Multicenter AIDS Cohort Study. We assessed longitudinal associations between EIS (2008-2009) and concurrent and future hypertension, diabetes, dyslipidemia, antiretroviral therapy adherence, HIV viremia, health care underutilization, and depression symptoms (2008-2019). We conducted causal mediation to assess the contribution of intersectional stigma to the relationship between self-identified Black race and persistently uncontrolled outcomes. **Results.** The mean age ($n = 1806$) was 51.8 years (range = 22-84 years). Of participants, 23.1% selfidentified as Black; 48.3% were living with HIV. Participants reporting EIS (30.8%) had higher odds of hypertension, dyslipidemia, diabetes, depression symptoms, health care underutilization, and suboptimal antiretroviral therapy adherence compared with participants who did not report EIS. EIS mediated the relationship between self-identified Black race and uncontrolled outcomes. **Conclusions.** Our findings demonstrate that EIS is a durable driver of biopsychosocial health outcomes over the life course. **Public Health Implications.** There is a critical need for interventions to reduce intersectional stigma, help SMM cope with intersectional stigma, and enact policies protecting minoritized people from discriminatory acts. (Am J Public Health. 2022;112(S4):S452-S462. <https://doi.org/10.2105/AJPH.2022.306735>)

FULL TEXT

Headnote

Objectives. To determine whether intersectional stigma is longitudinally associated with biopsychosocial outcomes. **Methods.** We measured experienced intersectional stigma (EIS; ≥ 2 identity-related attributions) among sexual minority men (SMM) in the United States participating in the Multicenter AIDS Cohort Study. We assessed longitudinal associations between EIS (2008-2009) and concurrent and future hypertension, diabetes, dyslipidemia, antiretroviral therapy adherence, HIV viremia, health care underutilization, and depression symptoms (2008-2019). We conducted causal mediation to assess the contribution of intersectional stigma to the relationship between self-identified Black race and persistently uncontrolled outcomes. **Results.** The mean age ($n = 1806$) was 51.8 years (range = 22-84 years). Of participants, 23.1% selfidentified as Black; 48.3% were living with HIV. Participants reporting EIS (30.8%) had higher odds of hypertension, dyslipidemia, diabetes, depression symptoms, health care underutilization, and suboptimal antiretroviral therapy adherence compared with participants who did not report EIS. EIS mediated the relationship between self-identified Black race and uncontrolled outcomes. **Conclusions.** Our findings demonstrate that EIS is a durable driver of biopsychosocial health outcomes over the life course. **Public Health Implications.** There is a critical need for interventions to reduce intersectional stigma, help SMM cope with intersectional stigma, and enact policies protecting minoritized people from discriminatory acts. (Am J Public Health. 2022;112(S4):S452-S462. <https://doi.org/10.2105/AJPH.2022.306735>)

The burden of chronic comorbidities is increasing as people with HIV(PWH) in the United States age, presenting key challenges to effective HIV care.^{1,2} The largest proportions of PWH in the United States are aged 45 years or older,³ the majority of whom are sexual minority men (SMM).⁴ Among aging PWH, noncommunicable diseases (NCDs) such as diabetes, hypertension, and dyslipidemia are common, complicating clinical care and contributing to poor HIV outcomes.^{2,5,6} Studies estimate that, by 2030, 84% of PWH will have at least 1 NCD, with 28% predicted to have 3 or more NCDs, and 40% of PWH predicted to experience HIV treatment complications because of multimorbidity polypharmacy concerns.^{1,7}

Domestically, there exist profound ethnoracial and socioeconomic disparities in the incidence, prevalence, and control of HIV and NCDs.⁸⁻¹³ These disparities are attributed to structural inequities, like racism, embedded in different aspects of society (e.g., employment, housing, and health care) that trickle down at the policy level and minimize the political power and access to resources that marginalized individuals require to maintain wellness.¹⁴⁻¹⁸ Compared with SMM who identify as White, SMM who identify as Black or Latinx experience higher HIV prevalence and incidence and lower rates of viral suppression.^{13,17,18} Populations who identify as Black experience higher prevalence of hypertension and lower rates of hypertension control compared with White populations.^{8,9,19} Populations who identify as Black or Latinx experience higher prevalence and incidence of diabetes and higher diabetes-related mortality rates compared with White populations.^{20,21}

Lower socioeconomic status has been associated with higher diabetes-related mortality in models adjusted for ethnoracial identity,²¹ suggesting that classbased structural inequalities (e.g., lack of universal health care in the United States, absence of universal basic income) contribute to effective NCD management and help explain underlying social gradients of health. Lower rates of dyslipidemia treatment and control have been found in populations who identify as Black relative to those who identify as White, and higher rates of dyslipidemia have been observed among populations who are low-income and those who identify as Latinx.²²⁻²⁴ Given that race is a social construct, ethnoracial inequities in HIV and NCD incidence, prevalence, and control are not biologically intrinsic. Therefore, sociocultural and structural inequities caused by interlinked systems of oppression such as racism, classism, and heterosexism have been hypothesized as fundamental drivers of health inequities.²⁵

Intersectional stigma offers a key framework for understanding pathways between systemic oppression and health inequities in multiply marginalized populations (e.g., SMM of color living with HIV).²⁶ Stigma (the process in which groups of people are devalued, negatively stereotyped, and discriminated against)^{27,28} is a multidimensional construct inclusive of anticipated, internalized, perceived, and enacted or experienced domains; in stigma frameworks, active discrimination can be viewed as a specific form of experienced stigma.^{26,29} Linking the stigma framework with intersectionality,³⁰ which conceptualizes how social identities overlap to engender different modalities of privilege and discrimination, intersectional stigma as coined by Berger "represents the total synchronistic influence of various forms of oppression, which combine and overlap to form a distinct positionality."^{261-^4} Intersectional stigma research elucidates relationships between multiple intersecting identities at both the microlevel of minoritized social status (e.g., race, sexuality, and HIV status) and the macrolevel of systemic oppression (e.g., racism, heterosexism, and HIV stigma), the multiple dimensions of stigmatization, and consequent mental, physical, and behavioral health inequities on individual and population levels.²⁹⁻³⁴

Research has begun to demonstrate associations between stigma and biological outcomes. Anticipated and experienced stigma have been shown to be associated with higher odds of hypertension among adults who identify as Black^{35,36}; discrimination has been associated with greater allostatic load among Puerto Rican adults.³⁷ Intersectional stigma has been associated with adverse psychosocial conditions, such as depression and substance use, among SMM, increasing failure risk along the HIV care continuum.^{38,39} This can cause minoritized people (i.e., people who are marginalized by systems of oppression beyond their control, such as racism and heterosexism) to avoid situations, such as health care environments, where they perceive that stigmatization occurs. Intersectional stigma has been associated with health care underutilization and antiretroviral therapy (ART) nonadherence. Because diabetes, dyslipidemia, and hypertension are, like HIV, chronic conditions requiring ongoing health care engagement, effective management of NCDs may also be affected by intersectional stigma.

Understanding the longitudinal pathways between minoritized populations, intersectional stigma, psychosocial health, and HIV and NCD outcomes remains limited. The aims of this study were threefold. First, we assessed the prevalence and correlates of experienced intersectional stigma (EIS) in adulthood in a mixed-serostatus cohort of aging SMM. Second, we prospectively assessed relationships between EIS and biopsychosocial health outcomes over 11 years. Third, we assessed mediation by EIS of the relationships between Black identity and persistently uncontrolled biopsychosocial conditions. Ongoing imbalances in social power and privilege are reflected in the US health care infrastructure and disproportionately affect people from historically excluded and often intersecting groups, heightening minoritized communities' vulnerabilities to social adversity. Therefore, we hypothesized that (1) participants from minoritized subgroups would report higher rates of EIS than their nonminoritized counterparts, (2) EIS would be associated with higher odds of biopsychosocial health outcomes, and (3) EIS would mediate relationships between Black ethnoracial identity and persistently uncontrolled biopsychosocial outcomes.

METHODS

The Multicenter AIDS Cohort Study (MACS) is an observational, community-based cohort that examines the natural and treated history of HIV/AIDS among SMM in Baltimore, Maryland/Washington, DC; Chicago, Illinois; Los Angeles, California; and Pittsburgh, Pennsylvania. Data and specimens collected at biannual study visits include sociodemographic and psychosocial characteristics, medications, hematology (HIV RNA quantification, lipid profile, glucose metabolism), health care utilization, and blood pressure. Biologically validated outcomes assessed include dyslipidemia, hypertension, diabetes, and HIV viral load.^{7,40} Additional methodology is available at <https://statepi.jhsph.edu/mwccs.40,41>

Measures

We assessed EIS via audio computer-assisted self-interviewing (ACASI) surveys conducted in 2008-2009 (n = 1806). For participants completing surveys at both timepoints, only initial responses were used. Using the 2-stage version of the Major Experiences of Discrimination Scale,⁴² participants reported EIS in adulthood (age ≥ 18 years) from any of 6 sectors (employment, education, community, housing, health care, or law enforcement). For each sector in which participants reported stigmatization, they were prompted to indicate identity-related (age, gender, race, ethnicity, religion, appearance, body shape, disability, HIV status, or sexual orientation) attributions that represented the top 3 reasons for stigmatization.⁴³ Data were operationalized to reflect any experienced stigmatization in adulthood in each sector, then aggregated across sectors to reflect all identity-related attributions. For primary analyses, we defined EIS as having reported 2 or more identity-related attributions (e.g., race and sexuality) for stigmatization across all sectors. For secondary analyses, we used the sum (0-10) of identity-related attributions.

Biological outcomes were assessed by using plasma collected after fasting. Among PWH, HIV viremia was defined as having a viral load of 200 copies per milliliter or more.⁴⁴ Diabetes was defined as glucose greater than 125 milligrams per deciliter (mg/dL) or self-reported diabetes with medication, concomitant with hemoglobin A1c of 7.5% or higher. Dyslipidemia was defined as total cholesterol 200 mg/dL or higher, low-density lipoprotein cholesterol of 130 mg/dL or higher, high-density lipoprotein cholesterol less than 40 mg/dL, triglycerides 150 mg/dL or higher, or use of lipid-lowering medications concomitant with a clinical diagnosis. Hypertension was defined as blood pressure 140/90 millimeters of mercury or higher or use of blood pressure-lowering medications concomitant with a clinical diagnosis.⁴⁵ Secondary analyses defined persistently uncontrolled outcomes as at least 2 occurrences of blood pressure 140/90 millimeters of mercury or higher (uncontrolled hypertension), fasting low-density lipoprotein cholesterol of 130 mg/dL (uncontrolled cholesterol), and fasting hemoglobin A1c of 7.5% or higher (uncontrolled diabetes) between 2008 and 2019.

Behavioral outcomes were assessed at each visit via ACASI. Health care underutilization was assessed with a 1-item measure ("Since your last visit, was there a time when you did not receive medical care, dental care, or prescription drugs when you thought you needed to?") consistent with other brief measures.⁴⁶ Among PWH, self-reported ART adherence was dichotomized to reflect 100% adherence versus less than 100% adherence over the previous 4 days.⁴⁷⁻⁴⁹ Secondary analyses defined persistently suboptimal ART adherence and persistent

health care underutilization as 2 or more reports of each behavior between 2008 and 2019.

Depression symptoms in the past 7 days were measured via ACASI, using the Center for Epidemiologic Studies Depression scale.⁵⁰ A cut-off of 20 was used to delineate depression symptoms.⁵¹ Secondary analyses defined persistently uncontrolled depression symptoms as 2 or more occurrences of scores of 20 or higher between 2008 and 2019.

Ethnoracial variables were collected at the baseline study visit using the following questions: "Are you of Hispanic (Spanish) or Latino origin?"; and "What is your race? Do you consider yourself (check all that apply) White, Black, Native Hawaiian/Pacific Islander, Native American, Alaskan native, Other?" Lowincome status (gross annual income <\$20 000/year) was collected at each study visit via ACASI and treated as timevarying. Sexual behavior was defined using behavior questions for the 6 years before 2008-2009 and treated as fixed.⁵² HIV status was assessed at each study visit via enzyme-linked immunosorbent assay for HIV-negative individuals and western blot to confirm seroconversion, and treated in analyses as timevarying for HIV-negative men to delineate seroconversions. Time (study visit) was treated as timevarying and specified as a random effect. Models adjusted for sociodemographics, site, and age (10-year increments).

Statistical Analysis

We used descriptive statistics to explore sociodemographics and frequency of settings and attributions for intersectional stigma. We used χ^2 and t tests to analyze differences in EIS by sociodemographics. We constructed a series of generalized linear mixed models (GLMM) with repeated measures to assess associations between EIS (2008-2009) and biopsychosocial outcomes, comprising a maximum of 22 potential visits. Analyses were conducted in SAS version 9.4 (SAS Institute, Cary, NC), with specifications for mixed effects (between-subjects and within-subject). We reported least-squares means estimates of outcomes at a given observation and adjusted odds ratios (AORs) by intersectional stigma group with corresponding 95% confidence intervals (CIs) and P values using the observed margins specification, which includes all nonmissing observations and averts listwise and pairwise deletion for observations where dependent variables are missing, maximizing the utility of the full observed data set. We constructed post hoc models with an interaction term (EIS-visit), to assess whether outcome trajectories differed by EIS. Results from post hoc models display regressed least-squares means estimates of outcomes by visit and EIS group.

To assess whether EIS mediated relationships between Black ethnoracial identity and persistently uncontrolled outcomes, we conducted secondary analyses using the 4-way decomposition approach for causal mediation.^{53,54} To include both PWH and seronegative participants, we created a variable summing non-HIV outcomes (total: 0-5 of persistently uncontrolled diabetes, hypertension, dyslipidemia, depression symptoms, and persistent health care underutilization occurring at least twice between 2008 and 2019) and used this as the outcome in a cross-sectional Poisson model. Black ethnoracial identity was the main predictor, and EIS (treated continuously) was the mediator. These models allowed us to assess decompositions including a pure direct effect (the expected inequality in outcomes attributable to Black ethnoracial identity) and a pure indirect effect (the mediating effect of intersectional stigma on persistently uncontrolled outcomes). Using established procedures for causal mediation,^{53,55-57} we reported the proportion of the effect mediated, and the proportion of the effect of Black ethnoracial identity on persistently uncontrolled outcomes that would be eliminated if EIS levels among participants who identified as Black were reduced to levels reported by participants who did not identify as Black. GLMM and causal mediation analyses adjusted for covariates. Because of low numbers of participants identifying as Native American, Asian, Native Hawaiian/Pacific Islander, and multiracial, these categories were aggregated into "Other ethnoracial identity" for GLMM analyses.

RESULTS

Table 1 describes the sample using baseline data from 2008-2009. Overall, 1806 participants responded to stigma-related questions and were included in analyses. The majority of participants identified as White (71.7%), 23.1% identified as Black, and 10.1% identified as Hispanic/Latinx. At the index visit, participants' mean age was 51.8 years (range = 22-84 years). Around half (48.3%) of participants were PWH. Table 1 shows that EIS rates varied

significantly by race ($\chi^2 = 50.8$; $P < .01$), with higher proportions of Black (42.7%) and multiracial (54.3%) respondents reporting EIS than White respondents (26.6%); by HIV status ($\chi^2 = 58.6$; $P < .01$), with higher proportions of PWH (34.1%) reporting EIS than HIV-negative participants (27.8%); by low-income status ($\chi^2 = 14.7$; $P < .01$), with higher proportions of low-income participants reporting EIS (38.1%) than higher-income participants (28.4%); and by age: the mean age of intersectionally stigmatized participants was 50.9 years, compared with 52.9 years for their counterparts ($t = 3.0$; $P < .01$).

Table A (available as a supplement to the online version of this article at <http://www.ajph.org>) describes frequencies of settings and identity-related attributions for stigmatization. The majority of participants (50.7%) reported experiencing stigmatization in adulthood. Law enforcement (29.3%), employment (hiring and promotion: each 19.2%; being fired: 13.5%), and health care sectors (10.4%) were the most common settings for stigmatization. A large minority (49.3%) attributed stigmatization to specific identities: sexuality (35.2%), race (17.2%), and age (11.6%) were the most common attributions. A minority (30.8%; $n = 577$) reported 2 or more identity-related attributions for stigmatization. Among this subsample, the most common discrete intersections were sexuality- and HIV-related stigma ($n = 42$; 7.5%), sexuality and appearance-related stigma ($n = 33$; 5.9%), and sexuality- and ethnoracial-related stigma ($n = 29$; 5.2%). Figure 1 shows a Venn diagram of identity-based intersections, classed into sexuality-, ethnoracial-, HIV-, and other-related stigma (remaining attributions, collapsed for interpretability) among intersectionally stigmatized participants. This figure illustrates the diversity of identity-based attributions: 58.3% ($n = 325$) of intersectionally stigmatized participants reported at least sexuality- and other-related stigma; 7.4% reported at least race- and HIV-related stigma ($n = 41$).

Table 2 (and Table B, available as a supplement to the online version of this article at <http://www.ajph.org>) shows results from adjusted GLMM with repeated measures constructed for each outcome, representing a maximum of 27 762 person-observations.

Participants who reported EIS had higher odds of health care underutilization at a given observation than those who did not (13.0% vs 7.8%; AOR = 1.76; 95% CI = 1.61, 1.93). Compared with participants who identified as White, those who identified as Black or other non-White had respectively lower odds of health care underutilization in adjusted models. Low-income participants had higher adjusted odds of health care underutilization than higher-income participants.

Participants who reported EIS had higher odds of depression symptoms than those who did not (18.7% vs 13.4%; AOR = 1.48; 95% CI = 1.38, 1.59). Compared with White participants, those who identified as other non-White had higher adjusted odds of depression symptoms; low-income participants had higher adjusted odds of depression symptoms than higher-income participants.

PWH using ART who reported EIS had higher odds of suboptimal ART adherence than those who did not (13.4% vs 9.9%; AOR = 1.41; 95% CI = 1.26, 1.59). Compared with higher-income PWH, low-income PWH had higher adjusted odds of reporting suboptimal ART adherence.

PWH who reported EIS had lower adjusted odds of HIV viremia than those who did not (7.2% vs 9.0%; AOR = 0.79; 95% CI = 0.69, 0.89). PWH who identified as Black or other non-White had higher adjusted odds of HIV viremia than White PWH. Low-income PWH had higher odds of HIV viremia than higher-income PWH.

Participants who reported EIS had higher odds of dyslipidemia than those who did not (81.9% vs 80.3%; AOR = 1.11; 95% CI = 1.03, 1.19). HIV-negative participants had lower odds of dyslipidemia than PWH. Compared with White participants, those who identified as Black had lower odds of dyslipidemia.

Participants who reported EIS had higher odds of diabetes than those who did not (12.2% vs 9.1%; AOR = 1.40; 95% CI = 1.27, 1.53). Compared with White participants, those who identified as Black or other non-White had higher adjusted odds of diabetes; Latinx participants had higher odds of diabetes than non-Latinx participants, and low-income participants had higher odds of diabetes than higher-income participants.

Participants who reported EIS had higher odds of hypertension than those who did not (58.6% vs 52.1%; AOR = 1.30; 95% CI = 1.23, 1.38). Compared with participants who identified as White, those who identified as Black had higher odds of hypertension. Participants who identified as Latinx had lower adjusted odds of hypertension than non-

Latinx participants.

In post hoc models constructed to assess outcome by time interactions, we found no significant differences in slope of each of the 7 outcomes over time by EIS (data not shown). Figure A (available as a supplement to the online version of this article at <http://www.ajph.org>) shows plots of regressed least-squares means estimates of outcomes overtime by EIS group, highlighting mean differences in outcomes, but similarity in trajectories, between groups.

Table 3 shows results from causal mediation analyses, demonstrating a positive association between Black ethnoracial identity and persistently uncontrolled biopsychosocial outcomes (natural direct effect 5 0.133; 95% CI 5 0.002, 0.264). The pure indirect effect (mediation by intersectional stigma of the relationship between Black ethnoracial identity and persistently uncontrolled biopsychosocial outcomes, attributable to mediation but not interaction) was significant (0.057; 95% CI 5 0.022, 0.092). More than one third (34.7%) of the effect of Black ethnoracial identity on persistently uncontrolled biopsychosocial outcomes was attributable to EIS. Estimates of the portion eliminated indicate that 22.8% (95% CI 5 2.0%, 43.6%) of the effect of Black ethnoracial identity on persistently biopsychosocial uncontrolled outcomes would be eliminated if EIS levels among SMM who identified as Black in this sample were reduced to levels reported by SMM who did not identify as Black.

DISCUSSION

This study extends empirical evidence for the effects of intersectional stigma on health by analyzing associations with NCDs, including diabetes, dyslipidemia, and hypertension, which are increasingly prevalent among PWH. We found that, in a mixed HIV serostatus sample of SMM, the majority experienced stigma in adulthood; a substantial minority reported intersecting identity-related attributions for stigmatization (EIS). These intersections were diverse, with a plurality radiating from sexuality-based stigma. Our results demonstrate that EIS was associated with higher likelihood of future health care underutilization, depression symptoms, suboptimal ART adherence (among PWH), and dyslipidemia, diabetes, and hypertension. Differences in these outcomes were persistent and robust after we adjusted for minoritized statuses. We found that higher rates of persistently uncontrolled biopsychosocial outcomes among participants who identified as Black were substantially attributable to higher levels of EIS, suggesting that efficacious intersectional stigma reduction interventions tailored to the lived experiences of SMM of color, including PWH, are likely to be impactful. Efficacious interventions focused on helping SMM of color cope with EIS have begun to show efficacy on outcomes including ART adherence.⁵⁸⁻⁶⁰ Our results provide further evidence that larger structural changes are necessary to support wider deployment of these interventions, research on new interventions reducing EIS in discrete settings (such as health care environments), and- most importantly-local, state, and federal antidiscrimination policies and enforcement frameworks that work to eliminate EIS in our communities at large. Future research should evaluate how changes in policies intending to minimize EIS inflect population health outcomes.

While intersectionally stigmatized PWH reported higher odds of suboptimal ART adherence, their odds of HIV viremia were lower than those of their counterparts. This counterintuitive finding has not been seen, to our knowledge, in previous literature and may reflect the low prevalence of HIV viremia in the study sample overall, limitations of ART adherence measures, adjustments for minoritized statuses, and efficacy of ART regimens when adherence is suboptimal.⁶¹ Otherwise, results from this prospective study are consistent with findings on relationships between EIS and mental health, health care underutilization, and ART adherence,⁶²⁻⁶⁴ and with emergent findings showing associations between experienced stigma and hypertension in Black-identifying adults⁶⁵ and experienced stigma and allostatic load among Puerto Rican adults.³⁷ Experienced stigma in non-HIV health care settings has also been associated with health care underutilization and lower non-HIV medication adherence.^{46,66} Results provide additional support for research identifying intersectional stigma as a key mediator of relationships between minoritized status and distress,⁵⁴ indicating that minority stressors may inflect myriad biopsychosocial outcomes over the life course.

Limitations

This study contains limitations, and findings should be interpreted cautiously. The MACS is not nationally representative. However, as the most longstanding community-based cohort of SMM in the United States, the

MACS provides a well-characterized sample of aging PWH and HIV-negative SMM living with diagnostically validated NCDs, while minimizing the potential selection bias and limited variance that clinic-based cohorts confer on biological outcomes. MACS recruitment efforts historically targeted gay and bisexual men⁶⁷; gender identity was not assessed at baseline, limiting our ability to assess differential experiences of intersectional stigma among transgender and nonbinary people, including those who underwent gender transition after enrollment.

While the intersectional stigma measure relied on the validated, 2-stage process developed by the Major Experiences of Discrimination Scale creators,⁶⁸ it was only operationalized for 1 timepoint; analyses cannot account for EIS after the index visit. By accounting for retrospective experiences of experienced stigma, the measure was subject to recall bias; it does not encompass internalized and anticipated stigma or structural stigma, restricting findings to a limited form of experienced stigma (active discrimination) and limiting our ability to assess societal-level conditions, like stable housing, that contribute to outcome disparities.⁶⁹ Experienced stigma may not be easily identified or may go unnoticed by minoritized people as they occur; for these reasons, intercategory measures may be more suitable.^{70,71} Other identity-related attributions for stigma (e.g., sex work, substance use, or write-in options) were not elicited, limiting available options; furthermore, participants could choose only the top 3 identity-related attributions for each stigmatization by setting. Self-reported ART adherence and health care underutilization were subject to recall and social desirability biases. The income measure used increments of \$10 000 and did not assess household size, limiting our ability to characterize whether participants met federal poverty level criteria.

Public Health Implications

Pathways between intersectional stigma and biopsychosocial outcomes are only beginning to be empirically elucidated, particularly within SMM assessed prospectively.^{2,25} Our findings demonstrate that intersectional stigma is a powerful and durable driver of health disparities among SMM over the life course and suggest that mechanisms by which intersectional stigma affects HIV care continuum outcomes may operate similarly for SMM along the NCD care continua. Future work should build on new research quantifying both intersectional stigma^{71,72} and the NCD continua of care⁷³⁻⁷⁵ to assess pathways between social position, intersectional stigma, psychosocial health, and NCD outcomes among PWH. Our results estimating that almost one quarter of the disparity in persistently uncontrolled biopsychosocial outcomes among participants with Black ethnic/racial identities could be eliminated if intersectional stigma levels in this group were reduced to levels reported by their counterparts reveals a critical need for intersectional stigma reduction interventions targeting comorbidity management among SMM, particularly SMM of color. >4JPU

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CONTRIBUTORS

M. R. Friedman was primarily responsible for initial conceptualization, writing and revisions, and data analysis. Q. Liu contributed to data analysis and article development and revisions. S. Meanley, S.A. Haberlen, A. L. Brown, J. E. Egan, B. Turan, J. M. Turan, M. Brennan-Ing, V. Stosor, M.J. Mimiaga, D. Ware, and M.W. Plankey contributed to refinement of concept, analytic strategies, and article development and revisions. M.R. Friedman, V. Stosor, M.J. Mimiaga, and M.W. Plankey additionally contributed to site-specific cohort recruitment and retention and data collection. S.A. Haberlen and D. Ware additionally contributed to data management and variable operationalization.

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CONFLICTS OF INTEREST

The authors attest no potential or actual conflicts of interest from funding or affiliation-related activities.

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DETAILS

Subject:	Discrimination; Mental depression; Diabetes; Health care; Human immunodeficiency virus--HIV; Stigma; Cholesterol; Hypertension; Health disparities; Race; Sexuality; Drug therapy; Antiretroviral therapy; Aging; Hemoglobin; Racism; Oppression; Blood pressure; Diabetes mellitus; Antiretroviral agents; Public health; Dyslipidemia; Acquired immune deficiency syndrome--AIDS; Socioeconomic factors; Ethnic identity; Health services; Viremia; Intersectionality; Fasting; Prescription drugs; Cohort analysis; Symptoms; Lipoproteins; Medical treatment; Sexually transmitted diseases--STD; Political power; Adults; Metabolic disorders; Gays & lesbians; Mens health
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Coining Intersectional Stigma: Historical Erasures and The Future

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ABSTRACT (ENGLISH)

There is a T-shirt hanging in my closet that simply states, "Cite Black Women." I bought this T-shirt in solidarity to support Christen Smith, a guest speaker on my campus in 2019, who delivered a presentation on why and how she created Cite Black Women, a multipronged campaign to engage in a "radical praxis of citation that acknowledges and honors Black women's transnational intellectual production."¹ It reminds me and others that citation practices matter, that Black women's academic achievements are often "overlooked, sidelined and undervalued"¹ and erased from the canon.

This T-shirt has taken on new meaning as I have discovered that my concept of "intersectional stigma," a central idea from my first book, *Workable Sisterhood: The Political Journey of Women with HIV/ AIDS*,² has animated questions in the field of public health and continues to stimulate substantial interest by government agencies that include the National Institutes of Health and the National Institute of Mental Health without any attribution to my work or scholars whose work I build on. I would not have been aware of how far intersectional stigma has traveled (without my name), were it not for the committed efforts of Lisa Bowleg, guest editor of this issue of *AJPH* and scholar of intersectional research. As the creator of the term "intersectional stigma" and a leading scholar on intersectionality, this news was equal parts surprising, disappointing, and infuriating to me. Thus, I am grateful for Lisa Bowleg's invitation for me to respond here.

FULL TEXT

There is a T-shirt hanging in my closet that simply states, "Cite Black Women." I bought this T-shirt in solidarity to support Christen Smith, a guest speaker on my campus in 2019, who delivered a presentation on why and how she created Cite Black Women, a multipronged campaign to engage in a "radical praxis of citation that acknowledges

and honors Black women's transnational intellectual production."1 It reminds me and others that citation practices matter, that Black women's academic achievements are often "overlooked, sidelined and undervalued"1 and erased from the canon.

This T-shirt has taken on new meaning as I have discovered that my concept of "intersectional stigma," a central idea from my first book, *Workable Sisterhood: The Political Journey of Women with HIV/ AIDS*,² has animated questions in the field of public health and continues to stimulate substantial interest by government agencies that include the National Institutes of Health and the National Institute of Mental Health without any attribution to my work or scholars whose work I build on. I would not have been aware of how far intersectional stigma has traveled (without my name), were it not for the committed efforts of Lisa Bowleg, guest editor of this issue of *AJPH* and scholar of intersectional research. As the creator of the term "intersectional stigma" and a leading scholar on intersectionality, this news was equal parts surprising, disappointing, and infuriating to me. Thus, I am grateful for Lisa Bowleg's invitation for me to respond here.

Intersectional stigma arises from the concept of intersectionality. Intersectionality has a long intellectual history with roots in the early 19th century writings of theorist and activist Anna Julia Cooper and others who argued that Black women's realities were intertwined with sexism and racism.^{3,4} Multiracial feminist activism and theorizing over the past 40 years brought this body of knowledge into academic communities.⁵ Intersectional theorizing is dynamic with a recurring set of six core ideas-social inequality, relationality, power, social context, complexity, and social justice-that offer approaches to critical inquiry, the production of knowledge, and analytical and methodological approaches to research.⁶

Workable Sisterhood was based on my doctoral research with stigmatized HIVpositive women activists living in Michigan who were former sex workers and substance users. I conducted lengthy ethnographic fieldwork and life history research in the late 1990s, which was unusual for a budding political scientist. I was the first political scientist to apply the concept of intersectionality as an analytical tool for understanding marginalized HIV-positive women's political mobilization. I used intersectional stigma to explain specific, qualitative differences that existed within the already marginalized HIV/AIDS community. Intersectional stigma as analytical rubric enabled me to understand "the various ways [that these] women are specifically disadvantaged in relation to all phases of the HIV/AIDS virus" and helped to explain their path to political consciousness.^{2(p24)} This rubric also highlighted the interpersonal dimensions of stigma, ones that were difficult to capture with a quantitative lens.

The rubric that I developed was not one that I thought would or could be applied anywhere and to all instances of stigma and HIV/AIDS. The nature and meaning of HIV stigma has dramatically changed since my book was published. Researchers now have an opportunity to create measures that identify interlocking forms of structural oppression as opposed to using my term solely to explore marginalized identities. Furthermore, to prevent future erasure of the rich intellectual genealogy of intersectional thought, developed primarily by scholars (and activists) from underrepresented groups, I encourage researchers to question the disciplinary boundaries and institutional patterns that underpin and reward epistemic invisibility. AiPU

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DETAILS

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Climate Change, Public Health, Health Policy, and Nurses Training

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ABSTRACT (ENGLISH)

There are few educational programs in the United States that have a primary focus on preparing nurses to engage in all levels of public health, health policy, and climate change. The United Nations sustainability development goals (SDG) and the Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity (2021) report underscored the importance of key stakeholders, including nurses, engaging in advocacy and policy to promote health equity. We discuss the role of nursing at the intersection of public health, policy, climate change, and the SDG. We also discuss the history and merger of the University of California San Francisco (UCSF) School of Nursing public health and health policy specialties, a significant innovation in our effort to promote health equity. We provide a brief overview of the redesigning of our curriculum that meets the needs of today's learners by including content on climate change, data analytics, and racial, social, and environmental justice. Finally, we emphasize the need to train the next cadre of nurses interested in careers in public health and health policy for us to meet the challenges facing our communities.

FULL TEXT

Headnote

There are few educational programs in the United States that have a primary focus on preparing nurses to engage in all levels of public health, health policy, and climate change. The United Nations sustainability development goals (SDG) and the Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity (2021) report underscored the importance of key stakeholders, including nurses, engaging in advocacy and policy to promote health equity. We discuss the role of nursing at the intersection of public health, policy, climate change, and the SDG. We also discuss the history and merger of the University of California San Francisco (UCSF) School of Nursing public health and health policy specialties, a significant innovation in our effort to promote health equity.

We provide a brief overview of the redesigning of our curriculum that meets the needs of today's learners by including content on climate change, data analytics, and racial, social, and environmental justice. Finally, we emphasize the need to train the next cadre of nurses interested in careers in public health and health policy for us to meet the challenges facing our communities. (AmJ Public Health. 2022;112(S3):S321-S327.

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The history of nursing is solidly anchored in nurses' engagement in public health and in advocating changes in policy. Mary Seacole is an example of a nurse's contribution to public health and policy. A nurse of color who rose to prominence during the Crimean War, Seacole is known for her care of wounded soldiers and her public health efforts in caring for victims of yellow fever, cholera, and dysentery.¹ Another example is Lillian Wald, who linked housing with health outcomes. Nurses' presence in the communities they serve is frequently advocated, as nurses serve a pivotal role in public health and health policy.² These examples demonstrate a history in which nurses' contribution to public health and policy were driven primarily by racial and ethnic discrimination, which denied them access to spaces where they could make significant differences in the field. This has changed, however, with the presence of US congresswomen Lauren Underwood and Cori Bush, both registered nurses working to address racial disparities in health and housing through policy at the federal level.

The racial uprising in the United States in 2020 as a result of the murder of unarmed Black Americans brought renewed attention and calls to eradicate systems of racism and racial and ethnic discrimination, including institutional and public policies that continue to broaden inequalities and disparities in health. The racial uprising in 2020 and the focus on health equity and climate change illuminate the continuing need to ensure that nurses are prepared to engage in advocacy to benefit the public's health. More recently the Future of Nursing 2020-2030 report emphasized the importance of nurses' engagement in advocacy and policy to promote health equity.³ It states that "[in] addition to addressing social needs, nurses are called upon to inform and implement policies that will ultimately affect the greatest numbers of people in the most profound ways."³

When the World Health Organization (WHO) declared 2020 the Year of the Nurse (extended to 2021 because of the impact of the COVID-19 pandemic), it highlighted that the investment in nursing promotes equity. Significantly, it stated that nurses are critical to the global efforts to meet the sustainable development goals targets.⁴

NURSING AND SUSTAINABLE DEVELOPMENT GOALS

The sustainable development goals, adopted unanimously by the United Nations member states in 2015, established 17 targets that promote equitable social and economic development. The goals recognize the intersectionality between health, education, and economic growth. Furthermore, the SDG acknowledge that addressing climate change is pivotal to achieving all 17 targets, including the reduction of poverty (<https://bit.ly/36d85h0>).^{5,6} The sustainable development goals also brought needed attention to gender equality, work that provides a livable wage and economic growth, reduced inequalities, decisive climate action, sustainable cities and communities, and peace, justice, and strong institutions.^{5,7}

Although the link between nursing and target 3 (good health and wellbeing) is unquestionable, the SDG offered nursing an opportunity to discuss its engagement in a broader approach to public health and policy, especially as health is threaded throughout several of the other goals as an indispensable condition to meeting all the targets. Importantly, the role of nurses in advocating the goals is supported by leading nursing organizations, including the International Council of Nurses and several US-based nursing organizations, including the American Nurses Association and the American Academy of Nursing.⁸⁻¹⁰

Furthermore, the SDG present nurses with a unique opportunity to develop and implement nursing education and a research agenda that responds to current concerns that negatively affect health, including research on the impact of a changing climate on individuals, families, and communities in the United States and globally.^{8,11-14} Moreover, the SDG offer an opportunity to further advance nursing education and research that centers equity in terms of gender, race, ethnicity, education, and the elimination of poverty and hunger, and to promote social, economic, and environmental justice by eradicating systemic racism and racial discrimination. Future leaders in nursing will be equipped with the tools to drive public health and health policy, which in turn will strengthen institutions that serve

communities.^{14,15}

Rosa et al.¹⁶ suggest that for nurses to assume leadership roles in promoting social justice, equity, and the SDG, it is necessary that nursing education and research include the following: (1) every nursing student at all levels of education must have an integrated curricular requirement to advance their understanding of politics and policy that would provide requisite education on the workings of policy and politics and related implications to teach students how to live and work in those spheres; (2) students and practicing professional nurses must have opportunities to do internships, residencies, and placements and have other forms of experience in public health and policy forums that interface with nongovernmental organizations and other agencies in their localities, state, nation, and beyond; (3) nursing scholarship that centers antiracism initiatives, health equity, and the elimination of health disparities must be advanced; and (4) leaders in nursing must have the responsibility to build relationships with people of influence and thought leaders to fully engage and integrate nursing's contribution in policy and public health arenas.¹⁶

The COVID-19 pandemic upended lives, economies, and health care infrastructure domestically and globally. It also provided an opportunity to increase awareness of the severe disparities in access to health care, wealth, food security, and stable housing as well as mass migration in and between countries-further exacerbating the crises brought on by climate change and the pandemic. It did, however, point to the fact that health care and public health systems cannot function without nurses and that nursing leadership is pivotal in addressing health and social crises. The pandemic also renewed calls for nurses to lead. At the UCSF School of Nursing, the masters of science graduate program includes 2 pioneering specialties that are at the forefront of equipping new generations of nurse leaders with the programmatic, policy, and political tools necessary to ensure nurses' response to current and future crises. These 2 specialties are advanced public health nursing (APHN) and health policy nursing. Students entering our programs are either practicing registered nurses with a bachelor of science degree or a second-degree nursing student who has completed an accelerated registered nursing program before starting either the graduate APHN or the health policy nursing specialty.

THE HISTORY OF THE 2 SPECIALTIES

The focus of the APHN specialty is to learn macrolevel skills in managing aggregates of clients, communities, environments, and health systems in a clinical nursing context. The coursework and practice-based learning provide a foundation for planning and evaluating community and public health programs; learning about community and public health concepts, health promotion, population-level interventions, grant writing, health care systems, leadership, and health policy; addressing health disparities of vulnerable and diverse populations; and practicing and consulting in diverse and multicultural settings and partnering with communities. Nurses who graduate from the APHN specialty understand the complex interactions between health and the social determinants of health and are able to identify systems-level solutions that can maintain or improve the health of diverse, vulnerable, and underserved populations and communities. Some master of science graduates whose specialty is APHN have taken positions implementing programs in public health departments and in other settings, including director of a statewide initiative to increase flu vaccination rates for elementary school students, state-level public health department coordinator of COVID-19 response, senior country-level technical nursing adviser for maternal child health in a global setting, and director of public health respite and sobering center for a department of public health.

Historically, the APHN specialty has adapted to the changes in competency expectations and revisions for community and public health nurses.¹⁷ Coursework for the APHN specialty is focused on the role of an advanced public health nurse, public health practice and APHN competencies, developing theoretical understanding of structural and social determinants of community and public health, and skills that demonstrate an ability to collaborate with community members to create partnership in planning, implementing, and evaluating programs with a focus on prevention and well-being. More recently, we have included topics on social and environmental justice, structural determinants of health, police violence and its effects on mental health in communities of color, and climate change and global health impacts.

Students engage in a communitybased public health residency practicum in which they are evaluated on their skills and attainment of community and public health competencies. Residencies are a minimum of 240 hours and must

include APHN competencies. Some examples of residency settings are public health departments, schools and universities, parishes and faith-based programs, home care, rural health, refugee and immigrant clinics, primary care clinics, jails and prisons, ambulatory outpatient facilities, voluntary organizations, and a variety of community, public, and private agencies and organizations.

Public Health Residency Experiences

Several APHN students' residency practicums are done in collaboration with a county-level public health nursing department. One example of a longitudinal, long-term partnership (more than 10 years) between the university and a county-level public health nursing department is a project focused on addressing mental health disparities in pregnant and postpartum women who receive WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) services. Each year the partnership responds to the needs of the community. The project began with developing an intervention called the WIC postpartum depression screen, which implemented depression screening for clients and was conducted by WIC staff. This partnership has resulted in a multiphase intervention that has been expanded to 8 WIC sites in Alameda County, California; in it, WIC staff completed depression screening for more than 20 000 pregnant and postpartum women. In 2018 through 2019, the WIC postpartum depression screen conducted 4852 client screenings, 8.6% of which were positive for being at risk for depression.¹⁸

On March 17, 2020, Alameda County issued shelter-in-place orders to curb the spread of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which is responsible for COVID-19. All WIC offices were closed to in-person appointments and given the directive to convert to remote operations and to discontinue ancillary activities, thereby stopping postpartum depression screenings. Part of this lapse in screening was attributable to the in-person paper-based format used before the pandemic. An organizational transition to a new electronic health record system called WICwise in the fall of 2019 coupled with closing county offices to in-person appointments reduced the client screenings at the county level. Responding to the impact of the COVID-19 pandemic, our APHN student intern worked with staff from the Alameda County Health Department to transition their depression screening program to a remote telehealth format. This transition facilitated the continuation of services for pregnant women in need and reinstated the depression screening program.¹⁹

APHN students have engaged in projects that included the development of a toolkit used to assist in training community providers, enabling them to screen and refer low-income women in California's San Francisco Bay Area for maternal depression. The toolkit was developed to support the implementation of California Assembly Bill 2193, which went into effect July 2019.²⁰ AB 2193 requires all obstetric and prenatal care providers to screen their patients for depression at least once during their pregnancy or 6 months postpartum. Our APHN and health policy students will continue to support and evaluate the implementation of this new law across the state.

Health Policy Specialty

The UCSF School of Nursing established master's and doctorate specialty programs in health policy in 2002 with initial funding from a Health Resources and Services Administration training grant. The founding faculty of the program believed that health policy education was a missing piece in nursing education and that a focused health policy specialty program would help to prepare nurses with the skills needed to play a greater role in local, state, and national policymaking and to act as policy leaders in a variety of settings.⁴ The program has met and continues to meet all the accreditation requirements, demonstrating the strength of providing policy analysis skills to nurses prepared at the postbaccalaureate level.

As in the APHN program, entering students are either practicing registered nurses with a bachelor of science degree or a second-degree nursing student who has completed an accelerated registered nursing program before starting the graduate program. Doctoral students have completed a master's degree or enter directly after completing a bachelor of science degree in nursing.

The program focuses on theory and contemporary policy issues and provides nurses with the skills with which to address those issues. It is designed to provide the tools to understand, analyze, communicate, and advocate, and to research policy issues relevant to health, health systems, and health services delivery. The master of science degree program includes a 15-month curriculum of classroom study and a summer policy residency. Courses help

students identify and critically analyze and assess the impact of laws, regulations, and policies at the institutional, local, state, and national levels; use in-depth knowledge of the history, structure, theory, and process of health policymaking in the United States (and, in some cases, internationally); evaluate the evidence base for policy proposals; and plan, implement, and evaluate policies.

Students completing the program understand the economic, ethical, and social implications of policy decisions for various affected groups and are prepared to creatively and effectively advocate evidence-based and data-driven policy change. The program emphasizes sensitizing students to the effects of policy on marginalized groups and developing students' capacity to identify emerging issues. The program offers an intensive in-person educational experience, and as of fall 2021 has graduated a total of 130 masters and 88 doctoral students.

Program graduates have secured positions in government agencies, the biotech industry, health care institutions, private health care foundations, academic institutions (as faculty and research staff), professional nursing organizations, and other advocacy or policy organizations. Many students have been promoted to policy and leadership positions in the organizations where they conducted their residency after enrolling in the program, thus moving from the bedside to the center of policy decision-making.

Health Policy Residency Experiences

A highlight of the program is the students' summer policy residencies, in which they spend a minimum of 240 hours working in a policy-related setting specifically selected to match their policy interests. Students have been placed in congressional offices, national advocacy organizations in Washington, DC, the WHO in Geneva, professional organizations in the United States, state legislative offices and regulatory agencies, and local public health and policy organizations. During these mentored residencies, students have the opportunity to prepare policy briefs, engage in public hearings, collect data and conduct policy analyses, and prepare policy recommendations to policymakers and decision makers at all levels, including at the global level. Additionally, these residencies offer students the opportunity to represent nurses, who play an important role in a range of policy arenas. For example, one student's residency experience at the WHO with the chief nursing officer led to the opportunity to contribute to the data collection for and authorship of the "State of the world's nursing 2020: investing in education, jobs and leadership" report.⁴ Another student's residency at the WHO involved the preparation of a training program that is used to educate regulators globally on several aspects of policies to regulate tobacco products.

Additional student residency experience includes being involved in preparing policy guidance on improving maternity care through midwifery, making recommendations for policymakers at the federal, state, and territorial levels and to private health sector decision makers.²¹ Finally, a student's residency in a state congressional office in Sacramento, California, provided the evidence-based and policy options that ultimately resulted in an expansion of access to care for all children regardless of immigration documentation status. The doctoral program in health policy is a focus area for students whose research interests are in health policy and health sciences research.

MERGING THE SPECIALTIES

The specialties we have described have operated independently of each other. However, providing our students with the collective tools they need to meet the major challenges facing health care infrastructure globally and domestically created the opportunity to merge them. Graduates of the APHN specialty are learning about policy, and it is stipulated that, without adequate systems-level change, public health cannot address health disparities, social and health inequalities, medical mistrust, medical racism, the negative effects of climate change, or food insecurities. Health disparities demand a public health workforce that is educated in policy analysis and the creation of systems-level solutions driven by nurses. Our merged specialty, which will begin enrolling students in fall 2022, will provide an opportunity for nursing educators to meet the needs of today's learners who are passionate about the issues we have mentioned.

Although our 2 specialties were separate from each other, they have traditionally collaborated by offering students the opportunity to enroll in overlapping courses. As the current pandemic has increased the call for more nurses to be involved in leadership at the organization level, at the institutional health systems level, and in the political arena, we hope that this long collaboration on a formal merger of these 2 specialties will equip learners with the tools they

need to engage with public health and policy experts in their field. The merger of the 2 specialties has provided a chance to blend both curricula to attract students with an interest in being a force for social justice and health equity. The demand for our specialties is driven primarily by nurses who are interested in establishing a career in public health or health policy and want to be a part of systems-level change to address health and social issues upstream rather than downstream (i.e., prevention and mitigation). Our specialties were created from the perspective of nurses who are experts in the field of public health and health policy. We differ from traditional programs of masters-level public health, policy, or advanced practice registered nursing by bringing the unique nursing advocacy perspective to public health and policy.²²

MEETING THE NEEDS OF TODAY'S LEARNERS

As the climate crisis continues to affect our local, state, national, and global communities, students have consistently asked for additional resources to assist them in meeting the climate challenge. The persistent droughts, wildfires, and heatwaves in California; the racial and social uprising in summer 2020; and the merger of our public health and health policy specialties have given us an opportunity to expand our course offerings to include content on climate change and its impacts on health, equity, and social justice issues (i.e., environmental, economic, and racial issues). Our main objective is to create a course that will be of interest to nurses and all students in the UCSF health professional schools. Our goal is to create a broad interdisciplinary survey and interactive course on climate change and its consequences that will include presentations by experts. Climate change and global warming cause extreme weather events; affect air quality, water, food production, industry, and economic and political stability; and present many other global challenges to sustainability.²³ The effects of climate change on health are broad and include communicable and noncommunicable diseases, such as childhood asthma, diseases of hunger, and HIV.

In this course, our students will gain the skills to link climate change with social justice, connecting climate change to health disparities, inequities, and other social vulnerabilities. Climate change affects every area of life and has an increased impact on vulnerable marginalized and minoritized populations. Social justice affects reach of the police state and the criminalization of poverty and homelessness, which increased in the evacuation process of the recent fires in several states across the United States. The people who are most likely to be affected by the climate crisis are least likely to be included in the conversation on how to respond to the crisis. Thus, this course will center the voice and perspective of nurse policymakers, public health officials, and local community activists.

Our merged, innovative curriculum also gives learners a foundation in data analytics to prepare them to use large public data sets so they can respond to health disparities. The volume of routine health care procedures data and population-level social determinants of health data is growing at an unprecedented pace. The availability of electronic health records, insurance claims data, and mobile health data and the ability to link these health care systems data with census, survey, and other data sources have brought fundamental changes to health care delivery, policy design and evaluation, and population-level health initiatives.

In this increasingly data-driven health care landscape, the UCSF policy and public health specialties recognize that nurses working in the public health and policy sectors must have the skills to use a variety of data sources to advance the policy process and public health strategies with data-driven solutions. We will teach this content integrated with research methods and data analysis to enable learners to prepare, use, and disseminate data in meaningful ways to inform evidence-based policy responses and public health initiatives to solve the problems of today and the future.

RECOMMENDATIONS

As our nation and our global communities continue to experience climate change, disparities in health, and structural inequalities, there is an urgent need to train the next cadre of nurses to meet the moment through decisive public health and health policy experiences.⁶ Furthermore, public health and health policy nurses are essential to meeting the SDG and eradicating systems of oppression that fuel inequalities. Thus, based on our experience and evidence, we offer the following recommendations for educating and training the next generation of nurse public health and health policy leaders:

1. ensure that nurses receive the knowledge and skills needed to engage in policy arenas at all levels (i.e.,

institutional, local, state, national, and global);

2. review, as needed, curricula to ensure that they are meeting the key areas recommended by the Future of Nursing 2020-2030;

3. recognize that not all advanced nursing roles are clinical by using language in educational competencies that includes nurses with primary roles in health policy and public health;

4. properly delineate the roles of nurses in public health and health policy in educational competencies;

5. integrate climate change and social justice content as standalone courses rather than topics embedded in an existing course;

6. expand the number of public health and policy programs and specialties across US schools of nursing, thus training more nurses in this area; and

7. enhance nursing schools' curricula to explicitly include content that focuses on ending systemic racism, racial and ethnic discrimination, and other inequalities among minoritized and marginalized communities.

CONCLUSIONS

Although few programs in the United States have a primary focus on preparing nurses to engage in all stages and at all levels of public health and health policy, such education is aligned with the American Association of Colleges of Nursing (AACN) educational essentials, including the emphasis on the policy role and the public health role in addressing social determinants of health and health disparities and promoting equity. The AACN makes it clear that preparation in health policy and public health and population health are equally important as preparation to work in clinical settings, emphasizing the need for nurses to have the ability to "analyze systems level and public policy influence on care coordination."¹⁰(p61)

Similarly, the latest AACN essentials propose that nurses be prepared to conduct policy research and understand how policy and regulations affect public health and health care delivery. Therefore, schools of nursing must evolve to meet the needs of today's learners who are interested in public health and health policy careers. Although our merged specialties provide the first step in preparing future nurses to engage in these arenas, we hope that they will also provide a blueprint to assist other schools of nursing in developing similar specialties. We also hope that our specialties demonstrate how nursing school curricula can be enhanced to include content that focuses on ending systemic racism and racial/ethnic discrimination and on increasing access and opportunities for minoritized and marginalized communities.^{11,13} >4JPH

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O.O. Harris conceptualized the topic that guided the development of the article and oversaw the final submission. All authors wrote sections of the article.

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Nursing and Public Health Special Issue

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ABSTRACT (ENGLISH)

In this AJPH special issue, "Nursing and Public Health," nurses and their colleagues share novel practice insights, cutting-edge research findings, educational guidance, and urgent calls to action for nurses and everyone working in public health and health care today. The articles showcase nursing research, leadership, education, and practice responses to critical public health challenges, such as the climate crisis, the COVID-19 pandemic, trauma and related issues, and workforce needs.

FULL TEXT

In this AJPH special issue, "Nursing and Public Health," nurses and their colleagues share novel practice insights, cutting-edge research findings, educational guidance, and urgent calls to action for nurses and everyone working in public health and health care today. The articles showcase nursing research, leadership, education, and practice responses to critical public health challenges, such as the climate crisis, the COVID-19 pandemic, trauma and related issues, and workforce needs.

PLANETARY HEALTH

Numerous articles focus on climate-related issues. Kurth and Potter (p. S259) exhort nurses to join forces to address the planetary health crisis, strongly supporting the public health infrastructure to address climate change and other planetary health crises. LeClair et al. (p. S256) explicate the challenges we will all face because of climate change, which inflicts unjust burdens on marginalized and displaced peoples, as well as other species and their interconnected ecosystems. Climate justice in nursing addresses the social, racial, economic, environmental, and multispecies factors related to climate changes and crises. Climate equality can be achieved by centering the experiences and knowledges of frontline and fence line communities and safeguarding nature to achieve planetary health. Watts and Brugger (p. S241) address how using paleofire data (i.e., sedimentary records of ancient fires) for public health planning related to wildfires can improve future public health system adaptation, population health, and planetary health.

COVID-19

Several articles address COVID-19 pandemic issues. Throughout the COVID-19 response, nurses at local, state, and federal levels have consistently answered the call with a resounding "Yes," performing jobs that blend clinical knowledge, science, and public health. Zauche et al. (p. S226) describe public health nursing (PHN) roles at the Centers for Disease Control and Prevention and how the nursing profession has been essential in ensuring the health and safety of our most vulnerable groups. As the COVID-19 pandemic has exacerbated the public health and health equity challenges experienced in the United States, Morone et al. (p. S231) underscore the importance of including nursing perspectives when addressing public health issues. Nurses hold significant positions in strengthening, rebuilding, and reimagining the public health system in the United States and advancing public health, yet they are underrepresented in the policy- and agenda-setting spaces.

McCauley (p. S218) responds to the articles by Zauche et al. and Morone et al., emphasizing the importance of nurses to public health policy and practice. Harris et al. (p. S245) describe a practical approach to health coaching based on stages of vaccine readiness and acceptance. Nurses are leading the nation's vaccine administration efforts and may be the most accessible source of answers to questions on safety, side effects, and benefits. Harris et al. offer a detailed explanation of the stages of vaccine readiness and acceptance that moves the conversation forward, instead of mainly focusing on vaccine hesitancy.

Additionally, Kershner et al. (p. S279) describe the implementation of a large, open, drive-through point of distribution site for eligible individuals to receive COVID-19 vaccinations. Such a safe and efficient distribution of preventive treatments, COVID-19 vaccines, via point of distribution sites were critical to mitigating significant morbidity and mortality of the general public. Freed et al. (p. S284) discuss the role of nurse practitioners in community and academic health center settings in response to the needs of vulnerable populations during a pandemic. Their nurse practitioner-led initiative provided patients and staff a safe and effective option for in-person, evidence-based, patient-centered, community-based clinical care during the COVID-19 pandemic. Finally, Singer et al. (p. S288) examine how spirituality may inform health and health care beliefs and behaviors among Black sex workers during COVID-19. Their findings indicate that integrating religion and spirituality in community-engaged health interventions may be one way for PHN to meet their needs and facilitate culturally safe care.

APPROACHES

Articles in this special issue also showcase PHN innovations and effectiveness across diverse settings and populations. A mural (p. S268) depicting pioneering nurses from diverse backgrounds who contributed to the fields of nursing and public health celebrates their successes. Szanton (p. S265) describes an evidence-based intervention that nurses could implement to increase the ability of older adults and their families to thrive in place.

This is a timely solution, particularly as health care shifts away from acute care hospitals to home- and community-based settings. Ballard et al. (p. S298) describe programming to address the long-term consequences on the health of children, adults, and communities that adverse childhood experiences can have. As health systems implement adverse childhood experience screening in primary care, a new traumainformed approach in PHN, delivered through maternal-child home visiting programs, can help identify and respond to families with current or historical trauma who may not access primary care. Support for rapid innovation through evidence-informed interventions such as trauma-informed approach PHN can equip public health systems and nurses to respond more quickly to the crisis of childhood trauma, particularly in the most underserved communities.

Huling et al. (p. S306) introduce the use of modern causal inference techniques for studying real-world PHN intervention data, enabling the rigorous study of policy-relevant questions of intervention effectiveness. This work is possible because practicing public health nurses have generated rigorous data during their routine documentation of evidence-based interventions for a high-risk population: children at risk for child welfare referrals. They used a multidisciplinary terminology called the Omaha System, which was designed to guide, document, and measure intervention effectiveness. Monsen (p. S220) responds to the articles by Ballard et al. and Huling et al., asserting that PHN family home visiting is ready for widespread dissemination, as nurses are equipped to translate family home visiting evidence into practice.

COMMUNITY RESILIENCE

Having influence at the population and community health levels is integral to advanced PHN practice. With a focus on promoting and creating community resilience, Duva et al. (p. S271) share their insights on a low-cost, replicable nurseled intervention to address public mental health needs. They demonstrate how nurse-led innovative trainings and crosssector programs support population mental health by strengthening the well-being of individuals, families, and communities. This feasible, effective implementation is part of a multifaceted approach that was adapted to improve population mental health during the COVID-19 pandemic. Austin et al. (p. S275) describe an academic-practice collaboration's community-based intervention that combines communitybased participatory methods and community-driven data to deepen the understanding of whole person health that includes strengths, challenges, and needs and serves as a platform for datadriven decision making. This novel approach lays the foundation of a system based on equitable health promotion and a shift in the focus of community narratives from deficits to strengths. Waters (p. S224) responds to the articles by Austin et al. and Duva et al., emphasizing PHN impact on strengthening community resilience. This is further exemplified by Horning (p. S269), who describes how PHN researchers at the University of Minnesota are partnering with the Twin Cities Mobile Market to rigorously study the full-service mobile market's effects on diet quality and food security.

POLICY

Furthermore, numerous articles address policy matters related to challenges facing the PHN workforce and education. Kneipp et al. (p. S292) describe an urgent need for reenvisioning workforce enumeration to ensure a public health workforce that is adequate for meeting the current goals of several public health and nursing initiatives. Reiss-Brennan et al. (p. S253) call for an end to siloing, or separating, primary care and public health. They emphasize that nurses are perfectly positioned to launch this seismic shift for US health care, including the integration of data systems, staffing, and strategic planning. Moreover, they call for meaningful partnerships between primary care, public health, and community organizations to achieve this level of cohesion.

ACADEMIA

Thurman et al. (p. S314) discuss the challenges facing PHN faculty, who possess expertise that is crucial to advancing public health and preparing nurses as practitioners, educators, and scientists to address social determinants of health and health inequities and to improve public health systems. They show how traditional academic structures in which PHN faculty work and the efforts needed to protect and improve public health are misaligned, and they urge PHN faculty to take collective action-as systemic change in nursing academia is necessary for the discipline to engage in the critical work of dismantling broken systems and building toward an equitable future.

Jones et al. (p. S237) urge schools of nursing to respond to the call for deeper investments in PHN, both in didactic and clinical courses, to prepare a workforce ready to address public health threats. Oerther and Oerther (p. S250) discuss educating public health nurses in the context of massive planetary environmental challenges brought about by the actions of humanity (i.e., in the Anthropocene). To ensure that no one is left behind, they propose solutions to the central question facing PHN educators adept in patient and individual as well as population health: "How do we improve interprofessional environmental health education to achieve effective collaboration beyond the bedside?"

Harris et al. (p. S231) emphasize the urgent need to train the next cadre of nurses who are interested in public health and health policy careers to prepare them for future challenges. Johnson (p. S222) responds in support of the recommendation of Harris et al. to expand PHN and health policy programs and dives deeper into long-standing issues needed to address advanced PHN education to have its maximal effect. Finally, Hassmiller (p. S262) discusses how advancing the recommendations from the National Academy of Medicine Committee's "The Future of Nursing 2020-2030" consensus study report will revitalize public health nursing.

FINAL THOUGHTS

We are encouraged by the compelling messages this AJPH special issue advances. Even as this special issue celebrates the power and potential of nursing, we realize we have barely scratched the surface of nursing's contributions to the public's health. Nor have we adequately explicated today's urgent public health challenges that are in need of a comprehensive, holistic nursing response. We urge nurses to lead, innovate, and advance public health—now, more than ever. ÅfPU

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An Overlooked Strategic Powerhouse: How Nurses Can Rise to the Challenge of Integrating Public



Health and Primary Care

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ABSTRACT (ENGLISH)

Although the United States is one of the wealthiest countries in the world and a leader in biomedical innovation, its health care system is consistently ranked among the worst in terms of cost and health outcomes. Americans have short life expectancies, high infant mortality and obesity rates, and soaring chronic disease rates compared with other wealthy nations. In 2021, the National Academy of Medicine (NAM) was charged with examining what it would take to improve US primary care. The NAM report described the practice of siloing public health from primary care or treating these areas as separate fields of scientific inquiry, practice, and billable service.¹ NAM identified this separation as a key driver of poor health outcomes and health inequities in the United States. The Institute of Medicine (IOM) examined similar phenomena in a 2012 report, noting how the two fields tend to operate independently, despite complementary functions and common goals.²

Where these silos persist, we see communication and process breakdowns at the point of care. For instance, when large swaths of Americans turned to trusted primary care providers for COVID-19 vaccine insights, their primary care providers did not always have the most up-to-date information, in part because of a lack of interprofessional cohesion (including fragmented public health messaging and data systems). If we are to remedy such issues, a substantive paradigm shift must take place: We must move toward what DeSalvo et al.³ termed "Public Health 3.0." In this model, multiple sectors, specialties, and stakeholders form coalitions to mobilize data, people power, and resources in a strategic manner to advance health for all. To be truly strategic, we must think carefully about how to leverage nurses—who care for patients across the lifespan and in nearly all public health nursing (PHN) and primary care settings—within these coalitions.

The 2021 NAM report urges health care teams to undertake the mission of integrating systems. However, NAM stops short of describing exactly how teams ought to accomplish this aim and the proposed makeup of said teams. Like any group project, success will depend on the ability of teams to identify leaders and clearly delineate responsibilities. The purpose of this editorial is to explore the potential of PHN and primary care nurses and to describe the roles they might assume in the collaborative integration of their respective silos.

FULL TEXT

Although the United States is one of the wealthiest countries in the world and a leader in biomedical innovation, its health care system is consistently ranked among the worst in terms of cost and health outcomes. Americans have short life expectancies, high infant mortality and obesity rates, and soaring chronic disease rates compared with other wealthy nations. In 2021, the National Academy of Medicine (NAM) was charged with examining what it would take to improve US primary care. The NAM report described the practice of siloing public health from primary care or treating these areas as separate fields of scientific inquiry, practice, and billable service.¹ NAM identified this separation as a key driver of poor health outcomes and health inequities in the United States. The Institute of Medicine (IOM) examined similar phenomena in a 2012 report, noting how the two fields tend to operate independently, despite complementary functions and common goals.²

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WHO ARE PUBLIC HEALTH AND PRIMARY CARE NURSES?

PHN is "the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences."⁴(p1) Between 37 000 and 41 000 public health nurses practice in the United States across all states and territories, with many employed by state and local departments of health.⁵ Although public health nurses often provide direct clinical services, their roles vary greatly, depending on community needs. Public health nurses may focus on health promotion, disease surveillance, community-based participatory research, or health advocacy, among other areas.⁵ In addition to health departments, they may be found working in "schools, homes, community health centers, clinics, correctional facilities, worksites, out of mobile vans and even dog sleds."⁴(p1) Primary care nurses, on the other hand, are found in primary care offices, telehealth and concierge health practices, retail health clinics, and community health clinics. These nurses promote primary prevention, manage chronic conditions, and support quality of life across disease trajectories. They often work with people and families over many years, providing important continuity of care within fragmented health care systems. Of the 3.5 million nurses practicing in the United States, only about 9% practice in ambulatory care, which encompasses primary care.⁶ This includes approximately 55 625 primary care nurse practitioners.⁷

Primary care nurses often work alongside public health nurses in community clinics and departments of health. Both may occupy roles spanning organizational levels from patient care, to care coordination, to office management, and to senior leadership. All nurses receive information on PHN and primary care in their prelicensure programs. However, few nurses are exposed to integrated models of care in communities; rarely is the power potential of fully integrating these two areas covered sufficiently either. Nurses can embrace their power and influence by developing education and certification programs that integrate these silos, teaching emerging nurses how to work across disciplines to improve health care.

THE VALUE OF LEADING FROM THE FRONT LINE

The 2021 NAM report clearly stresses the importance of placing patients, families, and communities at the center of measures for improved primary care (Box 1). This approach aligns with the nursing paradigm, which imagines optimized care as a web of considerations (one's family, culture, lived environment, finances, etc.), with the patient or community at the center. Nurses are therefore primed to consider how interlocking systems bear on individual and population health outcomes. At all levels, nursing preparation assumes this paradigm and emphasizes competencies relevant to public health leadership, including interprofessional collaboration, stakeholder engagement, and data analytics. These factors position nurses as ideal early adopters and influencers of professional integration.

Public health nurses and primary care nurses bring an intimate, human understanding of illness and barriers to care as well. Nurses live and work every day in the microtrenches of care, and they are trained to understand how everyday frustrations fit into a "macro" picture of fragmented systems and professional silos. We cannot underestimate the value of this perspective in strategic planning and change management. Nurses ought to be recognized and supported as frontline leaders with the skills, acumen, and lived experience necessary to achieve reforms.

ACTION AT EVERY LEVEL

Nurses can demonstrate this leadership potential through simple steps, including the following:

- * Nurses of all levels can pursue continuing education opportunities in PHN or primary care.
- * Nursing employers should cover continuing education costs, along with professional development opportunities (such as conferences).
- * Nurses of all levels can advocate for integration and educate colleagues via engagement with professional associations, social media, op-ed writing, workplace events, and inservices, among others.
- * Nurse managers can lead campaigns to promote work cultures where primary care is seen not as a specialty, but rather as essential to the implementation of all health care.
- * Nurse leaders can shift their organization toward an integrated model through the careful selection of data systems, the formation of strategic partnerships, and interprofessional staffing.

Nurse leaders should collaborate with primary care, public health, and community organizations to cultivate Public Health 3.0 coalitions.

SUSTAINING INTEGRATION THROUGH EDUCATION

Nurse educators will play a pivotal role in sustaining this work. In most nursing programs, there is too much focus on acute care and not enough focus on both primary care and public health. From the undergraduate level to the doctoral level, academic nurse leaders and faculty should critically examine curricula for such oversights. To start, nursing faculty should incorporate data analytics—a core public health competency—into curricula, regardless of the subject at hand. This will show future nurses that, with the right data, they can influence and continuously evaluate change from the individual level to the population level. It will also create a pipeline of nurses who are prepared to build data conduits from PHN surveillance to primary care practice. Any opportunities for weaving analytics and PHN science into doctoral dissertations should be considered.

In clinical settings, nursing students need to witness and participate in the integration of public health and primary care through hands-on learning. Students should have exposure to positive role models functioning at the top of their license in primary care. In fact, before home health nurses moved to staffing under private home care companies, students would have rotations with providers managing complex care at home. Limited hospital stays have further separated nurses practicing in hospitals from the communities where their patients live, work, and play. It is time to collaboratively revamp clinical education to ensure immersion across practice environments and disciplines.

CONCLUSION

For nearly three decades, the IOM, NAM, and other leading organizations have called for greater primary care/public health integration. Despite this urging, no one entity—educational or professional—has assumed accountability for implementation. Nurses are familiar with stepping up to wicked problems in health care when leadership is needed. Change will happen at the front lines of care; if true integration is to occur, it will take place in senior centers, places of worship, adult daycares, barbershops, beauty salons, and libraries. Nurses, already a trusted presence in these spaces, will be there to lead the way. .4jPU

Sidebar

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Shoring Up the Frontline of Prevention: Strengthening Curricula With Community and Public Health Nursing

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ABSTRACT (ENGLISH)

The terms "frontline" and "prevention" are now common everyday household words heard across America. However, the most exigent focus for investments in prevention is unclear, as is the location of the true frontline. County Health Rankings demonstrate that 80% of our health outcomes are not resolved within clinical or acute care settings.¹ However, the number of nurses practicing in community and public health settings has been consistently

declining, from 4% of the workforce in 2013 to 2.9% in 2020² Existing disparities in nursing salaries may be a contributing factor to the decline. In 2021, the US Bureau of Labor Statistics³ reported the average national registered nurse salary to be \$75 330, whereas the average public health nursing salary is \$68 661.4 Furthermore, public health funding decreased substantially across the nation prior to the pandemic, leading to lost staff positions, which resulted in a weaker public health workforce and infrastructure.⁵ Each successive surge of the COVID-19 pandemic has exposed the dire need for more nurses in public health and community settings. For years to come, concerns about the nursing workforce are likely to persist as we witness intensifying health care demands created by changes in the delivery of health care services, population shifts, and health care transformation.

In spite of these trends, many schools of nursing across the nation design and deliver a curriculum with a central focus on illness care or disease treatment to be rendered in inpatient settings.⁶ As a result, our nation's essential health interests beyond the bedside remain unequivocally compromised.

In this article, we argue that the predominant and pervasive curricular focus of nursing education on acute care has limited the ability to prepare a workforce ready to address public health threats, which has become more evident since the onset of COVID-19. We advocate for (1) intentional changes in nursing curricula designed to reinforce didactic teaching of public health sciences and social determinants of health, and (2) deeper investments in three-way community-academic-practice partnerships to promote a nursing workforce equipped for intersectoral practice in settings outside of the hospital, leading to a far-reaching impact on population health.

FULL TEXT

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County Health Rankings demonstrate that 80% of our health outcomes are not resolved within clinical or acute care settings.¹ However, the number of nurses practicing in community and public health settings has been consistently declining, from 4% of the workforce in 2013 to 2.9% in 2020² Existing disparities in nursing salaries may be a contributing factor to the decline. In 2021, the US Bureau of Labor Statistics³ reported the average national registered nurse salary to be \$75 330, whereas the average public health nursing salary is \$68 661.4 Furthermore, public health funding decreased substantially across the nation prior to the pandemic, leading to lost staff positions, which resulted in a weaker public health workforce and infrastructure.⁵ Each successive surge of the COVID-19 pandemic has exposed the dire need for more nurses in public health and community settings. For years to come, concerns about the nursing workforce are likely to persist as we witness intensifying health care demands created by changes in the delivery of health care services, population shifts, and health care transformation.

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ADDING POPULATION HEALTH TO CURRICULAR CONTENT MAPPING

Mapping population health in the nursing curriculum requires academic and health institutions to shift from a singular focus on individual holistic needs to a framework that emphasizes social and structural determinants of health, both in didactic and clinical training. Simply put, it is insufficient to address social needs, which represent the downstream effects of root causes. Instead, a robust nursing curriculum requires a critical examination of the upstream social determinants of health that directly and indirectly cause poor health outcomes.⁷ To inform the development of national nursing education guidelines, the Council of Public Health Nursing Organizations⁸ issued a statement in 2019 outlining priority social determinants of health and recommending key action steps for implementation in

academic and practice settings. The consistent refrain of these recommendations is the need to increase faculty development in community and public health, population health, advocacy, and policy to shape action-oriented curricula that will equip students to address racism, poverty, environmental injustice, and violence.

The American Association of Colleges of Nursing⁹ and the National Academies of Sciences, Engineering, and Medicine¹⁰ recently published revised guidelines for nursing education; the cross-cutting theme of both documents is not a call for greater investments in acute care but rather a reinvigoration of public health values and principles for population health and health equity. Hailed by some as a paradigm shift in nursing education and practice, this emphasis is not new for public health nurse educators. Since 1965, community and public health nursing content has been part of the required baccalaureate nursing curriculum.¹¹ However, advancing the quality and augmenting the impact of community and public health nursing education, practice, and research is critical for improved local to global health outcomes.

To prepare nursing students for practice through the lens of public health, we propose weighting, leveling, and distributing epidemiology, biostatistics, environmental science, emergency management, disaster preparedness, social determinants of health, health equity, care coordination, and disease prevention as the didactic core throughout the nursing curriculum. In addition, we assert the need for the clinical core of the nursing curriculum to include opportunities for intervention at all levels of practice: preparing nurses to design and deliver care at the level of the individual, family, community, systems, and populations.¹²

To implement this directional change, essential knowledge and skills in systems awareness, change management, cost containment, resource allocation, communication, team building, equity, and inclusion are required for competent, evidence-based practice, as is the development of competencies in informatics, data science, design, and systems thinking. Furthermore, an understanding of how local, national, and global structures, systems, politics, and rules and regulations contribute to the health outcomes of individual patients, populations, and communities will support students in developing agility and advocacy skills.

Additionally, effective advocacy requires consideration of the social needs of individuals, which are inextricably connected to structural determinants at the community, society, and policy level. Therefore, to affect the health of populations, nurses are called upon to make this broader, more integral connection between policies, systems, and environmental impact.

LEVERAGING COMMUNITY-ACADEMICPRACTICE PARTNERSHIPS

Didactic teaching provides nursing students with the conceptual foundation to achieve competency, whereas clinical practice allows students the opportunity to develop and demonstrate competency.¹³ To ensure effective clinical experiences, deliberate investments of time and resources are needed to support the development of mutually beneficial partnerships between community practice sites and academic institutions. This intentional work results in high-quality, positive experiences for students, practice sites, and clients alike.¹⁴

Evidence suggests that academicpractice partnerships positively affect outcomes for patients, staff, and student learners, providing a formalized means for translating evidence-based practice principles to improve clinical decision-making, increase staff knowledge of evidence-based practice and experiential learning, and inspire the growth of evidence-based population health initiatives.^{6,15}

Student learners immersed in academic-practice partnerships have unique opportunities to become experienced in evidence-based practice analysis and translation while growing their ability to become skilled, compassionate caregivers and attentive patient advocates. These partnerships provide opportunities to seek external funding to address population health concerns, build community capacity, and expand the existing public health nursing workforce. Overall, the published literature highlights the benefits of academicpractice partnerships to clinical agencies, school-based settings, ambulatory care, and health departments by providing an eager, competent student workforce to address individual, family, and community concerns.¹⁵ Although academic-practice partnerships have traditionally focused on health care environments, there is now an opportunity to invest ardently in 3-way community-academic-practice partnerships based in communities and community agencies. The priority for these partnerships is relationship building through the lens of equity, capacity building, and reciprocal

servicelearning benefits.

We encourage nursing faculty to pursue intersectoral partnerships beyond traditional clinical sites, exposing students to a wide variety of practice environments that deliver essential public health services. Examples of nontraditional partners include faith-based communities, where evidence has shown improved access to care and community capacity through the teamwork of nurses and community health workers.^{16,17} Partnerships with libraries promote community connections for those experiencing food insecurity, homelessness, and mental health crises¹⁸ while educating community and public health nurses on the application of evidence to inform practice.¹⁹ Additional partners could include commercial businesses, housing programs, governmental or nongovernmental organizations, transportation, and urban planners. By investing in unique partnerships, nurse educators challenge the stereotypical role of bedside nurse and affirm the upstream role of and place for nurses, who are bringing health to where people live, learn, work, play, worship, and age. Successful partnerships with sustainable outcomes will expand awareness of nurses' full scope of practice beyond the acute care setting, where many nursing schools and faculty currently limit their clinical training. A recent report issued 10 recommendations to prepare faculty to teach community and public health nursing, including the call to revise recruitment, hiring, orientation, and professional development practices to reflect public health nursing guidelines and competencies.²⁰ Developing structures and processes for successful community-academic-practice partnerships will strengthen clinical education and improve the preparation of the future public health nursing workforce. Additionally, the realities of structural determinants of health are more apparent in community settings, providing students with a real-world perspective about precursors to health outcomes and barriers to access.

In addition to providing learning opportunities for students, community-academic-practice partnerships are a mechanism for continuing professional development for the current community and public health nursing workforce across practice settings. Many community and public health nurses work in small, local public health departments unaffiliated with large academic institutions or hospitals and have limited access to evidence-based resources or financial support for professional development. Since 2017, the Nursing Experts Translating the Evidence project, an interprofessional collaborative effort between nurses and librarians, has been educating public health nurses on the acquisition, translation, and application of evidence to inform their practice.¹⁹ Through active community-academic-practice partnerships, community and public health nursing educators and governmental and nongovernmental public health agencies can build capacity for community and public health nursing practice for the future, as we continue to apply evidence-based, data-driven problem solving through the pandemic and beyond.

CONCLUSION

In schools of nursing across the country, administrators face dual expectations: managing faculty shortages and centering population health in curriculum revision focused on competency-based strategies.^{9,10} Given the small percentage of nurses who presently practice in community and public health, it is increasingly difficult to find faculty with expertise. However, instead of decreasing community and public health nursing clinical education hours and replacing them with more acute care clinical education hours, we urge schools of nursing to respond to the call for deeper investments in public health nursing, both in didactic and clinical courses, as outlined in this article.

Furthermore, we implore administration, accrediting bodies, and educators to audit the inclusion of public health nursing guidelines in curriculum development and to mandate continuing professional development through leading public health nursing organizations, as highlighted in the Future of Nursing 2020-2030 report.¹⁰

The time is right for the profession of nursing to influence the direction of health care delivery and health outcomes for populations and communities. Leading nursing organizations agree that population health and social determinants of health are drivers of change within the profession. May we not lose the opportunity to move forward boldly, not in appeasement but in authentic, robust curriculum reform that will shore up the frontline of prevention and propel the role of nurses and the profession of nursing from the bedside to the community. For nurses to be fully competent to address the social and structural determinants of health-in the context of all communities where 80% or more of health decisions happen in everyday life, work, and play-we must strengthen and reform the nursing curriculum to fully include these concepts and competencies. People, communities, and health systems are waiting

on us to do it differently. Public health nursing educators are the leaders who can influence this future. Our time is now. j&Acedil;PU

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K. L. Jones completed the literature review and initial conceptualization of the editorial, wrote core sections, and revised the editorial. L. A. Edwards provided critical feedback and initial conceptualization of the editorial, wrote core sections, and revised the editorial for logical flow. G. K. Alexander provided critical review with reorganization and revisions to clarify purpose and logical flow, and incorporated additional literature review and analysis in core sections to strengthen the editorial.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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Trauma-Informed Home Visiting Models in Public Health Nursing: An Evidence-Based Approach

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ABSTRACT (ENGLISH)

Traumatic experiences can have significant health effects, particularly when they are experienced during childhood. Structural determinants of health including environmental disasters and limited access to mental health services and affordable housing can contribute additional stress for parents with a personal history of childhood adversity. These factors can directly affect their children, contributing to intergenerational trauma. Pregnant people and families with young children are often referred to public health nursing maternal and child home visiting (HV) programs when

there are concerns about historical or evolving childhood trauma. The strict eligibility and participation requirements of existing evidence-based maternal and child HV programs can exclude families that have experienced or are experiencing childhood trauma and its effects and can limit innovation by public health nurses, a hallmark of the field. Therefore, we advocate and describe the implementation of the Trauma Informed Approach in Public Health Nursing (TIA PHN) model, which incorporates a trauma-informed approach into a traditional maternal and child HV program in 3 California counties. TIA PHN, which began enrollment in March 2021, involves public health nurses and community health workers and integrates program evaluations in pursuit of evidence-based status.

FULL TEXT

Headnote

Traumatic experiences can have significant health effects, particularly when they are experienced during childhood. Structural determinants of health including environmental disasters and limited access to mental health services and affordable housing can contribute additional stress for parents with a personal history of childhood adversity. These factors can directly affect their children, contributing to intergenerational trauma.

Pregnant people and families with young children are often referred to public health nursing maternal and child home visiting (HV) programs when there are concerns about historical or evolving childhood trauma. The strict eligibility and participation requirements of existing evidence-based maternal and child HV programs can exclude families that have experienced or are experiencing childhood trauma and its effects and can limit innovation by public health nurses, a hallmark of the field.

Therefore, we advocate and describe the implementation of the Trauma Informed Approach in Public Health Nursing (TIA PHN) model, which incorporates a trauma-informed approach into a traditional maternal and child HV program in 3 California counties. TIA PHN, which began enrollment in March 2021, involves public health nurses and community health workers and integrates program evaluations in pursuit of evidence-based status. (Am J Public Health. 2022;112(S3):S298-S305. <https://doi.org/10.2105/AJPH.2022.306737>)

Trauma, which includes adverse childhood experiences (ACEs), has long been recognized to have substantial negative effects on health and health behaviors across the life span. It is only in recent years that trauma has become recognized as a public health crisis that affects entire systems and communities across generations.¹ In the United States, evidence-based maternal and child home visiting (HV) programs have shown great promise for optimizing family health and, thus, reducing the longterm health-related effects of trauma.

Programs such as the Nurse Family Partnership and Healthy Beginnings are generally funded through county, state, and federal sources.²⁻⁴ These interventions require extensive research before they can be considered evidence-based and thus eligible to be supported by public funds and disseminated widely. They also perpetuate structural bias in that the counties and organizations that are already well resourced are the ones that are able to secure funding to implement and evaluate these types of programs.⁵ Furthermore, such requirements do not allow for flexible implementation of innovative approaches tailored to local needs and populations. As a result, health systems miss opportunities for public health nurses to have a positive impact on families experiencing trauma.

Since 2017, the Sonoma County (California) Field Nursing Team has been implementing the Trauma Informed Approach in Public Health Nursing (TIA PHN) HV program to mitigate toxic stress, improve resilience, and optimize health among low-income families that are at high risk for trauma and are experiencing medical or social challenges.⁶ Currently being piloted in 3 Northern California counties, the TIA PHN model is not yet considered evidence-based but represents a promising HV alternative for families affected by trauma. Here we describe the evolution of HV models and argue that innovation in addition to fidelity to evidence-based practice should be considered for HV and field nursing in the community. Furthermore, we suggest that support for interventions such as TIA PHN, which is evidence informed, can equip public health systems and nurses to respond more quickly to the crisis of childhood trauma, particularly in the most underserved communities.

BACKGROUND

Experiencing or being exposed to traumatic events during childhood can have substantial long-term effects on

children, families, and communities across the life span and across generations. Extensive research demonstrates that ACEs (defined as 10 forms of abuse, neglect, or household dysfunction before the age of 18 years) are both common and predict poor health and social outcomes in childhood and adulthood.⁷⁻⁹ The experience of trauma can result in stress responses that alter a child's biology and brain architecture, with long-term consequences on health including asthma, sleep disorders, and infections resulting in hospitalization.⁹ In addition, ACE exposure is correlated with high risks and poor outcomes in pregnancy, including greater odds of maternal depression, preterm birth, and fetal death.¹⁰

The effects of ACEs and the resulting toxic stress have been declared a public health crisis.¹ Trauma is not limited to ACEs, however, and can include community violence, homelessness, structural violence such as racism, environmental disasters driven by climate change, and global pandemics.¹¹

Screening for trauma and its consequences (e.g., toxic stress, posttraumatic stress disorder) can identify individuals most at risk for poor health and social consequences. Families that screen positive can be supported in accessing the care they need to address and mitigate trauma. Broad population screening of families for historical (parental) and evolving childhood trauma has gained acceptance, and research supports the acceptability of screening in clinical settings, including during pregnancy, as part of well-child pediatric visits, and by community-based nurses who work with parents of infants.¹²⁻¹⁶

In 2019, in response to growing data on the causal relationship between trauma and poor health, the surgeon general of California enacted a policy to guide implementation of ACE screening for children and adults in primary care settings. The ACEs Aware initiative provides reimbursement through Medicaid for screenings that are conducted in primary care settings as well as training and clinical protocols for settings that serve the Medicaid population. The goal of this policy initiative is to decrease ACEs and toxic stress by half within a single generation through statewide system change.¹⁷ Although this is a bold and important effort to change California's public health care system, limitations of screening within primary care settings exist.

MEETING THE UNIQUE NEEDS OF FAMILIES WITH TRAUMA

Screening for ACEs in primary care is feasible and acceptable, but not all individuals are seen within primary care settings, even publicly funded ones.^{18,19} In addition, simply screening for ACEs does not take into consideration the individual or family experience and the context in which trauma takes place (e.g., homelessness), nor does it mitigate or respond to evolving trauma within a family setting. Public health nursing, specifically maternal and child HV services involving a trauma-informed approach, is an ideal complement to primary care with respect to screening for trauma and responding to its consequences.

Traditional Home Visiting Services

Traditional maternal and child HV programs originated in the United States under a model of prevention and social justice with the goals of identifying medical, social, or safety needs early and linking families to community resources.²⁰ The first HV programs focused on improved maternal and infant health, universal kindergarten, and support for immigrant communities. Around the time of the civil rights movement, HV was an important component of efforts to address poverty and social inequities. Toward the end of the 20th century, HV was identified as a potential tool to prevent child abuse and neglect.²¹ Currently, maternal and child HV programs seeking government funding through the Maternal, Infant, and Early Childhood Home Visiting Program must implement evidence-based models focused on 6 prevention-based areas:

1. improving the health of mothers, newborns, and children;
2. preventing child maltreatment and reducing emergency room visits;
3. improving school readiness;
4. reducing crime and violence;
5. improving economic stability; and
6. improving referrals and coordination of community resources.²

Current State of Home Visiting Services

In recent years, attention has pivoted toward funding of and referrals for models that are considered evidence-based,

with the understanding that replicating services to model fidelity is more likely to result in positive outcomes. Several HV models have successfully demonstrated improved health and social status for enrollees, earning recognition as evidence-based models.²² Pediatricians have argued in favor of greatly expanding HV to families of young children through the use of available evidence-based models, with an endorsement of closer ties to primary medical home sites.^{21,23}

However, replicating model delivery to a scale that meets actual community needs can pose a challenge as fidelity measures move from the academic to the practice setting.²⁴ An analysis of data from Maternal and Infant Home Visiting Program Evaluation (MIHOPE) and MIHOPE-Strong Start studies of 4 evidence-based HV programs (delivered to 4229 families in 12 states and 2900 families in 17 states, respectively) confirmed benefits of selected early childhood and family health measures seen in the original studies. However, there was only limited benefit found in relation to expected birth outcomes and prenatal behavior, despite verification that services were delivered to fidelity.³ To our knowledge, these HV programs did not formally incorporate an ACE tool or a trauma-focused curriculum. We are not aware of any studies that have evaluated curricula specifically addressing the effects of trauma on maternal and child HV participants.

Inequities in access to evidence-based programs. Although previous research has shown that HV programs in general have demonstrated effectiveness in the provision of education, advocacy, and resources to families who are at high risk for adverse experiences, there are few data to support whether individual programs directly address the needs of families who have already experienced or are currently experiencing adverse events.²⁵ Furthermore, many families who would benefit from HV services are often ineligible or unable to participate in programs with proven efficacy because many of them have strict eligibility requirements that are challenging for families in crisis.²⁶ Of the 19 evidencebased maternal and child HV programs eligible for funding from the federal Maternal, Infant, and Early Childhood Home Visiting Program, 7 either require or strongly recommend that clients be first-time parents enrolling early in pregnancy; however, families experiencing historical and emerging trauma are less likely to access prenatal care, making necessary early enrollment very challenging.²⁷

Indeed, there are clear demographic disparities between those being served by evidence-based programs and those enrolled in emerging models; for example, 53% of clients enrolled in emerging models are Latinx/Hispanic (as compared with only 30% of those in evidencebased models), and 55% speak English as their primary language (as compared with 76% of those in evidence-based models).²⁸ These differences underscore the need for more equitable access to evidence-based HV services for vulnerable families. Families with historical and ongoing trauma may benefit most from tailored services that specifically address adverse childhood experiences. Emerging models providing a trauma-related curriculum in their approach offer an alternative to vulnerable families unable to meet the inclusion and participation criteria of existing evidence-based HV programs. It is hoped that, as these emerging models gather evidence to support their effectiveness, a greater number of evidence-based programs will extend to a wider population of diverse families in need of services.

Family First Prevention Services Act. The Family First Prevention Services Act of 2018 seeks to prioritize upstream interventions for families in which children have suffered maltreatment through expansion of referrals to evidencebased programs instead of to foster care.²⁹ However, in an examination of the effectiveness of available evidencebased models in addressing the complexities of this high-risk group, Testa and Kelly questioned whether unintended consequences could arise for subsets of the population (e.g., families living in poverty).³⁰ In addition, although strict adherence to fidelity measures and targeted eligibility has been cited as a factor in the success of evidence-based models, flexibility to address the root causes of parental challenges offers a more inclusive approach than filtering HV participants through narrow criteria known to correlate with effectiveness in research settings.^{31,32}

Furthermore, financial constraints on publicly funded preventive social and medical programs coupled with limited HV resources have resulted in the majority of referrals to HV services involving families referred after a negative medical or social outcome has already occurred, including challenging life circumstances.²⁰ These very experiences and circumstances, however, can make it difficult for families to participate in HV programs because of either

participation requirements (e.g., meeting on a set schedule) or eligibility requirements (e.g., being a first-time parent).

Many referrals to the Sonoma County Field Nursing Program are for families that have already encountered significant life stressors and traumas. From 2018 to 2021, more than one third of families referred were experiencing homelessness, and more than 40% were experiencing substance use. In fiscal year 2020-2021, half of families referred were experiencing interpersonal violence at the time of their first home visit, and 54% were experiencing current mental health concerns (as compared with 34% in 2018-2019 and 33% in 2019-2020). This shift from preventing trauma to responding to it indicates a new paradigm for HV programs. A unique area of focus regarding family challenges is parents' own childhood trauma history.

Addressing parents' childhood trauma histories. Several HV programs have piloted use of ACE questionnaires with data collected by home visitors, and findings have shown that higher child ACE scores are linked to developmental delays and that higher adult scores are correlated with postpartum depression.^{33,34} An examination of the nuances of social workers and PHNs delivering ACE questionnaires to parents receiving home visits revealed that higher ACE scores corresponded to positive depression screening responses.³⁵ Beyond the utility of ACE data in facilitating an understanding of the sequelae of trauma, ACE questionnaires can promote reflection of parents' and caregivers' experiences and what they wish to mitigate and prevent in their own child's experience. Therefore, we propose that incorporating adult ACE screening combined with a traumainformed curriculum for parents receiving HV services represents an innovative approach to meeting the needs of high-risk families that are not adequately served through existing evidence-based models.

TRAUMA-INFORMED APPROACH IN PUBLIC HEALTH NURSING

The Sonoma County Field Nursing Team developed the TIA PHN model in response to an increase in unmet needs among clients and as a means of addressing the crisis-driven nature of many of the referrals coming into the program.³⁶ TIA PHN is an example of an innovative, evidence-informed maternal and child HV approach that acknowledges and addresses the effects of toxic childhood stress to break the cycle of intergenerational trauma.⁶ In 2017, rates of homelessness, intimate partner violence, and mental health concerns among families enrolling in the county's Field Nursing Program increased by 17% to 28% in the months immediately following the Sonoma Complex Fire, which destroyed more than 5300 homes and significantly affected the community's overall economy and safety net.³⁷ Since 2017, the county has experienced nearly annual wildfires, flooding, and the COVID-19 pandemic. Each of these disasters has had a significant social and medical impact on the families served by the Field Nursing Team. In response, the TIA PHN model incorporates trauma-informed principles in all client and staff interactions, the delivery of the TIA PHN model curriculum, and conversations about ACEs with optional use of the original 10-item ACE questionnaire while continuing to implement the case management components employed in most evidence-based models: voluntary participation, development of an individual service plan, mental health screenings and referrals for adult caregivers, and developmental screenings and referrals for children. The participants consist of families in 3 counties referred by medical providers and community-based organizations to the maternal and child HV sections of public health departments; families included are those identified as having a high-risk pregnancy and those experiencing trauma (past or current).

Multidisciplinary Team

An integral component of the TIA PHN model is the use of a multidisciplinary team consisting of a public health nurse (PHN) and a community health worker (CHW). Use of such a team has been shown to improve participants' perception of the help and education they receive and to increase participants' reports of improved self-confidence and feeling that they have someone to talk to who cares.³⁸ The TIA PHN model acknowledges the need for nursing expertise outside of the clinic setting to identify and support families with complex medical needs (e.g., low birthweight, preeclampsia) and to provide and reinforce education surrounding medical risks associated with pregnancy and the postpartum period (e.g., sepsis, postpartum hemorrhage). The model also recognizes the need for CHWs to help support enrolled families with culturally competent health and safety education, demonstration of the use of social and medical services, and provision of assistance such as transportation to medical appointments.

Currently, however, there are no evidence-based maternal and child HV programs that incorporate the collaborative efforts of a PHN-CHW team.⁴

Providing Trauma-Informed Health Education

To address historical and evolving traumas experienced by enrolled families, the TIA PHN model incorporates a curriculum aimed at providing traumainformed health education. The curriculum was developed after an extensive review of the literature on ACEs, toxic stress, and trauma and their correlations with poor health outcomes. It provides both content and guidance for engaging in conversations with clients in the following overarching areas: (1) brain development and ACEs, (2) pregnancy and the postpartum period, and (3) mitigation of toxic stress through healthy eating, exercise, sleep, relationships, mental health, and mindfulness.³⁶ Rather than relying on a didactic approach to education, the curriculum employs motivational interviewing techniques to encourage clients' selfreflection and participation in the information being shared. Clients are encouraged to identify existing strengths and, in collaboration with the PHN or CHW, identify goals related to each topic that they would like to achieve. These goals are then supported by the PHN and CHW through additional education and linkages to local resources. Although the original 10-item ACE questionnaire is offered to adult clients, neither its completion nor reporting of scores is required. Instead, the focus of the conversation is on the effects that ACEs have on long-term health and the ways in which families can empower themselves to mitigate these effects and improve health. TIA PHN staffare encouraged to use their discretion as to the timing and frequency of delivery of the model curriculum. This flexibility in the curriculum structure acknowledges that many home visits occur as a family encounters a crisis that inhibits their ability to be receptive to education or engage in self-reflection.

Proposed Evaluation

After initial pilot work in Sonoma County, the TIA PHN model is currently in the midst of an expanded 30-month pilot phase in the counties of Napa, San Francisco, and Sonoma.⁶ The goal of this work, which involves a partnership with a nursing academic partner and is funded by the California Home Visiting Program, is to advance the TIA PHN model from evidence-informed to evidence-based status so that it can be disseminated widely and supported through government funding. The program evaluation is designed to answer a pair of questions: First, does implementation ofthe proposed program result in improved family health for program participants? Second, is there a difference in health and health care outcomes between clients who receive the TIA PHN intervention and comparable Medi-Cal recipients in the 3 counties? Over the course ofthe 30-month pilot, it is estimated that 750 families will be reached across the study counties. Data for the comparison group will be derived from Medi-Cal administrators in each county as well as other population-based information.

Client-level outcome data from program participants will be compared with a demographically similar Medicaid (Medi-Cal) nonparticipant population in the 3 counties. Outcomes of interest include rates of child immunization; contraception; linkage to primary medical and dental care; insurance coverage; rates and mean durations of breastfeeding; rates of screening, identification, and referral for perinatal mood disorders (e.g., depression); and rates of screening, identification, and referral for child developmental delays.

All indicators are standardized across counties and can be compared with county-level population data already being collected by Medicaid administrators or programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children. Indicators are recorded by HV staff as clients exit the program. In addition, mean intervention durations will be tracked, along with whether, when, and how often clients receive the 3 overarching elements ofthe TIA PHN curriculum described earlier. Data will be collected by PHNs and CHWs as they deliver services and complete the intervention components and will be documented in the electronic health record system of each county. Indicators for clients who have completed the program will be abstracted quarterly from each county electronic health record; data on clients who were lost to follow-up or who chose not to continue their participation in the program will also be tracked.

In addition, the team will examine data describing the reach and recipients ofthe TIA PHN model and differences with Medi-Cal participants with respect to age, stage at enrollment (prenatal, postpartum/newborn, pediatric), gender identity, sex at birth, sexual orientation, racial/ethnic identity, language spoken at home, numbers of pregnancies

and live births, and reason for referral, including housing insecurity, substance use, mental health concerns, intimate partner violence, and medical fragility. These data will help to identify whether the TIA PHN program is achieving its goal of reaching the most vulnerable populations. Preliminary data from the 3 counties show that 42% of enrollees between March and October 2021 reported a history of mental health concerns, 40% were homeless or housing insecure, approximately 25% reported intimate partner violence, and more than 20% reported current or past substance misuse (Table 1).

Two essential components of the TIA PHN model are the flexibility that it allows the PHN-CHW team in responding to the needs of clients and the discretion it affords them in determining the appropriate timing for delivery of various aspects of the intervention. Delivery of the ACE conversation, routine screenings, and the curriculum will be tracked for each participant enrolled. Other fidelity measures include recording of standardized training and assessment of staff participation in peer support (one on one and in groups). PHN and CHW staff will contribute qualitative data on facilitators of and barriers to implementation as well as information about their own experiences in delivering the program, including tailoring it to clients' needs. If feasible, the team will also conduct in-depth qualitative interviews with a subset of program clients to understand their experiences, with a particular focus on ACE conversations. These data will contribute to an overall understanding of the potential longer-term feasibility and effectiveness of more in-depth ACE conversations in contrast with simple ACE screening in primary care.

MOVING THE FIELD FORWARD

Public health researchers and policymakers in California are prioritizing the need to screen for ACEs within primary care and other health care settings. The California Department of Public Health has enacted a policy in which all Medi-Cal patients who access primary care in the state will be screened for ACEs. Although this is an important state-level policy, there is a need to offer interventions for families with historical or emerging trauma that may benefit from greater assistance to achieve healthy outcomes; interventions within medical settings are in early development, and an evidence base has not yet been established.

Because of their close relationships with families and the length of time afforded to each visit, home visitors are uniquely poised to address the health and social needs of families that have been exposed to adversity.³⁹ Current evidence-based HV programs primarily cater to families before situations of crisis (e.g., enrolling only first-time parents early in pregnancy); therefore, it is less likely that those programs will identify and remedy situations of late prenatal medical care, fetal exposure to substances, and risk of child abuse or neglect in families with prior child welfare involvement. In addition, these programs lack precise curricula focused on historical and emerging trauma. In response, Sonoma County public health nurses developed a model that brings a trauma-informed approach to public health nursing to a community that has experienced devastating environmental crises caused by the Tubbs, Nuns, and Pocket Fires (2017); the Kincadee Fire (2019); and the Glass and Lightning Complex Fires (2020). The TIA PHN model incorporates ACE conversations with optional screening facilitated by a multidisciplinary HV team of PHNs and CHWs. The team's ability to address trauma in a bicultural and bilingual manner can promote resilience in families with young children in which historical or emerging trauma has been identified.

The TIA PHN model is an example of an intervention building on the evolving work of public health nursing, an ethos embodied for more than 100 years to meet the needs of the populations served.⁴⁰ As public health nursing HV teams seek to employ evidence-based responses for families identified by the California ACEs Aware campaign, rigorous scientific evidence is needed to prove the effectiveness of existing practices for this population. According to preliminary findings from the TIA PHN pilot, clients achieved 80% to 100% of health-related outcome goals when receiving the intervention an average of 12 times over approximately 6 months.⁶ The TIA PHN model represents an evidence-informed approach in the process of evaluation with aspirations of eventually becoming an evidence-based model that meets the needs of families with historical and emerging trauma. In line with our state's goals, the program hopes to have an impact with respect to disrupting intergenerational trauma. >4JPM

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

No protocol approval was needed for this research because the data reported are regular service data collected from all home visiting clients enrolled in the study program.

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DETAILS

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Culturally Safe Nursing Care for Black Sex Workers in the Greater Chicago Area, 2020–2021

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ABSTRACT (ENGLISH)

Complex structural and social factors have created health inequities for Black sex workers. Black people, including those engaged in transactional sex, report leaning on spiritual beliefs to guide health-related decision-making, including whether to get the COVID-19 vaccine. Public health nurses can improve the health of Black sex workers through culturally safe care, which may include a community-stated vision of spiritual support. (Am J Public Health. 2022;112(S3):S288-S291. <https://doi.org/10.2105/AJPH.2022.306836>)

FULL TEXT

Headnote

Complex structural and social factors have created health inequities for Black sex workers. Black people, including those engaged in transactional sex, report leaning on spiritual beliefs to guide health-related decision-making, including whether to get the COVID-19 vaccine. Public health nurses can improve the health of Black sex workers through culturally safe care, which may include a community-stated vision of spiritual support. (Am J Public Health. 2022;112(S3):S288-S291. <https://doi.org/10.2105/AJPH.2022.306836>)

Black sex workers (SWs) experience identity-based stigma resulting from the criminalized nature of sex work and the intersection of their minority identities (i.e., race, sexual orientation, gender identity).¹ Moreover, systemic barriers to culturally safe care, such as lack of care provider diversity or awareness, perpetuate inequities experienced by Black SWs. Public health nurses (PHN) are uniquely poised to combat stigma and provide culturally safe care to SWs.

Cultural safety, initially articulated by Irihapeti Ramsden, explicitly addresses issues of historical and ongoing oppression and power differences that manifest through our institutions and clinical practices.² Nursing and health equity scholars continue to use and apply this model, most recently adapting it for clinicians working with lesbian, gay, bisexual, transgender, queer, intersex, asexual plus (LGBTQIA+) people. Mukerjee et al.³ identified five guiding tenets of culturally safe care:

1. partnerships,
2. personal activities of daily living,
3. patient centering,
4. prevention of harm, and
5. purposeful self-reflection.³

Committing to culturally safe care involves learning about people, using effective communication, and adopting practices aligning with community needs. This may mean including elements of religion to facilitate community-informed public health interventions to reduce barriers to preventive care,⁴ like COVID-19 vaccinations, for some Black SWs.

INTERVENTION

To address inequities and support culturally safe health care innovations, we partnered with Howard Brown Health, a federally qualified health center, to complete a qualitative study with Black SWs (n = 16) living in Chicagoland. Our community advisory board, co-facilitated by a respected community member, comprises current and former SWs, outreach workers, caseworkers, health care providers, and researchers who iteratively developed a qualitative interview guide to capture SWs' physical, sexual, and emotional health needs; conceptualizations and experiences of safety; and COVID-19-specific questions. Current and former SWs were trained to conduct interviews. This analysis focuses on themes related to religion and COVID-19.

PLACE AND TIME

This qualitative assessment of health-related needs and experiences of Black SWs in the greater Chicago area occurred from December 2020 through April 2021, the height of COVID-19.

PERSONS

The population included Black adults from Chicago who exchanged sex (oral, anal, or vaginal) for something of value (resources, money, or survival needs) within the past 12 months. Participants' ages ranged from 23 to 42 years (mean = 30.8). More than 50% were LGBTQIA+. Most had at least some college education (Table 1).

PURPOSE

We used qualitative interview data to understand what cultural safety practices would look like for PHN caring for Black SWs. We examined how a cultural safety framework can be used by PHN to inform how factors, such as violence, stigma, and criminalization, which have been further exacerbated by the pandemic, had an impact on Black SWs' ability to practice harm reduction and health-promotion behaviors.⁵ Historically, Black Americans have managed disease threats by turning to religion, defined here as the role of church or clergy, belief in a higher power, or support found through spiritual practices such as praying, yoga, meditation, and song.⁶ We explored how Black SWs in Chicago have used religion to guide coping and health-related decisionmaking during COVID-19. We highlight how infusing religion within community-based health interventions can be a cultural safety practice for PHN.

IMPLEMENTATION

We reached individuals within this vulnerable population by using clinic-based flyers, social media (e.g., Instagram), private community e-mail lists, and word of mouth. Participants gave consent and received a monetary incentive (\$50) for participation. Interviews were conducted over a secure institutional Zoom platform. Trust in a higher power emerged as a key theme across participants of various ages, backgrounds, sexual orientations, and gender identities.

Regarding COVID-19, participants spoke about spiritual beliefs and practices they used to cope. For example, when asked about their concern about contracting COVID-19, those not concerned explained that a higher power predetermined the likelihood of transmission. A 28-year-old transgender woman said, "I know God is the number one factor in any situation.... If he wants you to get it [COVID-19], he's going to allow you to come in contact with it. If he don't, he's not going to allow you to have it." When we inquired about COVID-19 vaccination, participants used this same theological argument to assert how the vaccine was part of God's plan and suggested that faith in the vaccine is faith in God.

In response to questions about emotional health and safety, participants described ways that God provides guidance and affirmation to counteract danger. A 31-year-old cisgender man said, "Religion centers me ... surrendering to a power higher than myself and knowing that there are things at work that are bigger than me is very, very liberating."

EVALUATION

Participant responses reflected three core themes. First, in alignment with other research, religious practices provide a foundation of support for SWs with intersecting health needs. Su found that religious coping was associated with decreased posttraumatic stress disorder and increased psychological well-being, highlighting the impact of religion on health outcomes.⁷

Second, participants highlighted the power of prayer in maintaining peace, psychological well-being, and security. This finding mirrors the work of Shaw, who examined populations at risk for HIV (including SWs) in Malaysia and identified that prayer served as a conduit for health assistance, and religion served to support care for their health.⁸ The third core finding underscores how mistrust in medical institutions, stemming from a long-standing history of medical abuse of Black bodies, has been mitigated by religion.⁹⁻¹¹ As stories of maltreatment have been passed down from generation to generation, stories of protection by Jesus, the church, and family prayer have been passed down, too. Together, this builds confidence in religion while undermining potential benefits of scientific advances.^{4,9} Given this complex relationship between medical mistrust and religion, nurses providing outreach must understand how historical trauma, religion, and disease prevention intersect for Black SWs to facilitate care in keeping with spiritual practices.^{10,11} To inform community-based, trauma-informed, culturally safe interventions for Black SWs, more research is needed to evaluate religion's role in coping and medical decision-making.

This work has limited generalizability given the qualitative focus on a small population of Black SWs in Chicago. Despite limitations, this study expands understanding of the ways religion may affect COVID-19 health beliefs and behaviors among Black SWs. Findings from this study will help pave the way for culturally safe, community-informed public health interventions moving forward.

ADVERSE EFFECTS

We observed no adverse effects.

SUSTAINABILITY

At the forefront of holistic care, public health nurses are uniquely positioned to combat stigma and provide culturally safe care for Black SWs.³ This study exemplifies how nurses can center community voices, learning about how a community integrates scientific advances such as COVID-19 vaccines within a vision of religious and spiritual support. As expert patient partners, nurses must understand and accept that communities' confidence in religion may outweigh distrust in a medical system rife with oppression and injustice.¹² Integrating questions, informed by the cultural safety framework, regarding the impact religion has on health allows PHN to better understand patients' lives. Nurses' self-reflection can uncover presumptions for health care decision-making and return to a focus on harm prevention, especially for communities experiencing structural injustice and health inequities.¹³

PUBLIC HEALTH SIGNIFICANCE

Cultural safety requires purposeful selfreflection consisting of a lifelong process of exploration that fosters trust and addresses power imbalances.³ Educating nurses through a cultural safety framework is crucial to guide nurses in building relationships with individuals from diverse communities and sets the foundation for conducting holistic assessments that include an exploration of religion. ÅfPU

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R. B. Singer contributed to the conceptualization and design of the work as well as acquisition, analysis, and interpretation of data for the article. N. Crooks contributed to conceptualization and design of the work as well as acquisition and interpretation of data. A. K. Johnson, A. U. Smith, and L. Wesp contributed to conceptualization and design of the work as well as analysis and interpretation of the data. A. Karczmar analyzed and coded data and contributed to preliminary article development. J. Stamps was a peer contributor to conceptualization and design of the work in addition to the acquisition and interpretation of the data. B. Pardes worked with the data and article to support a major revision. C. L. Patil and A. K. Matthews served as mentors throughout the process and contributed to the conceptualization and design of the work as well as the analysis and interpretation of data, and article editing and revisions. All authors drafted and revised the article. All authors have approved the contents of this article and have agreed to be accountable for all aspects of the work.

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Public Health Nursing's Impact on Strengthening Community Resilience

Waters, Catherine M, RN PhD ¹ ¹ Department of Community Health Systems, School of Nursing, University of California, San Francisco

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Although there is not a universal definition of community resilience, research indicates the positive impact resilience can have on a community's health and quality of life, particularly if it is bolstered and buffered by accessible, equitable, and sustainable systems.¹ The collective resilience of an already strained public health system was tested during the COVID-19 pandemic. Beginning with the Henry Street Visiting Nurse Service in 1895, public health nursing was envisioned by Lillian Wald and Mary Brewster to promote community resilience, in cooperation with multisectoral private-public partnerships, by meeting people where they are without blaming them for their problems.²

Two articles in this supplement demonstrate the impact of public health nursing practices and policies on strengthening community resilience at multiple levels of influence: adaptive (ability to adjust), absorptive (ability to cope), anticipatory (ability to predict and be proactive), and transformative (ability to transform systems to deal with change and uncertainty).³ Guided by the Community Resiliency Model, Duva et al. (p. S271) describe the impact of a nurse-led public health intervention designed to meet population mental health needs during the COVID-19 pandemic. In partnership with cross-sector entities in Georgia, nurses trained the public to build community resilience capacity against stress from adversity or trauma. Guided by the Public Health 3.0 and communitybased participatory frameworks, Austin et al. (p. S275) describe a communityvalidated mobile application that provided actionable data to communities to address substance use during the COVID-19 pandemic, shifting the focus of the communities from a deficit-based approach to a strength-based or resilience approach.

FULL TEXT

Although there is not a universal definition of community resilience, research indicates the positive impact resilience can have on a community's health and quality of life, particularly if it is bolstered and buffered by accessible, equitable, and sustainable systems.¹ The collective resilience of an already strained public health system was tested during the COVID-19 pandemic. Beginning with the Henry Street Visiting Nurse Service in 1895, public health nursing was envisioned by Lillian Wald and Mary Brewster to promote community resilience, in cooperation with multisectoral private-public partnerships, by meeting people where they are without blaming them for their problems.²

Two articles in this supplement demonstrate the impact of public health nursing practices and policies on strengthening community resilience at multiple levels of influence: adaptive (ability to adjust), absorptive (ability to cope), anticipatory (ability to predict and be proactive), and transformative (ability to transform systems to deal with change and uncertainty).³ Guided by the Community Resiliency Model, Duva et al. (p. S271) describe the impact of a nurse-led public health intervention designed to meet population mental health needs during the COVID-19 pandemic. In partnership with cross-sector entities in Georgia, nurses trained the public to build community resilience capacity against stress from adversity or trauma. Guided by the Public Health 3.0 and communitybased

participatory frameworks, Austin et al. (p. S275) describe a communityvalidated mobile application that provided actionable data to communities to address substance use during the COVID-19 pandemic, shifting the focus of the communities from a deficit-based approach to a strength-based or resilience approach.

These holistic, asset-based practical solutions employed technology in novel ways to address existing and emerging public health issues caused by an unexpected pandemic. Nurses know better than most other health professionals where the public health safety net system works and has plasticity and where the system does not work. Public health nurses know how to improve quality of care and serve diverse populations and communities more effectively and efficiently and in an egalitarian way. Too often, public health uses unnecessarily hierarchical and siloed approaches that focus on the deficits of populations, especially vulnerable or underrepresented populations, and on how population deficits contribute to the detriment of communities. Not many people intentionally want to be sick or intentionally want to engage in unhealthful behaviors, such as substance use, that negatively affect them and their communities. Not everyone, however, believes that they have volition and autonomy over circumstances in their lives.

Community participation gives communities a collective voice to provide feedback about public health nursing interventions that will affect the health of their citizenry. Although it may feel time intensive to engage with the community on solutions instead of providing a solution to the community, such an investment could have significant multigenerational health impacts: current generational accumulated stress, adversity, and trauma could be minimized, and future generational community resilience could be maximized to prevent and protect against accumulated stress, adversity, and trauma. Sometimes grassroots public health efforts are what is needed to solve community problems and protect community assets. Sometimes it does "take a village" to strengthen community resilience. This is the essence of the work of Duva et al. and Austin et al. They provide a blueprint for public health nursing interventions that built community resilience capacity against stress from psychological trauma and substance use during the COVID-19 pandemic.

We invite public health nurses to reimagine accessible, equitable, and sustainable public health systems by developing the leadership capacity of local communities to strengthen community resilience. They can do so by such means as organizing consumer or community advisory boards, encouraging community participation in private and public partnerships, and inspiring communities to provide testimonials on their efforts to their local public health commissions and policymakers.

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DETAILS

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Mobilizing Support for the Future of Advanced Public Health Nursing Education

Johnson, Karen E, RN, PhD ¹ ¹ School of Nursing, University of Texas, Austin

[ProQuest document link](#)

ABSTRACT (ENGLISH)

As a public health nurse educator, I was deeply disappointed when our advanced public health nursing (APHN) master's program shuttered in the late 2010s. I therefore found Harris et al.'s description (p. S231) of the evolution of their APHN program and health policy specialty at the University of California San Francisco (UCSF) to be an inspiring example that should compel nursing education leaders nationwide to consider how they can garner support for APHN education in their own institutions and communities. As evidence mounts regarding the influence of social determinants of health and our world continues to endure a time of upheaval that has magnified inequities on multiple fronts (e.g., the COVID-19 pandemic, climate change, racial injustice, violent geopolitical conflicts), our moral obligation to prepare a workforce that can effectively address structural drivers of health is stronger than ever. If nursing is to reach its potential in influencing health equity, we must teach nurses how systems outside the human bodywork (e.g., political systems) as well as how systems within the human body work (e.g., the cardiovascular system). We cannot do this without nursing faculty who have advanced preparation in public and population health nursing.^{1,2}

Although analyzing the future of APHN education is not their primary purpose, Harris et al. briefly recommend expanding the number of APHN and policy programs nationwide. Their recommendation—which I wholeheartedly support—compels me to reflect on and amplify what others have said regarding the state of APHN education, including our struggle within nursing to recognize the value of the APHN specialty.^{2,3} If nurses are to effectively step up as the systems-level practitioners that this pivotal point in history demands, we must begin by advocating for support for APHN education and the value of the specialty from both within and outside the profession.

FULL TEXT

As a public health nurse educator, I was deeply disappointed when our advanced public health nursing (APHN) master's program shuttered in the late 2010s. I therefore found Harris et al.'s description (p. S231) of the evolution of their APHN program and health policy specialty at the University of California San Francisco (UCSF) to be an inspiring example that should compel nursing education leaders nationwide to consider how they can garner support for APHN education in their own institutions and communities. As evidence mounts regarding the influence of social determinants of health and our world continues to endure a time of upheaval that has magnified inequities on multiple fronts (e.g., the COVID-19 pandemic, climate change, racial injustice, violent geopolitical conflicts), our moral obligation to prepare a workforce that can effectively address structural drivers of health is stronger than ever. If nursing is to reach its potential in influencing health equity, we must teach nurses how systems outside the human

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The evolution of UCSF's APHN and health policy programs over the last two decades is a bright spot in what has otherwise been a bleak period for APHN education nationwide. For decades, scholars have warned that the public health nursing specialty was at risk of extinction because of external and internal pressures that have indeed caused APHN graduate programs and the public health nursing workforce to dwindle overtime (e.g., biomedicalization and emphasis on direct care to individuals, proliferation of doctor of nursing practice programs, faculty shortages, stagnant funding for public health).^{2,3} With the recent releases of the Future of Nursing report and the new American Association of Colleges of Nursing (AACN) Essentials-both of which emphasize health equity and social determinants of health-we cannot allow the APHN specialty to disappear if nursing is to be an influential player in addressing health inequities.

Harris et al. discuss how student demand was a factor in the evolution of their program. This reminded me of what I heard in conversations with public health nursing experts as a research manager for the Future of Nursing report: a market-based approach alone, where we passively wait for student demand to drive the proliferation of APHN programs, is insufficient to meet societal needs for a nursing workforce that addresses health equity at a systems level. To be sure, interest in public health broadly has grown even as APHN programs have dwindled,³ suggesting that interest in APHN will exist if we can harness it. We must articulate a clear vision for APHN education, advocate for resources to support it (e.g., increased Health Resources and Services Administration funding), proactively recruit traditional and second degree students who are interested in public health into the specialty, and ensure there are jobs and leadership opportunities in education, research, policy, and practice waiting for them upon graduation.

This latter point requires us to address the challenges facing our specialty within public health systems too, where low salaries and benefits relative to nurses in acute care, few public health nurses in leadership roles-particularly those from diverse backgrounds-and limited opportunities for promotion limit enticing employment opportunities that can help drive demand for APHN education.⁴ Failure to proactively create and support such opportunities means we lose out on the benefits of nursing leadership, as can be seen from evidence suggesting that communities where local health departments had a nurse as their lead executive experienced greater improvement in community health outcomes than those with a lead executive who was not a nurse.^{4,5}

Programs such as UCSF's will be at the forefront of preparing nurses for public health leadership roles, and advocating for the very policies needed for the APHN specialty to proliferate so that society can benefit from its expertise (e.g., innovative ways of funding public health by governmental and nongovernmental organizations; increased research funding from the National Institutes of Health, the Centers for Disease Control and Prevention, and others to support science exploring APHN effectiveness; support from foundations and other organizations for mentoring and residency programs that can further develop APHN leadership potential postgraduation).⁴ In nursing education, where we pride ourselves on being innovative leaders, we must get creative in how we leverage the wealth of resources across the campuses on which we teach. We need to create cutting-edge programs and community partnerships in public health to prepare a nursing workforce that is ready to step into policymaking spaces to advocate for health equity and the critical role of APHNs in achieving it. APHN faculty cannot achieve this alone; we all must value what the specialty can offer our profession and the public. Jfm

Sidebar

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DETAILS

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A Community-Based Participatory Intervention in the United States Using Data to Shift the Community Narrative From Deficits to Strengths

Austin, Robin, RN-BC, PhD, DNP, DC; Rajamani, Sripriya, PhD, MBBS, MPH; Jones, R Clarence, MEd; Robinson, Kelly, RN, BSN; Eder, Milton, PhD

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ABSTRACT (ENGLISH)

With Minneapolis, Minnesota, partners, we developed a community-based participatory intervention using a mobile health application to provide actionable data to communities. More than 550 participants completed the survey. Key messages included strengths in our homes, neighborhoods, and faith communities. Key challenges were related to substance use and sleeping. We jointly conducted virtual community meetings such as webinars, Facebook Live shows, and online newsletters to begin to shift the community narrative from deficits to whole-person health, including strengths. (Am J Public Health. 2022;112(S3):S275-S278. <https://doi.org/10.2105/AJPH.2022.306852>)

FULL TEXT

Headnote

With Minneapolis, Minnesota, partners, we developed a community-based participatory intervention using a mobile health application to provide actionable data to communities. More than 550 participants completed the survey. Key messages included strengths in our homes, neighborhoods, and faith communities. Key challenges were related to substance use and sleeping. We jointly conducted virtual community meetings such as webinars, Facebook Live shows, and online newsletters to begin to shift the community narrative from deficits to whole-person health, including strengths. (Am J Public Health. 2022;112(S3):S275-S278. <https://doi.org/10.2105/AJPH.2022.306852>) In alignment with Public Health 3.0, we community members and nurses worked in partnership for communities to obtain timely and reliable community data for narrative development using a community-validated mobile health (mHealth) application (app).

INTERVENTION AND IMPLEMENTATION

Our long-term goal was to address health inequities by empowering communities with their own data to begin to shift the self-perceived community narrative from deficits to that of a whole-person, strengths-based perspective.^{1,2} Such narrative development underlies successful community transformation, and individuals benefit from community environments that buffer or mitigate challenges.³

Definitions that guided intervention development were as follows:

- * Public Health 3.0 is a partnership in which leaders serve as chief health strategists, partnering across multiple sectors and leveraging data and resources to address social, environmental, and economic conditions that affect health and health equity.¹
- * Community resilience is the sustained capacity to cope, strive, and be supported through equitable buffers that address sources of acute and chronic stress.³
- * Narrative shifts are essential to influencing our perceptions of who deserves empathy or support, and who does not, by examining the systemic barriers to resilience and the opportunities to reshape the landscape to overcome those barriers.²
- * Whole-person health consists of environmental, psychosocial and emotional, physical, and health-related behavioral aspects of health.⁴
- * Strengths are health assets: skills, capabilities, actions, talents, and potential in each family member, each family, and the community.^{4,5}

Community members (individuals and organizations) and nurses (community members, faculty, and students) committed to a shared goal of making valuable local data available and accessible to the community.¹ We agreed that the data should incorporate strengths and resilience along with social and behavioral determinants of health and related challenges (whole-person health).⁶⁻⁸ We chose a research-ready mHealth app for data collection with a consent page and 42 brief health assessments of strengths, challenges, and needs across all of health (Figure 1 and Figure A, the latter available as a supplement to the online version of this article at <https://www.ajph.org>). The app provides a personalized summary report for each participant, and aggregate data may be viewed in a community dashboard.

It incorporates a simplified version of the rigorous standardized multidisciplinary health terminology and instrument, the Omaha System.⁹ The Omaha System has been used for two decades by public health nurses and others to understand whole-person health of diverse populations.⁹ Over a series of meetings discussing health priorities, community members decided to collect data for 13 of the 42 Omaha System assessments (bold assessments in Figure 1).

The Omaha System exists in the public domain and may be viewed online at omahasystem.org.¹⁰ The mHealth app is freely available for use in clinical and research settings through the University of Minnesota office for technology commercialization.¹¹

We surveyed community members during neighborhood COVID-19 testing events. Adults accessed the survey by computer, tablet, or smartphone and received a \$10 gift card upon completion. Many shared the survey link with

acquaintances. This unexpected sharing of the virtual survey link by local participants resulted in data submissions from more than 550 participants, split evenly between local neighborhoods and elsewhere (New York to California). We organized and interpreted the data together with community members at three community events. We jointly conducted community meetings using multiple virtual modalities, such as webinars and Facebook Live shows, and disseminated our findings in online newsletters.

PLACE, TIME, AND PERSONS

In the Minneapolis, Minnesota, metro area during Fall 2020, we convened numerous stakeholders to plan and implement the intervention. Stakeholders included an organization promoting the health of persons of color, a nursing organization of persons of color, an organization providing educational support for vulnerable young children, a neighborhood council, the local governmental health department, individuals in the community, and nursing students and faculty.

PURPOSE

In partnership with communities, the purpose was to provide actionable data to communities to begin to shift the community narrative from deficits to whole-person health, including strengths.

EVALUATION AND ADVERSE EFFECTS

Key messages gleaned from this experience included greater strengths among local residents in comparison with those elsewhere, particularly in our homes, our neighborhoods, and our faith communities. Key challenges were related to substance use and sleeping. Compared with those without substance use challenges, those with substance use challenges had half as many strengths and five times as many challenges. Sleep-related issues resonated with community members deeply and became a focus of further community dialogue regarding the importance of sleep for overall well-being. Community members shared these findings and our intervention broadly, raising awareness of the power of community-led assessments to begin community narrative development.

We observed no adverse effects. One community partner observed,

Utilizing the app has allowed us to reach a diversity of neighborhoods, individuals, and groups with information that is being used for strategic health planning purposes. The students have added greatly to the project by their availability and willingness to assist as we are engaged in this project.

Another shared,

Working on the project was a robust experience and working with members from the community-academic partnership really made this project fun as everyone brought something different to the table.

Some neighborhoods collected local data to understand how the COVID-19 pandemic and the opioid epidemic affected both individuals and the broader community. The data that community members shared with the local health department suggested a need for additional resources to address substance use issues.

Limitations of the intervention are related to the challenge of avoiding bias in the data, because representing all groups in the community may be difficult using this sampling strategy. Therefore, the findings are not generalizable. There is a critical need to understand the community's perspective regarding such whole-person health strategies. Community members were enthusiastic about engaging with the University to continue this work.¹²

SUSTAINABILITY

A community-based participatory intervention using data to shift the community narrative from deficits to strengths created buy-in from key stakeholders in the community and a strong commitment from all partners to continue efforts. Nursing students and faculty committed to ongoing participation. Funding needs consisted mainly of incentives for survey completion, as the app was freely available.

Partners were already working in collaboration with various communities that were eager to have access to compelling local data. A new collaborator noted,

The app is a great opportunity and experience that is bringing our community together to learn about this valuable tool that will be beneficial and lead to positive health outcomes. The data will provide better understanding on identifying the needs of the community and utilizing the data to propose for programs/ services that are culturally specific to this community.

PUBLIC HEALTH SIGNIFICANCE

This community-based intervention aligns well with Public Health 3.0, building a new community narrative by engaging community members through data.¹ This approach has potential to enable cross-sector partnerships in collecting and using data to inform actions. Public health nurses are ideally positioned in community to contribute to and co-lead this transformation. This ongoing intervention is building toward a positive community-empowered approach with the goal of achieving equitable health care, starting by shifting the health narrative in communities and neighborhoods from deficits to whole-person health, including strengths.¹ AjPU

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CONFLICTS OF INTEREST

The authors report no potential or actual conflicts of interest.

HUMAN PARTICIPANT PROTECTION

The data were deidentified, and this study was deemed exempt from oversight.

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DETAILS

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Public Health Nurse Tailored Home Visiting and Parenting Behavior for Families at Risk for Referral to Child Welfare Services, Colorado: 2018–2019

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[ProQuest document link](#)

ABSTRACT (ENGLISH)

Objectives. To examine public health nurse (PHN) intervention tailoring through the Colorado Nurse Support Program (NSP). Our 2 specific aims were to describe the NSP program and its outcomes and to determine the effects of modifying interventions on short- and long-term outcomes among NSP clients. **Methods.** In our retrospective causal investigation of 150 families in Colorado in 2018-2019, intervention effects were modeled via longitudinal modified treatment policy analyses. **Results.** Families served by PHNs improved in terms of knowledge, behavior, and status outcomes after receiving multidimensional, tailored home visiting interventions. Case management interventions provided in the first month of PHN home visits had lasting effects on behavior outcomes, and 2 additional case management interventions in the first month were estimated to have even more of an impact. **Conclusions.** Modern causal inference methods and real-world PHN data revealed a nuanced, fine-grained understanding of the real impact of tailored PHN interventions. Public Health Implications PHN programs such as the NSP and use of the Omaha System should be supported and extended to advance evaluations of intervention effectiveness and knowledge discovery and improve population health.

FULL TEXT

Headnote

Objectives. To examine public health nurse (PHN) intervention tailoring through the Colorado Nurse Support Program (NSP). Our 2 specific aims were to describe the NSP program and its outcomes and to determine the effects of modifying interventions on short- and long-term outcomes among NSP clients.

Methods. In our retrospective causal investigation of 150 families in Colorado in 2018-2019, intervention effects were modeled via longitudinal modified treatment policy analyses.

Results. Families served by PHNs improved in terms of knowledge, behavior, and status outcomes after receiving multidimensional, tailored home visiting interventions. Case management interventions provided in the first month of PHN home visits had lasting effects on behavior outcomes, and 2 additional case management interventions in the first month were estimated to have even more of an impact.

Conclusions. Modern causal inference methods and real-world PHN data revealed a nuanced, fine-grained understanding of the real impact of tailored PHN interventions.

Public Health Implications PHN programs such as the NSP and use of the Omaha System should be supported and extended to advance evaluations of intervention effectiveness and knowledge discovery and improve population health. (Am J Public Health. 2022;112(S3):S306-S313. <https://doi.org/10.2105/AJPH.2022.306792>)

Public health nurse (PHN) home visiting is known for its tailored interventions and its effectiveness for high-risk populations such as families that have multiple complex social and health needs and whose children have the potential for long-term sequelae of early childhood adverse events.¹⁻⁵ Intervention tailoring, defined as personalizing care to meet specific client needs, is key to PHN intervention effectiveness.²⁻⁶

For decades, policymakers have mandated outcome evaluation to ensure PHN home visiting program effectiveness and justify continued funding. Administrators have responded to these mandates by adopting formal protocols (e.g., evidence-based guidelines⁷) and programs (e.g., the Nurse Family Partnership)⁶ that, in turn, generate data through routine PHN documentation for program evaluation and research.⁸⁻¹² Use of PHN-generated data sets for causal modeling is in its infancy; however, interventions tailored to meet diverse client needs create problematic data confounding with respect to the numbers and types of interventions a client receives and their outcomes.¹³

Adjustment for this confounding is critical to understanding the impact of PHN interventions.¹³

In PHN home visiting, clients receive a series of PHN visits, and in each visit interventions are applied. Over time, client characteristics, outcomes, and interventions vary, creating a rich source of information but also complex, time-varying confounding.¹³ The numbers and types of interventions delivered at a visit depend on the client's baseline health information, the numbers and types of interventions delivered in the past, and how the client responded to those interventions. These dynamics need to be taken into account in assessing the effects of interventions and their timing. As confounding is especially strong given the nature of PHN intervention tailoring, traditional methods of estimating time-varying intervention effects such as marginal structural models may result in biased or highly variable estimates of effects.^{14,15}

Recent work in causal inference has focused on estimating causal effects that depend on the observed number of interventions.¹⁶⁻¹⁸ These methods aim to answer questions such as "What would outcomes look like if, counter to fact, the numbers of interventions everyone received were slightly different than in reality?" The control group accounts for the observed data, and a comparison is made with the hypothetical population that received slightly more (or fewer) interventions. These approaches are referred to as modified treatment policies (MTPs), as they examine what occurs when the application of a treatment or intervention is slightly modified from actuality.¹⁶

The confounding present in this hypothetical comparison tends to be less difficult to adjust for than that associated with marginal structural models provided that the hypothetical increase or decrease in interventions is not too large,^{16,17} as MTPs require weaker assumptions. This stems from the fact that the counterfactual questions they pose are not drastically different from how interventions were applied in reality. MTPs have been extended to address time-varying interventions (longitudinal MTPs [LMTPs]) and are capable of answering counterfactual questions that depend on both individual characteristics and intervention timing, as in PHN intervention tailoring.¹⁶

Given the complexity and longitudinal nature of the PHN intervention tailoring problem, correspondingly complex and rich longitudinal data sets are needed to examine such intervention modifications. The data must incorporate information on the factors that affect PHN intervention tailoring to control for potentially time-varying confounding. Although PHN home visiting programs have often employed electronic health records as documentation,⁹⁻¹² 1 PHN support program generated data that were suitable for the study of both interventions and outcomes over time. The Nurse Support Program (NSP) was designed as a collaborative partnership between a local public health district and a number of county human service departments in Colorado to support families in need. PHNs visit families biweekly to provide evidence-based, tailored interventions known to maintain family integrity, improve family dynamics, and facilitate positive behavior change.^{6,7} Case management (CM) referrals to community resources for emergency funding, health care services, substance use cessation, or grief services are made only when appropriate and when needed by families. To be eligible for the program, families must be referred by child protective services and qualify for assistance from Colorado Works-Temporary Assistance to Needy Families. Established in the early 2000s for a single county, the NSP has grown to include agreements with 3 counties served by the public health district. In response to the need to evaluate the effects of the interventions on client outcomes, the NSP implemented a comprehensive measurement, decision support, and documentation process in 2013 using the Omaha System,⁸ a research-based nursing classification intervention and outcome system. This system has been employed to guide, document, and evaluate diverse PHN services including PHN home visiting programs across populations and settings in the United States and globally.^{7,8}

Using NSP data generated through routine PHN documentation, we examined intervention tailoring using LMTPs to deepen understanding about the impact of PHNs in terms of improving and optimizing intervention tailoring and outcomes. Our 2 study aims were (1) to describe the NSP and outcomes using PHN-generated Omaha System data and (2) to determine the effects of modifying interventions on short- and longterm outcomes among NSP clients.

METHODS

This retrospective, collaborative study involved practicing PHNs and academic researchers.

Instrument

The Omaha System consists of 3 relational instruments with documented psychometric properties: the Problem Classification Scheme (client assessment and problem list), the Problem Rating Scale for Outcomes (problem evaluation), and the Intervention Scheme (used for care planning and services; Table B, available as a supplement to the online version of this article at <http://www.ajph.org>).^{19,20} The Omaha System exists in the public domain, and evidence-based encoded interventions for PHN home visiting practice are available online at the system's Web site.⁷ The NSP provides extensive Omaha System training and mentoring, including specific guidelines for practice and documentation (e.g., identifying which system problems should be assessed in common scenarios, how often a system problem should be rated, and how to document tailored NSP interventions).⁸ Monthly practice sessions support uniformity in system use. Quality of documentation is measured quarterly through peer and supervisor reviews with reflective feedback.

Analysis

We used R version 4.1.1 in conducting all of our analyses.²¹ For our first aim (providing a description of the NSP), standard descriptive and inferential statistics were used to analyze program data. We used LMTPs, which allow for interventions to be longitudinally measured and for a counterfactual increase or decrease in interventions to occur at any specified time point of interest, for our second aim (assessing the effects of intervention modifications). Here the causal effect is the expected change in outcomes given the intervention modification: $E[Y(A_k + 8)] - E[Y]$, where $E[Y(A_k + 8)]$ is the expected potential outcome if the intervention at month k is modified by shifting the number of interventions by 8 (for this study, $8 = +2$ and -2) and $E[Y]$ is the expected outcome in the observed data.²² Those who receive more interventions often have more problems and worse outcomes and are otherwise different from those who receive fewer interventions; therefore, there is confounding.

The confounding in this study had a complex structure given consideration of time-varying interventions that may depend on what happened in the past. The assumptions required for our aim 2 analysis were as follows: (1) the

intervention modifications were plausible in that they were in the range of the observed number of interventions for all individuals, and (2) there was sequential ignorability in that all of the factors affecting the number of interventions received in a given month and the observed data in future months were measured.

Figure 1 shows the directed acyclic graph created on the basis of our study assumptions; arrows depict the causal structures and confounding relationships among the baseline and time-varying covariates, interventions, and outcomes.²³ Our first assumption holds because the intervention modifications explored were small (± 2) and there were no modifications that made an individual's number of interventions negative. Because the Omaha System captures information about why PHNs make care decisions, large degrees of the factors needed for our second assumption were measurable, yet some still may remain unmeasured. Given the emphasis on caretaking and parenting in the NSP, outcome variables were classified as caretaking and parenting Knowledge, Behavior, and Status (KBS) scale scores measured on a 5-point Likert scale longitudinally.

Targeted maximum-likelihood estimation,^{24,25} an alternative to g-computation and inverse probability weighting, was used to control for the time-varying confounding implied in Figure 1.^{26,27} Targeted maximum likelihood estimation requires estimation of inverse weights and regression functions; for these we used a combination of logistic regression, Bayesian additive regression trees, and others.²⁸⁻³¹

Modifications to the number of CM interventions were considered because variations in these interventions had been associated with differential outcomes in previous research.⁷ Hypothetical increases of 2 CM interventions were modeled at month 1, month 2, and month 3 separately. Similarly, we modeled hypothetical decreases of 2 CM interventions separately at months 1, 2, and 3. Modifications of 2 interventions were selected because a modification of 1 intervention may not be clinically relevant and larger modifications may deviate too substantially from the observed number of interventions, which would induce stronger confounding and more difficult adjustments. For each analysis, the change in month 4 KBS scores and the change in scores at the final measurement were estimated. Positive changes indicated that KBS outcomes were improved by the hypothetical change in the number of CM interventions, whereas negative changes indicated that outcomes were worsened.

Study Cohort

The data used in this study were generated through routine documentation of NSP PHN home visits in multiple counties with the Omaha System from May 2017 to December 2019. For the LMPT analysis, only data for primary caregivers were used. The variables used are summarized in the following sections; a full list of the variables is provided in Table A (available as a supplement to the online version of this article at <http://www.ajph.org>). The unit of analysis was the primary caregiver for each family.

Covariates, Exposures, and Outcomes

Baseline covariates. We controlled for total numbers of problems, signs or symptoms, and overall baseline KBS scores for each case to adjust for baseline information. Both total numbers of signs or symptoms for all problems and the total number for each problem were included. In addition, the presence of each sign or symptom for the caretaking and parenting problem was considered. The first KBS scores for each problem and each case were extracted to calculate mean baseline KBS scores across all problems as a baseline control variable. The overall mean KBS scores and first KBS scores for income and caretaking and parenting were included as baseline covariates. The baseline KBS data for other problems were excluded because of the amount of missing data (50% or more).

Exposures. Exposures were operationalized as the numbers of CM interventions in each of months 1, 2, and 3.

Time-varying covariates. In practice, health care providers adjust their care based on prior assessments and interventions, and thus KBS scores (monthly mean KBS scores overall and for each problem) and interventions were considered as time-varying confounders. In each case, the numbers of interventions were calculated for all problems and caretaking and parenting interventions provided in each month by all categories (teaching, guidance, and counseling; treatments and procedures; CM; and surveillance) to adjust the estimate of relationships between CM interventions and client outcomes. Each time-varying covariate was used to adjust the effect of subsequent exposure on the outcome (Figure 1). For instance, we controlled for the total numbers of teaching, guidance, and

counseling; CM; and surveillance interventions during month 1 in studying the effects on outcomes of CM interventions delivered during months 2 and 3. There were limited amounts of missing data for caretaking and parenting and overall KBS variables in month 3 (25%-35% of the sample). We addressed this issue via multiple imputation with the R package and random forest imputation; indicators of missing data were included as additional timevarying covariates.³²

Outcomes. Outcomes were operationalized as knowledge, behavior, and status with respect to the caretaking and parenting problem: (1) the first measured of each of the knowledge, behavior, and status outcomes monthly from month 4 to the final month and (2) the knowledge, behavior, and status outcomes measured in the last month of visits (which occurred in month 4 or later). Thus, there were 6 outcome variables (3 outcome measures x 2 time points) analyzed in 6 independent models. There were no missing outcomes.

RESULTS

A total of 339 individuals in 150 families were served by PHNs in the NSP in 2018-2019. Their services and outcomes and the findings of the causal intervention effectiveness analysis are described in the sections to follow.

Nurse Support Program Characteristics

As noted, 150 families (consisting of 339 individuals) were served and discharged from the program during the study period. On average, family primary caregivers had 3.2 signs or symptoms and received 164 interventions for 4.5 problems over 9 months of visits (range 5 4-19 months). In addition to caretaking and parenting (100%) and income (93%), the most frequent problems addressed were mental health (37%), the postpartum period (31%), substance use (25%), family planning (23%), and pregnancy (22%). The most common signs or symptoms were difficulty providing physical care or safety (26%), use of recreational drugs (14%), inaccurate or inconsistent use of family planning (14%), and sadness, hopelessness, or decreased self-esteem (10%). The vast majority of interventions involved surveillance (50%), followed by teaching, guidance, and counseling (30%) and CM (20%). By problem, interventions overwhelmingly focused on caretaking and parenting (47%) and income (24%); the remaining problems were addressed in 2% to 6% of interventions.

The mean and median numbers of CM interventions were 4.1 and 3 (range 5 0-28), respectively, in month 1; 2.67 and 2 (range 5 0-28) in month 2; and 2.09 and 1 (range 5 0-16) in month 3. Outcomes improved significantly overall for knowledge (from 2.88 [less than basic knowledge on admission] to 3.56 [basic to adequate knowledge on discharge]), behavior (from 3.45 [inconsistently appropriate behavior] to 4.05 [appropriate behavior]), and status (from 3.66 [moderate to minimal signs or symptoms] to 4.11 [less than minimal signs or symptoms]; all P s <.01). Trends were similar across problems with some variability.

Case Management Intervention Effects

The LMTP intervention tailoring analysis focused on primary caregivers, whose demographics were provided in aggregate by the NSP. Clients were on average 29.9 (SD 5 8.6) years of age and were primarily female (94%) and unmarried (68%). Omaha System data for LMTP analyses were available for 146 primary caregivers who received PHN visits for at least 4 months.

A hypothetical increase of 2 CM interventions in month 1 was estimated for caretaking and parenting behavior outcomes at both month 4 (change 5 0.07; P 5 .02) and the final month (change 5 0.11; P <.01; Figure 2).

Conversely, a hypothetical decrease of 2 CM interventions during month 1 was estimated to result in a decrease in caretaking and parenting final behavior outcomes (change 5 -0.07; P 5 .01; Figure 2). Although not significant, a hypothetical increase of 2 CM interventions in month 1 was positively related to status outcomes for month 4 (change 5 0.06; P 5 .16) and the final month (change 5 0.04; P 5 .27). Finally, a hypothetical increase of 2 CM interventions in any month did not result in a significant change at month 4 or the final month in knowledge outcomes (changes from -0.01 to -0.05; P 5 .89 to .07).

DISCUSSION

This retrospective study of existing PHN data justifies LMTPs as appropriate methods for analyzing public health nursing practice, demonstrates the value and effectiveness of the NSP, and provides additional evidence of the importance of intervention tailoring. The NSP descriptive analysis showed that outcomes among families served by

PHNs improved after the families received multidimensional, tailored home visiting interventions, in line with findings from numerous previous studies such as those examining PHN home visiting data sets⁹⁻¹² and the Nurse Family Partnership.⁶

Our retrospective longitudinal analysis involving advanced statistical techniques indicated that CM interventions provided early on during PHN home visits had a lasting impact on behavior outcomes. The finding that a reduction in the number of CM interventions in the first month of PHN visits resulted in worse behavior outcomes indicated that the number of CM interventions applied in the first month had a positive impact on behavior outcomes and that 2 more CM interventions in the first month may have even more of an effect. Further research with additional and larger data sets is needed to confirm and extend these findings.

Our findings regarding NSP program characteristics and outcomes demonstrate the importance and value of attention to program and documentation fidelity support for NSP PHNs. This aligns with Omaha System guidance to ensure the validity of findings when standardized documentation data are repurposed for evaluation and research.⁸ NSP program leaders affirmed that the findings observed reflected fidelity with program goals, expected assessments, and evidence-based interventions. This lends important process and content validity to our intervention tailoring findings and results. The rigor of the program and the findings related to the data lends confidence that PHNs both intervened appropriately and documented correctly. Generating such valuable data may be time consuming; therefore, administrators and PHNs must ensure that workflows are optimized to reduce documentation burden.^{8,33}

The small but significant improvement in short- and long-term caretaking and parenting behavior is meaningful given the granularity of our analysis. Such fine-grained guidance derived from PHNs' own data aids in optimizing intervention tailoring and acknowledges that interventions are already well tailored. The broad practice recommendation that 2 additional CM interventions be considered in the first month of services acknowledges that problem, target, and care description intervention components are absent. Such broad advice is useful in that it allows for intervention tailoring on the part of PHNs, who can direct CM interventions to areas that may be of the most benefit for a specific client.⁹⁻¹² In future LMTP research, various intervention components should be examined with respect to their impact on PHN outcomes.

There are unique data considerations in using LMTPs. The longitudinal intervention and KBS outcome data generated through routine documentation during PHN NSP home visiting were extracted manually to achieve our goal of understanding how PHNs may improve intervention strategies and optimize outcomes. This study demonstrates that adherence to documentation protocols and data extraction processes is fruitful. Therefore, improving documentation and data extraction procedures is warranted and critical for future research.

This study has introduced LMTPs as a way of assessing the impact of PHN interventions and their tailoring when granular, longitudinal PHN data are available. LMTPs are useful for informing incremental, as opposed to revolutionary, changes in practice because they focus on questions concerning what would occur in the event of such changes. We examined the timing of application of interventions; with a larger data set, further examination of interesting modifications would be possible, such as timing and adaptivity to client characteristics (e.g., what outcomes would result if interventions were shifted up or down for those who had low KBS scores at any visit?). However, for the valid use of LMTPs, sufficiently rich data on the many factors affecting PHN intervention tailoring are necessary.

The analytical aim of this study was causal in nature: to understand what changes in outcomes would occur if interventions were modified in certain ways. When aims are explicit, the assumptions required for a valid analysis are transparent. In particular, a valid LMTP analysis requires that all confounders that could affect the number of interventions at any given time point be measured.³⁴ It is not possible to guarantee that all confounders have been measured, and as such our results are subject to potentially not having a causal interpretation. This can be remedied in future analyses by considering sensitivity analyses assessing the robustness of findings to unmeasured confounders. However, the specificity of the Omaha System data enabled us to capture a substantial number of critical confounders, making our results plausible. Note that although intervention effects may have varied among

individual PHNs, our estimated effects can be interpreted as an average over the distribution of such effects.³⁵

Limitations

This study had several important limitations. First, the sample size was small, and thus we had limited ability to detect nuanced intervention effects. Second, because it was generated in a single region of the United States, the sample may be limited in terms of its representativeness of PHN clients more broadly. Third, our study was observational, and thus it is possible that the presence of unmeasured confounders biased our results. Future work should be conducted to assess the sensitivity of study results to unmeasured confounders.

Public Health Implications

Decision-makers and administrators should continue to support and extend PHN home visiting programs such as the NSP and use of the Omaha System for the purposes of improving constituent outcomes and population health. Also, they should make data available for advancing evaluations of PHN intervention effectiveness and knowledge discovery. Our study contributes to the body of knowledge supporting investment in members of the PHN workforce as key contributors to improving the health of vulnerable populations. Our findings should be used as evidence to advocate for changes at the policy and system levels to advance and support PHN intervention and outcome work.

Conclusions

This study demonstrates the potential of modern causal inference methods paired with real-world PHN data to deepen understanding of the effects of PHN interventions on outcomes among this group. LMTPs in conjunction with highly detailed Omaha System data showed the feasibility of achieving a more nuanced, fine-grained understanding of the real impact of such interventions. PHNs should consider offering 2 additional CM interventions in the first month to improve behavior outcomes among primary caregivers of families at risk for child welfare service involvement to optimize outcomes through intervention tailoring. Consistent with the results of previous PHN home visiting effectiveness studies, our findings demonstrate the known effectiveness of PHN interventions and outcome measures, reinforcing the importance of maintaining and supporting a qualified PHN workforce and thereby advancing PHN contributions to improve population health.

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J. D. Huling, R. R. Austin, M. M. Doran, V.J. Swarr, and K.A. Monsen conceptualized the study design and analytical strategy. J.D. Huling and S.-C. Lu developed and implemented the statistical analyses. J. D. Huling developed and implemented the causal analyses. All of the authors drafted, wrote, and edited the article.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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The University of Minnesota institutional review board deemed this study not to be human participant research. Full protocol approval was not needed because deidentified data were used.

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Using the Points of Distribution Site Model for Timely and Safe Administration of COVID-19 Vaccinations During the Pandemic

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ABSTRACT (ENGLISH)

The Georgia Department of Public Health-East Central District and its local partners implemented an open, drive-through point of distribution site to administer the COVID-19 vaccine to eligible populations. The site was in Augusta, Georgia, from mid-December 2020 through mid-May 2021. The target population for this intervention was individuals eligible for the COVID-19 vaccine to prevent and slow transmission of severe acute respiratory syndrome coronavirus 2 infection. The point of distribution site successfully provided 42 342 vaccines.

FULL TEXT

Headnote

The Georgia Department of Public Health-East Central District and its local partners implemented an open, drive-through point of distribution site to administer the COVID-19 vaccine to eligible populations. The site was in Augusta, Georgia, from mid-December 2020 through mid-May 2021. The target population for this intervention was individuals eligible for the COVID-19 vaccine to prevent and slow transmission of severe acute respiratory syndrome coronavirus 2 infection. The point of distribution site successfully provided 42 342 vaccines. (Am J Public Health. 2022;112(S3):S279-S283. <https://doi.org/10.2105/AJPH.2022.306820>)

The safe and efficient distribution of preventive measures during large public health emergencies is critical to mitigate significant morbidity and mortality of emerging diseases.¹ One mechanism to distribute preventive measures to the public is points of distribution sites (PODs). The overall goal of a POD is to systematically distribute preventive measures in the time frame necessary to mitigate the negative consequences to individuals without symptoms of the disease.²

INTERVENTION

Mass vaccination among populations is necessary to reduce cases, hospitalization, and deaths related to the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) with the hope of ending the pandemic.³ To promptly serve the large numbers of individuals eligible for vaccination in a safe environment, we established an open, drive-through POD site. Our goals in using the POD site were (1) to promptly administer COVID-19 vaccines without contributing to the transmission of SARS-CoV-2 virus, and (2) to sustain the POD site until the eligible population received the vaccine. To meet the goals of the intervention, we established protocols and procedures for vaccine administration. We formed a multidisciplinary team based on the Federal Emergency Management Agency's standardized structure for medical countermeasures.⁴ Nurses filled numerous roles throughout the use of the POD, including as clinical supervisor and in screening, medical evaluation, vaccine distribution, clinical monitoring, personnel management, and data entry. Management also ensured that the POD site was sustained over a projected time frame of six to eight months.

PLACE AND TIME

The POD site was a closed elementary school campus in Augusta, Georgia. The site was operational from mid-December 2020 to mid-May 2021. The site was opened to the public eight hours daily, Monday through Saturday. Most teams worked 10 to 12 hours daily (four to five days per week) to provide ongoing oversight, planning and operations, logistics, and security.

PERSON

The target population for the intervention was individuals in the public eligible for vaccines in the district. The largest county included was Richmond, Georgia. A total of 78 616 individuals older than 65 years, 299 616 individuals aged 18 to 64 years, 13166 individuals aged 16 to 17 years, and 25 686 individuals aged 12 to 15 years were eligible for vaccines. In addition, embedded in the implementation of the POD site was the staff needed to operate the site, approximately 53 staff members daily, 20 volunteers daily, and 6 soldiers from the National Guard. Staff included

health care providers as outlined by the Public Readiness and Emergency Preparedness Act (PREP Act; Pub L No. 109-148) declaration,⁵ emergency preparedness specialists, administrative support teams, information technology specialists, security and safety professionals, and communication specialists (Figures 1 and 2).

PURPOSE

The SARS-CoV-2 virus is highly transmissible and led to a devastating pandemic.⁶ The purpose of the intervention was to reduce barriers to vaccine access and provide a safe, convenient location for the local population to obtain vaccines to prevent and to slow the transmission of SARS-CoV-2 infection, thus promoting optimal population health.⁷

IMPLEMENTATION

The planning, response, implementation, and sustainability of the POD site was critical for providing the eligible public with access to vaccination. The Georgia Department of Public Health East Central Health District was responsible for the POD site. The large-scale public health emergency demanded a long-term response and required significant human and material resources.⁸

The district used the Federal Emergency Management Agency framework for a standardized command structure, with the incident commander (district health director) and three command staff (public information officer, safety officer, and liaison officer).⁸ We organized the POD site using the standardized medical countermeasures structure to meet the goals and objectives of the intervention with existing community partners and agencies (e.g., board of education, local emergency management agency, colleges of nursing, emergency medical services agencies) and National Guard soldiers.⁸ (Figure 1, "POD Organization," details how the site was organized.)

The leaders in the Incident Command System (ICS) and POD management implemented strategies to ensure the health and safety of all staff members and their families. Broad strategies to ensure the health and safety of all staff included the following:

- * providing specialized training for team leaders, staff, and volunteers;
- * having adequate numbers of trained staff, including partnering with student nurses from a local college of nursing (approximately 20 to 50 hours total);
- * employing evidenced-based protocols and procedures to protect against the transmission and spread of SARS-CoV-2;
- * providing vaccinations for eligible individuals, personal protective equipment supplies based on Centers for Disease Control and Prevention (CDC) recommendations at the time of the intervention, and other preventive physical and environmental measures; and
- * ensuring the physical safety and security of the staff.

As with all public health interventions in response to public health emergencies, ongoing planning and evaluation were critical to the success of the site. The ICS team met daily and as needed to ensure sustained site operations. Open communication between the leadership team with the ICS and the team leaders embedded in the site was scheduled daily and was always encouraged throughout the daily operations. Team leaders had direct communication with their teams to ensure that all issues were identified and reported to team leaders and the ICS leadership for timely resolution. Daily meeting included discussion of SARS-CoV-2 updates, COVID-19 vaccination updates, safety and security needs and updates, and changes in POD staffing.

After the implementation of the POD site, the administration of the COVID-19 vaccine began. Georgia's government leaders decided to approach vaccinating a large population via a staged approach that was based on specific risk factors associated with morbidity and mortality from SARSCoV-2 infection. This staged approach affected which individuals in the population could receive the vaccine during a given time frame (Figure 2). Therefore, several levels of screening and medical evaluation were necessary to ensure that eligible individuals received vaccines safely. Several actions were implemented to provide the vaccines safely, which included the following:

- * safe storage and handling of vaccines, including storage per manufacturer and CDC guidelines with transportation of vaccines daily to the POD site and continual temperature monitoring via a temperature data logger;
- * employing health care professionals qualified to administer vaccines in accordance with the PREP Act⁵ (including

nontraditional licensed or certified health professions, previously active and recently retired professionals, and health care students) specifically trained on the administration and side effects of COVID-19 vaccines;

- * educational information about the vaccines and potential side effects communicated both verbally and in writing to eligible individuals at the site; and

- * physical observation of individuals who received the vaccine based on the time frames recommended by the CDC and Advisory Committee on Immunization Practices.⁹

EVALUATION

The intervention successfully provided first and second doses of 42 342 Pfizer, Moderna, and Janssen vaccines administered to eligible individuals at the POD site. At the end of the intervention, 26.4% and 21.8% of individuals aged 18 years or older were provided first and second doses, respectively; and 43.1% and 38.6% of individuals aged 65 years or older were provided first and second doses, respectively, in the catchment area (including all efforts to provide vaccination in the district). The number of COVID-19 cases in Richmond County (which is the largest county in the district) declined as the number of COVID-19 vaccines administered increased (Figure 2).

ADVERSE EFFECTS

Adverse effects were limited to ICS leadership and POD staff, with poor morale, burnout, and fatigue being most prevalent.¹⁰ The health departments in the district lost 26% (n = 12) of the clinical staff during the height of the pandemic. Fatigue was most noted in the number of absences unrelated to illness, which increased significantly during the POD intervention.

SUSTAINABILITY

The POD site was closed when the demand for vaccines could be managed in normal operations of the health departments. Administration of vaccine is still readily available through multiple health facilities; therefore, the continued use of the POD site was not necessary.

PUBLIC HEALTH SIGNIFICANCE

Implementation of a large, open, drive-through POD site for eligible individuals to receive COVID-19 vaccination was critical to slowing the transmission and spread of the SARS-CoV-2 virus on the local, state, national, and international levels. According to the Georgia Department of Public Health, the weekly death rate (per 100 000 persons) in the district was 2.0 in November 2021, 6.92 in January 2021, 6.72 in February 2021, 1.83 in May 2021, and 3.67 in November 2021. Individuals who have received COVID-19 vaccinations now experience fewer consequences of the virus, including decreased admissions to hospital and decreased death rates.¹¹ Overall, the COVID-19 vaccine is a major mitigating factor of the negative effects associated with the pandemic.¹¹ >4JPH

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No protocol approval was necessary because our team analyzed only de-identified data.

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Improving Interprofessional Environmental Health Education Using the Leave No One Behind Framework

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ABSTRACT (ENGLISH)

In the midst of the Anthropocene, two questions continue to confront humanity: (1) How can technology be used to help us to continue to thrive when faced with the limitations of the global carrying capacity of the natural world? (2) How can social contracts be improved to promote justice, equity, diversity, and inclusion as the financial benefits- and environmental consequences-of thriving are apportioned among individuals, communities, and countries? Training future environmental health professionals with the tools they will need to solve these questions is a challenge for educators.

FULL TEXT

In the midst of the Anthropocene, two questions continue to confront humanity: (1) How can technology be used to help us to continue to thrive when faced with the limitations of the global carrying capacity of the natural world? (2) How can social contracts be improved to promote justice, equity, diversity, and inclusion as the financial benefits- and environmental consequences-of thriving are apportioned among individuals, communities, and countries? Training future environmental health professionals with the tools they will need to solve these questions is a challenge for educators.

ENVIRONMENTAL HEALTH IN PUBLIC HEALTH NURSING

The environment-where people live, learn, and labor-is a critical determinant of health. The practice of environmental health-undertaken by sanitarians, nurses, physicians, and engineers, among others-originated in the mid-19th century as humanity congregated increasingly in dense urban environments such as London, England.¹ During the Great Sanitary Awakening, Edwin Chadwick's efforts to revise the English Poor Laws (i.e., the social contract of the time) were as important as Joseph Bazalgette's efforts to design and construct London's sewers (i.e., the technology of the time). Both the work of Chadwick and the work of Bazalgette were influenced by the chief nurse theorist of the time, Florence Nightingale.

Nightingale's environmental theory- the normal state of a human is one of health, and the chief purpose of the nurse is to modify the environment to restore health-continues to guide research, education, and practice of environmental health into the 21 st century.¹⁻³ The human rights-based approach foreshadowed by Nightingale-"everyone has the

right to a standard of living adequate for the health and well-being of himself and of his family"⁴(Article25)-underlies the conceptual framing of modern sustainable development. The consensus meaning of sustainability was introduced globally in the seminal report, "Our Common Future,"⁵ which set the stage for the 1992 United Nations Conference on Environment and Development (also known as the Earth Summit) and the signing of the United Nations Framework Convention on Climate Change.

Although many public health nurses (PHNs) will recognize the definition of sustainable development as "meet[ing] the needs of the present without compromising the ability of future generations to meet their own needs,"⁵(paragraph27) fewer may be familiar with the entirety of paragraph 27 from the Overview section of the report.⁵ In particular, poverty is no longer accepted as inevitable [emphasis added], and the report notes that the true limitations on development arise from the twin challenges of (1) current social organization and available technology and (2) nature's ability to attenuate the effects of human activities.

Within the reality of a planet undergoing massive environmental challenges brought about by the actions of humanity (i.e., the Anthropocene), the central question facing educators of PHNs is, how do we implement interprofessional environmental health education to achieve effective collaboration beyond the bedside and into the community?⁶ As a proposed answer to this question, we suggest that the "leave no one behind" framework of the United Nations Sustainable Development Goals (SDGs) is an important piece of the puzzle, which may be highlighted using examples of nurses and engineers working together to achieve SDG number 2, zero hunger, as well as SDG number 11, sustainable cities and communities.⁷

TWO EDUCATIONAL EXAMPLES

The SDGs include 17 goals, which are underpinned by three universal values: (1)the necessity of a human rights-based approach, (2) the commitment to leave no one behind, and (3) the central role of gender equality and women's empowerment. The UN's State of the World's Nursing - 2020 report highlighted the fact that many members of the global nursing workforce are women, and therefore elevating and promoting nursing has an additional benefit of contributing to gender equality and women's empowerment.⁸ Nightingale's environmental theory foreshadows a human rights-based approach to development. But what about the commitment to leave no one behind, and how does nursing bring a unique contribution to interprofessional environmental health education? According to the Missouri Department of Health and Senior Services, "public health nursing is the practice of promoting and protecting the health of populations [emphasis added] using knowledge from nursing, social, and public health sciences" (<https://bit.ly/3LEpNJb>), whereas the code of ethics for nurses highlights "the care of individuals [emphasis added], families, groups, and communities" (<https://bit.ly/3Jc18tU>). Among those professionals who practice environmental health- including sanitarians, physicians, and engineers-PHNs bringthe unique perspective of formal preservice education both [emphasis added] in patient health (i.e., at the bedside) and in population health (i.e., beyond the bedside and into the community). By contrast, the preservice education of physicians focuses primarily on bedside care of individual patients (i.e., an MD or DO working in public health often obtains additional training such as the MPH when working with populations in the community), whereas sanitarians and engineers share an ethical obligation to protect "the public" (and thereby lack specific training on caring for individuals). This unique preservice education of PHNs-patient care plus population health-is highlighted in two examples of coteaching engineers and nurses in Missouri.

The first example of interprofessional environmental health education includes the cross-training of students of engineering to adopt qualitative research methods often used by PHNs, such as interpretive phenomenology, when engineers interview stakeholders from within heterogeneous communities.^{9,10} This novel approach to interprofessional environmental health education among engineers and PHNs is particularly useful when engineering students undertake open-ended, project-based learning such as the redesign of local food systems, which consider the twin goals of improving nutrition and reducing the environmental footprint.¹¹ Using the framework of leave no one behind means that aspirations of SDG 2, zero hunger, may be met "when all people [emphasis added], at all times, have physical and economic access to sufficient, safe, and nutritious food that meets their needs and food preferences for an active and health life."¹²(paragraph1) Thus, students of engineering

studying how to redesign the local food system for Phelps County, Missouri, have learned from PHNs how to address the issues of food and nutrition security for all people, which results in achieving no one left behind.

The second example of interprofessional environmental health education includes the cross-training of students of nursing to understand the design of housing projects such as the federal Housing Act of 1949. This novel approach to interprofessional environmental health education among engineers and PHNs is particularly useful when nursing students undertake community-embedded windshield surveys. Using the framework of leave no one behind means that aspirations of SDG 11, sustainable cities and communities, may be pursued as PHNs begin to understand how the intersection of policies-such as redlining-and the work of engineers-designing and building housing funded by federally backed home loans-contributed to the poor health outcomes observed in the cities of today.¹³ Thus, students of nursing studying the "Delmar Divide"¹⁴- a boulevard that runs from east to west through St. Louis, Missouri, demarking a socioeconomic and racial border between the northern and southern regions of the city-have learned from engineers how the use of technology to implement biased policies contributed to health inequities that impact modern cities.

CONCLUSION

These two examples of coteaching engineers and nurses in Missouri highlight the importance of maintaining a global perspective while addressing the health of local populations.^{1,15} In particular, the importance of leveraging the three universal values of the SDGs-human rights, no one left behind, and gender equality-are centered to improve interprofessional environmental health education. As described previously, nurses have an important leadership role to play as humanity confronts the important questions of the Anthropocene and convergence research is used to develop new solutions to these ongoing challenges.¹⁶ For example, engineers and sanitarians can practice alongside and learn with nurses (i.e., revisiting the collaborative period of Bazalgette, Chadwick, and Nightingale using modern technologies and social contracts such as leaving no one behind). Translators, developing the materials necessary for interprofessional education,¹⁶ have an explicit opportunity to leverage the unique contribution nursing brings to interprofessional environmental health education through the use of the leave no one behind framework. ÅfPU

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Superheroes Can Be Experts Too: The Importance of Nurses to Public Health Policy

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ABSTRACT (ENGLISH)

The COVID-19 pandemic has inflicted structural damage to public health systems that we cannot yet fully comprehend. Although much attention is now paid to COVID-19 issues of social and economic upheaval, public health nurses remain focused on the cracks in health care's foundation-such as the slow drip of resignations,

revenue loss, and rural clinic closures-that are steadily undermining our country's ability to provide health services to all citizens. Nurses, the "health care heroes" celebrated at the start of the pandemic, remain "inside the house," and they can see the direct causal relationships between health system breakdowns and the global disruptions making headlines today.

Frontline heroes can be system experts too. And yet, the visibility of nurses in public health policy remains woefully lacking. Despite nursing being the largest health care profession, chief nursing officers account for only about 0.8% of voting power on hospital boards, and nurses make up about 2.3% of voting power on community health boards.¹ The National Academy of Medicine's 2021 Future of Nursing Report 2020-2030 (<https://bit.ly/3NhiuJh>) highlights this staggering dichotomy between nurses' presence in health systems and their representation in roles of influence. The National Academy of Medicine underscores the needs not only to invest in nursing education and practice but to cultivate the leadership potential of nurses as well.²

Two articles in this special issue of AJPH (Zauche et al., p. S226; Morone et al., p. S231) describe the public health leadership roles nurses assumed during the pandemic, and both reach similar conclusions: the visibility of public health nurses must continue to grow. Florence Nightingale is widely acknowledged for her leadership both in the design of care and in measuring population health outcomes and instituting public health interventions. Despite Florence's legacy, the contributions of public health nurses have been largely overshadowed by prominent figures in medicine and epidemiology. A key focus of this special issue is to understand why.

FULL TEXT

The COVID-19 pandemic has inflicted structural damage to public health systems that we cannot yet fully comprehend. Although much attention is now paid to COVID-19 issues of social and economic upheaval, public health nurses remain focused on the cracks in health care's foundation-such as the slow drip of resignations, revenue loss, and rural clinic closures-that are steadily undermining our country's ability to provide health services to all citizens. Nurses, the "health care heroes" celebrated at the start of the pandemic, remain "inside the house," and they can see the direct causal relationships between health system breakdowns and the global disruptions making headlines today.

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Morone et al. argue that the lack of nursing appointments to policy boards and committees is entrenched in historical, structural, and social factors associated with a predominately female workforce. Male-dominated structures and institutions continue to preside over decisions affecting a health care workforce composed primarily of female nurses. The COVID-19 pandemic amplified nursing voices, yet nursing leaders are seldom present among policy groups addressing COVID-19-related issues, such as vaccine hesitancy and the deployment of services to underserved communities. When policies do not reflect the nursing perspective, critical oversights are bound to occur: Although physicians and epidemiologists offer a remarkable knowledge base, nurses lead in carrying the trust of people and communities. Nurses alone bring insights from human touch points across the lifespan and in every care setting imaginable.

Zauche and her colleagues from the Centers for Disease Control and Prevention (CDC) illustrate this point. This stellar group of nursing leaders in the CDC aims to highlight the impact of the organization's nursing workforce, which has gone largely unnoticed throughout CDC history. From nurses' central role in malaria surveillance in 1947 to the more than 200 nurses working in research, epidemiology, public health, clinical care, and communications today, CDC nurses have played a pivotal role in safeguarding the health of US populations.³ Nurses holding doctorates frequently serve in the Epidemiology Investigation Service, and nurses comprise the largest membership of the Commissioned Corps of the US Public Health Service. Together, these nurses offer a diversity of expertise that should be considered invaluable from a health care policy perspective.

Nurse leaders such as those at the CDC must be called on when national groups assemble in response to large-scale threats such as COVID-19. It is imperative to include nurses on committees deliberating the financing of public health infrastructure in particular. Likewise, funding bodies need to allocate substantially more direct public funding to community and public health nursing (including competitive nursing salaries). Real change starts at the policy level, where decisions are made on what we pay for and how much is spent. It is time for nursing to own the influence that they have earned. ^ÅfPU

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Enumeration of Public Health Nurses in the United States: Limits of Current Standards

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ABSTRACT (ENGLISH)

Recent national initiatives in nursing and public health have emphasized the need for a robust public health nursing (PHN) workforce. In this article, we analyze the extent to which recent national enumeration surveys base their counts of this workforce on the definitions, scope, and standards for practice and practice competencies of the PHN nursing specialty. By and large, enumeration surveys continue to rely on practice setting to define the PHN workforce, which is an insufficient approach for meeting the goals of major nursing and public health initiatives. We make recommendations for the development of new standards for PHN enumeration to strengthen the broader public health infrastructure and evaluate PHN contributions to population-level outcomes.

FULL TEXT

Headnote

Recent national initiatives in nursing and public health have emphasized the need for a robust public health nursing (PHN) workforce. In this article, we analyze the extent to which recent national enumeration surveys base their counts of this workforce on the definitions, scope, and standards for practice and practice competencies of the PHN nursing specialty.

By and large, enumeration surveys continue to rely on practice setting to define the PHN workforce, which is an insufficient approach for meeting the goals of major nursing and public health initiatives.

We make recommendations for the development of new standards for PHN enumeration to strengthen the broader public health infrastructure and evaluate PHN contributions to population-level outcomes. (Am J Public Health. 2022;112(S3):S292-S297. <https://doi.org/10.2105/AJPH.2022.306782>)

Over the past several years, an ongoing series of complementary yet independent efforts have directed the nation and the nursing profession toward an emphasis on health promotion and disease prevention. These include the Department of Health and Human Services' Public Health 3.0 initiative (PH3.0),¹ the American Association of Colleges of Nursing's (AACN's) Enhancing Public Health Concepts in Nursing curricula,²⁻⁵ the American Nurses Association's updating of Public Health Nursing: Scope and Standards of Practice,⁶ and the National Academy of Medicine's Future of Nursing 2020-2030 report.⁷ The lack of standardized criteria for determining which nurses in the nation should be "counted" as a public health nurse has hindered efforts to generate a more robust public health nursing (PHN) workforce for decades.⁸ While enumeration surveys have yielded some insight into the specialty role of PHN, the data are not sufficient to determine if an adequate PHN workforce is available to respond to current population health challenges and plan for future needs.

NATIONAL TRENDS IN PUBLIC HEALTH AND NURSING

PH3.0 is a national effort that returns public health to its population-based origins.¹ PH3.0 strategies include improving the social determinants of health (SDOH) by engaging with multiple sectors and community partners to generate a collective, positive effect on population health with a focus on "upstream" factors. By necessity, embracing PH3.0 requires the transformation of local public health funding away from the provision of clinical, disease treatment-oriented services within local public health departments toward prevention and health promotion

activities.

Specific to the nursing profession, the AACN—a leading national organization focused on nursing education—has increased expectations that core public health concepts are elevated to essential components and integrated throughout nursing curricula for undergraduate and graduate nursing programs nationwide.^{3,4} Current revisions to the AACN Essentials in 2021 continue to promote public health core concepts in nursing education.⁵ Despite these curricular mandates, there has been a drastic reduction in graduate nursing programs that prepare nurses for advanced PHN practice roles,^{9,10} while at the same time the demand for masters of public health programs has increased.¹¹

Finally, over the past 3 years, the Council of Public Health Nursing Organizations has updated the PHN practice competencies,⁶ and the American Nurses Association has drafted a new scope and standards for PHN practice.⁶ External to the profession, the Robert Wood Johnson Foundation funded the National Academy of Medicine to "[chart] a path forward for the nursing profession."^{7(p4)} The report recognizes the expertise of PHNs in addressing SDOH and identifies the need to ensure a sufficient distribution of nurses with a public health specialty to tackle the challenges of the next decade.⁷

Although each of these initiatives began before the arrival of COVID-19, the pandemic brought a sense of urgency and renewed interest in a PHN workforce able to adequately respond to population health trends, community needs, and national emergencies. With the persistent demands of COVID-19, public health as a discipline with a distinct set of competencies within the nursing profession has, at least temporarily, brought some recognition to the central role public health nurses have in protecting the health of people in the United States.^{12,13} Against the backdrop of what feels like a perpetual state of needing to justify PHN's existence as a specialty area of nursing practice, particularly from within our own discipline,⁹ some nurse scholars have questioned whether there is a future for PHN at all.¹¹ Taken together, the pandemic and the national impetus to move public health toward addressing SDOH as outlined in PH3.0, a window of opportunity exists to strengthen the PHN workforce. To seize this opportunity, however, clear, measurable, and standardized criteria that reflect accepted definitions of the PHN specialty are needed to discern which nurses, among the greater nursing workforce, are doing the actual work of public health.

DEFINING VS ENUMERATING PUBLIC HEALTH NURSING

Professional organizations representing the nursing workforce have written definitions of PHN in key documents used to guide PHN practice (Table A, available as a supplement to the online version of this article at <http://ajph.org>, provides a detailed list of select definitions). Used to direct PHN scope and standards of practice and practice-based competencies, a common denominator across definitions emphasizes population-based functions. As these definitions make clear, the population-focused roles are what differentiate PHN from other specialty areas of nursing practice. The well-known Public Health Intervention Wheel (aka The Minnesota Model)^{14,15} defines the scope of PHN practice by the population-based work nurses do at the individual, community, and systems levels that delineate it as a specialty practice.

Although widely accepted definitions for PHN are readily available, a chasm exists between the roles and functions reflected in them and how we identify which segment of the nursing workforce fulfills these roles. Since 1915, there have been regular efforts to enumerate the PHN workforce¹⁶ through national surveys of the nursing and public health workforce conducted or contracted by the Health Resources Services Agency Bureau of Health Professions, the National Sample Survey of Registered Nurses, the National Council of State Boards of Nursing, and the National Association of County and City Health Officials. To our knowledge, only 1 survey has sought to profile the PHN workforce in a more extensive and detailed manner than that conducted by the national sources identified here.¹⁷ Despite the extent to which we rely on these surveys for planning workforce needs in the United States as Tilson and Gebbie⁸ noted almost 2 decades ago, and restated by others more recently,¹⁸ enumeration surveys have been plagued by highly variable criteria for determining whether to "count" a nurse as a member of the PHN workforce. This lack of precision has severely impeded our ability to determine the actual number or supply of public health nurses in the workforce. Moreover, it has left us unable to assess if communities meet the recommended national minimum standard of a public health nurse-to-population ratio of 1 to 5000 in the United States, and, as COVID-19

has so painfully taught us, it rendered us unable to determine if this standard is adequate to meet the needs of the population during regular times and in times of crisis.¹⁹

Given the population-based initiatives described previously and the public health challenges that we face as a nation, we analyzed how national workforce enumeration studies have operationally defined PHN and measured the roles, functions, and job tasks or activities engaged in by public health nurses. Table B (available as a supplement to the online version of this article at <http://ajph.org>) details the measurement approaches taken for enumerating public health nurses across 7 national enumeration surveys from sources listed previously.

Notably, surveys designed to enumerate the public health workforce did not differentiate nurses by the level of licensure (licensed practical nurse or registered nurse) or educational preparation, whereas those enumerating the nursing or PHN workforce did so. Regardless of the target workforce, all surveys used practice settings to define public health nurses. Only 1 included a formal operational definition of PHN that used practice setting as a criterion;¹⁷ others defined public health nurses through their primary practice setting by default. Among surveys of the nursing workforce, response options used to count public health nurses by their settings spanned "public health," "public health/community health agency" (and specified these agencies were not clinic-based agencies), and those working in "justice, public order, and safety."

Relevant to the roles and functions that are prominent in defining the PHN specialty (Table A), no surveys of the public health workforce capture the roles public health nurses fulfill within their primary practice setting. Among surveys of the nursing workforce that include tangential indicators of the roles and functions that are part of formal definitions of the specialty, either "position held" or the "specialty area of a nurse's primary practice position" were most often used. Notably, the University of Michigan's Center of Excellence in Workforce Studies¹⁷ survey is the only one since 2000 that was designed to enumerate and characterize public health nurses, specifically. The survey did include a "job function" item, although the response options were limited in number ($n = 9$). This was the only item among the included reports that captured data to delineate job function in a way that can be mapped onto both individual and population-level role functions specified in the definitions that guide the PHN specialty (Table A). When included, measures of percentage full-time equivalent (%FTE) were most often used to sum the total %FTEs of public health nurses at the organizational level or identify the proportion of time spent in a primary and secondary setting. Only the National Sample Survey of Registered Nurses²⁰ asked nurses to estimate the percentage of their time in a typical work week spent carrying out several different job functions or tasks. Even the far more comprehensive University of Michigan survey¹⁷ of public health nurses restricted the %FTE questions to the proportion of time nurses spent across program areas, rather than the job functions or tasks carried out within program areas.

REENVISIONING MEASUREMENT CRITERIA FOR PUBLIC HEALTH 3.0

Our analysis indicates that, for the past 2 decades, practice setting is primarily used to identify which members of the public health or nursing workforce are doing the work of PHN. With a single exception, the measurement strategies used for enumeration do not reflect the defining features of PHN that undergird the specialty's definition for professional practice, the scope and standards of practice, or practice competencies. Measuring the PHN workforce in this manner is problematic on 3 fronts: (1) the use of setting as a proxy for roles and function, (2) the limited taxonomies used to characterize roles and functions, and (3) the minimal capture of %FTE spent carrying out multilevel job functions—particularly among positions, specialty areas, or program areas where nursing job functions may vary widely across individual and population levels of care. In what follows, we recommend 3 directions for reenvisioning how to more accurately enumerate the PHN workforce moving forward.

Moving Beyond Setting for Roles and Functions

We argue that setting may be acceptable when the sampling frame is restricted to governmental health departments whose core missions and functions are to achieve the Essential Public Health Services²¹—all of which occur at the population level. As such, it can be reasonably assumed that the nurses working within them or employed by them are carrying out the vision, mission, and functions of public health and are guided by the scope and standards and practice competencies of the PHN specialty.

When we attempt to enumerate which nurses function as public health nurses outside of health department agencies, the waters become murky, and setting alone is inadequate to identify which nurses are carrying out, and how frequently they are carrying out the roles and functions defined in each of the soon-to-be-released scope and standards' 8 salient areas for PHN practice:

1. health promotion and protection,
2. emergency preparedness and disaster recovery,
3. environmental safety and quality,
4. clinical interventions,
5. care coordination,
6. cross-sector collaboration and community engagement or partnership,
7. research, and
8. policy and advocacy.⁶

Inconsistencies in how national surveys^{21,22} define settings outside health department agencies add to a lack of precision and likely bias data in the direction of overinflating estimates of the PHN workforce. Ultimately, a setting-centered approach fails to accurately enumerate public health nurses whose roles and functions focus on broader population-level determinants and adversely affects our ability to ensure the health of the US public.

Developing Taxonomies of Roles and Functions

The use of non-public health taxonomies to assess the roles and functions of nurses cannot tell us if nurses are practicing in a manner consistent with PHN definitions, scope and standards of practice, or practice competencies. In acute care or hospital settings, there is a fairly narrow, well-defined, and relatively uniform range of roles and functions that nurses carry out when working in, for example, a "critical/intensive care" setting or specialty.^{20(p7)} In community-based and public health settings and specialties, there is significantly greater variation in the roles and functions of nurses across levels of care that span the range of individuals, families, communities, and larger populations.

Given this, we recommend that more definitive categories of job roles and functions, such as those being developed in the Public Health Workforce Taxonomy Revision Project,¹⁸ are widely adopted in surveys intended to enumerate or characterize the PHN workforce. Ongoing since 2014, this project now includes 46 common daily job functions carried out by the public health workforce—all of which are categorized within the Essential Public Health Services.²¹ Applying public health-specific taxonomies to identify the roles and functions nurses are engaged in would likely substantially reduce measurement error and more accurately reflect the population-based activities that define PHN practice.

Percentage of Time Spent on Public Health

A final recommendation is to shift the paradigm of enumeration in a way that can account for nurses carrying out PHN roles and functions based on an allocation of the %FTE they spend on them. Adopting this as a standard moving forward can also serve as a benchmark for the extent to which our nation is meeting the visions put forward in PH3.0 and the many nursing education and practice initiatives that seek to center a population health orientation within the profession. Capturing %FTE allocated to carrying out roles and functions will, for example, enable us to determine whether nurses working in community-based settings are, in fact, doing the work of addressing SDOH lauded in both the AACN Essentials²⁻⁵ and the Future of Nursing 2020-2030 report.⁷ Moreover, combining measures of %FTE with the more granular taxonomy of roles and functions such as those in the Public Health Workforce Taxonomy Revision Project¹⁸ will allow us to discern whether nursing efforts to tackle SDOH (regardless of setting) reflect the upstream focus required to make meaningful progress toward achieving health equity. Each measurement feature that is problematic for enumerating the PHN workforce can be remedied with increased and strategic collaboration between nursing and public health workforce researchers. As the many initiatives currently underway seek to shift nurses practicing outside the governmental public health system toward the provision of more population-focused care, methods for assessing this change are urgently needed. Similarly, adopting more precise approaches for understanding the roles, functions, and activities that public health nurses

working within or for governmental public health systems are engaged in can assist administrators in these agencies to assess the extent to which they may be understaffing or underutilizing their own PHN workforce, or both. While certification might be proposed as a strategy to identify public health nurses in workforce surveys, we do not believe this is viable for 2 reasons. First, PHN-specific certifications have been recently discontinued, despite opposition from those within the PHN specialty.²³ Second, while registered nurses in a small number of states may obtain a registration certificate as a public health nurse from their board of nursing, their registration is voluntary, and there is an associated cost when registering.^{24,25} If this approach were used, nurses who decide not to register as a public health nurse through the board of nursing despite working in a population-focused role would go uncounted. As such, the absence of a national approach to licensing and the variation in state rules and statutes make this strategy unfeasible.

CONCLUSIONS

At this critical juncture when awareness of public health is heightened and the role of nurses in health care is celebrated, organizations must ensure accurate enumeration of public health nurses. There is an urgent need for a uniform national framework for data collection, analysis, and reporting to more accurately quantify the size, distribution, and contributions of the PHN workforce. While the exact methodological specifications need development, measurement criteria grounded in PH3.0, the 8 updated roles and functions in the revised PHN scope and standards of practice, and the developing Public Health Workforce Taxonomy Revision Project¹⁸ is crucial, where setting and actual engagement in activities related to PHN roles and functions would be combined for PHN enumeration purposes moving forward.

We envision an approach that provides enhanced clarity and allows for comparable, standardized data to be used by decision-makers, policymakers, and public health strategists who depend on assessments of public health nursing supply and demand. Moreover, future work to pinpoint where these 8 roles and functions intersect with PH3.0 strategies could provide insight into public health nurses' current and future contributions to public and population health.

Public health nurses are professional registered nurses whose practice has an impact on individual-, community-, and systems-level outcomes.²⁶ Their multifaceted engagement, through their specialty-delineated roles and functions, distinguishes them from many other nurse colleagues working in community-based settings. There is now a clarion call through PH3.0 for organizations to align PHN practice roles with the scope and standards of this nursing specialty, and we must be able to measure the extent of the PHN workforce moving in that direction. This will require incorporating standardized definitions, roles, and functions that are specific to public health nurses into surveys so the results will be more useful for creating workforce plans that integrate public health nurses into the broader public health infrastructure and can inform how we evaluate the PHN contribution to population-level outcomes. While health workforce needs and resources differ by geography, population demographics, and political will, a desired outcome remains one that prioritizes public health organizational practices that move PHN roles in the direction of PH3.0. To achieve this goal, however, public health nurses must be included in decision-making processes for determining new enumeration approaches going forward. Å1PU

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Public Health Nursing and Older Adults: The CAPABLE Model

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ABSTRACT (ENGLISH)

Public health nurses have a long history of leading prevention and treatment of child health, parenting, infectious disease prevention, public health screening, and anticipatory guidance of all stages of life. Within these domains, there are many home-visiting programs for children, such as the Nurse-Family Partnership. One vital area of public health nursing that receives less attention is supporting older adults and their families within their communities.

FULL TEXT

Public health nurses have a long history of leading prevention and treatment of child health, parenting, infectious disease prevention, public health screening, and anticipatory guidance of all stages of life. Within these domains, there are many home-visiting programs for children, such as the Nurse-Family Partnership. One vital area of public health nursing that receives less attention is supporting older adults and their families within their communities.

BACKGROUND

For older adults, physical function is often ignored by the US health care system as being beyond the bounds of medical care, but, in some ways, it is the very foundation of older adults' ability to engage in meaningful roles. People with disability should be supported and included in society at any age and ability. The environmental context that includes social and physical attributes is crucial to support older adults to function with a range of abilities and disabilities.

Too often, public health nurses and other home visitors have focused on clinical issues such as diabetes and congestive heart failure; however, often it is more urgent to address social determinants of health such as lack of food, inability to bathe, and social isolation. There is an urgent need for public health nurses to adopt models of care that fully integrate the social determinants of health along with the clinical status of the older adult.

THE CAPABLE MODEL

One such model of care is Community Aging in Place-Advancing Better Living for Elders (CAPABLE), a four- to five-month, participant-directed, home-based program that increases mobility and function of older adults in their home environment. CAPABLE achieves this through identifying what matters to the older adult, their strengths, and optimal "fit" within the home environment. Each visit is tailored specifically to the older adult's self-selected goals. An interprofessional team comprising an occupational therapist (OT) and registered nurse (RN) works with the older adult to understand the person's goals (e.g., to walk downstairs, take a shower, or get dressed without pain) and then use modern behavioral science, such as action planning, along with home modifications by a handy worker, to enable the older adult to achieve them. In the CAPABLE program, the team conducts 10 in-home visits with participants to achieve six person-centered functional goals.

As examples, if a participant wants to be able to prepare food rather than wait for a neighbor to help, the OT and

participant strategize feasible, energyconserving approaches and tools. To complement these strategies, the nurse uses behavioral activation strategies to help the participant manage depressive symptoms and pain if they are interfering with meal making. The handy worker stabilizes stairs, levels or repairs floors, and improves lighting to enable participants to practice newly learned mobility skills safely and efficiently.

The CAPABLE program began in 2009 with a pilot and has since been tested in multiple peer-reviewed studies that show that the program reduces disability and depressive symptoms, increases confidence about completing daily tasks without falling, and reduces costs through reduced hospitalizations and nursing home visits (savings of approximately \$22 000 per participant over two years).^{1,2} CAPABLE participants routinely describe the life-changing impact of newly being able to take a bath, cook a meal with ease, or go to community events. CAPABLE is currently becoming embedded into systems of care^{3,4} and in three states in Medicaid.

CAPABLE addresses equity because it is tailored to each individual's cultural beliefs, strengths, and goals.

Clinicians visiting the home do not presuppose anyone's goals, nor their individual strengths. In CAPABLE, each person gets the same number of visits and potential goals, but the program completely tailors the content to the older adults. One person's goals may be to make meals without pain and shortness of breath, while another's might be to walk down the stairs and get into a car.

CAPABLE builds on the strengths of older adults using an approach that promotes self-efficacy. Able to bathe, dress, and leave the house, older adults are once again ready to advise small businesses, take care of grandchildren, contribute to their religious communities, and run for political office. People aged 65 years and older are our fastest growing natural resource.

CAPABLE AND AGE-FRIENDLY HEALTH SYSTEMS

CAPABLE may also be delivered through the Age-Friendly Health Systems model based on a framework using the four M's: what matters, mentation, medication, and mobility.⁵

For example, with CAPABLE, the RN and OT begin the first home visit by asking each participant what matters most to them. This becomes the basis for the older adult's goal setting and action plans for the program. The RN reviews the older person's medications and asks detailed questions about their regimen. In some cases, this leads to identification of potential adverse effects or interactions and a recommendation for the older person to have a conversation with their primary care provider. Regarding mentation, or the mind, both the RN and OT address issues related to potential dementia, delirium, and depression. As noted earlier, studies on CAPABLE have demonstrated improved scores on depression scales and referrals as needed when dementia or delirium are identified. Finally, the OT and handy worker address functional capacity through extensive evaluation of the older person and the home environment, including providing home modifications as indicated.

A PUBLIC HEALTH APPROACH

Public health nurses are well positioned to provide CAPABLE across the United States. The illustrious history of public health nurses includes the pivotal role of district nurses. If there were sufficient funding for public health nurses, those nurses could become familiar with the strengths and needs of older adults in their districts and assess them for CAPABLE eligibility.

In addition, public health departments and Area Agencies on Aging assess people for the need for home-delivered services; as part of that assessment, they could evaluate for CAPABLE, which could trigger a referral. Public health nurses could do this through health departments or other regional approaches to reaching older adults. In Massachusetts, the Area Agencies on Aging and Aging Service Access Points are implementing CAPABLE statewide through the Medicaid (MassHealth) 1915c Frail Elder Waiver. Four other states have received or identified funding to implement CAPABLE statewide via Medicaid or other state authorities. Similar to homevisiting programs for first-time parents, CAPABLE could be organized through health departments for people who have been identified in a health risk assessment to need resources and support to maintain their ability to age within the community. This is but one way for public health nurses and their interdisciplinary colleagues to use strengths-based approaches to improve older adults' health and well-being.

As The Future of Nursing 2020-2030 report⁶ makes clear, public health nursing and the US health care system must

focus on achieving health equity built on strengthened communitybased programs and services for people of all ages and abilities, across income levels and multiple cultural belief systems. Nurses are perfectly positioned to bring together public health, health care, social services, education, and public policy.

The health of communities can flourish within a system that supports health outcomes and wellness instead of simply capturing patient visits. As fiscal incentives align with population health, public health nurses will lead and ensure that people of all backgrounds and health states are included in equitable approaches to promoting quality of life. Demonstrating health benefits, as well as optimizing overall costs for the public and decisionmakers, will help promote policy changes to build an effective public health and health system infrastructure.

CAPABLE is one model in which unleashing people's potential can support their desire to contribute meaningfully to their communities. As health care shifts away from acute care hospitals to home and community-based settings, we must leverage the power of older adults, nurses, and public health departments to support wellbeing and quality of life of all people equitably within each community.

Sidebar

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CONFLICTS OF INTEREST

S. L. Szanton reported being an inventor of the Community Aging in Place-Advancing Better Living for Elders (CAPABLE) training program, for which she, Johns Hopkins University, and Thomas Jefferson University are entitled to fees. This arrangement has been reviewed and approved by theJohns Hopkins University in accordance with its conflict-of-interest policies.

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Challenges Facing Public Health Nursing Faculty in the United States: COVID-19 as a Catalyst for Change

Thurman, Whitney, RN, PhD; Heitkemper, Elizabeth, RN, PhD; Johnson, Karen E, RN, PhD

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ABSTRACT (ENGLISH)

We present an analysis of challenges facing public health nursing faculty members (PHNF) in the United States and their broader societal implications. The COVID-19 pandemic has exacerbated these challenges, making them untenable. Current academic structures-influenced by the broader sociopolitical climate-are problematic for PHNF: they disincentivize PHNF from researching social determinants of health and public health systems, teaching systems-level content that may be deemed "controversial" and that is not included on licensure exams, and engaging in service through advocacy and community partnerships. The fault lines within health care, public health systems, and higher education indicate that it is time to reevaluate how to incentivize sociallyjust and equitable outcomes. Toward this goal, we propose that collective action and systemic change, including the perspectives of PHNF, is needed to better realize our shared goals. The analysis serves as a catalyst for conversations about academic structures, health care systems, the role of public health, and the kind of society we envision for ourselves and future generations. (AmJ Public Health. 2022;112(S3):S314-S320. [https:// doi.org/10.2105/AJPH.2022.306819](https://doi.org/10.2105/AJPH.2022.306819))

FULL TEXT

Headnote

We present an analysis of challenges facing public health nursing faculty members (PHNF) in the United States and their broader societal implications. The COVID-19 pandemic has exacerbated these challenges, making them untenable.

Current academic structures-influenced by the broader sociopolitical climate-are problematic for PHNF: they disincentivize PHNF from researching social determinants of health and public health systems, teaching systems-level content that may be deemed "controversial" and that is not included on licensure exams, and engaging in service through advocacy and community partnerships. The fault lines within health care, public health systems, and higher education indicate that it is time to reevaluate how to incentivize sociallyjust and equitable outcomes.

Toward this goal, we propose that collective action and systemic change, including the perspectives of PHNF, is needed to better realize our shared goals. The analysis serves as a catalyst for conversations about academic structures, health care systems, the role of public health, and the kind of society we envision for ourselves and future generations. (AmJ Public Health. 2022;112(S3):S314-S320. [https:// doi.org/10.2105/AJPH.2022.306819](https://doi.org/10.2105/AJPH.2022.306819))

COVID-19 has become a generation-defining pandemic. Although the inhospitable and unsustainable environments

of nurses working in US hospital settings during the pandemic have been well documented,¹ less attention has been paid to how public health nurses working in various settings, including academia, have fared. As public health nursing faculty members (PHNF), our unique perspective of the pandemic-adjacent to the frontlines but fundamental to contributing to the evidence base, educating the public, and building the nursing workforce pipeline-has highlighted a critical need to reimagine the systems within which we work.

Since COVID-19 emerged, PHNF have been asked to meet prepandemic expectations in teaching, research, and service productivity within the uncharted realities and uncertain future that quickly became standard. At the same time, they have advocated for the needs of our current and future "health care heroes" working in hospitals who have been largely abandoned as the pandemic rages on. However, it is the most egregious of these challenges-the affronts to PHNF's credibility and ethical principles-that has catalyzed the need for change. Examples of these challenges include university leaders across the country implementing COVID-19 protocols in alignment with partisan decisionmaking at state and local levels and governmental public health agencies making recommendations steeped in individualism as opposed to the collective good. Such policies and recommendations have often been in direct contradiction to the principles of public health and evidenced-based practice.

In this article, we critically analyze the challenges facing PHNF that result from the current systems in which we work. We argue that these examples illustrate the need for a paradigm shift across academic nursing and society more broadly. We draw on our perspectives as PHNF to illuminate larger systemic, structural, and cultural issues in higher education that require attention and investment from the US public writ large if we are to prepare our future nurses, and citizens, with the knowledge and skills needed to achieve a healthy and equitable society. Long-standing health and social inequities have been revealed and exacerbated by the pandemic, and the role of PHNF in calling for and driving public dialogue is more important than ever. Next, we provide a brief overview of the scope of public health nursing in the United States before turning our attention to challenges specific to PHNF.

Ample evidence reveals gaps in understanding surrounding public health nurses' (PHNs') unique focus, preparation, role, and essential activities.²⁻⁴ Accounting for more than 20% of the public health workforce but just 1.5% of the registered nursing workforce,^{5,6} PHNs are distinct from other nursing specialties in their population-level focus on health. PHNs focus on the health of aggregates, which translates to examination of groups of people sharing certain characteristics and lived experiences (e.g., people living in a defined geographical community or identifying as a certain ethnicity). As such, this work is concerned with affecting group-level health indicators (e.g., addressing persistent inequities across health outcomes by social group). Unlike individual-level approaches to addressing health that have dominated nursing for decades and that focus efforts on the individual as the locus of intervention and change (e.g., precision health, symptom science and management), public health nursing operates from a systems-level perspective that views society, institutions, and policies as the locus of change. As such, PHNs must understand, develop, evaluate, and critically engage with stakeholders, programs, policies, laws, and institutions that shape social determinants of health and group-level health indicators to create upstream systems-level change. One salient example of how a concept critical to public health and PHNs has been often misused by those focused on individual-level interventions, is the application of social determinants of health.⁷ This term is frequently used to describe connecting individual patients with nonmedical resources that affect their ability to engage with the health care system or in healthy behaviors (e.g., providing patients with bus passes to attend health care appointments). Although important, this is an instance of meeting a social need, not addressing a social determinant of health. By definition, social determinants of health operate at systemic levels and must therefore be addressed through systems-level interventions (e.g., improving the public transportation system so that everyone benefits, or ensuring a livable wage so that everyone can afford to access public transportation). This issue highlights the different knowledge and skill sets that addressing social determinants of health requires, which have been reported to be lacking among nursing faculty.⁸ This lack of conceptual clarity in past and present scholarship is problematic for a profession positioning itself to sit at tables of influence focused on addressing social determinants of health (as evidenced by recent priority setting documents for nursing; e.g., the Future of Nursing Report,⁵ the new National Institute of Nursing Research [NINR] Strategic Plan⁹) and highlights how the specialized expertise of PHNF is

crucial to achieving health equity.

Yet, PHNF who do possess the expertise needed to work at the systems level often find themselves in the crosshairs of an increasingly hostile political landscape that remains a largely unacknowledged barrier. Specifically, public health is largely a function of local, state, and federal government, and the funding, implementation, and enforcement of public health programs and policies are often beholden to the political needs and strategies of a few elected officials. This reduction of public health imperatives to political football leaves PHNF, like public health more broadly, to balance what their science, scholarship, teaching, and service indicates should happen against frequently misaligned partisan realities. Like public health, public universities are especially vulnerable to state-level policy and politics, and partisan priorities often have tangible impacts on PHNF at such institutions. For these reasons, we focus this analysis on PHNF at public research universities in the United States as they strive to fulfill their tripartite mission of research, teaching, and service. Outlining how and why current systems work against PHNF in public universities as we rebuild the nursing and public health workforces decimated by the pandemic will codify the need to reimagine our systems and enact change.

COVID-19 AS CATALYST FOR REENVISIONING OUR SYSTEMS

Academic faculty at universities in the United States focus on 3 priority areas: (1) to develop a program of science and scholarship with clear impact, (2) to educate future generations, and (3) to give back to their profession through service. In evaluating progress toward these areas, universities have created metrics to define success. Over time, a status quo in which these metrics are uncritically accepted as what is required for academic success has been established. However, the fault lines within our health care and public health systems as well as higher education indicate that it is time to reevaluate whether current metrics incentivize socially just or equitable outcomes.

Using Albert Hirschman's Exit, Voice, and Loyalty¹⁰ as a heuristic, we posit that PHNF have reconciled their tensions with the status quo and maintained a "loyalty" to their institutions, professions, and students by infusing concepts such as social justice and structural competence throughout their courses¹¹ without challenging the economic and power structures driving higher education and health care in the United States. In the wake of the pandemic, however, it is apparent that this loyal subversion maintains and even reinforces a broken status quo of prevailing individualistic ideologies. That is, such loyalty relies on the efforts of individual faculty members who value public health to insert relevant concepts into the curriculum or their science ad hoc, instead of demanding a cultural shift in which social justice and health equity are expected outcomes of the academic enterprise. Further, leaving social justice up to individual nurse educators is problematic, owing to differing interpretations and conceptualizations of social justice across the profession.¹² Finally, loyalty on the part of individuals does not effect systemic change. Individuals may feel better in knowing that they have followed a righteous path in the face of structural opposition, but ultimately, this loyal subversion creates complacency about our current systems. Given this, we are now witnessing a logical end to the loyalty and maintenance of the status quo and the unjust systems this perpetuates.

Returning to Hirschman,¹⁰ the remaining option is to exercise voice to wield the collective power of the largest segments of the health care and public health workforces.^{13,14} PHNF may not hold all the answers, but PHNF do have specialized knowledge about the challenges and opportunities in public health and nursing practice to inform and expand public debate about social justice and health equity. We recognize, however, that the systems within which we work, partisan realities of public universities in the United States, and broader American culture often render such voices silent, even in the face of devastating inequities such as those endured by many during the COVID-19 pandemic. Thus, in the next sections we exercise voice by drawing attention to how current systems and structures undermine the ability of PHNF to succeed in advancing health equity and in preparing the future workforce to understand and address social determinants of health. We achieve this by focusing on the 3 pillars of academia: research, teaching, and service.

PUBLIC HEALTH NURSING RESEARCH

In the wake of the COVID-19 pandemic, it is critical that we accelerate the translation of knowledge and focus on science that can advance social justice.¹⁵ It has been argued that public health interventions cannot be socially just

unless they attend to the larger social determinants of health that create inequities.¹⁶ However, there is little support for PHNF to conduct such research to improve health equity by explicitly targeting social determinants of health or public health systems and infrastructure, as the majority of funding for health disparities research to date has targeted individual-level care delivered through the health care system.¹⁷ The National Institutes of Health has not typically funded research on systems improvement,¹⁸ and the recently founded Patient-Centered Outcomes Research Institute represents an increased focus on delivery of clinical services. This is in stark contrast with the previously identified lack of a centralized mechanism for research on public health systems and services.^{18,19} Funding priorities that exclusively advance individual-level interventions have thus limited advancements in public health nursing science and undermined progress on social determinants of health, populations, and systems. In addition to funding priorities that are not inclusive of public health research, the institutions within which PHNF work have been slow to fully prioritize our most urgent social problems. Many public universities profess a commitment to serving their communities and fostering an ethic of public service and social justice; some have established centers for community engagement or community partnerships.²⁰ This type of community engagement is central to public health nursing science and to the pursuit of socially just research. However, abundant evidence shows that university cultures, infrastructures, and tenure decisions impede community-partnered research and action.²¹ University structures continue to grade contributions to science in terms of awarded research dollars (which compensate for cuts in state funding) and ratings in citation indexes, instead of considering real-world impact on people and populations.²² These metrics have been widely criticized,²³ and they impede the ability of PHNF to engage authentically with communities over the long term to maintain reciprocal partnerships essential for meaningful public health nursing research.

The dissemination of research findings is critical to the advancement of science, but linking tenure and promotion decisions to journal impact factors and researcher h-index values limits the reach of science unnecessarily and unjustly to those with access to discipline-specific journals that are typically behind paywalls. Furthermore, at most research-intensive public universities, dissemination of research findings in non-peer-reviewed products is not counted as scholarship, further impeding the ability of community partners and policymakers to incorporate evidence into real-world efforts to change systems. These metrics undermine the ability of PHNF to pursue policy-relevant community-engaged research, and they contribute to a pervasive cultural belief that health and education exist merely for the private benefit of the individual instead of as public goods for healthy communities.

PUBLIC HEALTH NURSING EDUCATION

Education is a university's most visible mission. As a result, course content and students' achievement are of interest to policymakers, taxpayers, and other stakeholders.²⁴ In nursing education, close attention is paid to metrics such as the US News & World Reports annual rankings of "best" nursing schools.²⁵ Pass rates on the National Council Licensure Examination (NCLEX) are closely monitored as this is the nationwide examination for the licensing of registered nurses, with accreditation, funding, and prestige based on these rates. Given public scrutiny and the outsized importance of the NCLEX in nursing education, PHNF face misalignments between institutional priorities and public health principles, because the NCLEX does not cover public health nursing content.²⁵ In environments driven by NCLEX pass rates, there is little incentive for students or faculty to engage with or master content traditionally considered to be solely the purview of public health nursing. Thus, content related to social determinants of health, health inequities, and systems-level practice is often relegated to a stand-alone public health nursing course in the final semester of baccalaureate degree programs or discussed only within the context of individual-level practice.^{5(p199)}

Similar dynamics extend to graduate education. For example, curricula in PhD programs emphasize methods and theories that focus on explaining and intervening upon individual-level behaviors, social needs, and health outcomes, with little to no coverage of emancipatory methods and theories that might prepare nurse scientists strategically to produce scholarship focused on understanding, critiquing, and changing systems. This siloing of content has contributed to an overall neglect of public health nursing across the curriculum and to the implication that public health nursing is not "real nursing."

As the pandemic has unfolded, the broad scope of nursing practice, and the importance of public health nursing in particular, have become more apparent to the public. Within public universities, however, PHNF have found themselves and their course content at the center of partisan gamesmanship at local, state, and federal levels. Because public health nursing is concerned with social determinants of health and health equity, PHNF must discuss politically fraught topics such as structural racism, white supremacy, and misogyny—all of which have roots in laws and policies that continue to produce inequities. Yet, even in the face of racial inequities laid bare by the pandemic, officials in many states have made unprecedented attempts to censor this content.²⁶

Partisan gimmicks notwithstanding, a growing consensus that predates the pandemic is reflected in both the *Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*⁵ and the revised American Association of Colleges of Nursing (AACN) Essentials. Both call for nurses across the spectrum to be better educated in social determinants of health, health inequities, and systems-level practice. Attaining the *Future of Nursing* report's vision and meeting the expectations of accreditation bodies require PHNF with the expertise to teach students and support the curricular changes needed to thread this content throughout the curriculum. At present, however, the pipeline of nurses with public health expertise from diverse backgrounds who could lead these efforts has nearly dried up: graduate programs in advanced public health nursing at US universities have nearly disappeared,²⁷ the AACN has retired the Advanced Public Health Nurse certification exam, and a dwindling number of doctoral candidates in nursing are supported to pursue scholarship addressing social and structural determinants of health. This trend mirrors the broader erosion of the public health workforce,¹⁴ and as university policies dictate enrollment numbers needed for economic vitality, the degradation of advanced public health nursing programs has further undermined PHNF and, subsequently, the public's health.

PUBLIC HEALTH NURSING SERVICE

Universities often view service to the profession as the least important academic role, accounting for little weight in annual and tenure reviews.²⁸ Particularly for pretenure PHNF, the importance of strategic, limited service is consistently reinforced by senior faculty mentors, leadership, and administration. This approach may facilitate success in current systems, but it reduces service to fragmented tasks focused largely on peer review and committee appointments rather than a holistic set of productive activities with their own impact. This precludes any meaningful contribution of service work to faculty scholarship or teaching, which for PHNF is critical. Hospital academic affiliations and partnerships facilitate the scholarship of nurse faculty focused on clinical care and individual-level patient interventions, with minimal to no need for added service work to facilitate those relationships, because academic medicine incentivizes clinical partners to be involved in research with preexisting policies and procedures.²⁹ By contrast, PHNF often use service activities to build a network from which to identify collaborators, find partners willing to contribute precious resources to research that falls outside the scope of their job responsibilities, and navigate complex issues such as data sharing.

Academia's narrow view of service also discounts advocacy work as a form of population-level PHN practice. Nursing consistently frames itself as the patient's advocate (see Provision 3 of the American Nurses Association Code of Ethics³⁰); however, in public health nursing, advocacy often occurs at a systems level rather than the individual level.³¹ The discounting of advocacy as service for PHNF reflects the reliance of public health funding and policies on government and thus politics, which includes partisan agendas intended to dismantle long-accepted tenets of public health (e.g., mandating vaccines) and halt the uptake of new, emerging evidenced-based practices (e.g., mask wearing).³² Additionally, PHNF at state-funded research universities are public employees. Technically, there are no constraints on political engagement for public employees, but especially in states known to be combative to public health policies, it may be risky for PHNF to engage in advocacy work lest they be perceived or accused of having partisan motivations.^{33,34} Therefore, many PHNF have to choose between engaging in activities crucial to public health and protecting themselves and their livelihood. Perhaps the politicization of facts about public health could have been mediated or avoided had PHNF and other nurse scholars felt empowered to be an active presence in the policy realm during COVID-19.

INTERMEDIATE ACTION STEPS: BUILDING TOWARD THE FUTURE

The issues facing our profession and the public's health are daunting, but within crisis lies opportunity. Indeed, although the pandemic has exacerbated preexisting fault lines within our society, it has also clarified the need for immediate action. Importantly, a movement within nursing academia is beginning to take shape. For example, the much-anticipated Future of Nursing⁵ report released in May 2021 highlights the unique knowledge and skills of the nursing workforce. This consensus report explicitly endorses the important role of the nursing profession in the complex work of aligning public health priorities with medical and social care to reduce disparities and improve equity.⁵ These are central tenets of public health nursing, and achieving the important goals of the report will require the unique expertise of PHNF. Similarly, in November 2021, the NINR released its draft strategic plan framework to guide research efforts and priorities over the next 5 years. The draft framework prioritizes health equity, social determinants of health, population and community health, prevention and health promotion, and systems and models of care.⁹

Although encouraging, these actions will require close shepherding if they are to truly usher in a new paradigm. If adopted and implemented, the vision set forth by the new NINR strategic plan has the potential to transform nursing science and address many of the recommendations included in the Future of Nursing report. However, the urgency of this work has yet to fully permeate the nursing profession as some are already questioning the need for a paradigm shift, suggesting that the status quo needs no disruption.³⁵ Thus, we suggest supporting PHNF whose work, when at its best, is a partnership with communities. This will ensure dialogue that determines not if we disrupt our current systems, but rather how to best do so. This support should include clearer protections for all nursing faculty, but especially PHNF, as they engage in the policy arena to advance data-based, scientifically driven policies that are free from partisanship. It should also include protected time for PHNF to develop authentic community partnerships. These partnerships are essential for the coproduction, implementation, and dissemination of knowledge that is rooted in the experiences of those most harmed by social and structural inequities. We fear that without these steps, the efforts of PHNF to help nursing achieve this important vision will remain muted and society will continue to suffer.

NEED FOR COLLABORATION AND PUBLIC CONVERSATION

There is a direct connection between the obstacles faced by PHNF at public universities in the United States, our country's tragic response to the COVID-19 pandemic, and the nursing workforce exiting at rates that threaten the collapse of the US health care infrastructure.^{36,37} Traditional academic structures—and the economic interests that shape them—are clearly misaligned with the work needed to protect and improve public health. The loyal subversion of individual PHNF members is insufficient to achieve the goals of our profession and serve society: we must show in academia that we value public health as fundamental not just to nursing practice, education, and science, but to social justice. Collective action and systemic change will be required in nursing academia if our profession is to maximize its voice and play a central role in tackling the health and social inequities that continue to plague our society. We join Dillard Wright³⁸ in calling for a radical imagination to disrupt the status quo and extend an invitation to the nursing discipline writ large to engage in the difficult but hopeful work of rebuilding and transforming the systems in which we work and for which we prepare future nurses, nurse educators, and nurse scientists.

We contend that although PHNF are critical to this work, it is not ours alone. We have suggested short-term, intermediate steps toward action, but a clearly charted path for successful system transformation will require ongoing collaboration and public conversation. The issues that we have outlined are intended to raise public consciousness and inspire our collective imaginations toward a healthier future in which we can all flourish. We do know, however, that as with any social movement, this particular effort toward reenvisioning health and education as public goods necessitates participation from a broad, intentionally diverse coalition. The challenges facing PHNF stem from collective problems that will require complex solutions informed by public conversations about academic structures, health care systems, the role of public health, and what kind of society we envision for ourselves and for future generations. As nursing schools field record numbers of applications,³⁹ it is imperative that we welcome our future colleagues into institutions that are living out their professed commitments to the public good and graduate them into a profession that is true to its community-based roots and its commitment to social justice. Ultimately, as a

society, we must consider our work as a public good to support the changes that need to occur within the education system, and move away from reducing the sole function of education as workforce preparation to preparing citizens who have the capacity to engage in the critical conversations needed to empower society to flourish.

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DETAILS

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Paleofire Data for Public Health Nursing Wildfire Planning: A Planetary Perspective

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ABSTRACT (ENGLISH)

Public health is increasingly threatened by global warming, land use, and changing wildfire patterns that shape vegetation type, structure, and biodiversity and ultimately affect ecosystem services and our society.¹ Uncontrolled large wildfires emit greenhouse gases and aerosols that induce direct and indirect climate feedback through radiative forcing in the atmosphere² and irreversible changes of natural vegetation, thereby further accelerating climate change and associated fire risks.³ Wildfires are also harmful to human health because they create high pollution concentrations of fine particulate matter that are 2.5 micrometers or smaller (PM_{2.5}) and concentrations of coarse particulate matter that are between 2.5 and 10 micrometers in size. When inhaled, particulate matter significantly increases a myriad of health outcomes, including overall mortality, cardiovascular mortality, and emergency department visits for respiratory morbidity, congestive heart failure, chronic obstructive pulmonary disease, and angina.^{4,5} Between July and October 2020, high PM_{2.5} concentrations from massive wildfires surrounding a large regional hospital in the western United States were associated with a 6% increase in COVID-19 cases.⁶ Risks for developing adverse health effects from wildfire smoke are greatest among people who are living with chronic conditions; who are experiencing intergenerational racial, economic, and housing discrimination; and who are facing social inequities from the COVID-19 pandemic.⁴ The unprecedented recent wildfires in the western United States and their ill effects on human health and society, as well as the multiple other threats to people and places brought about by climate change, draw attention to the increasing urgency of developing new public health approaches and long-term adaptation strategies to support future population health.

Public health nurses routinely work with people living in communities affected by wildfires, and they provide care such as health assessment, referrals to health and social services, education, shelter care, case management, disease surveillance, screening, vaccination, and collaborative planning. New cross-disciplinary perspectives and collaborations to inform and implement more effective strategies to address threats to population health are urgently needed. Planetary health is a crossdisciplinary perspective that explains how humans and natural systems are connected and how the exploitation of ecosystems and natural resources anywhere is damaging to the health of the planet.⁷ Planetary health is also a crossdisciplinary social and scientific movement that aims to protect and improve the health of the planet and all its inhabitants.⁷ Understanding past wildfire events can help determine effective adaptive strategies for future public health nursing services that support planetary health.

FULL TEXT

Public health is increasingly threatened by global warming, land use, and changing wildfire patterns that shape vegetation type, structure, and biodiversity and ultimately affect ecosystem services and our society.¹ Uncontrolled large wildfires emit greenhouse gases and aerosols that induce direct and indirect climate feedback through radiative forcing in the atmosphere² and irreversible changes of natural vegetation, thereby further accelerating climate change and associated fire risks.³ Wildfires are also harmful to human health because they create high pollution concentrations of fine particulate matter that are 2.5 micrometers or smaller (PM_{2.5}) and concentrations of coarse particulate matter that are between 2.5 and 10 micrometers in size. When inhaled, particulate matter significantly increases a myriad of health outcomes, including overall mortality, cardiovascular mortality, and emergency department visits for respiratory morbidity, congestive heart failure, chronic obstructive pulmonary disease, and angina.^{4,5} Between July and October 2020, high PM_{2.5} concentrations from massive wildfires surrounding a large regional hospital in the western United States were associated with a 6% increase in COVID-19 cases.⁶ Risks for developing adverse health effects from wildfire smoke are greatest among people who are living with chronic conditions; who are experiencing intergenerational racial, economic, and housing discrimination; and who are facing social inequities from the COVID-19 pandemic.⁴ The unprecedented recent wildfires in the western United States and their ill effects on human health and society, as well as the multiple other threats to people and places brought about by climate change, draw attention to the increasing urgency of developing new public health

approaches and long-term adaptation strategies to support future population health.

Public health nurses routinely work with people living in communities affected by wildfires, and they provide care such as health assessment, referrals to health and social services, education, shelter care, case management, disease surveillance, screening, vaccination, and collaborative planning. New cross-disciplinary perspectives and collaborations to inform and implement more effective strategies to address threats to population health are urgently needed. Planetary health is a crossdisciplinary perspective that explains how humans and natural systems are connected and how the exploitation of ecosystems and natural resources anywhere is damaging to the health of the planet.⁷ Planetary health is also a crossdisciplinary social and scientific movement that aims to protect and improve the health of the planet and all its inhabitants.⁷ Understanding past wildfire events can help determine effective adaptive strategies for future public health nursing services that support planetary health.

UNDERSTANDING CHANGES THROUGH PALEOFIRE SCIENCE

Satellite data and other observations of the past decades suggest that the recent wildfire severity is unprecedented in many regions compared with the Holocene, defined as the past 12 000 years after the end of the Last Glacial Period.³ In addition, wildfire risks emerge in previously fire-free regions; for example, Greenland experienced a first natural fire in 2017. These recent observations suggest that rapidly changing wildfires and associated disruption of natural systems in response to climate change and growing human activities result in large atmospheric smoke plumes.

Observational fire data covering the past few decades give valuable information on current wildfire events.¹ However, these data hardly capture long-term trends (i.e., centennial to millennial time scales) of wildfires and associated atmospheric emissions that may help to improve future fire models and thereby provide the base to adapt public health systems.³ To understand long-term trends, natural archives preserve fire history on a wide range of spatial scales in the past beyond the period of observational fire data; examples include polar and highalpine ice cores; lake, peat, and marine sediment cores.^{3,8,9} Such paleofire records are based on measurements of the gaseous tracers ammonium and nitrate or particulate matter, such as levoglucosan and black carbon, and charcoal that reflect different components of wildfire-induced atmospheric smoke pollution.^{8,9} These paleofire records have previously identified complex regional interactions of humans, ecosystems, and climate change.³

Submicron-sized (100-500 nm in diameter) black carbon particles from wildfires and fossil fuel during the industrial era (i.e., the past 250 years) measured in ice cores and lake sediments can be used as a direct tracer for the release of harmful PM_{2.5} to the atmosphere.^{8,10} Such paleo black carbon records have been established from both polar and high-alpine glaciers on several continents and are recently developed from lake sediments.¹⁰ These found significant changes of fire activity in response to climate and human impact and enhanced pollution levels varying both in time and space. For example, the 13th century first humans arriving in New Zealand from Polynesia used fire for land clearing that caused enhanced blackcarbon concentrations in Antarctic ice cores more than 7000 kilometers away.¹¹ In addition, these ice cores give a long-term analog of past societies' responses not only to fire but also to other events, such as the Black Death pandemic of the 14th century or climatically warmer or cooler periods that, together with written historical sources, add to a holistic understanding of societies in the past (Figure 1).⁹ These historical data can help with understanding current wildfire effects and needed adaptation strategies.

INCORPORATING PALEOFIRE DATA INTO ADAPTATION STRATEGIES

Public health nurses' work uniquely spans between nursing and public health with a focus on community, system-level change, and population health equity.¹² As such, public health nurses are experts in the needs of the populations in which they serve.¹² As the climate crisis continues, there will be an increased need for rapid implementation of local adaptation strategies against wildfires to protect future population health. With public health nurses being well positioned to understand population health needs, planetary health, and the health consequences of wildfires, public health nurses can improve upon wildfire adaptation planning and essential public health services by understanding historical perspectives from past fires.^{9,11,13}

Paleofire data provide direct estimates of historical atmospheric emissions from past wildfires and associated harmful concentrations of particulate matter over long distances. Incorporating paleofire data into public health

adaptation strategies demonstrates the concept within planetary health that human needs and natural systems are connected.⁷ Furthermore, given that large parts of society do not believe in global warming and future associated wildfire changes,¹⁴ public health nurses can use paleofire and paleoclimate data as a tool to communicate climate oscillations, centennial-to-millennial scale wildfire patterns, and how these wildfires have affected past societies. Public health nurses are representatives of a trusted health profession who are skilled in translating scientific or medical information in relatable terminology while addressing cultural sensitivity.¹² By using paleofire data as a storytelling communication tool, public health nurses can address their communities' diverse views on climate change and wildfire patterns.

In the United States, approximately 43% of Americans are worried about the consequences of wildfires to their local areas.¹⁴ Paleofire data provide an understanding of the geographic distribution of future wildfire risks with changing climate and socioecological factors and the frequency and return intervals between wildfires in a given area.³ Comparing and contrasting paleofire data with recent observational fire data can be useful to identify locations potentially vulnerable to future wildfires. Public health nurses can prioritize and target adaptation strategies for communities that are at risk for experiencing wildfires and associated smoke plumes. Public health nursing adaptation strategies can include home assessments for ventilation and filtration, diagnosis of comorbidities, identification of economic and social capital, assessment for availability of asthma rescue and reliever medications, and access to clean water. Additional planning could involve public health nurses partnering with regional tertiary care systems to support preparation for wildfire events and potential surges in Emergency Department use. Additionally, public health nurses can combine paleofire data with recent observational fire data to identify potential locations to establish nonurgent screening clinics that could be used during a regional wildfire event for nonurgent health assessment screenings. Combining paleofire data with recent observational fire data can support public health nurses in identifying the communities that are at highest risk and guide a targeted approach to implementing wildfire and wildfire-associated smoke plume adaptation strategies.

Given the ongoing COVID-19 pandemic and immediate health needs surrounding the pandemic, planning for wildfires may not be in the forefront of public health nursing practice. However, planning for the health consequences associated with wildfires will continue to be needed, with the consequences associated with wildfires potentially worsening the COVID-19 pandemic.^{4,6} To address future wildfire consequences, public health nurses may need to collaborate with partners across disciplines and organizations and with community partners. To identify collaborators, public health nurses can reach out to emergency planners within state, local, and territorial public health departments and tertiary care systems, frontline emergency planners, paleofire and wildfire scientists at universities, and community members with lived wildfire experience.

By having community members with lived experience, the collaboration would be investing in a communitybased participatory approach. By having a team with diverse perspectives and diverse organizational approaches led by public health nurses or public health emergency planners, such collaborations could plan for mitigating health risks associated with wildfires in the coming decades, thus promoting an equitable and sustainable health system. ÂfPU

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The authors have no conflicts of interest to declare.

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Health Coaching Across the Stages of Vaccine Readiness and Action: A Practical Guide for Public Health Nurses

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ABSTRACT (ENGLISH)

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which causes COVID-19, is part of a family of coronaviruses. It was identified to be the cause of a highly contagious severe respiratory syndrome that resulted in a global pandemic starting in early 2020.¹ In the United States, relatively high COVID-19 morbidity and mortality have been documented among older adults, people with chronic health conditions, people with low socioeconomic status, the underinsured, and those from diverse racial and ethnic backgrounds.^{2,3} For example, African Americans represent 13.4% of the US population but accounted for more than 24% of the COVID-19-related deaths.^{4,5} Adjusted for age, the rate of death from COVID-19 is twice as high for Latinx, African American, and Indigenous people as it is for their White counterparts.^{6,7} COVID-19's disproportionate impact on racial and ethnic minorities and vulnerable populations has amplified the need to increase vaccination outreach among these groups as a matter of equity.

In May 2020, just a few months after the initial identification of the SARS-CoV-2 virus, the US federal government established a program (Operation Warp Speed) to accelerate the development of an effective vaccine against COVID-19. Several months after the establishment of Operation Warp Speed, PfizerBioNTech, Johnson & Johnson, and Moderna all received Emergency Use Authorization from the US Food and Drug Administration for their vaccines against COVID-19. The development of an effective vaccine against COVID-19 was a major accomplishment of science and was seen as the primary public health strategy to reduce infections and deaths and thereby to end the pandemic. Yet, lack of vaccine uptake puts in peril the goal of controlling the spread of the virus, particularly among communities that are at greatest risk of contracting and dying of the illness.

FULL TEXT

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which causes COVID-19, is part of a family of coronaviruses. It was identified to be the cause of a highly contagious severe respiratory syndrome that resulted in a global pandemic starting in early 2020.¹ In the United States, relatively high COVID-19 morbidity and mortality have been documented among older adults, people with chronic health conditions, people with low socioeconomic status, the underinsured, and those from diverse racial and ethnic backgrounds.^{2,3} For example, African Americans represent 13.4% of the US population but accounted for more than 24% of the COVID-19-related deaths.^{4,5} Adjusted for age, the rate of death from COVID-19 is twice as high for Latinx, African American, and Indigenous people as it is for their White counterparts.^{6,7} COVID-19's disproportionate impact on racial and ethnic minorities and vulnerable populations has amplified the need to increase vaccination outreach among these groups as a matter of equity.

In May 2020, just a few months after the initial identification of the SARS-CoV-2 virus, the US federal government established a program (Operation Warp Speed) to accelerate the development of an effective vaccine against COVID-19. Several months after the establishment of Operation Warp Speed, PfizerBioNTech, Johnson & Johnson, and Moderna all received Emergency Use Authorization from the US Food and Drug Administration for their vaccines against COVID-19. The development of an effective vaccine against COVID-19 was a major accomplishment of science and was seen as the primary public health strategy to reduce infections and deaths and thereby to end the pandemic. Yet, lack of vaccine uptake puts in peril the goal of controlling the spread of the virus, particularly among communities that are at greatest risk of contracting and dying of the illness.⁸

The reasons for the lack of COVID-19 vaccine uptake among some communities in the United States are multifaceted, some of which include concerns about the safety or effectiveness of the vaccines, the speed in which the vaccines were developed, misinformation about the vaccines, and systemic barriers affecting community access (i.e., online appointment systems, inadequate transportation, and lack of child care).^{9,10} For many communities of color, including African American and Latinx individuals, COVID-19 vaccine reluctance is rooted in both historical and contemporary experiences of systemic racism, forced sterilization of Latinx women in California, the Tuskegee Study of Untreated Syphilis in the Negro Male (renamed as the US Public Health Service Syphilis Study at Tuskegee), marginalization, medical distrust, neglect from the scientific and medical communities, poor public health infrastructure, and institutional abandonment.^{2,3,10} In addition to those reasons, the politicization of the vaccine development process and efforts to increase vaccination after the 2020 US presidential election have deepened distrust among some communities. However, although many Americans, including members of communities of color, have significant reasons to be skeptical about receiving the COVID-19 vaccine, skepticism does not always equal vaccine refusal.¹⁰

Nurses and other public health workers conducting vaccination outreach play a critical role in engendering trust in vaccines, specifically COVID-19 vaccines. A 2021 Kaiser Family Foundation survey found that 79% of US adults who have not yet been vaccinated say they would likely turn to a trusted nurse, doctor, or other health care provider when deciding whether to get a vaccination.¹¹ As health care professionals, nurses and other public health workers are often a patient's first clinical contact and are among the most trusted sources of information about the vaccines. They are well positioned to have discussions about COVID-19 vaccines, having served on the front lines of the fight against the pandemic in both inpatient care and public health response through leadership in contact tracing and case investigation efforts. Nurses are leading the nation's vaccine administration efforts and, to many, are the most accessible source of information for questions about safety, side effects, and benefits.^{11,12} To be effective, nurses and other public health workers require an understanding of the reasons that prevent people from getting vaccinated and have practical tools to support people with their decisions regarding if, when, and how they get vaccinated against COVID-19. We propose a framework, developed by a nurse scientist, titled the Stages of Vaccine Readiness and Action, along with health coaching tools that are applicable to each stage of the framework to increase vaccination uptake among all communities at risk for contracting the SARS-CoV-2 virus.¹³ Altogether, our experiences and the vignettes in this perspective are based on our work of training and supporting more than 11 500 pandemic response specialists, vaccine outreach workers, and other pandemic response specialists (including many

nurses) across the state of California.¹⁴

Our Stages of Vaccine Readiness and Action framework (Box 1) was adapted from the transtheoretical model,¹⁵ which was developed to understand how people engage in complex health behavior change by assessing readiness and motivation. We posit that individuals move through five stages of vaccine readiness and action: vaccine skepticism, vaccine curiosity, vaccine readiness, vaccine action, and vaccine maintenance. The relationship between the stages in the framework are cyclical, and individuals can move in either direction at different points in time when exposed to new information (e.g., negative news reports) or negative experiences (e.g., a family member who had an adverse reaction). For each stage, different strategies or interventions drawn from the techniques of health coaching may help to move the person to the next stage of the cycle and support them to action, in which they are actively seeking vaccination against COVID-19. These techniques are based on decades of research in health coaching and its parent philosophy of motivational interviewing as methods to influence health behavior to improve chronic disease management, combat addiction and destructive behaviors, and improve health.¹⁶⁻¹⁹ Below, we provide a case scenario along with a brief overview of each of the stages of vaccine readiness and action and provide health coaching strategies that can be used to move persons from one stage to the next.

VACCINE SKEPTICISM

Joe is a healthy, middle-aged adult who has known only a few people mildly affected by COVID-19. He's suspicious of the hurried pace of vaccine development and doesn't like being "pushed into" getting the vaccine.

Vaccine skepticism refers to a disinterest in or lack of trust in vaccines generally or specifically regarding the COVID-19 vaccine. One of the main drivers of the distrust in the COVID-19 vaccines is the politicization of the vaccine development process.^{20,21} Although politicization has deepened vaccine skepticism in some sectors, skepticism may be found across the political spectrum.^{22,23} Unlike the commonly used term vaccine hesitancy, vaccine skepticism acknowledges the valid reasons why people might not be interested in the vaccine, including safety concerns, uncertainties about potential side effects, misinformation, medical racism, or distrust in the government or health care institutions. Some vaccine skeptics may have deeply entrenched beliefs and may not be open to discussions about receiving a COVID-19 vaccine. Others may be willing to engage in discussion if the approach is respectful. The HEAR technique (Box 1) is a tool to defuse emotion and explore motivation and beliefs in a nonconfrontational way, regardless of the drivers of skepticism.²⁴ The HEAR technique is an acronym for hear, Cupres gratinude, ask about pros and cons, and respond. It begins with asking open-ended questions to understand someone's perspective more deeply and reflecting back to them their thoughts and feelings (hear), as well as to share appreciation for the person's willingness to talk or share concerns (express gratitude). Asking about the reasons that people do not want to get the vaccine (ask) and any motivation that they may have to get the vaccine (pros) is a powerful way to open a conversation about personal motivations for and against vaccination (ask about pros and cons). The final step is to ask if it's okay to share more information about the person's specific concern for them to consider as they make their own decision (respond). Someone in the stage of vaccine skepticism may not be 'ready' to 'Change their mind'; reaching the point at which they are open to new information is a significant achievement.

VACCINE CURIOSITY

Elena has been meaning to talk with her 14-year-old daughter's pediatrician about getting the vaccine and is glad you called her today. Her sister told her that the vaccine can disrupt the menstrual cycle and might later affect fertility. She wants to know if it's safe for young people who might someday want to have kids.

Individuals in this stage of vaccine curiosity are interested in getting vaccinated but have questions or concerns that they would like to address first. These may include questions about the safety or effectiveness of the vaccine, whether it is needed after "natural immunity" is acquired from infection, side effects, or lifelong consequences such as effects on pregnancy or impact on chronic illness. The "ask-tell-ask" technique uses open-ended questions to explore concerns and share tailored information that these individuals can use to make an informed decision about receiving the vaccine. For example, if someone shares, "Yes, I've been thinking about it, but I wonder if I should just wait and see," a public health nurse might respond, "Thanks for sharing that! May I ask what you've heard that

makes you want to wait and see?"

VACCINE READINESS

Antonia wants to get the vaccine but cannot take time off work. On weekends she takes care of her kids and doesn't want to put them at risk by bringing them to the vaccination site.

People who are vaccine ready want to get the vaccine but may face various barriers, including but not limited to the ability to navigate the registration system, transportation to the vaccine administration site, immigration concerns, accessibility and site hours, inadequate access to the Internet to schedule appointments online, and competing responsibilities. Action planning is a health coaching tool that may be used to support people in breaking down complex challenges into next steps (Box 1). This entails developing a menu of options from the individual's experience and asking what would work best for them. Follow-up questions can help an individual think about the first step, how and when they can do it, and who can support them to the point of full vaccination.

VACCINE ACTION

Suneet scheduled his vaccine appointment online and showed up at the pharmacy over his lunch break on time to receive it, but he was told that his appointment was actually at a different location across town. When he asked if he could receive it at the current pharmacy he was at, he was told that he could not. Frustrated, he returned to work without having received the vaccine.

Someone in the stage of vaccine action is actively seeking a vaccine but may continue to experience barriers to receiving the vaccine. As in the stage of vaccine readiness, action planning is a tool that can help them overcome barriers that they encounter. Should they encounter barriers that prevent them from securing a vaccine, they may be back at the stage of vaccine readiness, and a return to vaccine action may be the next step.

VACCINE MAINTENANCE

Charles completed his primary vaccine series. However, he is skeptical about being asked to get a "booster" shot. "First, they say that if I get two shots, I'm protected, and now they're talking about a booster shot! Why should I trust anything they say anymore?"

Individuals in the vaccine maintenance stage may have completed a primary COVID-19 vaccine series and now require regular vaccine boosters to maintain protection against the virus. It looks increasingly likely that maintaining immune protection against COVID-19 will require regular maintenance vaccines or boosters. Even among people who have completed a primary vaccination series, their response to being asked to get additional vaccinations will likely range from skepticism to readiness. Understanding their stage of readiness for additional boosters can allow the public health nurse or outreach worker to use the tools described above to respond respectfully. For example, one might recognize Charles's response described above as an example of vaccine skepticism and use the HEAR technique to engage with him (Box 1).

CONCLUSIONS

The Stages of Vaccine Readiness and Action framework provides a set of tools to identify and respectfully engage with people at different stages of readiness. It is important to note that the stages of vaccine readiness are fluid. The issues that people are considering may span several stages, and people may not move linearly between stages. For example, the individual who doesn't think he needs the vaccine as a young, healthy person but who is planning to get it to appease a family member might be simultaneously in the stages of vaccine skepticism (because he doesn't think he needs the vaccine) and vaccine readiness (because he intends to receive the vaccine). Although vaccine skepticism and vaccine curiosity can often be addressed on the individual level, effectively addressing challenges faced by people who are vaccine ready may require breaking down system-level barriers to achieve full vaccination.²⁵ Promoting uptake of the COVID-19 vaccine is the critical task of the moment. Our Stages of Vaccine Readiness and Action framework, coupled with health coaching tools, may provide a practical approach to equipping people such as public health nurses and outreach workers on the front lines of vaccine outreach and administration.

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O.O. Harris conceptualized the Stages of Vaccine Readiness and Action framework, wrote major sections of the paper, and oversaw the final submission. R. Willard-Grace oversaw and wrote the sections on health coaching and contributed to the final manuscript. K. D. Taylor and A. Maher also contributed equally to the manuscript in terms of writing other sections of the manuscript.

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Revitalizing Public Health Nursing for the Future

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ABSTRACT (ENGLISH)

Public health nurses have served valiantly on the front lines of the COVID-19 pandemic for the past two years, saving lives through contact tracing, educating people about selfisolation and quarantining, vaccinating communities, and interpreting for their communities vacillating guidance from the Centers for Disease Control and Prevention (CDC). They have worked long hours and assumed new and unfamiliar roles without adequate staffing. I include school nurses in my definition of public health nurses because school nurses take on similar roles to improve population health. They improve health care access; engage school communities, parents, and health care providers to promote wellness and improve health outcomes for children; and address social needs and the social determinants of health for the families and communities they serve.

Yet, the government's decision to underfund the public health infrastructure for more than a decade has undermined the ability of public health professionals to respond to the pandemic as robustly as they could have.¹ These funding shortfalls have meant that as public health nurses have devoted their efforts to mitigating the pandemic, they have watched long-standing efforts to address maternal health care and other vital programs lose ground.² Working in underresourced communities, many public health nurses have witnessed firsthand the devastating and unequal toll that the pandemic has taken on poor and marginalized communities. They find themselves under siege from a segment of the public and some political and media figures who have threatened, cursed, and attacked them.³ Frustrated parents have criticized school nurses when their children have been subjected to quarantine and isolation. In addition, acute care nurses' more visible contributions have received more attention than public health nurses' efforts to combat the pandemic.

FULL TEXT

Public health nurses have served valiantly on the front lines of the COVID-19 pandemic for the past two years, saving lives through contact tracing, educating people about selfisolation and quarantining, vaccinating communities, and interpreting for their communities vacillating guidance from the Centers for Disease Control and Prevention (CDC). They have worked long hours and assumed new and unfamiliar roles without adequate staffing. I include school nurses in my definition of public health nurses because school nurses take on similar roles to improve population health. They improve health care access; engage school communities, parents, and health care providers to promote wellness and improve health outcomes for children; and address social needs and the social determinants of health for the families and communities they serve.

Yet, the government's decision to underfund the public health infrastructure for more than a decade has undermined the ability of public health professionals to respond to the pandemic as robustly as they could have.¹ These funding shortfalls have meant that as public health nurses have devoted their efforts to mitigating the pandemic, they have watched long-standing efforts to address maternal health care and other vital programs lose ground.² Working in underresourced communities, many public health nurses have witnessed firsthand the devastating and unequal toll that the pandemic has taken on poor and marginalized communities. They find themselves under siege from a

segment of the public and some political and media figures who have threatened, cursed, and attacked them.³ Frustrated parents have criticized school nurses when their children have been subjected to quarantine and isolation. In addition, acute care nurses' more visible contributions have received more attention than public health nurses' efforts to combat the pandemic.

THE FIELD IS STRESSED

In many cases, their stress has reached a breaking point: a CDC survey released in July 2021 found that more than half of people working in public health at the state, tribal, local, and territorial levels during the pandemic reported symptoms of depression, anxiety, suicidal thoughts, and post-traumatic stress disorder.⁴ Many public health nurses are retiring or seeking higher-paying jobs in other health care settings. Within the public health workforce, participation by nurses has fallen faster than that of other professional groups.⁵

We must commit to a better future for public health nurses that starts with fully funding the field and recognizing that they are essential to improving population health and advancing health equity. Public health nurses intervene at early ages, focus on prevention, and connect with their communities to understand and address social needs and the social determinants of health, according to the National Academy of Medicine (NAM) report, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*.⁶ School nurses, among the most visible public health nurses, are sometimes the only health professionals schoolchildren visit regularly. They detect illnesses early, help manage chronic conditions, and provide mental health support. Yet, one in four schools has no school nurse, and 35% employ a school nurse only parttime.⁷ Schools with a higher proportion of low-income families are less likely to employ a school nurse. The NAM report contains comprehensive recommendations that, if followed, would provide public health nurses with the support and structure they need to care for themselves and their communities more fully.

RECOMMENDATIONS TO REVITALIZE PUBLIC HEALTH NURSING

Perhaps most important, the NAM report recommends that federal and state governments ensure adequate funding for school and public health nursing, including paying public health nurses competitive wages compared with nursing positions in other health care organizations and sectors. "Underfunding limits the ability of school and public health nurses to extend health care services and create a bridge between health care and community health," the report notes.⁶(p176) The Biden administration has taken an important step in committing significant resources to buttress the public health nursing workforce.⁸ Similarly, the report calls on the government to rapidly increase the number of public and community health nurses. Students who plan to work in professional shortage areas should be eligible for scholarships and have their loans forgiven, the report notes. Similarly, the government and private foundations should provide major investments for nursing education and traineeships in public health.

In addition to the infusion of federal funds to support public health nursing, the report calls on federal, tribal, state, local, and private payers and public health agencies to explicitly value nurses' contributions to care by reforming payment systems to pay for services that address the social determinants of health and advance health equity. Payment systems should reimburse for team-based care, improved communication between providers and patients, and proven interventions and strategies that can reduce health inequities.

The report recognizes that too few nurses are entering public health nursing to fill vacant positions and replace the many public health nurses who are on the cusp of retirement or leaving the field. To that end, the report calls on schools of nursing to better incorporate the social determinants of health and health equity into the curricula and to expand community learning opportunities. This will better prepare all nurses to advance health equity, regardless of the care setting in which they ultimately seek employment, and should encourage more nursing students to seek out these roles upon graduation.

The report also recognizes the need for our society to fully support nurses to enable them to advance health equity. The report includes a number of recommendations for creating structural and cultural changes, primarily that nursing education programs, employers, nursing leaders, licensing boards, and nursing organizations initiate the implementation of structures, systems, and evidence-based interventions to promote nurses' health and well-being, especially as they take on new roles to advance health equity. One cultural change that could be particularly

beneficial for public health nurses could include requiring them to take time off, because the CDC survey found that public health workers who were unable to take time off from work were nearly twice as likely as others to experience poorer mental health. Although employers allowed their workers to take time off, the workers said they did not take time off because of feelings of guilt, because no one else was available to take their place, or because they worried about work accumulating during their absence.³

Finally, the report calls on all nursing organizations to leverage the expertise of public health nurses. It calls on the Council of Public Health Nursing Organizations (composed of the Alliance of Nurses for Healthy Environments, the American Nurses Association, the American Public Health Association Public Health Nursing Section, the Association of Community Health Nursing Educators, the Association of Public Health Nurses, and the Rural Nurse Association) to work with other leading nursing organizations to develop a shared agenda for nursing to address the social determinants of health and to advance health equity. The nursing organizations should identify specific priorities across nursing practice, education, leadership, and health policy.

Taken together, these comprehensive recommendations offer a roadmap to rebuild and revitalize the public health nursing workforce to better protect our nation's health, address the social determinants of health, and advance health equity. >4JPH

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Intersectional Stigma and Prevention Among Gay, Bisexual, and Same Gender–Loving Men in New York City, 2020: System Dynamics Models

Lutete, Priscila, MPH; Matthews, David W, MBA; Sabounchi, Nasim S, PhD; Paige, Mark Q, MS; Lounsbury, David W, PhD; Rodriguez, Noah, BS; Echevarria, Natalie, BS; Usher, Dashawn, BS; Walker, Julian J, BA; Dickerson, Alexis, BS; Hillesheim, Joseph, BA; Frye, Victoria, DRPH

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ABSTRACT (ENGLISH)

Objectives. To create causal loop diagrams that characterize intersectional stigma experiences among Black, gay, bisexual, same gender-loving, and other men who have sex with men and to identify intervention targets to reduce stigma and increase testing and prevention access. **Methods.** Between January and July 2020, we conducted focus groups and in-depth interviews with 80 expert informants in New York City, which were transcribed, coded, and analyzed. These qualitative insights were developed iteratively, visualized, and validated in a causal loop diagram (CLD) using Vensim software. **Results.** The CLD revealed 3 key feedback loops-medical mistrust and HIV transmission, serosorting and marginalization of Black and gay individuals, and family support and internalized homophobia- that contribute to intersectional HIV and related stigmas, homophobia, and systemic racism. On the basis of these results, we designed 2 novel intervention components to integrate into an existing community-level anti-HIV stigma and homophobia intervention. **Conclusions.** HIV stigma, systemic racism, and homophobia work via feedback loops to reduce access to and uptake of HIV testing, prevention, and treatment. **Public Health Implications.** The CLD method yielded unique insights into reciprocal feedback structures that, if broken, could interrupt stigmatization and discrimination cycles that impede testing and prevention uptake.

FULL TEXT

Headnote

Objectives. To create causal loop diagrams that characterize intersectional stigma experiences among Black, gay, bisexual, same gender-loving, and other men who have sex with men and to identify intervention targets to reduce stigma and increase testing and prevention access.

Methods. Between January and July 2020, we conducted focus groups and in-depth interviews with 80 expert informants in New York City, which were transcribed, coded, and analyzed. These qualitative insights were developed iteratively, visualized, and validated in a causal loop diagram (CLD) using Vensim software.

Results. The CLD revealed 3 key feedback loops-medical mistrust and HIV transmission, serosorting and marginalization of Black and gay individuals, and family support and internalized homophobia- that contribute to intersectional HIV and related stigmas, homophobia, and systemic racism. On the basis of these results, we designed 2 novel intervention components to integrate into an existing community-level anti-HIV stigma and homophobia intervention.

Conclusions. HIV stigma, systemic racism, and homophobia work via feedback loops to reduce access to and uptake of HIV testing, prevention, and treatment.

Public Health Implications. The CLD method yielded unique insights into reciprocal feedback structures that, if broken, could interrupt stigmatization and discrimination cycles that impede testing and prevention uptake. (AmJ Public Health. 2022;112(S4):S444-S451. <https://doi.org/10.2105/AJPH.2022.306725>)

Gay, bisexual, same gender-loving, and other men who have sex with men (SGL/MSM) are disproportionately affected by HIV in the United States.¹ In 2018, over two thirds of new HIV cases were attributed to male-to-male sexual contact, and SGL/MSM make up about 40% of new HIV cases nationwide.^{2,3} Geographic hotspots in urban areas of northeastern states report new case rates among Black SGL/MSM that are equal to those of some southern states.⁴ New York City (NYC) is the metropolitan area with the largest number of new HIV infections among MSM, with prominent racial disparities in HIV infection.⁵

Increasing uptake of postexposure and preexposure prophylaxis (PEP/ PrEP) is critical to ending the HIV epidemic in the United States,⁶ especially among Black SGL/MSM, but prescribing data reveal that Black and Latinx SGL/ MSM make up just 25% of PrEP users^{7,8} and are 6 times less likely to be prescribed PrEP as White MSM. HIV testing is crucial to access, and infrequent testing delays diagnosis, contributing to morbidity and mortality.⁹ Approximately 80% of new infections are transmitted from the 40% of people living with HIV but undiagnosed or not in care.¹⁰ Thus, consistent testing is now recommended for MSM.¹¹

Black SGL/MSM are more likely than White MSM to be living with undiagnosed HIV.^{12,13} Although HIV testing has increased among Black and Latinx MSM,¹⁴ health care access and quality,¹⁵ lack of structurally or culturally competent services,¹⁶ low risk perception^{17,18} and fear of a positive result¹⁹ present multilevel barriers to testing among Black SGL/ MSM.²⁰ Barriers to PrEP use are also multilevel,²¹ and include health care system-level factors (e.g., funding or health insurance, access to settings with PrEP, messaging), provider-level factors (e.g., inadequate knowledge, discomfort discussing sexual behavior, cultural competency, and bias),²²⁻²⁴ and individual-level factors (e.g., cost, stigma, lack of awareness, and low risk perception).^{22,25-27}

HIV-related stigmas (e.g., HIV stigma, HIV testing stigma, and PrEP stigma)^{28,29} and homophobia act independently and in combination to reduce prevention and treatment access among MSM. HIV stigma is a key barrier to HIV testing,^{30,31} care engagement,³² antiretroviral therapy use,³³ and intention to use PEP/PrEP.³⁴ HIV testing stigma also impedes self-testing.³⁵ Additionally, PrEP/PEP stigma,³⁶ which emerged in the early days of PrEP,³⁷ continues to be reported by MSM,³⁸ and community-level and anticipated PrEP stigma³⁹ influences uptake of biomedical prevention.⁴⁰ Homophobia is a barrier to prevention^{41,42} and is negatively associated with PEP awareness and use.⁴³ Although associations between homophobia and HIV testing are mixed,⁴⁴ internalized homophobia has been associated with never testing among Black MSM.⁴⁵

HIV-related stigma and homophobia are often racialized, exacerbating barriers to testing, prevention, and treatment among MSM of color.^{42,46,47} The intersections among systemic racism, HIV stigma, HIV-related stigmas, and homophobia particularly affect MSM of color, as systemic racism, manifest in discriminatory policies and practices,^{48,49} blocks opportunities and produces stratification.⁵⁰ Medical racism⁵¹ is of particular importance to Black SGL/ MSM⁵²⁻⁵⁴ and, together with medical mistrust, is a barrier to testing, care, and prevention independently and in interaction with HIV-related stigmas and homophobia.⁵⁵⁻⁵⁸ This intersectional interaction among systems of oppression fundamentally condition how stigmatized individuals experience their social worlds.⁵⁹ Combined, they interact to drive fear and anxiety (e.g., fear of positive HIV test results or being identified as gay), avoidant coping (e.g., HIV or sexual health-related service aversion), and medical mistrust or medication skepticism (e.g., selective communication, side effect concerns), which reduce testing and PEP/PrEP uptake.²⁸

Social policies as well as community-level and multilevel interventions can reduce experienced stigma and support individuals in responding to and resisting stigma and discrimination.⁶⁰⁻⁶² However, the knowledge base upon which to build complex anti-intersectional stigma and discrimination interventions is sparse. To address this gap, we applied a qualitative system dynamics (SD) modeling approach to create causal loop diagrams (CLDs) that characterize the dynamic interactions among intersecting stigmas and systems of oppression, including HIV stigma, homophobia, and racism, among Black SGL/MSM in NYC. SD modeling is a systems science approach that has been used to study the dynamic behavior of complex systems and problems in health care, engineering, and social work and provides a framework to develop insights into potential interventions.⁶³ SD allows researchers to represent complex systems, including modifying and mediating factors.^{64,65} The primary aim of the CLD development process here was to identify intervention targets to reduce intersectional stigma and increase HIV testing and prevention uptake. Thus, as a qualitative SD model, our model formalizes feedback loops, but does not yield a simulation of a mathematical SD model. In this article, we present the results of the CLD development process and application of these results to intervention component design; next, the components will be pilottested and integrated into an existing community-level intervention.⁶²

METHODS

System dynamics modeling provides a systematic method for description, exploration, and analysis about the dynamic behavior of intersectional stigma experiences among Black SGL/MSM. We generated CLDs based on analysis of transcripts and notes from a series of focus groups (n = 11 groups; n = 59 participants) and in-depth interviews (n = 21) with 80 expert informants, comprising Black SGL/MSM (n = 59) and HIV and social service professionals of color (n = 21) between January and July 2020. We conducted both individual and group interviews because each inquiry method yields different insights (e.g., social interactions critical to norm formation may be observed in groups, whereas individual interviews may yield personal information). Participants were recruited online (e.g., Facebook and Instagram), in person, and via word of mouth; allies and community leaders shared promotional materials on personal pages. All participants self-identified as male and 96% self-identified as Black or African American; participants ranged in age from 24 to 61 years and half self-reported living with HIV. All participants identified their gender as male; 95% identified as gay, SGL, or homosexual. Two thirds reported having an undergraduate degree or higher. All participants lived in the NYC metropolitan area. Our groups and interviews used scripts that elicited "systems thinking" (e.g., vignettes, presentation of simplified CLDs) to explore the roles of HIV stigma, homophobia, and racism on sexual behavior, partnering, HIV-related prevention and care access, family and community experiences, and other relevant and emergent areas. Our scripts evolved as data began to accrue and emergent focal areas were identified.

The analysis used text data ("quotes") from the interviews and groups, which were digitally recorded, professionally transcribed, and coded in an Airtable- a cloud collaboration service that we designed to organize the data for creating CLDs. The table included 14 columns: interview and group number, coder, quotes, and quote summary, among others. The first and second author (P. L. and D. W. M.) read and coded all transcripts in waves. First, we applied 5 "tags" or broad codes or areas of focus, including stigma, homophobia, racism, pandemic (COVID-19/SARS-CoV-2) and PrEP/PrEP. Next, we coded several "causes," including internalized homophobia, HIV stigma, medical mistrust, intersectionality, and PrEP education and marketing. We then coded primary, secondary, and tertiary "effects," based on the content of individual participant quotes, including PrEP usage, HIV stigma, HIV transmission, access to HIV care, mental health (including self-esteem), internalized homophobia, concealing of sexual identity, and medical mistrust. Finally, we coded the "relationship" or the direction of the relationship. We instructed the coders to code the same quote twice if more than 1 cause and effect was described in the quote. Coders were also instructed not to code previous paragraphs (to the focal quote) to give context to quotes. In-depth interviews were coded by 3 analytic team members; focus groups were coded by 2 members of the same team. Select focus groups and interviews were double coded to enhance consistency. The analytic team developed codes for variables and initial and plausible relationships (linkages), with the full study team meeting weekly to discuss the coding process, develop the CLD, and resolve coding discrepancies. A designated column in the Airtable ("dataset

item") served as means to reference the variables that were added to the CLD.

We developed the CLD using these data in Vensim modeling software. Members of the analytic team read each transcript and generated relevant queries. Numerous rereadings of the quotes occurred during meetings and relabeling of variables, and new variables were added through this iterative process. The analytic team led a series of structured discussions designed to validate the CLD, which visualizes the processes, or feedback structures, using positive (1) and negative (-) signed links that form either "reinforcing" or "balancing" loops. Reinforcing loops explain exponential growth or decline, and balancing loops bring variables into steady states and stabilize the system. We identified feedback processes that represented narratives reflected in the text data, beginning with the dynamics of stigma, then layering in homophobia, racism, PrEP, and HIV testing. Collectively, the resultant CLD represents a dynamic hypothesis, or statement, about a given problem of focus. CLDs often serve as a formative step in building formalized SD models for mathematical simulation. Here, we used the models to develop novel anti-intersectional stigma intervention components. Thus, the CLD was presented in a series of meetings with study advisors, including members of MOBI (Mobilizing Our Brothers Initiative) and academic intervention design and analysis experts, where we focused on select loops within the CLD, identifying theoretical intervention targets and brainstorming interventions. The process resulted in the novel anti-intersectional stigma intervention components.

RESULTS

Through this analytic process, we identified individual, community, and social constructs (termed "variables" in the CLD) and connections among them, resulting in a synthesized CLD that illustrates the entirety of the structures of a system and their causal relationships based on the data we collected. Our synthesized CLD contains several hundred loops and dozens of variables, including broad systems, such as HIV stigma, racism, and homophobia, as well as smaller systems (subsystems) embedded within the broader systems. A simplified version of the synthesized CLD is illustrated in Figure A (available as a supplement to the online version of this article at <http://www.ajph.org>), depicting medical mistrust (red), mental health (green), and serosorting (blue). We also identified loops that combined subsystem loops that are not color coded. Because of the complexity of the synthesized CLD, we isolated subsystems for further analysis. Specific variables and connections from those isolated subsystems are described below, first using the language of the "story" or narrative that the loops "tell" and then as applied to the theoretical and conceptual factors that could be targeted in various intervention components.⁶¹ Table A (available as a supplement to the online version of this article at <http://www.ajph.org>) displays key variables and selected participant quotes that informed the identification of the variable and the polarity of the links in 2 focal loops.

Feedback Loop 1

Medical mistrust and HIV transmission. This feedback loop depicts the medical mistrust and HIV transmission variables and connections (Figure B, available as a supplement to the online version of this article at <http://www.ajph.org>). The "story" of this reinforcing loop suggests that decreased trust in medical professionals among Black and gay patients reduces sexual identity and orientation disclosure and increases sexuality hiding to health care providers, among others, which subsequently decreases patients' HIV testing and knowledge- and therefore disclosure of their HIV status to sexual partners. This increases the likelihood of sexual contact between people living with HIV and those who are not, which can increase HIV transmission. More infections drive further HIV stigma among all community members, including physicians who may stereotype and label patients. With more labeling of patients, Black gay men have more stigmatizing experiences with medical professionals. In sum, this sequence leads to continuous reduction in patients' trust in their medical professionals, in a vicious cycle, where the problem worsens over time at an increasing rate of speed.

In reinforcing loops, the cause-and-effect relationships perpetuate growth and repeatedly reinforce one another. This loop can be a virtuous cycle, with all its variables positively supporting each other, or a vicious cycle where a decline in 1 variable is propagated throughout the loop into a downward spiral. As indicated by the polarity of the arrows, some connections reinforce the direction of change, whereas others balance and oppose the direction of change. Notably, the loop adjacent to the medical mistrust and HIV transmission loop depicts the influence of representation in the health care of Black SGL/MSM ("Black gay representation in health care") on patient-provider interaction

("physicians disclosing similar experiences with patients") and on the quality of health care ("quality of care, humanizing and culturally competent care"), which links back to the focal loop via comfort with health care providers ("Black gay patients being uncomfortable at doctor's appointment").

Application to intervention component design. This loop informed our intervention component design by focusing us on the roles of patient-provider interactions and mistrust of biomedicine due to medical racism and lack of representation of people of color and of gay, lesbian, and bisexual people in health care provision. Thus, our component design targeted theory of change factors, such as provider disclosure of shared sexual and other behaviors and identities that increase feelings of connectedness and solidarity between the provider and patient, which in turn encourages patient disclosure of behaviors and conditions that are relevant to maintenance of sexual health and well-being. Representation in medicine may also be related to increased culturally and structurally competent health care provision (by all providers) via pathways external to this model, including increased emphasis in training on issues related to diversity, equity, and inclusion, as well as antiracist practices. The resultant component is a dramatization of a telehealth visit depicting patient-provider interaction in a clinical encounter; the component, implemented via videoconferencing technology because of the COVID-19 pandemic, is followed by a structured discussion with participants, both providers and potential patients, in break-out rooms.

Feedback Loop 2

Serosorting and marginalization of Black, gay, lesbian, and bisexual people. Our second potential focal area of intervention is a reinforcing feedback loop, representing the dynamics of within-community serosorting and marginalization among Black SGL/MSM (Figure C, available as a supplement to the online version of this article at <http://www.ajph.org>). This loop may be interpreted as follows: higher levels of HIV stigma (particularly experienced and perceived community stigma) increase serosorting-the practice of selecting sexual partners based on HIV status- which increases disclosure of HIV status, which in turn ultimately results in an increase of marginalization of Black SGL/MSM within the Black community. This results in negative mental health effects, which stimulate the growth of internalized and enacted stigma. This vicious cycle connects experienced stigma to mental health effects and to enacted stigma, which then drives generalized stigma.

Application to intervention component design. Applying the same approach as described for feedback loop 1, we developed a scenario that depicts an attempted disclosure of a recent HIV diagnosis by a young Black man to his older "mentor." The conversation also includes another individual, who is older than the mentor and was present during the early days of the HIV epidemic. Within the scenario, the oldest participant describes how they would not date someone with HIV because of the burden that the disease places on the caregiver. Here, the impact of community-level norms around respect for age and experience collides with more modern understandings of both HIV care and how sexual exclusion based on status (serosorting) can be experienced as stigmatizing.

Communication style and content are also theoretical targets. Finally, effective strategies to interrupt stigmatization by addressing the use of language is 1 focus of the postdramatization debrief, which was designed to include a role play and practice of stigma interruption skills.

Family Support and Internalized Homophobia Feedback Loop

From online Figure A, the feedback loop depicted in green was a key focus in the CHHANGE community-level intervention; this loop illustrates how family support and internalized homophobia operate to influence disclosure, self-acceptance, and internalized homophobia. The loop may be interpreted as follows: low or absent family support of gay, lesbian, and bisexual people increases opportunities for experiencing trauma, which can reduce self-esteem and self-love and can increase internalized homophobia. Higher levels of internalized homophobia decrease individuals' self-acceptance of their own sexual orientation, which leads to a corresponding drop in disclosure of sexual orientation. Participants described family dynamics in which gay, lesbian, and bisexual people expect that the disclosure of their sexual orientation will lead to a loss of family support. This sequence reduces self-acceptance and disclosure of sexual orientation. In this feedback loop, the impact of both may serve to support a higher level of internalized homophobia. Unlike reinforcing loops, which cause an acceleration of change, balancing loops usually serve to stabilize and slow the rate of change in the system to not only oppose initial changes in variables but also to

drive the system toward a stable goal. This loop (online Figure C) is disconnected visually to improve readability. We focused intensively on this loop in the CHHANGE intervention as described previously,⁶⁶ and thus we do not discuss its integration into the novel components.

Combined Loops

The interaction of the 3 feedback loops is depicted in online Figure C. The medical mistrust and HIV transmission loop is in red and connects with other loops present in online Figure A through the variables HIV stigma, disclosure of sexual orientation, and disclosure of HIV status. The purpose of these loops was to illustrate the intersectional effects of stigma and related variables. The variables colored gray were variables that, although connected to the feedback loops in question, did not necessarily form a feedback loop themselves. The balancing loop of family support and internalized homophobia (online Figure A, green) illustrates a force that brings stasis to the system. Through this loop, we expect meaningful changes in the current rate of disclosure of gay sexual orientation to be less likely to occur within the Black community. In other words, the rate of disclosure of gay sexual orientation is not expected to increase exponentially because it tends to reach an equilibrium. As reflected by participants' stories, disclosure of gay sexual orientation within the Black community is considered consistently low, which in turn reinforces lower rates of HIV testing, more transmission of new HIV infections, and increased HIV stigma in the reinforcing loop of medical mistrust and HIV transmission (Figure A, red). Finally, the rate of disclosure of HIV status interacts with the reinforcing loop of serosorting and marginalization of Black gay, lesbian, and bisexual people (blue). Serosorting ultimately increases HIV stigma, which in turn escalates the transmission of new infections among Black MSM in a feedback loop that includes medical mistrust and HIV transmission.

DISCUSSION

We developed a CLD grounded in participant stories that identified feedback loops highlighting broader systems affecting the health and well-being of SGL/Black MSM. The modified qualitative SD methodology encouraged significant engagement from participants during data collection and resulted in data adequate to characterize the complex system that Black SGL/MSM face that is consequential to HIV prevention and treatment. The resultant CLD reveals how various subsystems interact with and influence each other, sets of relations that are dynamic and change overtime. Because CLDs are living models, we expect that as new information, data, and interpretation emerge, the model may be enhanced.

On the basis of the CLD that emerged, we identified 2 key loops that could be realistically centered for intervention components to complement our existing CHHANGE community-level anti-HIV stigma and anti-homophobia intervention.^{62,66} Because of the COVID-19 pandemic, we imagined our novel components as being virtually delivered and in partnership with community members expert in delivering relevant and engaging content to Black SGL/MSM via digital formats. The components that eventually emerged, through input from a panel of expert advisors and a series of meetings with the MOBI team, included a theatrical presentation of dramatizations of technology-mediated social interactions where intersectional stigma unfolds. The postdramatization break-out activities and discussion are designed to unpack the issues and provide alternative ways of communicating and behaving to reduce experienced intersectional stigma.

The advantage of our approach, using the CLD rather than a matrix to map theoretical targets, is that the CLD isolates feedback loops and how the loop "behaves" in manifesting the dynamics of stigma, homophobia, and racism. Another advantage is that the full CLD is complex, multifaceted, and dynamic, making clear that effective interventions must also be multilevel and adaptive to achieve and sustain desired outcomes over time. This is a particularly important advantage as it forces the interventionist to face the complexity and dynamism of intersectional of oppression and privilege systems. Additionally, although the whole system can be taken into account, it is also possible to evaluate the impact of interventions based on specific subsystems. Understanding the whole system clarifies how a subsystem-focused intervention component may interrupt a specific feedback loop while another loop blocks its impact on the whole system. Because public health is conditioned by and the product of intersectional systems of oppression and privilege, the method can be applied to a range of public health concerns.

We applied a CLD to develop a better understanding of the complex system involving HIV stigma, HIV-related

stigmas, homophobia, and systemic racism, as they influence access to and uptake of HIV testing and biomedical prevention among Black SGL/MSM living in an urban area. Results were used to design novel intervention components to interrupt feedback loops in the whole system and to complement our existing community-level anti-HIV stigma and anti-homophobia intervention. Piloting the novel components will yield information on their feasibility and acceptability. The next steps will include integrating the new components into the existing intervention and evaluating its impact using methods optimized for estimating the impact of community-level and multilevel interventions on intersectional stigma-related outcomes. *Am J Public Health*

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CONTRIBUTORS

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CONFLICTS OF INTEREST

The authors have no potential conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

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Methods in HIV-Related Intersectional Stigma Research: Core Elements and Opportunities

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ABSTRACT (ENGLISH)

Researchers are increasingly recognizing the importance of studying and addressing intersectional stigma within the field of HIV. Yet, researchers have, arguably, struggled to operationalize intersectional stigma. To ensure that future research and methodological innovation is guided by frameworks from which this area of inquiry has arisen, we propose a series of core elements for future HIV-related intersectional stigma research. These core elements include multidimensional, multilevel, multidirectional, and action-oriented methods that sharpen focus on, and aim to transform, interlocking and reinforcing systems of oppression. We further identify opportunities for advancing HIV-related intersectional stigma research, including reducing barriers to and strengthening investments in resources, building capacity to engage in research and implementation of interventions, and creating meaningful pathways for HIV-related intersectional stigma research to produce structural change. Ultimately, the expected payoff for incorporating these core elements is a body of HIV-related intersectional stigma research that is both better aligned with the transformative potential of intersectionality and better positioned to achieve the goals of Ending the HIV Epidemic in the United States and globally. (AmJ Public Health. 2022;112(S4):S413-S419. <https://doi.org/10.2105/AJPH.2021.306710>)

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Headnote

Researchers are increasingly recognizing the importance of studying and addressing intersectional stigma within the field of HIV. Yet, researchers have, arguably, struggled to operationalize intersectional stigma.

To ensure that future research and methodological innovation is guided by frameworks from which this area of inquiry has arisen, we propose a series of core elements for future HIV-related intersectional stigma research. These core elements include multidimensional, multilevel, multidirectional, and action-oriented methods that sharpen focus on, and aim to transform, interlocking and reinforcing systems of oppression. We further identify opportunities for advancing HIV-related intersectional stigma research, including reducing barriers to and strengthening investments in resources, building capacity to engage in research and implementation of interventions, and creating meaningful pathways for HIV-related intersectional stigma research to produce structural change.

Ultimately, the expected payoff for incorporating these core elements is a body of HIV-related intersectional stigma research that is both better aligned with the transformative potential of intersectionality and better positioned to achieve the goals of Ending the HIV Epidemic in the United States and globally. (AmJ Public Health. 2022;112(S4):S413-S419. <https://doi.org/10.2105/AJPH.2021.306710>)

Researchers have recognized, studied, and addressed the role of stigma in HIV prevention and treatment since the early years of the epidemic. Stigma is a social process supported by social power that distinguishes people based on social statuses and results in devaluation.¹ As the HIV epidemic has become concentrated in populations at the nexus of multiple forms of oppression, such as Black sexual minority men in the United States, researchers have increasingly sought to adopt an intersectional lens when studying stigma. Yet, researchers have, arguably, struggled to operationalize intersectional stigma.

Intersectional stigma recognizes that HIV stigma intersects with other stigmas, such as stigma associated with race and sexuality, to create unique and sometimes new oppressive conditions and experiences.² (For more on the definition and framework of intersectional stigma, see Bowleg's introductory editorial in this supplement, p. S224.) Operationalizing intersectional stigma presents challenges because theoretical frameworks do not prescribe to researchers a predetermined set of variables to be measured or associations to be tested.³ They instead offer researchers essential tenets to guide their choices of research questions, study designs, measures, and analyses. To guide future innovation in HIV-related intersectional stigma research, we propose a series of theory-based core elements of, and identify several opportunities for, advancing HIV-related intersectional stigma research.

CORE RESEARCH ELEMENTS

Core elements of HIV-related intersectional stigma research include multidimensional, multilevel, multidirectional, and action-oriented methods that sharpen focus on, and aim to transform, interlocking and reinforcing systems of oppression. As described here and in Box 1, these methods can be integrated into research in many ways. We describe examples of studies that have applied these core elements to HIV-related stigma research, including research on stigma experienced by key populations and people living with HIV, in the sections that follow. Many of these examples incorporate only 1 or 2 core elements (e.g., multidimensional or multilevel elements); consequently, incorporating multiple core elements (e.g., multidimensional and multilevel elements) is a key next step for HIV-related intersectional stigma research.

Multidimensional

Much of the recent methodological innovation related to intersectional stigma research has focused on the multidimensional aspect of intersectionality or the ways in which multiple, interlocking dimensions of stigma (e.g., racism, heterosexism, transphobia, HIV stigma) shape HIV and other health outcomes.^{4,5} Although work on multidimensional methods is certainly not complete, it has perhaps been the first frontier of HIV-related intersectional stigma research. Qualitative methods were the cornerstones of early work.³ For example, qualitative findings suggest that Black gay and bisexual men generally experience their social identities as interlocking and mutually constitutive rather than independent and additive (although underscoring the complexity of intersectionality, some Black gay and bisexual men view themselves as Black first).⁶ Qualitative methods continue to play key roles in intersectional stigma research given their capacity to yield insights into complex social phenomena that play roles in HIV prevention and treatment.^{3,5}

Researchers have recently made innovations in quantitative approaches to capturing the multidimensional nature of intersectional stigma, many of which have been summarized in recent reviews.^{4,5,7} Multidimensional measurement

approaches include intercategorical measures that capture stigma across a range of intersections of social identities and positions: the Intersectional Discrimination Index does not include attributions for discrimination, instead asking participants to reflect on experiences they have had or expect to have because of "who they are."⁸ Measures additionally seek to capture unique experiences of stigma within specific groups: the Black Men's Experiences Scale measures experiences at the intersection of race and gender among Black men in the United States.⁹ Other approaches incorporate parallel measures of multiple dimensions of stigma: the Multiple Discrimination Scale measures stigma associated with sexual orientation, race/ethnicity, and HIV status with parallel items.¹⁰ Multidimensional analytic approaches identified by Turan et al.⁵ and Bauer⁴ include moderation (e.g., regression models with product terms to assess for potential interaction), hierarchical regression, latent variable approaches, and structural equation modeling. For example, latent class and profile methods have been used to identify patterns of interpersonal stigma experiences within samples and to explore associations between these patterns and health outcomes.⁵

Multilevel

Intersectionality calls for the consideration of how systems of oppression operating at multiple social-ecological levels create inequities within society and ultimately affect HIV prevention and treatment outcomes. Stigma exists at multiple levels, including individual (e.g., internalized stigma), interpersonal (e.g., discrimination), and structural (e.g., laws).^{1,11} Although HIV-related intersectional stigma research to date has primarily focused on capturing the multidimensional nature of stigma at the individual or interpersonal levels (as described in the previous section and in other reviews⁵), there have been notable recent advancements in measuring stigma at the structural level.¹¹ This work has provided new evidence that policy and legal structures create and reinforce intersectional stigma via sociopolitical systems that systematically reproduce oppression and ultimately generate inequities in health. For example, Black sexual minority men living in US states with high levels of both structural racism and anti-lesbian, gay, bisexual, transgender, and queer policies are at heightened risk of precursors to suicidality and HIV risk, and those living in US states with high levels of anti-lesbian, gay, bisexual, transgender, and queer policies report less frequent HIV testing.¹² Focusing on the structural level yields insight into how intersectional stigma is manifested within and between organizations and institutions of power and privilege. For example, HIV disclosure policies within employment settings prevent the hiring and promote the firing of people living with HIV.¹³

Attending to cultural contexts can inform understanding of how intersectional stigma is locally manifested by preventing stigmatized individuals from fully participating in local, culturally valued activities.¹⁴ Culturally salient measures can be used to better attend to cultural contexts. The WMM (What Matters Most) Cultural Stigma Scale for Women Living With HIV in Botswana captures culturally relevant aspects of stigma at the intersection of gender and HIV (e.g., achieving capabilities core to "womanhood" or taking care of home and children).¹⁴ Methods that attend to spatial contexts can help researchers explore how intersectional stigma is attached to various spaces, places, and locations. Photovoice, a participatory research method involving photographs and storytelling, has been used to explore how contextual factors within clinical settings shape stigma experienced by people who use drugs.¹⁵ Network methods offer powerful tools to understand how intersectional stigma is shaped by social relationships and experienced from unique sources. A sociocentric network study of a rural region of Uganda found that individuals endorse greater HIV stigma if their peers also endorse greater HIV stigma.¹⁶

These studies have mostly focused on stigma processes that occur above the individual and interpersonal levels. Innovation in multilevel methods, or those that can be used to integrate multiple social-ecological levels of stigma simultaneously, is a key next direction for research. Emerging research provides some promising examples of the kind of multilevel work that is needed. As examples, researchers have begun to explore associations between stigma at the structural (e.g., same-sex marriage and civil union laws) and interpersonal (e.g., discrimination) levels.^{17,18}

Multidirectional

Intersectional stigma is a dynamic, reciprocal, and reinforcing social phenomenon. Once researchers have established a foundation of multidimensional and multilevel methods, they may expand their focus to multidirectional

methods that enable researchers to study how changes in HIV-related intersectional stigma at one level produce changes in HIV-related intersectional stigma at other levels, which may in turn produce reciprocal changes at the original level. Researchers may study the construction of HIV-related intersectional stigma by investigating how stigma at one level reinforces and strengthens stigma at other levels. Stigma can be constructed from the top down: the introduction of a same-sex marriage ban was associated with increasing rates of homophobic bullying among youths in California between 2008 and 2009.¹⁷ Stigma can also be constructed from the bottom up: individuals with high levels of stigma toward people with opioid use disorders are more supportive of punitive versus public health-oriented policies to address the opioid crisis.¹⁹

Researchers may study the deconstruction of HIV-related intersectional stigma by investigating how empowerment at one level destabilizes and weakens stigma at other levels. Stigma can be deconstructed from the top down: longitudinal research suggests the passing of civil union legislation was associated with decreased experiences of stigma and better mental and behavioral health outcomes among sexual minority women, with greater benefits for racial/ethnic minority women and those with less formal education.¹⁸ Stigma can also be deconstructed from the bottom up: activism led by people living with HIV has contributed to the repeal of HIV criminalization policies worldwide.²⁰ Intersectionality recognizes that systems of oppression are interlocking²¹; thus, as stigma associated with one social status is deconstructed, stigma associated with other social statuses may also weaken.

Action-Oriented

As a critical social theory, intersectionality is a tool for social change that calls for action.²¹ We echo and amplify other theorists²² by proposing that action-oriented methods that promote social change in partnership with communities of people living with and affected by HIV are a core element of HIV-related intersectional stigma research. Such action-oriented methods are made more effective through the integration of multidimensional, multilevel, and multidirectional methods. Community-based participatory research and participatory action research approaches that emphasize the equal participation of community stakeholders and researchers are needed to promote social change through research. The liberation of communities most affected by HIV-related intersectional stigma cannot be achieved without leadership reflective of those communities.

Centering considerations of social structural contexts encourages interventionists to set their sights on structural change to eliminate HIV inequities. For example, interventions that aim to establish and enforce rights-based policies are needed to dismantle HIV-related intersectional stigma. Moreover, community-led research that investigates how to prevent and eliminate intersectional stigma across contexts, sources, and levels is critical for stigma reduction efforts. In particular, research that focuses on policymakers, health care providers, and hegemonic community norms can investigate strategies to rebalance interlocking systems of power and transition from an exclusion-focused "them/deficits" approach to an inclusion-focused "we/assets" approach to HIV prevention and treatment.

RESEARCH OPPORTUNITIES

Despite growing recognition of the importance of adopting an intersectional stigma lens within HIV research, there are several prominent barriers to engaging in this work. Following, and in Box 2, we identify key opportunities for addressing barriers to enhance the field's potential for engagement in HIV-related intersectional stigma research.

Reduce Barriers and Strengthen Investment

Identifying structural determinants of HIV prevention and treatment is foundational to HIV-related intersectional stigma research. Opportunities exist to strengthen access to resources to enable researchers to better study these determinants. First, access to and the development of data sets needed for multidimensional and multilevel analyses can be facilitated. These include geocoded data sets to enable researchers to examine associations between structural and contextual factors with individual-level HIV risk and prevention outcomes; population-based data sets that include multidimensional stigma measures and that oversample underrepresented key populations to facilitate adequate statistical power for intersectional analyses; and data sets with indicators of structural stigma, which often require substantial time and resources to develop, yet are vital for multilevel analyses. Establishing a centralized mechanism for collecting longitudinal data on laws, policies, and other institutional factors could greatly accelerate

the scalability of research by enabling researchers to more easily incorporate indicators of HIV-related intersectional stigma into a wide range of studies.²³

Second, barriers must be removed to facilitate the use of geographic indicators in international, national, and local-level data sets. Numerous health data sets provide insufficient information on participants' geographic residence, which prevents the examination of structural factors. Other data sources release data at only 1 geographic level of analysis (e.g., state), which restricts researchers' ability to examine structural determinants across multiple geographic levels, or provide geographic indicators but restrict the ability of researchers to use it (e.g., variables that may identify a particular state), which limits the types of analyses that are possible.¹¹ Third, the creation of a compendium of intersectional stigma methods could accelerate their uptake and usage by researchers. Fourth, continued investment in funding opportunities would promote the development of innovative methods for HIV-related intersectional stigma research.

Build Capacity

Intersectional stigma is a complex phenomenon that requires advanced understanding of theory and specialized skill sets to research. Training early career investigators in theory and methods for HIV-related intersectional stigma research and strengthening mentorship networks will accelerate this area of research. All training should include a strong focus on theory to ensure that research remains rooted in considerations of power, social justice, and Black feminist thought.^{21,22} Increasing the diversity of the biomedical and scientific workforce, with a focus on communities that have been disproportionately affected by the HIV epidemic, will ensure that HIV-related intersectional stigma research is informed and led by researchers with relevant lived experiences. Investments can additionally be made in professional development of established researchers via workshops, training institutes, and short courses to enable them to engage with HIV-related intersectional stigma research as investigators, mentors, and peer reviewers. In their roles as peer reviewers, established researchers act as gatekeepers to innovative methods—accelerating or blocking their advancement.

Create Pathways to Structural Change

To achieve the action-oriented elements of intersectionality research, we recommend the creation of pathways for research to contribute to structural change. Greater engagement between researchers with policymakers and health care leaders at the local, state, and national levels through advocacy, networking, and other initiatives can better enable research findings to inform policy and health care decisions. Researchers may bridge the research-policy and bench-to-bedside gaps by communicating with policymakers and health care providers in ways that meet the demands of policymakers' and providers' time and needs (e.g., synthesized, policy- and practice-relevant, easily digestible communications).²⁴ Similarly, policymakers and health care leaders may bridge these gaps by investing in systems, programs, and personnel that better tap the expertise of researchers.

For research to inform structural change, communities living with and affected by HIV should be engaged in all stages of the research process. Researchers can provide opportunities for community members to engage in the formulation of research to ensure that research projects reflect community priorities surrounding HIV-related intersectional stigma. Funders can ensure that community members receive funding to engage in grant projects, rather than relying on their involvement as volunteers, to promote equitable research partnerships. Funders can also support efforts for communities to sustain their work after the research project so that research can promote lasting changes in intersectional stigma.

CONCLUSIONS

Recognition of the importance of adopting an intersectionality lens within HIV-related stigma research is growing. To date, most of the field's methodological innovation related to intersectional stigma has focused on developing multidimensional methods that explore how multiple, interlocking dimensions of stigma shape HIV outcomes at the individual or interpersonal levels. Although this work has been important, multilevel, multidirectional, and action-oriented methods are critical for understanding and transforming interlocking and reinforcing systems of oppression. These core elements may not be easily captured with a single study design, measure, or analysis. Instead, researchers should consider employing multiple methods in concert to triangulate evidence regarding HIV-related

intersectional stigma. Ultimately, we believe that the payoff for incorporating these core elements and addressing barriers to their implementation will be a body of HIV-related intersectional stigma research that is both better aligned with the transformative potential of intersectionality and better positioned to achieve the goals of Ending the HIV Epidemic in the United States and globally. ÂfPU

Sidebar

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Note. The findings and conclusions in this article are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Addressing the Critical Need for Timely Solutions for Improved Food Access and Food Security

Horning, Melissa L, RN, PhD, PHN

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ABSTRACT (ENGLISH)

Experiencing food insecurity is linked to myriad poor health outcomes and comes with a \$77 billion price tag in annual medical care costs.¹ In the United States, 10.5% of people experienced food insecurity.²

The Twin Cities Mobile Market of The Food Group³ is working to turn the needle on health disparities and improve equity. The Twin Cities Mobile Market is a grocery store on wheels, a city bus converted into a grocery store. As you step inside, there are shopping carts and baskets. The seats have been removed and replaced with shelving and coolers for healthy foods from across the food groups—a one-stop-shop—a full-service single aisle grocery store. The Twin Cities Mobile Market goes to the doorsteps of communities that experience lower access to grocery stores and places where food affordability is more challenging. The mobile market staff hear stories from customers that suggest the mobile market is having a positive influence in the community. Community members are concerned about food—how to access it, afford it, buy it, cook it, and eat healthy foods.

In Minneapolis and St. Paul, Minnesota, public health nursing researchers at the University of Minnesota are partnering with the Twin Cities Mobile Market to study the impact of the full-service mobile market.

FULL TEXT

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In Minneapolis and St. Paul, Minnesota, public health nursing researchers at the University of Minnesota are partnering with the Twin Cities Mobile Market to study the impact of the full-service mobile market.

Starting with small studies with promising findings,⁴⁻⁶ this partnered research has grown into a large cluster randomized trial to rigorously study the impact of the full-service mobile market on diet quality and food security. The data show that even before the COVID-19 pandemic, in 2019, 85% of mobile market customers experienced food insecurity,⁶ and in 2021, 92% experienced food insecurity, demonstrating the high food needs of the mobile market customers.

Food access and affordability matter. Food can bring people together, as we all need to eat, but not everyone has equitable or affordable access to healthy, quality foods. As public health nurses and public health nursing researchers, we can and must continue to innovate to address disparities in food access and food security in collaboration with our clients, community partners, and within our systems.

ABOUT THE AUTHOR

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- 3 The Food Group. Twin Cities Mobile Market. Available at: <https://thefoodgroupmn.org/twin-cities-mobile-market>. Accessed January 12, 2022.
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DETAILS

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Recent Key Efforts to Improve HIV-Related Intersectional Stigma and Discrimination Research

Goodenow, Maureen M, PhD ¹ ; Rausch, Dianne M, PhD ² ¹ Office of AIDS Research, National Institutes of Health (NIH), Rockville, MD ² Division of AIDS Research, National Institute of Mental Health, NIH

ABSTRACT (ENGLISH)

HIV-related Intersectional stigma and discrimination persist as significant barriers to effective HIV prevention and management. People with or affected by HIV continue to face multiple stigmas at the Individual, Interpersonal, community, and societal levels. There is an urgent need for HIV-related intersectional stigma and discrimination research to significantly advance the science and provide the opportunity to successfully translate and implement efficacious strategies into practice, programs, and policies. Addressing these issues is a high priority for the National Institutes of Health (NIH) HIV research agenda and is essential if implementation is to be transformative and emancipatory.

To that end, in 2020 the NIH Office of AIDS Research and the National Institute of Mental Health, Division of AIDS Research developed and implemented a deliberative process to actively engage researchers, community members, and government officials in a rigorous review of the concepts, theories, measurements, and interventions that address HIV-related intersectional stigma and discrimination. The hub of this process was a workshop that convened multifaceted workgroups composed of more than 100 scientists, health providers, ethicists, and community representatives. Meeting virtually over a three-month period, they assessed the science and formulated next best steps needed to understand and address the multiple structural and social factors of HIV-related intersectional stigma and discrimination.

FULL TEXT

HIV-related Intersectional stigma and discrimination persist as significant barriers to effective HIV prevention and management. People with or affected by HIV continue to face multiple stigmas at the Individual, Interpersonal, community, and societal levels. There is an urgent need for HIV-related intersectional stigma and discrimination research to significantly advance the science and provide the opportunity to successfully translate and implement efficacious strategies into practice, programs, and policies. Addressing these issues is a high priority for the National Institutes of Health (NIH) HIV research agenda and is essential if implementation is to be transformative and emancipatory.

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The workshop, titled HIV-Related Intersectional Stigma Research Advances and Opportunities (HIVIS; <https://bit.ly/3upDk1S>), was designed specifically to apply intersectionality, a concept emerging from Black feminist theory and activism,¹ to HIV-related stigma scientific discovery. The workshop goal was to narrow the gap between theory, research methods, practice, and implementation. The resulting assessments and insights are informing how intersectional stigma and discrimination can be better understood, addressed, and measured to improve HIV prevention and treatment outcomes, particularly for high-incidence HIV populations (e.g., US Black sexual minority men, transgender women of color, and people who inject drugs). It is through collaboration with community and other implementing partners that these insights and conclusions are further examined, refined, and practiced. The co-occurring amplification of the COVID-19 pandemic and persistent racial injustices further exposed the intersecting effects that racism, economic disenfranchisement, gender inequity, heterosexism, and other forms of systemic discrimination have on people belonging to multiple socially oppressed groups and the reality that people

experiencing multiple forms of oppression suffer the greatest harms to their health. Addressing the complex Interlocking systems of disadvantage and oppression In HIV-related intersectional stigma and discrimination requires rectifying the traditional hierarchical relationships in societies. Genuine community-based participatory approaches respect the Innate knowledge ofthe community with its inherent strengths and assets while engaging community members as partners to Inform the entire research process-from framing the research questions to designing, conducting, analyzing, and Interpreting findings- which benefits from research and community perspectives. This Is needed to effectively promote social justice and health equity while reducing HIV-related disparities.²

Addressing HIV-related Intersectional stigma and discrimination in their most salient forms Is critical to ending the HIV pandemic domestically and globally. The NIH Is broadening HIV stigma research to include the study of HIVrelated intersectional stigma³ to further develop, test, and implement interventions that improve HIV outcomes. Based on data and studies presented during the NIH workshop and described in its summary report as well as using insights and discussions contained in this HIV special issue of AJPH, the NIH will continue the development of next-generation initiatives and cross-sector partnerships to better address HIVIS. As a global health research agency, the NIH is leading the way to improve understanding of HIV-related intersectional stigma and to apply intersectionality frameworks to health research broadly for the enhancement of the public's health.⁴

Sidebar

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DETAILS

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The COVID-19 Pandemic and the Push to Promote and Include Nurses in Public Health Policy

Morone, Jennifer F, RN PhD MA-ATR ¹ ; Tolentino, Dante Anthony, RN-BC PhD ² ; Aronowitz, Shoshana V, FNP-BC PhD MSHP ³ ; Siddiq, Hafifa, RN PhD MSN ⁴ ¹ National Clinician Scholars Program, Yale University School of Medicine, New Haven, CT ² National Clinician Scholars Program, University of Michigan, Ann Arbor, and the School of Nursing, University of Michigan ³ Department of Family and Community Health, University of Pennsylvania School of Nursing, Philadelphia ⁴ School of Nursing, Charles R. Drew University of Medicine and Science, Los Angeles, CA, and the Division of General Internal Medicine and Health Services Research, University of California, Los Angeles

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ABSTRACT (ENGLISH)

The response to the COVID-19 pandemic highlighted the microcosm of public health and health equity challenges that we are experiencing in the United States. The pandemic response also heightened the importance of including nursing perspectives when addressing public health issues. However, nurses are largely excluded from national public policy conversations about the pandemic response. Here we explore the historical, structural, and social factors that created and perpetuated this dynamic and offer ways to amplify the visibility and influence of nursing perspectives in shaping public health policy at the academic, health system, and research levels.

FULL TEXT

The response to the COVID-19 pandemic highlighted the microcosm of public health and health equity challenges that we are experiencing in the United States. The pandemic response also heightened the importance of including nursing perspectives when addressing public health issues. However, nurses are largely excluded from national public policy conversations about the pandemic response. Here we explore the historical, structural, and social factors that created and perpetuated this dynamic and offer ways to amplify the visibility and influence of nursing perspectives in shaping public health policy at the academic, health system, and research levels.

NURSES: A CRITICAL WORKFORCE ESSENTIAL TO HEALTH CARE

Nurses represent a sizable workforce essential to health care and play a critical role in promoting and implementing public health policy. Nursing is the largest health care and support profession in the United States, with more than 5.8 million US nurses overall (registered nurses, licensed practical or vocational nurses, and nursing assistants) and 3.8 million registered nurses (<https://bit.ly/35sWKsJ>).¹ Nurses provide care in multisector community settings across the care continuum and have unique patient-adjacent perspectives and skills that can aid public health policy development, including interpersonal and communication skills and support and management skills (Figure 1). In outpatient settings, nurses are educating communities, administering community-based and home-based specialty care, and serving as community care team coordinators. At the bedside, nurses are routinely leveraging their training and skills to transform access to and delivery of health care across communities and sectors through

quality improvement initiatives, research, and policy advocacy. Nurses are also critical in disaster response and mitigation efforts. The COVID-19 pandemic highlighted how nurses endure to provide compassionate and competent care when caring for critically ill and infectious patients, despite challenging work environments. This multifaceted expertise makes nurses ideally suited for cross-collaborative policy development roles (<https://bit.ly/3NEQVcO>).^{2,3} However, despite these invaluable positions and skills, nurses are notably underrepresented in public health media and policy discussions.

Broadening public understanding and awareness of the rigorous training, unique knowledge and skills, and essential roles of nurses is imperative to increasing nurse visibility and inclusion in policy, media, and decision-making spaces. For instance, nurses receive extensive health care training and skill development in disease treatment, management and prevention, and health and wellness promotion. Nurses excel at interdisciplinary team leadership and are experts in patient education, adapting treatments and crafting self-management regimens.

Nurses are also most often responsible for disease and public health monitoring, assessment, and planning decisions. In hospital and care settings, nurses often spearhead efforts to enhance care quality by leading quality improvement efforts, care delivery system planning and operations, and resource allocation. Nurses' unique set of knowledge, skills, expertise, and perspective is critical to informing and crafting local, state, and national public health innovation and transformation. Neglecting to include them in policy-making conversations and decisions is detrimental to patients, communities, and national health.

UNDERREPRESENTATION OF NURSES IN HEALTH POLICY DISCUSSIONS

For more than 19 consecutive years, nursing has consistently ranked as the most trusted profession in the United States (<https://bit.ly/3uGdlC5>). However, evidence suggests that when journalists and media outlets are looking to find influential voices representing US public health, they rarely turn to nurses. The George Washington University Center for Health, Policy, and Media Engagement released a 20-year update of the original 1997 Woodhull Study on Nursing and the Media.⁴ The findings revealed that nurses were quoted in 2% of public commentaries in newspapers, magazines, and health industry publications covering health-related issues and were mentioned in only 13% of the media sampled. When cited, nurses were quoted on topics related to the profession of nursing itself, as opposed to their perspectives on or expertise in public health, health policy, or the health care industry. By contrast, physicians were quoted 10 times more frequently (21 %) than nurses.

Media representation is consequential to policy-making agendas and action. The results from the updated Woodhull Study reflect the underrecognized value of nursing and the implications of perpetuated bias and inequity within the media. Notably, in the second phase of the recent Woodhull replication, researchers asked journalists and communication, public relations, and media staff from health care organizations and university settings to comment on why nursing expertise was not solicited more often.⁵

The study team found that although nurses were considered useful in enriching a health-related news story, journalists did not believe that nurses were credible voices of authority. Interviewees also cited difficulty finding experienced nurses to interview and stated that health care organizations and universities often do not nominate their nursing staff as authority figures. In addition, the results suggested systemic barriers to nursing inclusivity at the level of editorial processes and policies that prevent nurses from being sourced. Finally, the findings revealed that the nursing profession was less strategic than other health professions (e.g., medicine) in engaging public health journalists.⁵

Although representing a sizable health care workforce, nurses are also significantly underrepresented in leadership arenas, adding another element to their public policy invisibility. For instance, among the thousands of US hospital networks, only 33 hospital chief executive officers are nurses (<https://bit.ly/3qR4P20>). Moreover, despite there being four times as many registered nurses as physicians in the United States, currently three nurses are members of Congress (<https://bit.ly/36LeuAf>), as compared with 17 physicians (<https://bit.ly/3JZN08e>). These statistics illustrate that limited progress has been made since the 2010 Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* highlighted the value and critical importance of nursing perspectives and presence in decision-making roles (<https://bit.ly/3DqDrpg>).

Additional sociocultural and structural factors based on gender, media preferences, and medical hierarchy contribute to the invisibility of nurses in the media and in public health and policy discourses. Most apparent is that nursing is still a predominantly women-dominated field, with more than 87% of nursing assistants and vocational and registered nurses identifying as women (<https://bit.ly/3uHZkDO>). Even as nursing becomes increasingly gender diverse, it continues to be deemed "women's work," undervalued both figuratively and literally as just part of the hospital "room and board."⁶ In this regard, nursing is no different from other female-dominated fields wherein women are less likely than men to be called on as expert sources (<https://bit.ly/3iOLtWS>; <https://bit.ly/3K185za>).⁷ The continued omission of nursing perspectives in the media may also be partly due to the disinterest of lay or academic outlets in highlighting nurses' work. Deena Costa, the senior author of the article "Ignoring Nurses: Media Coverage during the COVID-19 Pandemic,"⁸ shared that the study team initially received rejections from several lay newspapers and academic journals before the group's work was published in the *Annals of the American Thoracic Society*. When asked about the etiology of these continued rejections, Costa replied that "some [publishers] said we were trying to do too much, and others said it wasn't impactful enough. One journal just said they weren't interested in it. Period" (D. Costa, personal communication, 2021).

Furthermore, perspectives about the value of nurses have deep roots within the medical hierarchy. Historically, nurses have been viewed as subservient and submissive to the male-dominated field of medicine, a likely nascent factor of this power imbalance.⁹ This long-held perception of nursing as a low-skilled, physician-servant profession ignores nurses' tremendous levels of skill and autonomy and continues to be perpetuated through media misrepresentation. For example, *Saving Lives: Why the Media's Representation of Nursing Puts Us All at Risk* examines the role of nursing's misrepresentation and underrepresentation in the media in perpetuating stereotypes, including in many popular medical television shows in which physician characters offer all necessary care and nurses possess little expertise or value and are portrayed as peripheral servants.¹⁰

All of these synergistic and interrelated factors contribute to nursing's current low-impact position in public discussions about health policy. The implications of this underrepresentation and misrepresentation of nurses in national public health dialogues and policy agenda setting are far-reaching and detrimental to public health progress. The COVID-19 pandemic has presented a stark example of this invisibility and provides a ripe opportunity to shift the current dynamic toward greater nurse inclusivity in public health policy dialogues.

COVID-19: AN EXEMPLAR OF NURSING'S INVISIBILITY

The COVID-19 pandemic revealed a dismal picture of nursing representation in public health and health policy discussions and decision making. Staff nurses were at the forefront of advocating for policies on safe working environments, and nurse scientists found innovative solutions to the pandemic's challenges, including research examining delivery of care for patients with COVID-19 and the differential effects of the virus across populations.¹¹ However, no nurses were included in the Trump administration's Coronavirus Task Force. In response to this omission, Dermenchyan and Choi opined that nurses bring essential knowledge, skills, and experience to health policy decision making, citing that a nurse on the task force would be an opportunity to include valuable interdisciplinary perspectives (<https://bit.ly/3qOal5m>).

This trend of omission from policymaking tables was not limited to the Trump administration; Joe Biden's Transition COVID-19 Advisory Board—originally composed of commissioners, physicians, public health experts, and academics—also did not include nurses (<https://bit.ly/3uK0Mpd>; <https://bit.ly/3iUVrG0>). In a CNN opinion piece, Ghazal and Dorsen argued that nurses could provide critical expertise for the advisory board, offering an important perspective regarding hospital staffing issues and resource shortages in health care systems (<https://cnn.it/3iTn2HG>). In response, Jane Hopkins, a psychiatric nurse, was later added to the board (<https://bit.ly/3iU3P8U>).

Underrecognition of nurses' role is not limited to national policy conversations. For instance, throughout the pandemic school nurses have frequently been left out of critical discussions about reopening schools safely. Many education officials have neglected to offer school nurses a seat at the table when decisions about COVID-19 school safety are being made, and in many cases nurses' recommended protocols have been ignored (<https://wapo.st/3JXdiz5>).

The COVID-19 pandemic continues to place a significant strain on nurses' health, well-being, and ability to properly perform their jobs, and minoritized nurses have been disproportionately affected.¹² Particularly devastating are studies showing that nurses of color account for more than half of the deaths among nurses caused by COVID-19, despite representing only 24.1% of the workforce (<https://bit.ly/3iSBkZb>). Furthermore, during the pandemic onset, nurses cited a concerning trend of fear of repercussions and retaliation in response to their advocacy for proper protective equipment and other hospital policies. Many nurses were ambivalent about being regarded as "health care heroes" in the media, which they felt was an oversimplification implying that they were willing to sacrifice themselves for others (<https://bit.ly/3LuROTI>). To add, this performative appreciation of nurses was coupled with omission of their voices from media coverage and policy planning and development.

RECOMMENDATIONS TO INCREASE NURSE VISIBILITY

Across fields and levels of education, nurses possess a multitude of transferable skills for public health policy development. Thus, it is paramount that policy development at the system, local, and national levels incorporate nursing representation. Moreover, academic institutions serve as a key entry point for journalists and policymakers to engage nurse experts. To this end, we highlight recommendations and practical tools to increase nursing visibility and influence in public health policy at the individual, community, systems, and national levels.¹³

Nurse Educators and Academic Institutions

As outlined in the newly revised Core Competencies for Professional Nursing Education of the American Association of Colleges of Nursing, there are missed opportunities to empower individual nurses to engage in policy and advocacy work during their nursing education. Notable examples include integrating transformative learning experiences during nursing and clinical education, such as:

- * Embedding structural (political) competencies and health policy curricula within nursing education at the associate, bachelor, master, and doctoral levels. Structural competencies should outline how policies shape the health care work environment and affect health at the community level.^{14,15}
- * Teaching nurses the value of media presence and visibility by incorporating training on the use of social and lay media as a personal and professional advocacy tool.¹⁶
- * Establishing interdisciplinary collaboration opportunities between schools of medicine, pharmacy, social work, and public health. Interdisciplinary collaboration promotes exposure of nurses and their expertise and enhances understanding of different roles and scopes of practice across disciplines.¹⁷ Collaboration may also promote a better understanding of complementary roles of nursing, medicine, and other disciplines.

Community Health Organizations and Health Systems

Leaders at the community and health systems level should leverage nurses' existing leadership, communication, and advocacy skills. Examples of ways to further build on and disseminate nurses' transdisciplinary lens and expertise include:

- * Explicitly allocating seats for nurses on various committees, boards, and quality improvement projects. Serving on boards allows nurses to partner with other leaders to promote change and advance health.¹⁸
- * Enhancing community perceptions and knowledge of nurses' wideranging roles by referring journalists and media outlets seeking to publish health care-related stories to nurse informants.

Nurse Scientists

Nurse scientists possess additional leadership and interdisciplinary expertise transferable to health policy development and agenda setting. Opportunities to leverage research-trained nurses include:

- * Increasing the number of doctorally prepared nurses engaged in the health policy process, whether through participation in institutional decision making, engaging with policies and procedures, or taking action at the local or national government level.
- * Preparing and presenting policy briefs, writing letters to editors and elected officials on public health-related issues, and educating the lay public through speaking engagements with local community-based and civic organizations. These are excellent ways to directly influence the policy-making process.
- * Expanding pathways for nurses to conduct policy-relevant and action-oriented research through fellowship training

opportunities and involvement on boards (e.g., the Robert Wood Johnson Clinician Scholars Program, the National Clinician Scholars Program, and the Nurses on Boards Coalition).

CONCLUSIONS

The COVID-19 pandemic has underscored how nurses' voices have been underrepresented in public health policy. Nurses occupy a critical mass of the health care and public health domains and possess unique and transferable skills and perspectives relative to public health policy. However, they are often excluded as authority figures and content experts in public health policy development and agenda setting. The cyclical nature of the social and historical factors contributing to this exclusion with respect to media presence and public health policy leadership perpetuates such underrepresentation. Increasing the visibility of nurses will require collective promotion of the profession as a source of credible and competent expertise in promoting the health of communities and populations across settings including the academic, community, health system, and policy arenas. ^Jpu

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Defining Climate Justice in Nursing for Public and Planetary Health

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ABSTRACT (ENGLISH)

Climate justice is key to protecting public health in climate change. The United Nations describes immediate threats and unjust harms for people and ecosystems resulting from a rise in global temperature.¹ As public health nurses (PHNs) and representatives of the Alliance of Nurses for Healthy Environments' Global Climate Justice in Nursing Steering Committee,² we believe that PHNs are uniquely positioned to address climate injustices in partnership with communities and ecosystems. The purpose of this editorial is to propose a definition of climate justice in nursing. To support the development of this definition, the following sections briefly explore (1) the climate justice movement, (2) climate justice frameworks, (3) a definition of climate justice in nursing, and (4) implications for nursing roles in climate justice through research, education, advocacy, and practice.

FULL TEXT

Climate justice is key to protecting public health in climate change. The United Nations describes immediate threats and unjust harms for people and ecosystems resulting from a rise in global temperature.¹ As public health nurses (PHNs) and representatives of the Alliance of Nurses for Healthy Environments' Global Climate Justice in Nursing Steering Committee,² we believe that PHNs are uniquely positioned to address climate injustices in partnership with communities and ecosystems. The purpose of this editorial is to propose a definition of climate justice in nursing. To support the development of this definition, the following sections briefly explore (1) the climate justice movement, (2) climate justice frameworks, (3) a definition of climate justice in nursing, and (4) implications for nursing roles in climate justice through research, education, advocacy, and practice.

THE CLIMATE JUSTICE MOVEMENT

Climate change intensifies health burdens caused by environmental racism, which has impacted Black, Indigenous, and other communities of color for centuries through overexposure to polluted and risky geographies.^{3,4} These communities are sometimes referred to as "frontline" or "fenceline communities." Frontline communities are those that are often the first to experience the impacts of climate change and whose members have important insights and skills in coping and policy solutions.³ Fenceline communities are groups living close enough to an industrial or toxic environment to experience harm from the associated pollution and are at elevated risk for further harm from climate events.⁴

The concept of climate justice was created as a submovement of the environmental justice movement to redefine climate change as a human rights and environmental justice issue.³ Public health equity is intrinsic to the vision that grassroots leaders advanced in the 1991 Principles of Environmental Justice.⁵ Formal climate justice principles were published in 2002 for the Earth Summit in Bali,³ and policy recommendations were published that same year at the Second National People of Color Environmental Leadership Summit.⁶ Further recommendations were put forth at the national Mobilization for Climate Justice when a climate justice community delegation attended the 2009 United Nations Climate Change Conference in Copenhagen.⁷ The climate justice movement continues to evolve and strengthen.

CLIMATE JUSTICE FRAMEWORKS

In the following subsections, we consider three frameworks that provide elements important to defining climate justice in nursing, including the Just Transition Framework, the Planetary Health Education Framework, and the Critical Environmental Justice Nursing for Planetary Health Framework.

Just Transition Framework

The Just Transition Alliance, formed in 1997, created principles for a transition from an extractive economy to a regenerative economy.⁸ The Climate Justice Alliance adapted the Just Transition Alliance's principles into a Just Transition Framework.⁹ The Just Transition Framework is applied by the ClimateJustice Alliance to respond to escalating climate disasters in the United States, where they provide technical training and capacity building for frontline communities. The framework guides strategies that are rooted in the work of environmental justice groups and labor unions, in alliance with fenceline and frontline communities, to define a transition away from polluting industries that are harming workers, public health, and the planet. Thus, planetary health is regarded as integral to this transition.

Planetary Health Education Framework

The Planetary Health Education Framework highlights the interconnectedness between Earth's natural systems and the health of all forms of life and considers the geographical and temporal distribution of social, environmental, distributive, intergenerational, and multispecies justice issues.¹⁰ "Multispecies justice" is a term that expands the idea and practice of justice to encompass and respond to the destruction of multispecies lifeways, advances the rights of Nature, and rejects the idea of human exceptionalism.¹¹ The framework supports learners by equipping

and enabling them with the necessary knowledge, skills, literacy, values, and attitudes to drive transdisciplinary and mutually reinforcing actions that protect and restore planetary health. It calls for the elimination of systemic inequities and acknowledgment of how historical, political, and geographical injustices have disenfranchised populations and degraded ecosystems.

Critical Environmental Justice Nursing for Planetary Health Framework

The Critical Environmental Justice Nursing for Planetary Health Framework describes how planetary health injustices have been fueled by supremacy (e.g., White, male, human) and capitalism for centuries, guaranteeing disadvantages for all but a few and creating the illusion of scarcity to justify extraction.¹² This framework conceptualizes the human roots in planetary health, expressed as patterns of violence (e.g., slavery, ecocide, femicide, and genocide) that are manifested in patterns of public health (e.g., despair, morbidity, and mortality). Thus, patterns of domination (e.g., racism, sexism, classism, ableism, and speciesism) overlap and mutually reinforce these injustices. The framework calls for a radical shift toward worldviews and ways of knowing that embrace regeneration and transformation of existing power relationships for health.

DEFINING CLIMATE JUSTICE IN NURSING

Climate justice has become a driving force for innovation in science and is at the forefront of the planetary health and environmental justice movements; yet, it has not been formally defined in relation to nursing. We used the previously described principles and frameworks to guide the development of an initial definition of climate justice in nursing to help inform climate justice strategies in public health nursing research, education, advocacy, and practice: Climate justice in nursing addresses the social, racial, economic, environmental, and multispecies justice issues of the climate crisis through centering the experiences and ways of knowing in frontline and fenceline communities and safeguarding the rights of Nature to achieve planetary health.

IMPLICATIONS FOR ADVANCING CLIMATE JUSTICE

PHN research in climate justice has only recently emerged but is grounded in environmental justice and planetary health. PHN researchers are using critical methodologies for transforming power relationships in the context of planetary health.¹² PHNs need to develop new interventions and case studies for ecological mitigation, restoration, and regeneration to advance multispecies justice and improve public health.

As climate injustices increase, PHNs will need to be prepared in the science and practice of planetary health to better understand how to protect the environments that people and multispecies communities live in. The interconnection of public and planetary health should be considered a critical global component of PHN education and the PHN standards of practice. Planetary health pedagogical frameworks that promote justice provide new opportunities for expansion into regenerative worldviews and ways of knowing.^{3,12}

Just as PHNs need new orientation to knowledge, policy solutions for climate justice must be centered within the ways of knowing, needs, and experiences of frontline and fenceline communities and ecosystems. PHNs design and implement public health policies to promote population health equity. Continued development of this definition of climate justice in nursing will further clarify and accelerate our policy work. Meaningful inclusion and input are critical to ensuring policy solutions provide benefits for communities and ecosystems.

Many climate-affected communities are leading the way in developing solutions to climate crisis.² Through the formation of transdisciplinary and nurse-community partnerships, PHNs can support community-led interventions and be responsive to the interconnectedness of climate injustices to improve public health. As the definition of climate justice in nursing is used and informed by nurse partnerships with communities and ecosystems, we anticipate that the definition will evolve and inform future global nursing work to advance climate justice.

CONCLUSION

The climate crisis is an immediate public health threat. Climate justice is central to restoring planetary health and rights for all life. We welcome critical discourse to catalyze PHN action in advancing climate justice through community and ecosystem partnerships. /4JPH

Sidebar

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US Government Health Agencies' Efforts to Address HIV-Related Intersectional Stigma

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ABSTRACT (ENGLISH)

The US Department of Health and Human Services (HHS) and its agencies are committed to identifying and addressing the challenges that impede people from utilizing available HIV prevention and treatment options. Among these challenges are intersectional stigma and discrimination, which HHS is working to address through its programs and initiatives, including within the Ending the HIV Epidemic in the US (EHE) initiative, which aims to reduce new HIV infections in the United States by at least 90% by 2030.¹ Through EHE and other concerted programs and efforts, the goal of HHS is to develop and equitably deliver effective health-related support services to people who need them. Despite the availability of critical evidence-based options (e.g., advances in antiretroviral therapy, models of effective HIV care and prevention, pre-exposure prophylaxis, and syringe services programs), access to, uptake of, and persistent use of these options remain uneven within and across communities, regions, and demographic groups.

Interlocking systems of oppression (e.g., racism, classism, sexism, homophobia, and transphobia) are drivers of HIV-related intersectional stigma (HIVIS). Acknowledging this, HHS embraces an HIVIS perspective to address the full, inclusive spectrum of health and life experiences among people affected by HIV. This perspective acknowledges that systems of power have an adverse impact on the health of people experiencing multiple forms of oppression.

FULL TEXT

The US Department of Health and Human Services (HHS) and its agencies are committed to identifying and addressing the challenges that impede people from utilizing available HIV prevention and treatment options. Among these challenges are intersectional stigma and discrimination, which HHS is working to address through its programs and initiatives, including within the Ending the HIV Epidemic in the US (EHE) initiative, which aims to reduce new HIV infections in the United States by at least 90% by 2030.¹ Through EHE and other concerted programs and efforts, the goal of HHS is to develop and equitably deliver effective health-related support services to people who need them. Despite the availability of critical evidence-based options (e.g., advances in antiretroviral therapy, models of effective HIV care and prevention, pre-exposure prophylaxis, and syringe services programs), access to, uptake of, and persistent use of these options remain uneven within and across communities, regions, and demographic groups.

Interlocking systems of oppression (e.g., racism, classism, sexism, homophobia, and transphobia) are drivers of HIV-related intersectional stigma (HIVIS). Acknowledging this, HHS embraces an HIVIS perspective to address the full, inclusive spectrum of health and life experiences among people affected by HIV. This perspective acknowledges that systems of power have an adverse impact on the health of people experiencing multiple forms of oppression. Federal efforts to address HIVIS, in partnership with communities, are contributing to achieving EHE milestones. These efforts are also important to the National HIV/AIDS Strategy for the United States 2022-2025, which states, The United States will be a place where new HIV infections are prevented, every person knows their status, and every person with HIV has high-quality care and treatment, lives free from stigma and discrimination, and can achieve their full potential for health and well-being across the lifespan. This vision includes all people, regardless of age, sex, gender identity, sexual orientation, race, ethnicity, religion, disability, geographic location, or socioeconomic circumstance.^{2(p1)}

Lessons learned about HIVIS can add strategies, tools, and insights to the fight against HIV in the United States and globally.

EFFORTS AND APPROACHES

HHS addresses HIVIS through an interrelated set of approaches, exercised and shared through agency missions, which include research, surveillance, research and community input synthesis, program and communication campaign development, service delivery, and capacity building. HHS accomplishes this through partnering with communities, government agencies, academia, health and public health services, and other program entities at the local, state, tribal, national, and international levels.

A selection of key examples of HIVIS-related efforts from several HHS agencies are provided here:

Office of the Assistant Secretary for Health

Through the Minority HIV/AIDS Fund, the HHS Office of the Assistant Secretary for Health has supported demonstration and pilot projects that stress holistic and syndemic strategies to address HIV among racial and ethnic minorities.³ Minority HIV/AIDS Fund-supported activities are designed to address racial inequities by focusing on system changes and strategic partnerships that aim to integrate biomedical, behavioral, and structural approaches for HIV, viral hepatitis, and sexually transmitted infections.⁴

Centers for Disease Control and Prevention

In addition to its public health research, research synthesis, and programmatic HIVIS-related activities through funded health departments and community-based organizations, the Centers for Disease Control and Prevention monitors stigma nationally through surveillance and develops and disseminates HIV-related health communication materials under its Let's Stop HIV Together campaign.⁵ These materials include messaging to prevent HIV-related stigma, such as the benefits of viral suppression for prevention, supported through public-facing resources on transmission risk estimates and an interactive risk-reduction tool.^{6,7}

Health Resources and Services Administration

Since the inception of the Ryan White HIV/AIDS Program (RWHAP), administered through the Health Resources and Services Administration (HRSA), mitigating stigma-related barriers to accessing HIV care, treatment, and support have been addressed by organizations providing those services across the United States. With funding from HHS's Minority HIV/AIDS Fund and input from the National Institutes of Health (NIH), HRSA recently developed a proposal to address stigma titled Reducing Stigma at Systems, Organizational, and Individual Client Levels in the RWHAP (HRSA-20-112), referred to as ESCALATE.⁸ This project aims to reduce stigma for people with HIV on multiple levels throughout the health care delivery system, including on the individual client, organization, and system levels. The program addresses a multidimensional model of privilege and intersectionality as well as focuses on implementing various stigma-reducing approaches to increase cultural humility (e.g., self-reflection and self-critique of biases) in care and treatment settings for people with HIV within the RWHAP.

Indian Health Service

The Indian Health Service, with its tribal and urban Indian health partners, through their Native Advocacy Workgroup for Trans Health, developed and released the Trans & Gender-Affirming Care in I/T/U Facilities Strategic Vision and

Action Plan.9 The plan highlights case examples of how each agency could promote an intersectional approach (including approaches that address racism toward Indigenous peoples) in research, services, and implementation to improve health for transgender communities.

National Institutes of Health

Addressing HIV-related stigma, including HIVIS, is a high research priority at NIH as stated in its FY 2021-2025 NIH Strategic Plan for HIV and HIV-Related Research.¹⁰ Working with partners, NIH is advancing HIVIS science through research programs, initiatives, and other dedicated activities. NIH organized the 2020 virtual HIVIS Research Advances & Opportunities Workshop and this special issue as part of its evolving emphasis on HIVIS. These efforts and others are catalyzing NIH-supported HIVIS science, including a keystone 2019 funding opportunity announcement, Promoting Reductions in Intersectional Stigma (PRISM) to Improve the HIV Prevention Continuum.¹¹

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration's flagship HIV grant programs use an evidence-based, multilevel approach that considers the burden of stigma, social marginalization, and discrimination on prevention and treatment adherence for key populations. This approach encourages multisectoral partnerships (e.g., health care, schools, justice systems, social services, faith, and other relevant community sectors) and addresses policies and programs to meet the needs of institutions, providers, communities, and individuals simultaneously. The Prevention and Treatment of HIV Among People Living With Substance Use and/or Mental Disorders guidelines highlight effective practices utilizing this framework.¹²

THE WAY FORWARD

Through EHE and other strategic collaborations, federal agencies within and outside of HHS are taking actions to address HIVIS. The way forward requires federal agencies to better address the challenges of intersectionality, including how power dynamics are perpetuating inequities. This requires federal agencies to do the following:

Utilize Collective Understanding

- * Increase understanding of HIVIS within the context of HIV prevention, treatment, and care as well as within a broad structural context.
- * Engage collaborators in solving HIVIS challenges, including policies and programs not reaching people in need.
- * Work with partners to utilize the understanding of and implement solutions to address the complex systems, roles, and behaviors that enact and perpetuate intersectional stigma and discrimination.

Measure and Monitor Stigma

- * Identify commonalities and differences in intersectional stigma across health conditions.
- * Harmonize intersectional stigma and discrimination methods and measurements.
- * Ensure measurement and monitoring are ongoing and iterative.
- * Identify opportunities within, across, and beyond HHS agencies, especially within EHE geographic areas, to monitor intersectional stigma and discrimination.

Develop and Apply Interventions

- * Highlight the evidence base of current interventions designed to reduce intersectional stigma and discrimination.
- * Examine and address laws, policies, and practices that reinforce intersectional stigma and discrimination, including HIV criminalization laws.
- * Develop or adapt interventions that address HIVIS at multiple socioecological levels.
- * Address drivers of adverse health and social outcomes.
- * Support integrated and braided holistic interventional approaches.
- * Integrate and tailor intersectional interventions to advance EHE goals and improve HIV prevention and treatment outcomes.

Scale Up Implementation

- * Build collaborative, equitable partnerships between researchers and communities to improve health outcomes.
- * Ensure community perspectives and experiences inform all steps of the research and intervention development

process.

* Determine effective combinations of interventions and strategies for addressing HIVIS to reduce HIV transmission and disparities in HIV rates, including for gay and bisexual men, transgender persons, racial and ethnic minorities, and persons residing in domestic and global areas with the highest HIV rates.

* Incorporate progress and lessons learned to address HIVIS within and outside the United States.

To effectively address the characteristics and complexities of HIVIS, the way forward requires expanded thinking and dynamic initiatives, including and beyond what has been presented in this article. Intersectional stigma, including HIVIS, is fueled by deeply embedded structural and systemic challenges that need to be identified and addressed. This approach, with focused and coordinated efforts, is key to addressing HIVIS. HHS's role in this is an integral aspect of an all of government and all of society strategy to end HIV in the United States and globally.

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Sidebar

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DETAILS

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Addressing HIV-Related Intersectional Stigma and Discrimination to Improve Public Health Outcomes: An AJPH Supplement

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ABSTRACT (ENGLISH)

Intersectional stigma and discrimination (ISD) pose critical barriers to HIV services and drive HIV inequities. This AJPH supplement represents a combination of research, theoretical articles, and community insights to move the

field toward actions to reduce ISD. This focus builds on scholarship on stigma and HIV published in AJPH. In 1987, six years after the start of the US HIV epidemic, Kelly et al.¹ used case vignettes in which patients were described as having either AIDS or leukemia and being either heterosexual or gay to measure physicians' stigma. They concluded, "While some attitude negativity was anticipated, the strength and consistency of the stigmatization was disquieting."¹(p790) Also, before intersectionality was explicitly discussed in the HIV field, researchers were documenting the impact of multiple forms of stigma among sexual minority men.^{2,3} AJPH has since published more than 800 articles addressing HIV and stigma,⁴ illustrating that HIV-related stigma remains a persistent challenge to ending the HIV epidemic.

FULL TEXT

Intersectional stigma and discrimination (ISD) pose critical barriers to HIV services and drive HIV inequities. This AJPH supplement represents a combination of research, theoretical articles, and community insights to move the field toward actions to reduce ISD. This focus builds on scholarship on stigma and HIV published in AJPH. In 1987, six years after the start of the US HIV epidemic, Kelly et al.¹ used case vignettes in which patients were described as having either AIDS or leukemia and being either heterosexual or gay to measure physicians' stigma. They concluded, "While some attitude negativity was anticipated, the strength and consistency of the stigmatization was disquieting."¹(p790) Also, before intersectionality was explicitly discussed in the HIV field, researchers were documenting the impact of multiple forms of stigma among sexual minority men.^{2,3} AJPH has since published more than 800 articles addressing HIV and stigma,⁴ illustrating that HIV-related stigma remains a persistent challenge to ending the HIV epidemic.

RECONCILIATION, CITE, AND CHALLENGE

Berger,⁵ who first coined the term "intersectional stigma," reminds us here in her editorial (p. S218), that citing foundational scholars⁶⁻⁹ such as herself is a necessary acknowledgment of Black women's academic achievements and that not doing so renders them and their contributions invisible. Aligned with this, Smith et al. (p. S220) provide a conceptual review and integration of intersectionality and syndemics theory and argue that ISD fuels domestic HIV-related syndemics. An editorial by Bowleg (p. S224) challenges the HIV field even further by questioning the term "intersectional stigma and discrimination" itself because of how it can obscure intersectional social-structural processes.

RESISTANCE, STRENGTHS, AND RESILIENCE

Ancestors and elders such as those who formed the Combahee River Collective, a Black feminist lesbian organization active from 1974 to 1980, viewed resistance as essential when they joined to challenge oppression such as racism, heterosexism, and sexism.⁷ Several publications in this supplement echo the importance of resistance and resilience to addressing ISD. For instance, Poteat and Logie (p. S227) urge the need for HIV research to use a strengths-based lens that recognizes the value of community resources, multilevel resilience processes, and existing community assets to enhance the sustainability and contextual relevance of responses to HIV. Echoing Poteat and Logie, as well as findings from a 2018 AJPH editorial on intersectionality, resilience, and HIV stigma among Black women,¹⁰ Quinn et al.'s (p. S285) qualitative research with Black sexual minority men found that taking pride in intersectional identities, perseverance, community advocacy, and social support facilitated thriving and action against racism and heterosexism.

METHODS, MEASUREMENT, MONITORING, AND INTERVENTIONS

Authors delineate opportunities to improve methods and monitoring of ISD in HIV research. For instance, Earnshaw et al. (p. S293) propose core elements for future HIV ISD research (i.e., multidimensional, multilevel, multidirectional, action-oriented) and opportunities (e.g., reduce barriers, strengthen investment, build capacity, create pathways to structural change). A systematic review by Sanchez Karver et al. (p. S300) found measurement of HIV-related ISD to be concentrated in high-income countries and focused on the intersection of two identities (e.g., race

and gender). Rodriguez-Hart et al. (p. S230) propose priorities for the intersectional implementation of Ending the HIV Epidemic monitoring activities such as ensuring access to ISD measures and support for their use, motivating use of such measures via policy and data feedback loops, and establishing equitable community partnerships. Sievwright et al. (p. S236) recommends principles for ISD interventions, including recognizing and naming how systems of power, privilege, and oppression intersect to fuel stigma; dismantling systems of power, privilege, and oppression and mitigating harms caused by those systems; ensuring community leadership and meaningful engagement; and supporting collective action, cohesion, and resistance. In implementation settings, Kerr et al. (p. S242) provided recommendations to enhance the impact of ISD interventions, including prioritizing community ownership, engagement, and connectedness; incorporating the experiences of frontline service providers; and creating an accessible, living, and open database of research and community efforts. Similarly, Nnaji and Ojikutu (p. S247) call for interventions that are culturally and linguistically tailored, multilevel, and conducted in partnership with community to address ISD for Black African immigrants living with HIV in the United States.

SPACE AND PLACE AS STRUCTURAL OPPRESSION

Two articles in the special issue focus on space and place as both reflections of historical oppression and reinforcers of ISD, which in turn negatively impact mental health and HIV outcomes. For instance, Wright et al. (p. S313) found that within-neighborhood and surrounding neighborhood characteristics (negative and positive) were associated with experiences of ISD, mental health, viral load, and medication adherence among Black women living with HIV. Consistent with these findings, Taggart et al. (p. S251) suggest conceptualizing space as a modifiable driver of ISD; using place-based methodological approaches; and investing in community-led, place-based, and systems-focused approaches to address HIV inequities.

SEXUAL MINORITY MEN OF COLOR

Sexual minority men of color are disproportionately affected by HIV worldwide, and several articles focus on ISD's impact on this group. Ogunbajo et al. (p. S254) propose a socioecological conceptual framework through which to understand ISD's impact on HIV services among sexual minority men in sub-Saharan Africa. Among Black sexually diverse men in the United States, Lutete et al. (p. S324) used a qualitative system dynamics approach¹¹ to characterize ISD experiences and identified three feedback loops: medical mistrust and HIV transmission, marginalization of Black and gay individuals and serosorting, and family support and internalized homophobia. Friedman et al. (p. S332) found that sexual minority men experiencing ISD had higher odds of hypertension, dyslipidemia, diabetes, depression symptoms, healthcare underuse, and suboptimal treatment adherence. Among young sexual minority men, Talan et al. (p. S278) discuss manifestations of ISD and encourage the use of event-level measures that indirectly capture experiences of ISD by documenting emotions felt across space and place. Driffin et al. (p. S257), in reflecting on the aforementioned publications and what is needed, noted that "the answer must be rooted in Blackness and queerness" and called for investments to support Black queer people living with HIV to become principal investigators.

COLLECTIVE ACTION AND COMMUNITY VOICES

Several notes from the field centered community voices and described current collective action in the face of ISD. A note by Nnaji et al. (p. S260) provides a glimpse into work being done by United We Rise, a collective of Black people living with HIV, activists, researchers, and health providers. The collective aims to answer the question, "What would the response to HIV look like if it were led by Black people?" It has five focus areas: intersectionality, Black community engagement, Black leadership and organizations, policy, and sexual and gender identity. Spieldenner et al. (p. S264) provide an overview of how an international coalition of sexual minority men, people who use drugs, sex workers, and transgender and gender-diverse people organized the HIV2020 Conference and leveraged this solidarity to call out ISD in a challenge to the International AIDS Society.¹² Recognizing the dearth of studies exploring Latina/x/o health in the context of multiple systems of oppression, including racist xenophobia, heterosexism, ageism, and transprejudice, Arreola et al. (p. S267) call for community-based participatory research approaches, support for grassroots and community-led movements, and advocacy aimed at the decriminalization of undocumented immigrants. Arnetta Phillips (p. S270), in an inspirational first-person narrative piece, reminds us that

work to address ISD ought to make tangible improvements in the day-to-day lives of people living with HIV through necessary structural changes (e.g., housing and employment).

THE WAY FORWARD

To end the HIV epidemic, the field must be unwavering in its focus on the interplay between systems of oppression, power dynamics, community-led collective agency, and action-core tenets of intersectionality and Black feminist traditions. Collectively, the articles in this special issue of AJPH direct the field to interrogate what ISD research aims to accomplish and how research is imagined and implemented. In addition, they highlight space and place as important loci for researching and addressing ISD and the urgent need for improved methodological approaches for studying ISD. However, no analytic tool or research project will get us closer to reducing ISD without simultaneously engaging in explicit anti-ISD interventions. Ultimately, to reduce ISD and end the HIV epidemic, research and resources are needed to support programs in real-world settings that are led by people living with and disproportionately affected by HIV, not just researchers committed to ISD work.

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CONFLICTS OF INTEREST

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Capturing Daily Experiences of Intersectional Stigma Among Young Sexual Minority Men in HIV Prevention Research

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ABSTRACT (ENGLISH)

Sexual minority men (SMM) of color experience pervasive structural forms of oppression (e.g., homophobia, heterosexism, systemic racism)¹ and interpersonal forms of stigma (i.e., "everyday" or episodic interactions).² Rooted in social inequality, power asymmetry, and systemic hierarchy, these experiences act as significant contributors to health inequities.³ While extant literature draws attention to the burden of stigma and the resulting impact on health, it often conflates or ignores the complexity of intersecting, marginalized social positions.⁴ We advocate research that acknowledges the subtleties, contextual nature, and distinctions between and within marginalized intersecting social positions.

FULL TEXT

Sexual minority men (SMM) of color experience pervasive structural forms of oppression (e.g., homophobia, heterosexism, systemic racism)¹ and interpersonal forms of stigma (i.e., "everyday" or episodic interactions).² Rooted in social inequality, power asymmetry, and systemic hierarchy, these experiences act as significant contributors to health inequities.³ While extant literature draws attention to the burden of stigma and the resulting impact on health, it often conflates or ignores the complexity of intersecting, marginalized social positions.⁴ We

advocate research that acknowledges the subtleties, contextual nature, and distinctions between and within marginalized intersecting social positions.

EXPERIENCES OF INTERSECTIONAL STIGMA

The historical injustices endured within and across generations of young SMM of color warrants particular attention from researchers conducting intersectionality-informed quantitative research, ensuring the use of methodological techniques that appropriately capture rich and multifaceted lived experiences and realities.^{5,6} Furthermore, recent research examining the impact of multiple forms of oppression presented contrary findings: those who embodied multiple marginalized social positions reported discrimination at lower rates than those with a single marginalized social position.⁷ The authors posit that "ceiling effects" and expectations of discrimination can influence the subjective reporting of discrimination among communities with multiple marginalized social positions. In our qualitative work, we were interested in uncovering additional approaches to indirectly capture experiences of intersectional stigma.

INTERSECTIONAL STIGMA AND PERSONAL NARRATIVE

In 2019, our research team examined the complexities of conceptualizing and implementing research among communities experiencing intersecting forms of oppression, specifically among Black and Latino/e/xSMM aged 16 to 29 years. We conducted 19 semistructured, individual interviews (in person, by video, and over the phone) to examine themes of daily experiences of intersectional stigma from both a practical and conceptual perspective. We used purposive sampling to recruit participants from across the United States who either (1) engage with Black and Latino/e/x young SMM in their academic, clinical, or health services work or (2) embody marginalized social positions experienced by Black and Latino/ e/xyoung SMM.

Our findings suggest that intersectional measurement should consider not only how stigma manifests or the frequency in which it occurs but also how it integrates into a person's narrative. When asked how intersectional stigma manifests, participants described it as considerably more insidious than forms of unidimensional stigma and yet presenting differently across time, place, and space. Intersectional stigma was described by participants as ubiquitous, leading to changes in behavior such as code switching, changing one's presentation both visually and in mannerism, and having an impact on the kinds of spaces one seeks out or avoids.

Our interviews suggested that while some stigma experiences can be attributable to a specific social position (e.g., a homophobic slur), marginalized intersecting social positions can also feel inextricable, and the salience of one's identity is often context dependent (certain situations can elicit aspects of one's identities while concealing others). Most commonly, participants described inequitable experiences of comfort and safety in public space resulting from intersectional stigma. Participants explained how those holding marginalized intersecting social positions are more likely to conceal or adjust themselves in an effort to minimize enacted stigma. Relatedly, participants expressed that embodying privileged social positions can have a "buffering" effect (e.g., the impact of Whiteness on sexual minority status) and how privilege manifests in the ability to navigate places and social interactions without having to adjust or conceal aspects of their identity.

THE ROLE OF INTERSECTIONAL QUANTITATIVE RESEARCH

We maintain that intersectional quantitative research has the potential to generate innovative exploration of health inequities across a range of marginalized intersecting social positions, help identify interacting causal processes, and create solutions for health inequities through a social justice lens. To avoid relying on attribution, we advocate the inclusion of event-level measures of intersectional stigma that indirectly capture experiences of intersectional stigma by capturing emotions felt (e.g., isolated, confident, invisible, safe, uncomfortable) across space and place and while socializing with others. Furthermore, participants emphasized the very powerful forms of resilience, comradery, friendship, and solidarity born out of shared experiences of stigma. It is still possible to lose sight of community strengths, resistance, and empowerment in stigma research, and we advocate the inclusion of positive emotions and experiences in event-level measures of intersectional stigma.

Finally, when considering event-level methodologies (e.g., daily diaries, ecological momentary assessments) to assess and examine experiences of stigma, researchers must consider how the methodology contributes to

participant burden. Before capturing participant experiences, researchers should identify the ways in which participants are vulnerable to emotional, mental, and spiritual harm. Researchers can consider the length and frequency of surveys, privacy and confidentiality concerns, and age-appropriate and inclusive survey language, as well as available resources and support services to offer participants. We recommend community-informed and resilience models for conducting stigma research not only to reduce power imbalances in the research process but also to bolster solidarity and resilience across community members.

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A.J. Talan contributed to the conceptualization of the study, data analysis, and article preparation. O. Shalhav contributed to data collection, project administration, data analysis, and article preparation. A. Tilove contributed to data collection, data analysis, and article preparation. C. Wolf contributed to project administration, article review, and editing. D. English and V. Patel contributed to study conceptualization, article review, and editing. H.J. Rendina contributed to study conceptualization, article preparation, and funding acquisition.

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CONFLICTS OF INTEREST

The authors report no potentialor actualconflicts of interest from funding or affiliation-related activities that may have influenced the article.

HUMAN PARTICIPANT PROTECTION

The institutionalreview board at CUNY's Hunter College approved all study procedures.

Sidebar

Data collection for this study was conducted at Hunter College of CUNY, and affiliations reflect authors' institutions at the time of the most recent article submission, which were not directly involved in the human participants' portion of the research.

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Public Health Nursing: Difference Is Power Mural

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[ProQuest document link](https://www.proquest.com/scholarly-journals/capturing-daily-experiences-intersectional-stigma/docview/2717341324/se-2?accountid=211160)

FULL TEXT

Across the walls in the hallway of the School of Nursing building at the Parnassus campus of the University of California, San Francisco (UCSF), the 16foot by 8-foot Difference Is Power mural honors and acknowledges the lives of nurses from diverse backgrounds, who made pioneering, unique, and significant contributions to the fields of nursing and public health. Catherine Gilliss, Dean of the UCSF School of Nursing, commissioned the mural in late 2017 after nursing students advocated more representation of contemporary images of people from diverse backgrounds to look at and to be inspired by as they enter the School's main office. The artists, Jessica Sabogal and Shanna Strauss, took five months to complete the mural offsite. In a public ceremony, the mural was installed on October 2, 2019.

Much of the public art that has become a UCSF hallmark can be found on the Parnassus campus. As a public university, the mural is seen by countless passersby. In the mural, the artists bridge nursing and public health images of the past with nursing and public health images of today. The mural is a representation of the importance of diversity, equity, and inclusion in advancing health care for all. On the walls of a learning environment, the mural spotlights the accomplishments of four extraordinary nurses who made a difference by improving health care

delivery to low-income families in rural communities; leading the way as a public health officer in the care of mothers, infants, and children during the most difficult years of the AIDS epidemic; innovating to advance the next generations of the nursing workforce to be reflective of society; and working to care for the transgender community. The four nurses in the mural are, from left to right, Sarah Gomez Erlach, Florence Stroud, Marilyn Chow, and Emma Deboncoeur. The Difference Is Power mural reflects the revolution of public health nursing and provides a visual opportunity for us to pause and celebrate nursing.

Sidebar

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Permission to use the photo has been granted by the person who commissioned the mural (Catherine Gilliss, Dean of the University of California, San Francisco, School of Nursing), and the artists (Jessica Sabogal and Shanna Strauss).

CONFLICTS OF INTEREST

The author has no conflicts of interest to disclose.

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A Nurse-Led, Well-Being Promotion Using the Community Resiliency Model, Atlanta, 2020–2021

Duva, Ingrid M, RN, PhD, MN; Murphy, Jordan R, PhD, PNP; Grabbe, Linda, PhD, FNP, PMHNP

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ABSTRACT (ENGLISH)

The wrath of COVID-19 includes a co-occurring global mental health pandemic, raising the urgency for our health care sector to implement strategies supporting public mental health. In Georgia, a successful nurse-led response to this crisis capitalized on statewide organizations' existing efforts to bolster well-being and reduce trauma. Partnerships were formed and joint aims identified to disseminate a self-care modality, the Community Resiliency Model, to organizations and communities throughout the state.

FULL TEXT

Headnote

The wrath of COVID-19 includes a co-occurring global mental health pandemic, raising the urgency for our health care sector to implement strategies supporting public mental health. In Georgia, a successful nurse-led response to this crisis capitalized on statewide organizations' existing efforts to bolster well-being and reduce trauma.

Partnerships were formed and joint aims identified to disseminate a self-care modality, the Community Resiliency Model, to organizations and communities throughout the state. (Am J Public Health. 2022;112(S3):S271 -S274. <https://doi.org/10.2105/AJPH.2022.306821>)

COVID-19 exacerbated stress and trauma universally, creating a secondary pandemic that increased demand for mental health care in a system on the verge of crisis. An intense and immediate need for population well-being support resulted, and subsequent requests for resiliency training quickly followed. In response, three nurses in Georgia certified to teach the Community Resiliency Model (CRM) fast-tracked existing efforts to share this mental wellness training program across their state.

INTERVENTION AND IMPLEMENTATION

CRM, developed by the Trauma Resource Institute, has a rapidly growing body of evidence.¹⁻⁴ The model helps individuals (1) understand stress reactions in biological terms, (2) distinguish between sensations of distress and well-being, and (3) use sensory awareness skills to deal with difficult situations.⁵

The nurses created a Web site (www.crmgeorgia.org) to share their information and facilitate implementation of the model. In largely rural Georgia, variability in resources and access to care compound existing health disparities, so novel approaches were required.⁶ Cross-sector partnerships between health care and community organizations improve implementation outcomes.⁷ This prompted the nurses to strategically align with Resilient Georgia, a statewide coalition of more than 600 partners and stakeholders committed to addressing childhood trauma and building a stronger, more resilient Georgia, and the Georgia Nurses Association (GNA), the largest professional nursing association in the state.

The collaboration provided funding for participants, increasing the program's capacity to provide classes at no charge, and created a larger network to support statewide reach. The objective was to reach all of Georgia's 159 counties with free CRM classes. This would ensure geographically dispersed training and access to CRM throughout the state. The program aim was to support well-being for all Georgians by increasing resilience to stress and trauma. A logic model depicting this "pathway to resilience" is shown in Figure A (available as a supplement to the online version of this article at <http://www.ajph.org>).

Our cross-sector approach improved program planning, connecting nurses directly to community leaders to better understand local needs, provide follow-up consultations, and refer interested participants to the Trauma Resource Institute for CRM teacher certification.⁴ The Georgia Nurses Association hosted the virtual classes and conducted evaluations. Resilient Georgia added CRM to its "roadmap" for 16 regional grantees (a cluster of counties or organizations focused on increasing resilience). Grantees selected dates for a series of one-hour virtual CRM classes, remotely provided via Zoom's Webinar platform. Word of mouth led other organizations to schedule classes. Class participants were introduced to CRM and the six easy-to-use wellness skills (Table 1).⁵ Three-hour workshops to reinforce model concepts and provide practice in CRM skills were offered as follow-up.

PLACE, TIME, AND PERSONS

This nurse-led approach for innovative population mental health was based in Atlanta but delivered across the state of Georgia. Program planning began in March 2020. The first virtual training was held in June 2020 and is ongoing. Free, virtual sessions were piloted with the Georgia Nurses Association and two health care organizations: Emory Healthcare, Georgia's largest health care organization, and Grady Healthcare, the state's largest public, not-for-profit provider. During this trial period of virtual deployment, training reached individuals in more than 50 of Georgia's counties, with the goal of eventually providing training in all 159 of the state's counties.

Collaborating with Resilient Georgia cast a broader net. Its funding included training for caregivers of the most vulnerable children and families in 16 multicounty Georgia regions. Community coalitions in the middle, northern, western, and eastern regions were also trained one by one via locally focused, remote delivery. Other training included staff from state-level organizations such as the Department of Education, Department of Juvenile Justice, and Division of Family and Children Services, as well as the Georgia Association of School Nurses and Association of Social Workers.

The program targeted all Georgians, beginning with front-line health care workers. During an 18-month response to

the COVID-19 crisis, more than 1000 Georgians were trained. The largest number of participants trained at one time was 140, with an average of 20 individuals per training session.

PURPOSE

Resilience is protective against stress and trauma. The pandemic is a stressful and traumatic event at all levels. Risk of burnout, secondary stress, suicidality, and intent to leave the profession existed among health care workers before COVID-19 and is expected to worsen. In the populace, poor mental health, substance use, domestic violence, and self-injury are concerns.⁸ Previous CRM research demonstrated increased well-being in members of low-resource and low-recovery communities^{1,9} and reduced secondary traumatic stress and an improved sense of well-being among front-line health care workers.^{2,3} CRM incorporates trauma awareness along with resiliency skills, and thus it is a universally applicable model. Based in neuroscience, CRM is an evidence-informed approach to population mental health in times of both stability and crisis. Its concepts and skills are intended for laypersons and can be peer taught, and accordingly the model is an inexpensive, feasible approach that can be adapted and sustained in local contexts.

EVALUATION AND ADVERSE EFFECTS

Participant feedback was collected after each training on a four-question Likert scale and a qualitative question in Survey Monkey. Class organization, instructor effectiveness, content relevance, and incorporated skills were ranked on a scale of poor (1) to excellent (5); the overall mean ranking was 4.6 (range 3-5). Remarkably, after just one hour of virtual CRM training, participants reported anecdotal use of CRM skills for their own well-being and to support others. Debriefings were held with collaborators every three months to identify improvement opportunities, primarily related to registration and scheduling. Evaluations also included the number of counties reached (50), the number of participants taught (almost 1000 in 18 months), and the number of referrals to CRM teacher certification through the Trauma Resource Institute (10).⁴ The implementation, including evaluations, has continued.

There have been no reported adverse effects of the implementation. CRM is highly trauma sensitive and invitational. For individuals with a trauma history, body awareness skills may be challenging or unpleasant, so CRM teachers are prepared to guide participants who become unsettled.

SUSTAINABILITY

A goal for sustainability is to certify more teachers to champion content in their local community. Any motivated person can become a CRM teacher. However, as influential community members, nurses are well positioned to integrate CRM teaching in both personal and work settings, contributing to a more widespread and scalable solution to the pandemic's trauma. The model has a strong mind-body component, so it fits well with nursing's wholeperson health paradigm. Community health nurses are ideally situated to teach CRM and champion resilience.

CRM training sessions are live, brief, and free-standing. They offer a protective effect with the potential to contribute to large-scale improvement of public mental health.¹⁰ This program can be initiated for the price of a teacher certification (see the Trauma Resource Institute Web site).⁴ CRM is affordable and accessible, two critical aspects of a scalable and sustainable intervention. The large number of attendees and the distribution of locales trained contribute to a "critical mass" of resiliency. As community resiliency is enhanced, stress levels are more likely to stay low, even in the face of crises and emergencies, thus meeting the interests of community stakeholders for well-being across the state.

PUBLIC HEALTH SIGNIFICANCE

The public deserves attention to its collective mental health. Stress and trauma are ubiquitous, and the pandemic is an ongoing crisis that is exacerbating mental health problems and creating trauma at all levels of society. CRM is an efficient self-care model that complements other stress-reducing or clinical mental health modalities (e.g., psychotherapy, yoga, mindfulness practices). Leveraging nursing leadership and cross-sector partnerships to implement CRM is feasible and can be part of a multifaceted approach to improving population mental health.

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CONTRIBUTORS

I. M. Duva contributed to conceptualization, implementation, and evaluation of the program. J. R. Murphy contributed to the implementation of the program. L. Grabbe contributed to conceptualization and the implementation of the program. All of the authors contributed to the writing of the article.

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CONFLICTS OF INTEREST

There are no conflicts of interest to declare.

HUMAN PARTICIPANT PROTECTION

The actions described here were taken for public health purposes and not for research. Following the involved institution's review board determination process, this implementation did not meet the published criteria for review.

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COVID-19 Evaluation and Testing Strategies in a Federally Qualified Health Center

Freed, Shelby Lee, DNP FNP-BC APRN; Thiele, Doria, PhD CNM; Gardner, Madilyn, CMA; Myers, Emily, MD

[ProQuest document link](#)

ABSTRACT (ENGLISH)

Federally Qualified Health Centers (FQHCs) are organizations that provide primary care services to our nation's most vulnerable communities. This nurse practitioner-led intervention sought to double the number of available COVID-19 evaluation and testing appointments within an FQHC. Results showed a significant increase in the availability of respiratory clinic appointments, the number of completed appointments, and the number of tests completed. This demonstrates nurse practitioners' ability to work with organizations to develop innovative systems that can be adapted for future use. (Am J Public Health. 2022;112(S3):S284-S287.

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FULL TEXT

Headnote

Federally Qualified Health Centers (FQHCs) are organizations that provide primary care services to our nation's most vulnerable communities. This nurse practitioner-led intervention sought to double the number of available COVID-19 evaluation and testing appointments within an FQHC. Results showed a significant increase in the availability of respiratory clinic appointments, the number of completed appointments, and the number of tests completed. This demonstrates nurse practitioners' ability to work with organizations to develop innovative systems that can be adapted for future use. (Am J Public Health. 2022;112(S3):S284-S287.

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This intervention took place within a Federally Qualified Health Center (FQHC) that is associated with an academic health center in the Pacific Northwest. At the beginning of the COVID-19 pandemic, the first author, a family nurse practitioner, quickly garnered support from the clinic's leadership team, procured resources, developed workflows and protocols, and mobilized and trained staff and clinicians in the creation of a service in which a clinician (i.e., nurse practitioner, physician, or physician assistant) evaluated and tested patients of all ages for COVID-19. This service, later deemed a "respiratory clinic," started in a tent outdoors in March 2020 and moved indoors in October 2020. The clinic separated patients exhibiting symptoms of COVID-19 from patients and staff who were not. Specifically, this nurse practitioner-led intervention sought to double the number of available COVID-19 evaluation and testing appointments within the respiratory clinic between November 1, 2020 and March 31, 2021.

INTERVENTION AND IMPLEMENTATION

Patients who contacted the FQHC were triaged by phone or video visit by a registered nurse, nurse practitioner, physician, or physician assistant, and referred for in-person respiratory clinic evaluation based on symptom profile.

The goal of each respiratory clinic visit was to determine the patient's acuity and appropriate level of care, and to offer COVID-19 testing when indicated. Potential outcomes of a respiratory clinic visit included testing, treatment, recommendation to self-monitor in the community during a quarantine or isolation period and return as needed, transfer to an emergency department, or any combination of these.

Before November 1, 2020, the respiratory clinic was staffed by one clinician and two medical assistants five days per week. Ten patient appointments were available per four-hour clinic session, or 50 per week. Although this had been adequate, the onset of winter months, increased time spent indoors during the upcoming holiday season and reduced ability to socially distance, and the anticipated co-occurring presence of other respiratory conditions such as seasonal influenza increased the risk of transmission of and complications from COVID-19.¹ The intervention increased staffing to three medical assistants and two clinicians on November 1, 2020. With this change, 10 patient appointments were available per clinician, totaling 20 patient appointments per four-hour session or 100 per week, double the number available before the intervention. The clinic projected a twofold increase in the number of available appointments compared with the previous five months.

PLACE, TIME, AND PERSONS

This project took place within an FQHC in Portland, Oregon between June 20, 2020 and March 31, 2021. FQHCs are federally funded, patient-centered organizations that provide comprehensive, cost-effective primary health care services to our nation's most underserved communities.² This FQHC serves over 17 000 individuals; approximately half are considered low income, 34% are of a racial or ethnic minority, 71% are uninsured or publicly insured, and over 50% have one or more chronic medical conditions (Troy Carpenter, e-mail communication, August 28, 2020). Patients served by FQHCs have higher rates of chronic medical conditions such as hypertension, diabetes, kidney disease, asthma, obesity, mental health, and substance use disorders than the general population.² Individuals with chronic conditions are at higher risk of hospitalization and all-cause mortality than those without.³ When chronic conditions are combined with illnesses such as COVID-19, an individual's risk of death increases between 1.5-fold and fivefold.⁴

PURPOSE

Because of the baseline elevated risk for the patients served, the impacts of social determinants of health, and the risk of poor health outcomes, FQHC staff sought to increase the number of available respiratory clinic appointments, increase testing for and treatment of COVID-19, manage comorbidities more effectively, encourage patients to reduce high-risk behaviors, mitigate preventable adverse outcomes, and reduce burden on emergency departments and hospitals by maintaining care in the primary care medical home.⁵

EVALUATION AND ADVERSE EFFECTS

Pre- and postimplementation data compared the number of available respiratory clinic appointments between June 20, 2020 and March 31, 2021. Results showed a significant increase in the availability of respiratory clinic appointments, the number of completed appointments, and the number of tests completed during these months (Figure 1). Overall COVID-19 detection rates at this FQHC were higher than the state average during this intervention (7.4% and 6.0%, respectively), a possible reflection of the elevated baseline risk of the FQHC population.⁵ There was a direct correlation between the number of respiratory clinic appointments available, appointments completed, and tests performed.

The anticipated rise in community prevalence of COVID-19 during the implementation of this project was a contributing factor to its success.

Ethical considerations were threefold. First, individuals of lower socioeconomic status often experience barriers to accessing health care, such as inconsistent access to transportation; historic distrust of the health care system; implicit and explicit clinician bias, particularly when health care systems are at capacity; and potential consequences of detected test results, such as loss of employment or housing.⁶⁻⁸ To address some of these barriers, community health workers assisted patients diagnosed with COVID-19 with accessing housing, transportation, community funds, food and medication delivery, cleaning supplies, and interpersonal violence resources, as well as scheduling medical and behavioral health visits. Second, this intervention increased staff exposure to COVID-19 and the overall

risk of contracting this disease. Three measures were taken to mitigate risk of disease transmission between patients and staff: the academic health center infection prevention and control team continuously reviewed the respiratory clinic space, workflows, and procedures to ensure safety and best practice; staff was provided with the proper amount and type of personal protective equipment; and the FQHC distributed this work equally among clinicians and medical assistants while offering those with high-risk circumstances the opportunity to opt out. Finally, as of November 2020, clinician burnout was at an unprecedented high point.^{9,10} Close attention was paid to workforce well-being, which ultimately played a large role in capacity improvement measures and sustainability.

SUSTAINABILITY

This respiratory model paved the way toward safe integration of respiratory and nonrespiratory care. At the conclusion of the intervention, this model was applied across primary care and outpatient practices within both the FQHC and the larger academic health center, increasing the number and type of staff doing this work, distributing it more evenly across the system, and increasing access to respiratory care overall.

PUBLIC HEALTH SIGNIFICANCE

The COVID-19 pandemic has reshaped how health care is delivered in the United States. It also highlighted inequities and disparities that existed long before COVID-19 was first detected.¹¹ This intervention developed evidencebased workflows and protocols and maintained access to basic health services that were urgently needed for medically underserved communities during a pandemic.¹¹ This intervention highlights the critical role of nurse practitioners in community and public health. It underscores nursing acumen and skill, and the unique insight nurses have into the needs of their health systems, colleagues, and communities. It also exemplifies the expertise nurse practitioners have in the development of policies, protocols, and systems that enable each discipline to work to their full scope of practice, in a safe, efficient, and effective manner, to meet the needs of vulnerable communities in an evidence-based and patient-centered way. Finally, this intervention demonstrates the ability of the nurse practitioner to work with health systems of all sizes to advocate for resources, create innovative methods, and deliver high-quality, evidencebased, patient-centered care in a time of crisis. This nurse practitioner-led model can be adapted to future respiratory endemics and pandemics and used in the ongoing care of patients suspected to have or diagnosed with COVID-19 in ambulatory and primary care settings. ÅfPU

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CONTRIBUTORS

S. L. Freed created and led this project to meet the requirements for the Doctor of Nursing Practice program at the Oregon Health and Science University School of Nursing and was lead clinician for this article. D. Thiele was the chair for this Doctor of Nursing Practice project and provided feedback and guidance in the creation of this article. M. Gardner was the lead medical assistant for the respiratory clinic and participated in data collection for this project. E. Myers was the clinic medical director during the time of this project and supported all respiratory clinic efforts.

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CONFLICTS OF INTEREST

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HUMAN PARTICIPANT PROTECTION

The project was not deemed as research involving human participants by the Oregon Health and Science University institutional review board (IRB) due to its nature as quality improvement (IRB #22180).

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Public Health Nurses: The Most Essential Single Factor

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ABSTRACT (ENGLISH)

This special issue of AJPH on nursing and public health celebrates a long history of nursing aimed to protect, promote, and improve public health. According to a 1926 AJPH editorial, 1885 may have been the first year a graduate nurse was employed in a public health setting (<https://bit.ly/37ZtUI0>). Nurses were actively involved in the American Public Health Association (APHA), formally launching the APHA Public Health Nursing section of AJPH a century ago, in 1922.

FULL TEXT

This special issue of AJPH on nursing and public health celebrates a long history of nursing aimed to protect, promote, and improve public health. According to a 1926 AJPH editorial, 1885 may have been the first year a graduate nurse was employed in a public health setting (<https://bit.ly/37ZtUI0>). Nurses were actively involved in the American Public Health Association (APHA), formally launching the APHA Public Health Nursing section of AJPH a century ago, in 1922.

AJPH has long acknowledged, documented, and celebrated the importance of nursing to public health. A literature search in PubMed found that the first AJPH article about public health nurses was published in 1913. In this article, the health nurse was proclaimed the "most essential single factor" (<https://bit.ly/3LuiAek>; p350) for promoting and improving public health. A review of 1913 AJPH titles found topics related to many of the articles in this Nursing and Public Health supplement: various vulnerable populations (infants, children, higher age groups), social evil in relation to health, sex hygiene, the freezing of vaccines, and numerous air washing and other environmental health topics. A 1924 census of public health nursing reported 3032 agencies doing public health nursing, 78% of which employed their first public health nurse in 1914 or later. AJPH editors noted, "This stocktaking of public health nursing in the United States shows what has been done and also what there is still to do to make public health nursing available to all who want and need it" (<https://bit.ly/37ZtUI0>; p823). During the 1920s, AJPH articles began to appear with such topics as mental hygiene, teaching children about wholesome foods, the injurious effects of tobacco on youths, climate, racism ("the color problem"), public health nursing qualifications and education, the interprofessional collaboration among public health disciplines including nursing, the relation of the public health nurse to the practicing physician, public health nomenclature, and public health nursing effectiveness research (<https://bit.ly/3PvLcae>). One author asked, "Is the public health nurse a carrier of infection?" (<https://bit.ly/3wAF5sB>) which, in the COVID-19 era, is once again an important topic.

Since 1913, AJPH has published 14 articles per year on average related to nursing, with yearly numbers increasing overtime. In 1923, there was a regular column titled "Public Health Nursing" by Annie M. Brainerd. By far, the greatest number of articles in AJPH related to nursing in a year was 172 in 2021; 22 have already been published to date as we write this editorial for the Nursing and Public Health supplement in 2022.

We are honored to serve as guest editors of this special issue that builds on more than a century of AJPH

recognition of the multifaceted role and crucial service of nurses and provides a glimpse of nursing's thought leadership, research, education, and practice in the 21 st century. Given our proud history, unique disciplinary insights, workforce presence, and leadership capacity, we expect the nurse as innovator and leader, trusted team member, and skilled practitioner will continue wholeheartedly to solve pressing public health problems of today and the future.

Will these same public health topics and global health priorities persist for the next century? Or will technological, genomic, precision health, and pharmacological solutions shift these conversations? To those of you who are our readers 100 years from now, we hope you perceive that this special issue expresses our passion for nursing and public health, the urgency with which we strove to address the immense challenges of our day, and the legacy we upheld as a foundation for your anticipated service, education, and research. We are optimistic that in the future nurses will continue working together with colleagues of all disciplines, making real progress toward a shared vision of health for all.

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Trust, Translation, and Transparency in Public Health Nurse Family Home Visiting

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[ProQuest document link](#)

ABSTRACT (ENGLISH)

Evidence over the years has demonstrated the clear impact of public health nurse (PHN) home visits on outcomes of those raising infants and children: PHNs save lives and improve health and social outcomes-not just in the short term, but for decades to come.¹⁻³ The family home visiting articles in this special issue of AJPH (Ballard et al., p. S298; Huling et al., p. S306) extend and advance intervention effectiveness knowledge for PHN family home visiting practice. They also demonstrate that PHNs are ready and willing to do whatever it takes to provide effective, high-quality, life-changing care and transparently document outcomes to prove quality and effectiveness. In this era of extreme accountability and transparency for health care professionals, PHNs serve as leaders and exemplars of what can be done with nursing data to demonstrate effectiveness and value. PHNs have been generating useful, valid, and reliable data through routine documentation for more than two decades-consistently validating positive family home visiting outcomes in program evaluation and research.³⁻⁵ Based on an extensive body of literature across home visiting programs, translations of PHN family home visiting evidence to practice in everyday public health have been highly successful and should continue. Indeed, the public health system would be well advised to add PHN family home visiting to any population of interest to enhance outcomes and reduce downstream social and financial costs. What, then, is preventing the widespread deployment of PHN family home visiting to address the complex health and social needs of those at highest risk for poor outcomes?

FULL TEXT

Evidence over the years has demonstrated the clear impact of public health nurse (PHN) home visits on outcomes of those raising infants and children: PHNs save lives and improve health and social outcomes-not just in the short term, but for decades to come.¹⁻³ The family home visiting articles in this special issue of AJPH (Ballard et al., p. S298; Huling et al., p. S306) extend and advance intervention effectiveness knowledge for PHN family home visiting practice. They also demonstrate that PHNs are ready and willing to do whatever it takes to provide effective, high-quality, life-changing care and transparently document outcomes to prove quality and effectiveness. In this era of extreme accountability and transparency for health care professionals, PHNs serve as leaders and

exemplars of what can be done with nursing data to demonstrate effectiveness and value. PHNs have been generating useful, valid, and reliable data through routine documentation for more than two decades-consistently validating positive family home visiting outcomes in program evaluation and research.³⁻⁵ Based on an extensive body of literature across home visiting programs, translations of PHN family home visiting evidence to practice in everyday public health have been highly successful and should continue. Indeed, the public health system would be well advised to add PHN family home visiting to any population of interest to enhance outcomes and reduce downstream social and financial costs. What, then, is preventing the widespread deployment of PHN family home visiting to address the complex health and social needs of those at highest risk for poor outcomes?

First, consider that although we affirm PHN family home visiting's effectiveness, we are slow to acknowledge and trust that it is the PHN—who is highly educated, emotionally available, and greatly connected—who makes the intervention effective.^{4,5} Instead, we put our trust in "evidence-based programs" that diminish the role of the PHN to that of a technician who delivers a scripted intervention. Expanding PHN family home visiting programs depends on trusting and respecting the capability of skilled PHNs and supporting their ability to tailor interventions to each person. This is fundamental to expanding the availability of PHN family home visiting, simply because funding mechanisms require PHNs to be prepackaged in expensive, restrictive evidence-based programs rather than embedded as expert interventionists acting in the fabric of the public health system to improve the public's health. Second, let us question the notion that evidence-based PHN family home visiting services should be available only as replicated evidence-based research programs. Such replication is a costly process often accompanied by burdensome requirements of accreditation and oversight as well as extensive, time-consuming data collection protocols. This results in siphoning of resources away from the PHNs and public health agencies and into the external programs, thereby reducing funds available to pay PHNs to do the work. Furthermore, such models have restrictive eligibility requirements that are in opposition to the mission of many public health departments: to serve those who need services in their jurisdictions. In fact, PHN family home visiting is effective for a broad range of family home visiting groups and needs,¹⁻⁵ and to deny effective services to those who are in need in the name of program fidelity is unethical.

Finally, let us acknowledge the truth in the data generated by PHNs and support the most trusted profession to practice to the full extent of its licensure in our communities. PHNs are equipped and ready to do so, but the systems in which PHNs must function need to take a hard look at political assumptions and willingness to act on the evidence PHNs have provided. PHNs have long accepted the responsibility of demonstrating intervention effectiveness; this is the message that the Ballard et al. and Huling et al. articles affirmed once again. It is time to listen. >4JPH

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Answering the Call: The Response of Centers for Disease Control and Prevention's Federal Public Health Nursing Workforce to the COVID-19 Pandemic

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[ProQuest document link](#)

ABSTRACT (ENGLISH)

Many public health challenges face our world today, including systemic racism, the opioid epidemic, and the COVID-19 pandemic. Nurses are well-qualified and well-positioned to respond to these challenges, as nurses represent 50% of the global health workforce and are leaders not only in clinical settings but also in public health.¹ The professions of nursing and public health have been closely intertwined since the founding of the modern-day nursing profession by Florence Nightingale, a pioneer in the field of epidemiology.²

Nursing incorporates many tenets of public health. Nurses are taught to view individuals within the context of their communities and to consider each patient's social determinants of health in the provision of care. Nurses have in-depth knowledge of disease and wellness and are trained to plan, implement, and evaluate health interventions based upon health assessment at both the individual and population levels. In addition, nurses are trusted professionals who communicate and educate patients and communities about important health messages related to disease prevention and wellness promotion while considering cultural implications. The purpose of this editorial is to describe the contributions of nurses at the US Centers for Disease Control and Prevention (CDC) during the COVID-19 pandemic, and to generate a call to action to support the need for a strong public health nursing workforce.

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NURSES AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION

Nurses are integral to the workforce of many health care organizations, including state and local health departments and the CDC, the public health agency of our nation. The CDC aims to protect the US population from disease and disability by conducting scientific research and surveillance that provides health information to the public and responds to new and emerging health threats.³ Nurses at the CDC perform a variety of roles, serving as clinicians, health scientists, epidemiologists, public health advisors, nurse consultants, and communication and education specialists. Nurses fulfill leadership and managerial roles at various levels within the agency. In addition, many CDC nurses are commissioned officers of the US Public Health Service (USPHS), one of the eight active-duty uniformed services of this nation. Of more than 6100 Commissioned Corps officers in the USPHS, nurses comprise the largest percentage of health professionals.⁴ Nurses have also been part of CDC's Epidemic Intelligence Service program, a globally recognized fellowship program renowned for its response efforts to investigate outbreaks of infectious disease and environmental and occupational health and safety issues throughout the program's 70-year history.⁵

RESPONSE TO THE COVID-19 PANDEMIC

Since the onset of the COVID-19 pandemic, the nursing profession has been in the world's spotlight as nurses have been on the front lines providing care for COVID-19 patients, performing key functions in state and local health departments, and preventing severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission in health care facilities, workplaces, and communities.⁶ At the CDC, nurses have been at the forefront of CDC's response to the pandemic. The CDC and Agency for Toxic Substances and Disease Registry Nurses' Work Group (CNWG), a group of nurses that provide expertise and support to nurses throughout the agency, have assisted in disseminating and fulfilling requests for deployments to support the COVID-19 response at CDC.

The CDC activated the Incident Management System for the 2019 COVID response in January 2020. As a part of this response, an application called Emergency Operations Management System tracks the work hours of employees, fellows, and contractors who contribute to the response. The CNWG maintains an administrative list of all CDC nurses who are a part of the CNWG membership, although not all nurses who work at CDC are members of CNWG. Using information from Emergency Operations Management System and CNWG's administrative list, we determined that, among 190 CNWG members, 146 (76.8%) were deployed on the COVID-19 response at some time between January 21, 2020, and September 18, 2021. Together, they logged more than 24600 person-days and nearly 198 000 person-hours on the response.

Nurses contributed to multiple COVID-19 task forces supporting the agency's response through COVID-19 deployments. Except for Commissioned Corps officers, all deployments were voluntary; agency Commissioned Corps officers were also deployed across the country on behalf of the Office of the Assistant Secretary for Preparedness and Response. The following roles and contributions of CDC nurses parallel the work of dedicated public health nurses at state and local health departments:

Responding to Clinical Inquiries

CDC's COVID-19 response deployed clinicians, including CDC nurses, to answer clinical inquiries 24 hours per day. The call center initially answered questions related to the clinical determination of persons under investigation, collection and shipping of specimens to CDC, and contact tracing. As transmission of SARS-CoV-2 accelerated in communities, the call center began fielding questions from frontline clinicians and health departments regarding guidance about COVID-19 testing and available assays, treatment, underlying medical conditions, risk mitigation, serological viral indicators, and viral shedding. CDC clinicians provided real-time consultation for inquiries related to a wide variety of topics. Most inquiries came from clinical sites in which clinicians inquired about exposure risk, regarding both their own safety and transmission risk to patients.⁷ In addition, frequent inquiries included risk assessment after a known or potential exposure, implementing the correct return-to-work strategy for exposed personnel, isolation and quarantine guidance, and guidance on personal protective equipment (PPE) use in a health care setting. CDC nurses also participated in a series of clinical outreach and communication activity calls to educate health care providers.

Creating Guidelines to Reduce Transmission Risk

Throughout the COVID-19 response, multidisciplinary teams, including nurses, created guidelines for health care settings, correctional institutions, schools and childcare facilities, businesses and workplaces, and many other community settings. CDC nurses organized calls with CDC's partners and webinars to answer questions to help schools, businesses and workplaces, and communities make key decisions about safely resuming operations by incorporating COVID-19 mitigation strategies. CDC nurses have developed materials and resources during the COVID-19 response, including guidance that helps people understand what actions they can take to reduce the risk of COVID-19 as well as accompanying toolkits to help operationalize the guidance. For example, CDC nurses were vital contributors in the development of telehealth guidelines to reduce the risk of exposure to SARS-CoV-2 in health care personnel, patients, and communities.

Providing Personal Protective Equipment Guidance

The COVID-19 pandemic created an unprecedented need for respirators as well as immediate guidance and information dissemination related to the use, disinfection, reuse, and optimization of respiratory protection devices for health care and public safety workers. The National Personal Protective Technology Laboratory team located within the National Institute for Occupational Safety and Health includes scientists, nurses, and engineers who conduct research on PPE and promote proper respirator selection, maintenance, and use. In addition, this group fielded questions related to PPE via e-mail, which was a critical extension of the CDC's COVID-19 response. This team provided responses to more than 7000 inquiries over 19 months from the public regarding PPE.

Leading Vaccine Distribution and Monitoring Safety

CDC nurses worked with state, tribal, local, and territorial health departments to facilitate the roll-out and distribution of COVID-19 vaccines to priority groups by providing oversight and coordinating field teams in assigned regions. CDC nurses also contributed to the development of COVID-19 vaccine training and educational materials for health professionals, including online training modules and guidance for vaccine transportation, storage, preparation, and administration. In addition, nurses were deployed to the CDC's Vaccine Task Force to monitor the safety of the COVID-19 vaccines through the Vaccine Adverse Event Reporting System, the Myocarditis Outcomes After mRNA COVID-19 Vaccination Investigation Team, and v-safe, a smart phone-based app that contains links to Web-based surveys where individuals can report any adverse effects after vaccination.⁸ On the Vaccine Task Force, nurses reviewed and replied to vaccine-related inquiries; performed abstraction of medical records for reports of adverse events, including myocarditis and cerebral sinus venous thrombosis; and called clinicians to conduct surveys about myocarditis. In addition, nurses provided clinical support and helped coordinate and develop standard operating procedures for the CDC's COVID-19 v-safe pregnancy registry. Nurses called pregnant people to assess pregnancy outcomes following vaccination; data from the v-safe pregnancy registry directly informed clinical guidance for COVID-19 vaccination during pregnancy.

Serving as Health Department Liaison Officers

Several CDC nurses worked as health department liaison officers, serving as the primary conduit and resource for state, tribal, local, and territorial public health agencies as well as other federal partners across the nation, including Health and Human Services, Assistant Secretary for Preparedness and Response, and Federal Emergency Management Agency. Health department liaison officers provided guidance, resources, and tools necessary to meet the needs of various partners in several areas, including contact tracing, case investigation, COVID-19 vaccination, and testing access. They also helped address the safety and health of those at increased risk for severe COVID-19 illness and those at increased risk of acquiring or transmitting COVID-19.

Providing Protection for the Workforce

Workforce protection for emergency response activities is coordinated through the Office of Safety, Security, and Asset Management. This office's Occupational Health Clinic (OHC) permanent staff of 10 registered or advanced practice nurses, two physicians, and support staff play a pivotal role in ensuring the health and safety of those involved in responses. With the surge in response activities because of COVID-19, the OHC required additional health care and public health staff. In the last year, the OHC provided medical clearances for multiple responses, including COVID-19, polio, Ebola, wildfires, hurricanes, and Operation Allies Welcome, which supported the evacuation of US citizens and Afghanistan nationals to the United States.⁹ Civil servant health care professionals and USPHS officers, most of whom were registered and advanced practice nurses, deployed to the OHC to support the increased demand. More than 5000 medical clearances have been completed during the pandemic thus far, all response and critical laboratory staff are monitored daily for illness, and COVID-19-symptomatic or-positive staff are monitored and provided medical advice. In addition, COVID-19 and influenza vaccination clinics ran simultaneously, administering thousands of vaccines to CDC staff, contractors, and other federal employees. Polymerase chain reaction testing for SARS-CoV-2 was also instituted and available to all employees.

Leading and Supporting Field Deployments

CDC nurses also supported diverse field deployments, many of which included leadership roles. These influential leadership positions included providing clinical and epidemiological support in tribal nations and leading outbreak investigations in settings such as medical centers, summer camps, and households. In state, tribal, local, and territorial offices throughout the United States, CDC nurses were involved with contact tracing in federal prisons and early repatriation missions. In addition, they conducted infection control assessments of long-term-care facilities, screened for COVID-19 symptoms at international airports, and supported health departments. CDC nurses also served as Career Epidemiology Field Officers¹⁰ and field team leads, coordinating communication between CDC field and headquarters teams, local and state public health officials, laboratories, and medical staff. They developed standard operating procedures and served as subject matter experts for a variety of topics ranging from infection prevention and control to specimen collection in long-term-care facilities, mass testing sites, and as part of large state-led surveys.

Other Roles

Other roles included but were not limited to serving as quarantine medical officers, performing phlebotomy and collecting nasal swab specimens for epidemiological investigations, providing analytic support, addressing vaccine hesitancy, and improving vaccine confidence. Nurses also contributed to scientific studies by conducting qualitative interviews with public health workers to assess the effects of the COVID-19 pandemic on their mental health. Many nurses published high-impact articles in journals, including CDC's *Morbidity and Mortality Weekly Report* and *New England Journal of Medicine*.¹¹⁻¹⁴

In summary, CDC nurses served in a variety of capacities, including roles in clinical practice, surveillance, data analysis, public education, and leadership, all of which significantly contributed to the federal COVID-19 response. Although it is important to highlight the various roles of nurses within CDC, recognizing the work of nurses beyond the federal level is crucial in understanding the broader impact of the nursing profession in efforts against the COVID-19 pandemic. Nurses have continuously and courageously provided patient care at the bedside. They have also served within local and state public health agencies and departments as policy experts, contact tracers, researchers, epidemiologists, nurse consultants, and patient advocates. In this capacity, nurses have provided the

necessary care and resources to underserved communities who may otherwise go without proper health care follow-up or guidance. As such, nurses, both those in clinical settings and those in public health, have been essential in efforts to curb this pandemic.

A CALL TO ACTION

The COVID-19 pandemic has increased the visibility of both the nursing and the public health professions and has highlighted the incredible, multifaceted roles that nurses have in responding to public health crises. However, the COVID-19 pandemic has exposed vulnerabilities in our public health systems globally and nationally at the federal, state, and local levels rooted in a lack of public health investment, which has contributed to a shortage of public health nurses.^{15,16} The current public health nursing workforce is insufficiently sized to adequately address a pandemic, much less prevent and address underlying causes that have contributed to COVID-19 mortality and morbidity, such as chronic diseases and health inequalities.^{17,18} It is estimated that the United States has about half of the public health nurses needed to meet the public health needs of our nation.^{17,18} Consequences of a shrinking public health nurse workforce can compromise the ability of health departments to respond effectively during crises such as the COVID-19 pandemic and can exacerbate other public health issues that existed before the pandemic. The heavy toll of the COVID-19 pandemic can be felt by nurses worldwide. Many nurses fighting the pandemic on the front lines are exhausted and burned out.^{19,20} Prioritizing and protecting the health and mental well-being of nurses will strengthen nurse resilience, which is essential for sustaining the nursing workforce.²⁰ Crises, like a pandemic, can prompt change. It is essential that we emerge from the COVID-19 pandemic with a reimagined and stronger public health system. The American Nursing Association and National Academy of Medicine have called on all levels of government to increase funding to further develop the public health nursing workforce.^{15,16,21} In addition, nursing education curricula need to incorporate more content and clinical practicum hours related to public health. Although the American Association of Colleges of Nursing has guidelines for incorporating population-focused and public health concepts into curricula, most nursing programs heavily focus on acute care content with almost all clinical practicum hours occurring in acute care or hospital settings.²² The emphasis on acute care in nursing education is perpetuated by this same focus on the National Licensure Examination. As a result, many nurses do not even consider careers in public health.

Nurses are trained to be communicators, critical thinkers, innovators, and leaders. The value and contribution that these skills, paired with clinical experience and compassion, bring to the field of public health cannot be overstated. Throughout the COVID-19 response, nurses have consistently answered the call with a resounding "Yes," performing jobs that blend clinical knowledge, science, and public health.

It is essential to invest in strengthening the public health nurse workforce; leverage the skills of nurses in public health surveillance, program management, and policy development; and elevate nurses as leaders. We need a strong public health nurse workforce, especially at the local and state levels, but also at the federal level. As demonstrated through work in the COVID-19 pandemic, nurses are critically needed to protect and promote the health of all individuals and communities in our world. No pandemic—neither the current COVID-19 pandemic nor future pandemics—will be conquered without the leadership and vital contributions of nurses at every level.

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CONFLICTS OF INTEREST

There are no conflicts of interest to disclose from any of the authors.

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DETAILS

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Barriers to HIV prevention and treatment in the United States persist. Although the Ending the HIV Epidemic (EHE) initiative holds promise, the success of the program may be stymied by inadequate frameworks and tools for monitoring intersectional stigma. Originating from a Black feminist critique of the consequences of treating race and gender as mutually exclusive categories,¹ intersectionality is a theoretical framework that examines how intersecting and mutually interdependent forms of power and oppression (e.g., racism, classism, cisgenderism, ableism) drive health inequities.² Given that populations most affected by HIV are often impacted by stigma related to multiple axes of marginalization (e.g., race, socioeconomic position, sexual orientation), intersectionality is a valuable framework to understanding HIV inequities in the United States, and monitoring for intersectional stigma should be a key component of EHE activities because it allows for assessing health status and relevant behaviors over time to better determine intervention needs. We view monitoring expansively as ongoing, systematic processes to collect, analyze, disseminate, and utilize information regarding precursors, mechanisms, and outcomes of intersectional stigma within multilevel spheres of influence (e.g., within both academic research and public health practice). In this article, we discuss (1) current data sources and opportunities for monitoring intersectional stigma in public health practice, (2) key gaps within intersectional stigma research, and (3) implementation strategies for successful monitoring, which we believe will lead to more comprehensive, equitable, and ethical EHE interventions in the United States.

Arreola, Sonya, PhD., M.P.H., Ramírez-Valles, J., PhD, & Diaz, R. M., PhD. (2022). Structural HIV stigmatization and discrimination among Latina/x/o immigrants: Intersections with heterosexism, ageism, and transprejudice. *American Journal of Public Health, Suppl. Supplement 4*, 112, S387-S389. Retrieved from <https://www.proquest.com/scholarly-journals/structural-hiv-stigmatization-discrimination/docview/2717342558/se-2?accountid=211160>

HIV stigmatization and discrimination (S&D) remain global health concerns for people at risk for or living with HIV. However, few studies have examined Latina/x/os' health in the context of multiple systems of oppression targeting their identities, including anti-immigrant prejudice. Despite evidence that Latina/x/o immigrants in the United States have better health outcomes than non-Latina/x/o Whites, advantages are lost over time. HIV S&D generate barriers to accessing services along the HIV care continuum for Latina/x/os.¹ Undocumented Latina/ x/o immigrants experience unique factors that shape their health before, during, and after migration,² including S&D and sociopolitical marginalization (e.g., state-sanctioned discrimination, condemnation as criminals, underpayment for work) as well as structural barriers to accessing HIV services (e.g., denial of care, cultural/language incompetency). Unsurprisingly, undocumented Latina/x/o people living with HIV enter care with more advanced disease than documented individuals.³ Intersectional frameworks are needed to illuminate and alter or eliminate interlocking systems of oppression. These systems include sexism (assumption that men are superior to women), classism (belief that social or economic status determines a person's value), ableism (belief that able-bodied individuals are superior to individuals with disabilities), racism (belief that Whites are superior to those of other races/ethnicities), colorism (belief that a lighter skin tone is superior to a darker skin tone), heterosexism (assumption that heterosexuality is the only normal and natural expression of sexuality), ageism (belief that younger people are superior to older people), and transprejudice (negative valuing and stereotyping of individuals whose appearance or identity does not conform to social expectations or conventional conceptions of gender). Here we focus on heterosexism, ageism, and transprejudice to exemplify ways in which intersectional S&D affect Latina/ x/o immigrants.

Quinn, K. G., PhD., Dickson-Gomez, J., Pearson, B., Marion, E., Amikrhanian, Y., PhD., & Kelly, J. A., PhD. (2022). Intersectional resilience among black gay, bisexual, and other men who have sex with men, Wisconsin and Ohio,

2019. American Journal of Public Health, Suppl.Supplement 4, 112, S405-S412.
doi:<https://doi.org/10.2105/AJPH.2021.306677>

Objectives. To investigate resilience strategies used by Black gay, bisexual, and other men who have sex with men (MSM) to navigate racism and heterosexism. **Methods.** In 2019, we conducted in-depth interviews with 46 Black MSM in Milwaukee, Wisconsin, and Cleveland, Ohio. Thematic analysis, informed by intersectionality, was used to identify intersectional resilience within the context of participants' lives. **Results.** Our analyses revealed ways in which Black MSM respond to stigma and oppression. We identified the following themes that capture these experiences: pride in intersectional identities, perseverance, community advocacy, and social support. Our analyses reveal how men draw on these assets and resources to positively adapt despite experiences of racism and heterosexism. **Conclusions.** Intersectional resilience can support Black MSM in navigating racism and heterosexism. However, public health interventions at the institutional and system levels are needed to directly target the root causes of oppression and support resources that facilitate intersectional resilience. (Am J Public Health. 2022;112(S4):S405-S412. <https://doi.org/10.2105/AJPH.2021.306677>)

Nnaji, Chioma, M.P.H., M.Ed., & Ojikutu, Bisola O, MD, M.P.H., F.I.D.S.A. (2022). Intersecting stigmas: Being black african, immigrant, and living with HIV in the united states. American Journal of Public Health, Suppl.Supplement 4, 112, S367-S370. Retrieved from <https://www.proquest.com/scholarly-journals/intersecting-stigmas-being-black-african/docview/2717342344/se-2?accountid=211160>

Nationally, HIV incidence among African immigrants is six times higher than in the general population and nearly twice that of US-born Black individuals.^{1,2} The precise number of African immigrants living with HIV (ALWH) in the United States is unknown, because of the lack of disaggregated HIV surveillance data on Blacks or African Americans by country of birth. Compared with the HIV epidemiological profile for US-born Black people, among ALWH there are higher rates of heterosexual transmission and higher rates among women. Although some ALWH may have acquired HIV prior to migration, a significant proportion acquire HIV after migration.² HIV risk after migration is due to complex sociocultural, psychosocial, and structural conditions, such as xenophobia and racism. African immigrants are less likely to test for HIV and often present late to care.^{3,4} HIV-related stigma is higher among African immigrants than among other groups, further exacerbating risk factors and systemic barriers.³ As this population grows, it is critical to understand their unique experiences with HIV-related stigma and address intersecting stigmas associated with race, nativity, immigration status, ethnicity, language, and HIV status.

Karver, Tahilin Sanchez, PhD., M.P.H., Atkins, K., M.P.H., Fonner, Virginia A, PhD., M.P.H., Rodriguez-Diaz, C., Sweat, M. D., PhD., Taggart, Tamara, PhD., M.P.H., . . . Kerrigan, Deanna, PhD., M.P.H. (2022). HIV-related intersectional stigma and discrimination measurement: State of the science. American Journal of Public Health, Suppl.Supplement 4, 112, S420-S432. doi:<https://doi.org/10.2105/AJPH.2021.306639>

Background. Across settings, individuals from populations that are multiply stigmatized are at increased risk of HIV and experience worse HIV treatment outcomes. As evidence expands on how intersecting stigmatized identities and conditions influence HIV outcomes, researchers have used diverse quantitative approaches to measure HIV-related intersectional stigma and discrimination. To date, no clear consensus exists regarding how to best quantitatively measure and analyze intersectional stigma and discrimination. **Objectives.** To review and document existing quantitative measures of HIV-related intersectional stigma and discrimination to inform research, programmatic, and policy efforts. **Search Methods.** We searched 5 electronic databases for relevant studies. References of included articles were screened for possible inclusion. Additional articles were screened on the basis of consultations with experts in the field. **Selection Criteria.** We included peer-reviewed studies published between January 1, 2010, and May 12, 2021, that were HIV related and presented 1 or more quantitative measures of stigma and discrimination using an intersectional lens in measure design or analysis. **Data Collection and Analysis.** Systematic methods were used to screen citations and abstract data via a standardized coding form. Data were analyzed by coding categories stratified according to 2 subgroups: (1) studies incorporating a single intersectional measure and (2) studies that examined intersectional stigma through analytical approaches combining multiple measures. **Main Results.** Sixteen articles met the inclusion criteria, 7 of which explicitly referenced intersectionality. Ten studies were from the United

States. All of the studies included participants living with HIV. Among the 4 studies incorporating a single intersectional stigma measure, 3 explored race and gender stigma and 1 explored gender and HIV stigma. Studies involving analytic approaches (n = 12) mostly examined intersectional stigma via interaction terms in multivariate regression models. Three studies employed structural equation modeling to examine interactive effects or latent constructs of intersectional stigma. Conclusions. Research on the measurement of HIV-related intersectional stigma and discrimination is currently concentrated in high-income settings and generally focuses on the intersection of 2 identities (e.g., race and gender). Efforts are needed to expand appropriate application of intersectionality in the development, adaptation, and use of measures of HIV-related intersectional stigma and discrimination. The use of context-, identity-, or condition-adaptable measures should be considered. Researchers should also carefully consider how to meaningfully engage communities in the process of measurement development. Public Health Implications. The measures and analytic approaches presented could significantly enhance public health efforts in assessing the impact of HIV-related intersectional stigma and discrimination on critical health outcomes. (Am J Public Health. 2022;112(S4):S420-S432. <https://doi.org/10.2105/AJPH.2021.306639>)

Nnaji, Chioma,M.P.H., M.Ed, Smith, Justin C,M.S., M.P.H., Daffin, G. K., B.A., Wallace, Stephaun E,PhD., M.S., & Hopkins, E., B.A. (2022). Engaging in intersectional liberation for every(black)body impacted by anti-blackness and HIV-related stigma. American Journal of Public Health, Suppl.Supplement 4, 112, S380-S383. Retrieved from <https://www.proquest.com/scholarly-journals/engaging-intersectional-liberation-every-black/docview/2717342250/se-2?accountid=211160>

Despite the availability of effective medications for HIV treatment and prevention, Black people continue to experience a disproportionate burden of the disease. In 2019, more than 40% of people living with HIV in the United States were Black, and they had lower rates of viral suppression than members of other racial and ethnic communities.¹ This epidemiological pattern has persisted since the beginning of the HIV epidemic.² Recent literature indicates that the same underlying socioeconomic structural issues that give rise to negative health outcomes among Black people also impact how HIV is both experienced and addressed within Black communities.^{3,4} Underlying these health outcomes is the pervasive impact of anti-Black racism, which is prejudice, attitudes, beliefs, stereotyping, or discrimination that explicitly or implicitly reflects the view that people of African descent are inferior to those in other racial groups. Anti-Black racism prohibits Blackness from being valued and systematically marginalizes people perceived to be of African descent. Simultaneously, Black people hold intersectional, socially stratified identities based on ethnicity, nationality, sexuality, gender, and other characteristics. Interlocking systems of oppression which target overlapping identities (e.g., Black, gay, immigrant) compound the experience of oppression, amplifying vulnerability to HIV for specific Black communities. Intersectional HIV stigma is the manifestation of oppressive policies and practices within systems that result in prejudice and discrimination directed at people living with HIV or people perceived to be at greater risk of HIV acquisition. Stigma enacts a psychological toll and directly impacts health-seeking behaviors of people living with HIV and others from marginalized populations, such as lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+) communities; people who use drugs; sex workers; and immigrants. HIV-related stigma can be interpersonal, institutional, or internalized and occurs in personal, work, and health care settings. Addressing intersectional HIV stigma and its impact on Black communities is complex, given the paramount challenges posed by anti-Black racism, nativism, heterosexism, and other systems of oppression. It requires an intentional approach that centers the voices and leadership of Black people.

Poteat, T. C.,PhD.M.P.H., & Logie, C. H., PhD. (2022). A case for strengths- based approaches to addressing intersectional stigma in HIV research. American Journal of Public Health, Suppl.Supplement 4, 112, S347-S349. Retrieved from <https://www.proquest.com/scholarly-journals/case-strengths-based-approaches-addressing/docview/2717342212/se-2?accountid=211160>

Stigma reduction is essential for reaching global goals for ending the HIV epidemic, and HIV researchers have paid increasing attention to the intersectional nature of stigma. In *Workable Sisterhood*, Berger first defined intersectional stigma as the relationship between interlocking forms of oppression (i.e., intersectionality) and the ways in which people become socially defined as "other" (i.e., stigma).¹ She illustrates how HIV stigma compounds structural

inequities along axes of race, class, and gender for marginalized women living with HIV. She also demonstrates how experiences of intersectional stigma can expose the structural roots of oppression and inspire mobilization of internal (e.g., faith) and external (e.g., peer support) resources to challenge oppressive structures. This conceptualization of intersectional stigma is grounded in empowerment to transform inequitable power systems. Yet, subsequent HIV-related intersectional stigma research has largely focused on deficit-based outcomes. A scoping review of quantitative intersectional stigma research revealed that a minority of studies (13 of 32) explored empowerment-based factors in conjunction with intersecting stigma.² Although intersectional stigma research often focuses on the harms of stigma to argue for social and structural change, this approach has limitations.

Credits. (2022). American Journal of Public Health, Suppl. Supplement 4, 112 Retrieved from <https://www.proquest.com/scholarly-journals/credits/docview/2717342171/se-2?accountid=211160>

Sievwright, K. M., M.H.S., Stangi, A. L., PhD.M.P.H., Nyblade, L., PhD.M.A., Lippman, S. A., PhD.M.P.H., Logie, C. H., PhD.M.S.W., Mascena Veras, Maria Amélia de Sousa, MD PhD, M.P.H., . . . Sevelius, J. M., PhD.M.A. (2022). An expanded definition of intersectional stigma for public health research and praxis. American Journal of Public Health, Suppl. Supplement 4, 112, S356-S361. Retrieved from <https://www.proquest.com/scholarly-journals/expanded-definition-intersectional-stigma-public/docview/2717342167/se-2?accountid=211160>

Intersectionality-an analytic tool that enables researchers and historically marginalized communities to investigate how "intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life"¹(p2)-is becoming a prominent lens through which to conduct social and behavioral science research, particularly within the field of public health.¹⁻³ Intersectionality is now recognized as critical to ending the HIV epidemic, as well as addressing other public health priorities.^{2,4} Stigma researchers are applying an intersectional lens to understand and address health inequities among groups at the most marginalized intersectional positions, as stigma reduction cannot be fully achieved without centering the structures and systems that drive stigma and discrimination.^{2,5,6} For example, without understanding how racism and homophobia mutually shape the experiences and opportunities of sexual minority people of color, we cannot fully understand or address the stigma and discrimination they experience. To realize its full potential for improving health equity, a closer look at the concept of intersectional stigma and how it is operationalized in research and practice is warranted. Berger defined intersectional stigma as the "total synchronistic influence of various forms of oppression which combine and overlap to form a distinct positionality."⁷(p24) Logie et al. defined intersectional stigma as the "interdependent and mutually constitutive relationship between social identities and structural inequities."⁵(p9) Considering these definitions, the next logical step in understanding and addressing public health inequities is to deliberately integrate intersectional stigma frameworks into interventions to improve health outcomes. To address intersectional stigma and its sequelae, it is important to consider what it means for a stigma reduction intervention to be "intersectional." We recommend that an intersectional stigma reduction intervention should hold the following principles: (1) recognize and name how systems of power, privilege, and oppression intersect to affect individual experiences and fuel stigma; (2) aim to dismantle systems of power, privilege, and oppression, and mitigate the harms caused by those systems; (3) ensure community leadership and meaningful engagement; and (4) support collective action, cohesion, and resistance to address the intersecting axes of inequities. We explore these principles to guide progress toward achieving health equity.

Spieldenner, A., PhD., Chang, J., M.A., Thomas, R. M., B.A., Castellanos, E., B.A., & Ayala, G., PsyD. (2022). Stronger together: Coalitions as interventions against intersectional stigma. American Journal of Public Health, Suppl. Supplement 4, 112, S384-S386. Retrieved from <https://www.proquest.com/scholarly-journals/stronger-together-coalitions-as-interventions/docview/2717342133/se-2?accountid=211160>

HIV continues to disproportionately impact key populations- gay and bisexual men, transgender people, people who use drugs, and sex workers-worldwide, especially those who are financially poor and those who are Black and Brown. In 2020, according to UNAIDS, key populations represented 65% of new HIV infections globally- far beyond the proportion of the general population.¹ Governments legislate against key populations: 70 countries outlaw gay sex, most countries criminalize drug use, and nearly all countries have laws against sex work.² Forty years after the

first cases of AIDS were published, intersectional stigma continues to push key populations to the margins of society. The problems of stigma, discrimination, violence, and criminalization cannot be treated away with antiretroviral medications; yet, because the mainstream HIV response has become ever more reliant on biomedical solutions, it struggles with addressing these systemic and endemic problems. Service organizations, advocacy groups, and governments do not often use intersectional stigma as a lens through which to be developing health care policies and practices, addressing laws and policies, and even in organizing convenings. Indeed, the level of attention and resources devoted to redressing intersectional stigma, discrimination, violence, and criminalization remain incommensurately small in comparison with the scale of the problem and its impacts. Intersectional stigma describes how interlocking forms of social oppression impact people with multiple stigmatized identities (e.g., the effects of racism, transphobia, criminalization of sex work, and HIV-related stigma on a Black transgender sex worker living with HIV).³ Key populations are overlapping communities that share common experiences of exclusion, pathologization, discrimination, and dismissal. Stigma marks gay and bisexual men, people who use drugs, sex workers, and transgender people as sick, immoral, deviant, and, in many contexts, criminal. Key populations are often scapegoated for social and political ills and are often delegated to the role of helpless, passive recipients of services or objects of research.^{4,5} The global HIV response has not been able to provide clear enough pathways toward solutions and instead has at times contributed to the problem.

Ogunbajo, Adedotun, PhD., M.P.H., Mayer, K. H., M.D., Kanki, P. J., ScD., & Tsai, Alexander C, M.D., PhD. (2022). Intersectional stigma and HIV Continuum Outcomes among sexual minority men in sub-Saharan Africa: A conceptual framework. *American Journal of Public Health, Suppl. Supplement 4*, 112, S374-S376. Retrieved from <https://www.proquest.com/scholarly-journals/intersectional-stigma-hiv-continuumoutcomes-among/docview/2717342131/se-2?accountid=211160>

Sexual minority men (SMM)-which we define as cisgender and transgender men who are romantically attracted, sexually attracted, or both to other cisgender and transgender individuals-in sub-Saharan Africa are at heightened risk for HIV infection and have a higher HIV prevalence and incidence compared with the general population. This disparity has been largely attributed to the stigma and discrimination-on the basis of sexual orientation or gender identity-to which SMM in sub-Saharan Africa are subjected. Recently, there has been a stronger emphasis on investigating how different patterns of intersectional stigma contribute to health inequities among marginalized communities. Intersectional stigma, a term coined by Michele Tracy Berger in her book *Workable Sisterhood*,¹ refers to the confluence of multiple stigmatized identities and how they interact with structural context and factors (e.g., cultural norms and practices, social policy) to have an impact on health outcomes. Sexual orientation, HIV status, and socioeconomic status may each affect the health of SMM in sub-Saharan Africa. A systematic review published in *The Lancet* in 2019 found that while 67% of SMM in sub-Saharan Africa had ever tested for HIV, among SMM living with HIV, only 24% were currently on antiretroviral therapy, and 25% of them had achieved viral load suppression.² While it is increasingly recognized that intersectional stigma-related to HIV status and sexual minority identity-affects HIV prevention and care outcomes, there are notable gaps in the literature, with no existing model to frame the mechanisms through which experiences of intersectional stigma affect HIV prevention and care outcomes among SMM in sub-Saharan Africa. Understanding these mechanisms has important implications for future HIV intervention development and policymaking.

Bernard, E. J., B.A., Symington, Alison, LL.M., L.L.B., B.A., & Beaumont, S., D.U. (2022). Punishing vulnerability through HIV criminalization. *American Journal of Public Health, Suppl. Supplement 4*, 112, S395-S397. Retrieved from <https://www.proquest.com/scholarly-journals/punishing-vulnerability-through-hiv/docview/2717342073/se-2?accountid=211160>

"HIV criminalization" refers to the unjust application of criminal law to people living with HIV for nonmalicious HIV transmission, perceived or potential HIV exposure, or nondisclosure of known HIV-positive status. Although many HIV-specific criminal statutes were misguidedly enacted with the primary purpose of protecting public health, it has been extensively documented that HIV criminalization in fact poses a barrier to HIV prevention, care, and treatment and negatively affects the quality of life of those affected by HIV.¹⁻⁴ As a result, HIV criminalization is an important issue for policymakers, public health practitioners, and health care providers, in addition to people living with HIV

and justice advocates. Obtaining accurate information on how HIV criminalization laws are applied is challenging, given the lack, or inadequacy, of systems to track them in most jurisdictions. At the HIVJustice Network, we monitor HIV-related criminal laws and cases in real time, based primarily on media reports. These are collated and classified according to alleged crime, known demographics, and disposition in our searchable Global HIVCriminalisation Database.⁵ Our analysis based on these reports strongly suggests that people living with HIV often receive unjust treatment in the legal system. Moreover, we observe that HIV criminalization serves as a proxy for discrimination based on class, ethnicity, gender identity, migrant status, race, sex, sexual orientation, and other markers of social vulnerability. The most aggressive push to criminalize people living with HIV tends to occur at the intersection of several stigmatized identities.

Kurth, A., PhD.M.P.H.C.N.M., & Potter, T., R.N.PhD. (2022). The public health crisis is planetary-and nursing is crucial to addressing it. *American Journal of Public Health, Suppl. Supplement 3*, 112, S259-S261. Retrieved from <https://www.proquest.com/scholarly-journals/public-health-crisis-is-planetary-nursing-crucial/docview/2717342060/se-2?accountid=211160>

If the Earth were our client, her status would be multisystem failure. She is not ready for hospice, but she does need intensive care to survive. Signs and symptoms include catastrophic wildfires, unprecedented and extended periods of severe heat, climate-related disasters of historic proportions, massive biodiversity loss, deforestation and desertification of the land, emerging infectious and zoonotic diseases including COVID-19, severe air pollution, and changes in water quality and availability. Each of these changes profoundly impacts the health of humans and often impacts structurally vulnerable populations disproportionately. In September 2021, more than 200 global nursing, medical, pharmacy, dental, and public health journals issued a joint statement titled, "Call for Emergency Action to Limit Global Temperature Increases, Restore Biodiversity, and Protect Health." Its authors wrote: As health professionals, we must do all we can to aid the transition to a sustainable, fairer, resilient, and healthier world. Alongside acting to reduce the harm from the environmental crisis, we should proactively contribute to global prevention of further damage and action on the root causes of the crisis.¹(p1135)

Driffin, D. D., M.P.H., Simmons, E. M., B.A., Robinson, Ace, M.H.L., M.P.H., & Farrow, K. (2022). Black sexual minority male HIV researchers, clinic administrators, and activists call for the advancement of an intersectionality approach to address HIV stigma. *American Journal of Public Health, Suppl. Supplement 4*, 112, S377-S379. Retrieved from <https://www.proquest.com/scholarly-journals/black-sexual-minority-male-hiv-researchers-clinic/docview/2717342006/se-2?accountid=211160>

HIV-related research that focuses on Black sexual minority men (SMM) often treats that particular community as monolithic. The research often focuses on the disparate rates of HIV infection while offering little insight into the social, cultural, political, and economic dynamics shaping the lives of Black SMM that impact decision-making and behavior or access to health care or public health systems. We postulate that these insufficient and often uninformed hypotheses are due to the lack of queer Black people living with HIV in HIV-related public health leadership, clinical research, health care delivery, and academia. This dynamic expressly exacerbates instead of reduces the experienced external and internal stigmas. We are happy to see articles in this special supplement of AJPH addressing the Black diaspora of SMM and raising the need for more investment in understanding intersectionality and an intersectional lens to build future research. Recent research uses an intersectional framework to explain HIV prevention and treatment inequities. For Black SMM, links are found between lived experiences of racism and queerphobia¹ and reduced HIV-related health-seeking behaviors (e.g., poorer medication adherence, less frequent HIV screening).² These articles in this special supplement highlight the systemic racism within academia while also showcasing that these "isms" are only a small portion of the many enacted stigmas that impact Black SMM.

Wright, I. A., PhD., Reid, R., M.S., Shahid, N., B.A., Ponce, A., M.P.H., Nelson, C. M., Sanders, J., M.S., . . . Dale, S. K., PhD. (2022). Neighborhood characteristics, intersectional discrimination, mental health, and HIV outcomes among black women living with HIV, southeastern united states, 2019–2020. *American Journal of Public Health, Suppl. Supplement 4*, 112, S433-S443. doi:<https://doi.org/10.2105/AJPH.2021.306675>

Objectives. To examine the effects of within-neighborhood and neighboring characteristics on discrimination, stigma, mental health, and HIV outcomes among Black women living with HIV (BWLWH). **Methods.** A total of 151 BWLWH in a southeastern US city provided baseline data (October 2019-January 2020) on experienced microaggressions and discrimination (race-, gender-, sexual orientation-, or HIV-related), mental health (e.g., depression, posttraumatic stress disorder), and HIV outcomes (e.g., viral load, antiretroviral therapy adherence). Neighborhood characteristics by census tract were gathered from the American Community Survey and the National Center for Charitable Statistics. Spatial econometrics guided the identification strategy, and we used the maximum likelihood technique to estimate relationships between a number of predictors and outcomes. **Results.** Within-neighborhood and neighboring characteristics (employment, education, crime, income, number of religious organizations, and low-income housing) were significantly related to intersectional stigma, discrimination, mental health, HIV viral load, and medication adherence. **Conclusions.** Policy, research, and interventions for BWLWH need to address the role of neighborhood characteristics to improve quality of life and HIV outcomes.

Kerr, J., PhD., Lelutiu-Weinberger, C., Nelson, L. E., R.N. PhD., Turan, J. M., PhD., Frye, V., PhD., Matthews, D. W., M.B.A., . . . Hightow-Weidman, L. (2022). Addressing intersectional stigma in programs focused on ending the HIV epidemic. *American Journal of Public Health, Suppl. Supplement 4*, 112, S362-S366. Retrieved from <https://www.proquest.com/scholarly-journals/addressing-intersectional-stigma-programs-focused/docview/2717341969/se-2?accountid=211160>

Stigma is defined as a process by which individuals or groups are devalued because of attributes or behaviors deemed "deeply discrediting."¹ HIV stigma, the social discrediting of people living with HIV, often intersects with other forms of social marginalization. Intersectionality is a framework that considers how interlocking social systems of privilege and oppression (racism, sexism, transphobia, heterosexism, classism, xenophobia) condition (at a microlevel) the experiences of people with intersecting, often marginalized social identities (e.g., race, gender identity, sexual orientation, socioeconomic status, country of origin, health status).^{2,3} In the HIV context, an intersectional stigma lens recognizes that multiple marginalized social positions, processes, and identities are "mutually constituted" and that disparities cannot be effectively addressed if racial, gender, and sexual minority status among people living with HIV are treated separately.⁴ An intersectional approach becomes particularly relevant given the social groups most affected by HIV in the United States. In 2019, HIV incidence was higher among Black (45.0 per 100 000), Latinx (21.5 per 100 000), and multiracial (18.8 per 100 000) individuals than among White individuals (5.3 per 100 000).⁵ In addition, 70% of transmissions were attributed to male-to-male sexual contact, as compared with 23% by sexual contact between cisgender men and cisgender women.⁵ Black women account for more than half of new HIV cases among women overall,⁵ and rates of heterosexual HIV transmission among Black women are considerably higher than rates among Black men.⁵ From 2015 to 2019, the only gender categories for which HIV incidence increased were transgender women and transgender men. Black gay and bisexual men and transgender women demonstrate the lowest preexposure prophylaxis use, HIV diagnosis rates, linkage to and retention in care, and viral suppression rates of all racial and gender groups.

Taggart, Tamara, PhD., M.P.H., Rendina, H. J., Boone, Cheriko A, MSW, M.P.H., M.A., Burns, Paul, PhD., M.S., Carter, J., M.A., English, D., PhD., . . . Bowleg, Lisa, PhD., M.A. (2022). Stigmatizing spaces and places as axes of intersectional stigma among sexual minority men in HIV prevention research. *American Journal of Public Health, Suppl. Supplement 4*, 112, S371-S373. Retrieved from <https://www.proquest.com/scholarly-journals/stigmatizing-spaces-places-as-axes-intersectional/docview/2717341952/se-2?accountid=211160>

Table of contents. (2022). *American Journal of Public Health, Suppl. Supplement 4*, 112, S331-S332. Retrieved from <https://www.proquest.com/scholarly-journals/table-contents/docview/2717341929/se-2?accountid=211160>

Smith, L. R., PhD., Patel, Viraj V, M.D., M.P.H., Tsai, Alexander C, PhD., M.D., Mittal, M. L., M.D., Quinn, K., PhD., Earnshaw, V. A., PhD., & Poteat, Tonia, PhD., M.P.H. (2022). Integrating intersectional and syndemic frameworks for ending the US HIV epidemic. *American Journal of Public Health, Suppl. Supplement 4*, 112, S340-S343. Retrieved from <https://www.proquest.com/scholarly-journals/integrating-intersectional-syndemic-frameworks/docview/2717341899/se-2?accountid=211160>

In the US HIV epidemic, intersectional stigma research illustrates how multiple interlocking systems of oppression (e.g., classism, racism, misogyny, drug use stigma) amplify HIV vulnerability and related health inequities.¹ Michele Tracey Berger¹ first coined the term intersectional HIV stigma, grounding the core of this intersectional approach in Black feminist theory to articulate individual and collective experiences of status-based oppression and to advance liberation.^{2,3} To date, intersectional HIV-related stigma research has focused largely on understanding how stigma is experienced among populations with multiple interlocking stigmatized statuses in relation to a single health condition, HIV.⁴ In contrast, the past decade of HIV research has leveraged the theory of syndemics to understand how the co-occurrence of multiple health conditions (and their interactions) amplifies HIV vulnerability and related health inequities.⁵ Integrating the foci of these frameworks can better target efforts to end the HIV epidemic (EHE) in the United States. Recently, HIV scholars have explored the usefulness of coapplying intersectionality and syndemic analytic frameworks.⁶⁻⁸ We briefly review each framework's theoretical foundations to provide an integrated understanding of the sociostructural processes through which US HIV disparities are amplified. Finally, we explore community-led efforts to disrupt the paths through which intersectional stigma cultivates domestic HIV-related syndemics.

Phillips, A., Madhu, A., B.S., & Dale, S. K., PhD. (2022). Becoming in the face of intersectional stigma- black, gay, woman, and living with HIV. *American Journal of Public Health, Suppl. Supplement 4*, 112, S390-S392. Retrieved from <https://www.proquest.com/scholarly-journals/becoming-face-intersectional-stigma-black-gay/docview/2717341886/se-2?accountid=211160>

My name is Ms. Arnetta Phillips. When I was young, the schools were segregated. White students went to White schools, and Black students went to Black schools. We had different drinking fountains, and buses had yellow lines going through the middle- separating us by race. These memories I have as a little Black girl still linger to this day. Growing up, Sunday school at church helped to uplift me. I loved Sunday school because we talked about "loving thy neighbor" and learned that it did not matter where you came from or the color of your skin. However, during regular service, the pastor berated the LGBTQ + (lesbian, gay, bisexual, transgender, queer) community, which frightened me because I knew at an early age that I liked girls. For many years I prayed to God to "take the gay away," forced myself to have relationships with men, and tried to be someone I was not. When I was diagnosed with HIV, I then prayed for God to take the HIV away. Many days, I cried and crawled on the floor praying for my diagnosis to change. The stigma I faced and the sadness that came from not accepting my sexuality and my HIV status took me down the path of addiction. With drugs, I did not have to think, feel, or deal, and it was a way to escape the realities of my life. However, when my father died in my arms from a massive heart attack, I was determined to fulfill his wishes for my sobriety. Once I accepted my drug problem and that I was living with HIV, my life began to change. Twenty years after my initial diagnosis, I visited the pharmacy to get my HIV medication for the first time, and then I sat in the car and cried. I cried because I was finally ready to take charge of my health but also because every day these pills would serve as a reminder that HIV is alive within me. What I did not know that day is that my lived experiences would become a source of empowerment for others.

Ayala, G., PsyD. (2022). Change is incremental but worth fighting for: Breaking the silence about HIV intersectional stigma. *American Journal of Public Health, Suppl. Supplement 4*, 112 doi:<https://doi.org/10.2105/AJPH.2022.306746>

Bowleg, L., PhD.M.A. (2022). The problem with intersectional stigma and HIV equity research. *American Journal of Public Health, Suppl. Supplement 4*, 112, S344-S346. Retrieved from <https://www.proquest.com/scholarly-journals/problem-with-intersectional-stigma-hiv-equity/docview/2717341857/se-2?accountid=211160>

I commence with a confession. As compelling as I find the argument that stigma is a fundamental cause of health inequities,¹ and as much as I believe (obviously) that intersectionality is an indispensable critical lens for health equity research,²¹ I am not convinced that intersectional stigma is the right concept to advance more equitable HIV treatment and prevention outcomes. The incongruity of this confession is not lost on me. In addition to my role as a guest editor of this special supplement of AJPH, I am also a principal investigator of an intersectional stigma project funded by the same National Institute of Mental Health (NIMH)³ initiative that sourced this supplement. My primary opposition is that intersectional stigma, at least as currently conceptualized, obscures interlocking oppressive social-

structural systems such as structural racism, sexism, and heterosexism (to name some) that more accurately explain why, four decades into the HIV/AIDS epidemic in the United States, we can foresee the end of the epidemic for relatively more privileged groups such as White sexual minority men but not Black and Latino sexual minority men or cisgender and transgender women.

Friedman, M. R., Liu, Q., M.S., Meanley, Steven, PhD., M.P.H., Haberlen, S. A., PhD., Brown, Andre L, PhD., M.P.H., Turan, B., PhD., . . . Plankey, M. W., PhD. (2022). Biopsychosocial health outcomes and experienced intersectional stigma in a mixed HIV serostatus longitudinal cohort of aging sexual minority men, united states, 2008–2019. *American Journal of Public Health, Suppl. Supplement 4*, 112, S452-S462. doi:<https://doi.org/10.2105/AJPH.2022.306735>

Objectives. To determine whether intersectional stigma is longitudinally associated with biopsychosocial outcomes. **Methods.** We measured experienced intersectional stigma (EIS; ≥ 2 identity-related attributions) among sexual minority men (SMM) in the United States participating in the Multicenter AIDS Cohort Study. We assessed longitudinal associations between EIS (2008-2009) and concurrent and future hypertension, diabetes, dyslipidemia, antiretroviral therapy adherence, HIV viremia, health care underutilization, and depression symptoms (2008-2019). We conducted causal mediation to assess the contribution of intersectional stigma to the relationship between self-identified Black race and persistently uncontrolled outcomes. **Results.** The mean age ($n = 1806$) was 51.8 years (range = 22-84 years). Of participants, 23.1% selfidentified as Black; 48.3% were living with HIV. Participants reporting EIS (30.8%) had higher odds of hypertension, dyslipidemia, diabetes, depression symptoms, health care underutilization, and suboptimal antiretroviral therapy adherence compared with participants who did not report EIS. EIS mediated the relationship between self-identified Black race and uncontrolled outcomes. **Conclusions.** Our findings demonstrate that EIS is a durable driver of biopsychosocial health outcomes over the life course. **Public Health Implications.** There is a critical need for interventions to reduce intersectional stigma, help SMM cope with intersectional stigma, and enact policies protecting minoritized people from discriminatory acts. (*Am J Public Health. 2022;112(S4):S452-S462. <https://doi.org/10.2105/AJPH.2022.306735>*)

Berger, M. T., PhD. (2022). Coining intersectional stigma: Historical erasures and the future. *American Journal of Public Health, Suppl. Supplement 4*, 112, S338-S339. Retrieved from <https://www.proquest.com/scholarly-journals/coining-intersectional-stigma-historical-erasures/docview/2717341810/se-2?accountid=211160>

There is a T-shirt hanging in my closet that simply states, "Cite Black Women." I bought this T-shirt in solidarity to support Christen Smith, a guest speaker on my campus in 2019, who delivered a presentation on why and how she created Cite Black Women, a multipronged campaign to engage in a "radical praxis of citation that acknowledges and honors Black women's transnational intellectual production."¹ It reminds me and others that citation practices matter, that Black women's academic achievements are often "overlooked, sidelined and undervalued"¹ and erased from the canon. This T-shirt has taken on new meaning as I have discovered that my concept of "intersectional stigma," a central idea from my first book, *Workable Sisterhood: The Political Journey of Women with HIV/ AIDS*,² has animated questions in the field of public health and continues to stimulate substantial interest by government agencies that include the National Institutes of Health and the National Institute of Mental Health without any attribution to my work or scholars whose work I build on. I would not have been aware of how far intersectional stigma has traveled (without my name), were it not for the committed efforts of Lisa Bowleg, guest editor of this issue of *AJPH* and scholar of intersectional research. As the creator of the term "intersectional stigma" and a leading scholar on intersectionality, this news was equal parts surprising, disappointing, and infuriating to me. Thus, I am grateful for Lisa Bowleg's invitation for me to respond here.

Harris, Orlando O, RN, PhD, M.P.H., F.N.P., Bialous, S. A., D.R.P.H., Muench, Ulrike, PhD., M.S.N., Chapman, Susan, RN, PhD., M.P.H., & Dawson-Rose, C. (2022). Climate change, public health, health policy, and nurses training. *American Journal of Public Health, Suppl. Supplement 3*, 112, S321-S327. doi:<https://doi.org/10.2105/AJPH.2022.306826>

There are few educational programs in the United States that have a primary focus on preparing nurses to engage in all levels of public health, health policy, and climate change. The United Nations sustainability development goals (SDG) and the Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity (2021) report underscored the importance of key stakeholders, including nurses, engaging in advocacy and policy to promote health equity. We discuss the role of nursing at the intersection of public health, policy, climate change, and the SDG. We also discuss the history and merger of the University of California San Francisco (UCSF) School of Nursing public health and health policy specialties, a significant innovation in our effort to promote health equity. We provide a brief overview of the redesigning of our curriculum that meets the needs of today's learners by including content on climate change, data analytics, and racial, social, and environmental justice. Finally, we emphasize the need to train the next cadre of nurses interested in careers in public health and health policy for us to meet the challenges facing our communities.

McCauley, Linda A, R.N., PhD., Waters, Catherine M, R.N., PhD., & Monsen, Karen A, RN, PhD., M.S. (2022). Nursing and public health special issue. *American Journal of Public Health, Suppl. Supplement 3*, 112, S215-S217. Retrieved from <https://www.proquest.com/scholarly-journals/nursing-public-health-special-issue/docview/2717341761/se-2?accountid=211160>

In this AJPH special issue, "Nursing and Public Health," nurses and their colleagues share novel practice insights, cutting-edge research findings, educational guidance, and urgent calls to action for nurses and everyone working in public health and health care today. The articles showcase nursing research, leadership, education, and practice responses to critical public health challenges, such as the climate crisis, the COVID-19 pandemic, trauma and related issues, and workforce needs.

Reiss-Brennan, B., Hayes, Rose, R.N., M.A., & McCauley, Linda, R.N., PhD. (2022). An overlooked strategic powerhouse: How nurses can rise to the challenge of integrating public health and primary care. *American Journal of Public Health, Suppl. Supplement 3*, 112, S253-S255. Retrieved from <https://www.proquest.com/scholarly-journals/overlooked-strategic-powerhouse-how-nurses-can/docview/2717341759/se-2?accountid=211160>

Although the United States is one of the wealthiest countries in the world and a leader in biomedical innovation, its health care system is consistently ranked among the worst in terms of cost and health outcomes. Americans have short life expectancies, high infant mortality and obesity rates, and soaring chronic disease rates compared with other wealthy nations. In 2021, the National Academy of Medicine (NAM) was charged with examining what it would take to improve US primary care. The NAM report described the practice of siloing public health from primary care or treating these areas as separate fields of scientific inquiry, practice, and billable service.¹ NAM identified this separation as a key driver of poor health outcomes and health inequities in the United States. The Institute of Medicine (IOM) examined similar phenomena in a 2012 report, noting how the two fields tend to operate independently, despite complementary functions and common goals.² Where these silos persist, we see communication and process breakdowns at the point of care. For instance, when large swaths of Americans turned to trusted primary care providers for COVID-19 vaccine insights, their primary care providers did not always have the most up-to-date information, in part because of a lack of interprofessional cohesion (including fragmented public health messaging and data systems). If we are to remedy such issues, a substantive paradigm shift must take place: We must move toward what DeSalvo et al.³ termed "Public Health 3.0." In this model, multiple sectors, specialties, and stakeholders form coalitions to mobilize data, people power, and resources in a strategic manner to advance health for all. To be truly strategic, we must think carefully about how to leverage nurses—who care for patients across the lifespan and in nearly all public health nursing (PHN) and primary care settings—within these coalitions. The 2021 NAM report urges health care teams to undertake the mission of integrating systems. However, NAM stops short of describing exactly how teams ought to accomplish this aim and the proposed makeup of said teams. Like any group project, success will depend on the ability of teams to identify leaders and clearly delineate responsibilities. The purpose of this editorial is to explore the potential of PHN and primary care nurses and to describe the roles they might assume in the collaborative integration of their respective silos.

Jones, Krista L, RN, DNP, M.S.N., P.H.N.A.-B.C., Edwards, Lori A, RN, DrPH, MPH, BSN, C.N.S.-P.C.H., B.C., & Alexander, Gina K, RN, PhD, M.P.H., M.S.N. (2022). Shoring up the frontline of prevention: Strengthening curricula with community and public health nursing. *American Journal of Public Health, Suppl. Supplement 3*, 112, S237-S240. Retrieved from <https://www.proquest.com/scholarly-journals/shoring-up-frontline-prevention-strengthening/docview/2717341717/se-2?accountid=211160>

The terms "frontline" and "prevention" are now common everyday household words heard across America. However, the most exigent focus for investments in prevention is unclear, as is the location of the true frontline. County Health Rankings demonstrate that 80% of our health outcomes are not resolved within clinical or acute care settings.¹ However, the number of nurses practicing in community and public health settings has been consistently declining, from 4% of the workforce in 2013 to 2.9% in 2020.² Existing disparities in nursing salaries may be a contributing factor to the decline. In 2021, the US Bureau of Labor Statistics³ reported the average national registered nurse salary to be \$75 330, whereas the average public health nursing salary is \$68 661.⁴ Furthermore, public health funding decreased substantially across the nation prior to the pandemic, leading to lost staff positions, which resulted in a weaker public health workforce and infrastructure.⁵ Each successive surge of the COVID-19 pandemic has exposed the dire need for more nurses in public health and community settings. For years to come, concerns about the nursing workforce are likely to persist as we witness intensifying health care demands created by changes in the delivery of health care services, population shifts, and health care transformation. In spite of these trends, many schools of nursing across the nation design and deliver a curriculum with a central focus on illness care or disease treatment to be rendered in inpatient settings.⁶ As a result, our nation's essential health interests beyond the bedside remain unequivocally compromised. In this article, we argue that the predominant and pervasive curricular focus of nursing education on acute care has limited the ability to prepare a workforce ready to address public health threats, which has become more evident since the onset of COVID-19. We advocate for (1) intentional changes in nursing curricula designed to reinforce didactic teaching of public health sciences and social determinants of health, and (2) deeper investments in three-way community-academic-practice partnerships to promote a nursing workforce equipped for intersectoral practice in settings outside of the hospital, leading to a far-reaching impact on population health.

Ballard, Julianne, RN, P.H.N., M.S.N., Turner, Laura, RN, PHN, M.H.S., M.S.N., Cuca, Yvette P, PhD., M.P.H., Lobo, Brittany, M.A., M.P.H., & Dawson-Rose, C. (2022). Trauma-informed home visiting models in public health nursing: An evidence-based approach. *American Journal of Public Health, Suppl. Supplement 3*, 112, S298-S305. doi:<https://doi.org/10.2105/AJPH.2022.306737>

Traumatic experiences can have significant health effects, particularly when they are experienced during childhood. Structural determinants of health including environmental disasters and limited access to mental health services and affordable housing can contribute additional stress for parents with a personal history of childhood adversity. These factors can directly affect their children, contributing to intergenerational trauma. Pregnant people and families with young children are often referred to public health nursing maternal and child home visiting (HV) programs when there are concerns about historical or evolving childhood trauma. The strict eligibility and participation requirements of existing evidence-based maternal and child HV programs can exclude families that have experienced or are experiencing childhood trauma and its effects and can limit innovation by public health nurses, a hallmark of the field. Therefore, we advocate and describe the implementation of the Trauma Informed Approach in Public Health Nursing (TIA PHN) model, which incorporates a trauma-informed approach into a traditional maternal and child HV program in 3 California counties. TIA PHN, which began enrollment in March 2021, involves public health nurses and community health workers and integrates program evaluations in pursuit of evidence-based status.

Singer, R. B., PhD., Crooks, N., PhD., Johnson, A. K., PhD., Smith, A. U., PhD., Wesp, L., PhD., Singer, R., D.N.P., . . . Matthews, A. K., PhD. (2022). Culturally safe nursing care for black sex workers in the greater Chicago area, 2020–2021. *American Journal of Public Health, Suppl. Supplement 3*, 112, S288-S291. doi:<https://doi.org/10.2105/AJPH.2022.306836>

Complex structural and social factors have created health inequities for Black sex workers. Black people, including those engaged in transactional sex, report leaning on spiritual beliefs to guide health-related decision-making, including whether to get the COVID-19 vaccine. Public health nurses can improve the health of Black sex workers through culturally safe care, which may include a community-stated vision of spiritual support. (*Am J Public Health*. 2022;112(S3):S288-S291. <https://doi.org/10.2105/AJPH.2022.306836>)

Waters, C. M., R.N. PhD. (2022). Public health nursing's impact on strengthening community resilience. *American Journal of Public Health*, Suppl. Supplement 3, 112, S224-S225. Retrieved from <https://www.proquest.com/scholarly-journals/public-health-nursings-impact-on-strengthening/docview/2717341671/se-2?accountid=211160>

Although there is not a universal definition of community resilience, research indicates the positive impact resilience can have on a community's health and quality of life, particularly if it is bolstered and buffered by accessible, equitable, and sustainable systems.¹ The collective resilience of an already strained public health system was tested during the COVID-19 pandemic. Beginning with the Henry Street Visiting Nurse Service in 1895, public health nursing was envisioned by Lillian Wald and Mary Brewster to promote community resilience, in cooperation with multisectoral private-public partnerships, by meeting people where they are without blaming them for their problems.² Two articles in this supplement demonstrate the impact of public health nursing practices and policies on strengthening community resilience at multiple levels of influence: adaptive (ability to adjust), absorptive (ability to cope), anticipatory (ability to predict and be proactive), and transformative (ability to transform systems to deal with change and uncertainty).³ Guided by the Community Resiliency Model, Duva et al. (p. S271) describe the impact of a nurse-led public health intervention designed to meet population mental health needs during the COVID-19 pandemic. In partnership with cross-sector entities in Georgia, nurses trained the public to build community resilience capacity against stress from adversity or trauma. Guided by the Public Health 3.0 and community-based participatory frameworks, Austin et al. (p. S275) describe a community-validated mobile application that provided actionable data to communities to address substance use during the COVID-19 pandemic, shifting the focus of the communities from a deficit-based approach to a strength-based or resilience approach.

Johnson, Karen E, R.N., PhD. (2022). Mobilizing support for the future of advanced public health nursing education. *American Journal of Public Health*, Suppl. Supplement 3, 112, S222-S223. Retrieved from <https://www.proquest.com/scholarly-journals/mobilizing-support-future-advanced-public-health/docview/2717341653/se-2?accountid=211160>

As a public health nurse educator, I was deeply disappointed when our advanced public health nursing (APHN) master's program shuttered in the late 2010s. I therefore found Harris et al.'s description (p. S231) of the evolution of their APHN program and health policy specialty at the University of California San Francisco (UCSF) to be an inspiring example that should compel nursing education leaders nationwide to consider how they can garner support for APHN education in their own institutions and communities. As evidence mounts regarding the influence of social determinants of health and our world continues to endure a time of upheaval that has magnified inequities on multiple fronts (e.g., the COVID-19 pandemic, climate change, racial injustice, violent geopolitical conflicts), our moral obligation to prepare a workforce that can effectively address structural drivers of health is stronger than ever. If nursing is to reach its potential in influencing health equity, we must teach nurses how systems outside the human bodywork (e.g., political systems) as well as how systems within the human body work (e.g., the cardiovascular system). We cannot do this without nursing faculty who have advanced preparation in public and population health nursing.^{1,2} Although analyzing the future of APHN education is not their primary purpose, Harris et al. briefly recommend expanding the number of APHN and policy programs nationwide. Their recommendation—which I wholeheartedly support—compels me to reflect on and amplify what others have said regarding the state of APHN education, including our struggle within nursing to recognize the value of the APHN specialty.^{2,3} If nurses are to effectively step up as the systems-level practitioners that this pivotal point in history demands, we must begin by advocating for support for APHN education and the value of the specialty from both within and outside the profession.

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