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HIV/AIDS Community Awareness and Prevention in Atlanta, Georgia

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Prevention, Consultation, and Advocacy

Social Change Portfolio

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Contents

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OVERVIEW

Keywords: HIV, AIDS, Community, Awareness, Prevention, Atlanta, Georgia, Advocacy.

HIV/AIDS Community Awareness and Prevention in Atlanta, Georgia

Goal Statement: To discuss HIV/AIDS awareness and preventive measures that may aid in mitigating the disease, and suggest ways for advocacy.

Significant Findings: The prevalence of HIV/AIDS continues to be on the rise in Metro Atlanta areas with the black men who have sex with men (MSM) being disproportionately affected. Findings indicated that the black MSM were mostly affected due to great number of them praticicng same sex act (Hicks, 2017). Subsequent finding showed that the high prevalence was due to unprotected sex, substance and alcohol abuse, and mental health issues (Pérez et al., 2018). Collaborative efforts from governmental and non-governmental entities to combat the disease, and effectuate recommended programs are integral to the process of HIV/AIDS prevention.

Objectives/Strategies/Interventions/Next Steps:

The main objective of this project is to identify the areas and the target population in Georgia that has the highest HIV/AIDS cases, and suggest ways to reduce the infection. Available data has shown that Georgia ranked 5th among the states that have high prevalence of HIV/AIDS cases. Identifying the areas in Georgia that are mostly affected with HIV/AIDS infection and the target population is paramount. The Georgia Department of Public health HIV surveillance data will be used to examine the prevalence. Intervention will include Clinical Mental Health Counselors to help counsel the population mostly affected. Partnering with

community-based agency to support an existing program or providing HIV/AIDS monthly training that is cost effective will help in educating the affected population.

INTRODUCTION

HIV/AIDS Community Awareness and Prevention in Atlanta, Georgia

Despite enhanced programs implemented to assist people living with HIV/AIDS and efforts made to get those insured lower out-of -pocket costs for medicines to manage the disease in Georgia, the prevalence still remains on the rise. The 2021 Georgia Department of Public Health surveillance data showed that 58, 615 people with HIV lived in Georgia in 2019. Out of the HIV diagnosis in 2019, 79% were males, 67% were MSM, 71% were Blacks, and 10% were Hispanics (Georgia Department of Public Health, 2021). HIV means (Human Immunodifficency Virus). This virus makes the immune system weak by destroying the cells that fight infections in the body. The disease progresses to Acquired Immonudefficincy Syndrome (AIDS) when untreated (Georgia Department of Public Health, 2020). AIDS occurs when the immune system is severely destroyed which causes the reduction of CD4 count to below 200 cells/mm making the immune system susceptible to opportunistic infections (Centers for Disease Control and Prevention [CDC], 2021). HIV can among other means be transmitted through vaginal fluid, blood, and semen (Georgia Department of Public Health, 2020).

The disease can not be cured, but can be managed with the treatment of Anti Retrovial Therapy (ART). HIV treatment includes two new preventive methods namely: pre-expoure prephylaxis [WP1] (PrEP) and post- exposure prophylaxis [WP2] (PEP). PrEP provides protection for at risk individuals free of HIV while PEP protects people who have the suspicion that they might have been exposed (Georgia Department of Public Health, 2020). The

consquences resulting from HIV in metro Atlanta and in Georgia as a whole has been experienced through adverse health issues, emotional and psychological issues, and economic burden. Reaserchers had shown that the cost of HIV treatment was far higher than the preventive messages (National Center for Primary Care [NCPC], 2013). With the available overwhelming data on HIV cases in Georgia, there is need to emphasis on awareness and prevention. Effective prevention strategies and collaborative efforts that require governmental and nongovernemental assistance is highly needed to combat this disease. Further discussion will be geared to scope and consequences, social ecological model showing risk and protective factors, theories of prevention, adversity and ethical considerations, and advocacy.

PART 1: SCOPE AND CONSEQUENCES

HIV /AIDS Community Awareness and Prevention in Atlanta, Georgia

HIV/AIDS are public health issues that have become public health global concern. Atlanta is the most populous city in Georgia state, and the Metro Atlanta areas have been marked as notorious for HIV/AIDS. Counties known for having the highest rate of people living with HIV are Fulton, Cobb, Dekalb, and Gwinnett (Georgia Department of Public Health, 2021). In Metro Atlanta, the number of HIV cases are on the rise. In 2016, there were 69% people living with HIV/AIDS (PLWHA) in metro Atlanta. A surveillance data from Georgia Department of Public Health (2021) showed that the rate of HIV infections increased from 69% in 2016 to 70% in 2019. The increase was higher in males than in females. Available data showed that the males' HIV infection rate in Metro Atlnata was higher than that of the females at the ratio of 3:1 in comparison with other cities in GA that has the ratio of 2:1. The cases of HIV/AIDS in Metro

Atlanta are mainly among men as a result of a great number of men practicing male-to-male sexual activity (Hicks, 2017).

Among the population of men living with HIV in Metro Atlanta, black MSM males were disapproportionately affected. Current data showed that the HIV infection among black MSM increased to 46% placing them higher than that of the white MSM who had 13% (Hicks, 2017). Sullivan et al (2015) ascertained in their longitudinal cohort study that the black MSM in Atlanta, GA had higher rate of HIV infection more than the white MSM especially among younger black men ages 18-24. Some of the causes of the high prevalence have been attributed to unprotected sex, substance and alcohol abuse, and mental health issues (Pérez et al., 2018). Within the past 5 years, about 3.7% men in the state of GA indulge in same sex activity while in Metro Atlanta alone, the rate differed by 6.6% (Georgia Department of Public Health, 2021). There is need for people in Metro Atlanta and other parts of Georgia to understand the consequences of HIV infection and the necessity for appropriate monitoring and implementation of preventive measures. The goal of this project is to discuss HIV/AIDS awareness and preventive measures that may aid in mitigating the disease, and suggest ways for advocacy.

PART 2: SOCIAL-ECOLOGICAL MODEL

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The socio-ecological model (SEM) had been severally modified since it was first proposed by Bronfenbrenner in 1979 (Stormshak & Dishion, 2002). It postulates that individuals can interact in a multfacted level within social system. SEM impacts behaviroal change and helps in understanding the factors that affect the health issue that is being discussed. This model will help in bringing awareness to the risk and protective factors. Risk factors of HIV include the behaviors or issues that will contribute to the raise of the disease while protective factors relate to

the characteristics that will decrease the progression of the disease or its bad effects. Using this framework and its four levels: individual, relationship, community, societal impacts; the risk and protective factors of HIV/AIDS will be discussed. The awareness of risk and protective factors is paramount to prevention especially when explained through the four levels of SEM.

The individual level of the SEM deals with the biological and personal history factors that incorporates knowledge, behavior, and developmental history as well as gender, race/ethnicity, and age (American College Health Association [ACHA], 2015). The developmental characteristics of this factor can motivate a HIV patient to understand the severity of the disease, and indulge in healthy sexual behaviors. Risk factors of HIV infection differs due to the mode of transmission (Cohen, 2021). Risk factors may be biological, psychogical, or culturally (Substance Abuse and Mental Health Services Administration, [SAMSHA], n.d.). Risk factors under this level can be sex addiction which may exposure someone to multiple partners. In terms of protective factors, an indidvdual living with HIV can protect him or herself by adopting self-control over sex or by practicing abstiance. Under this level of SEM, the important aspect is to be aware of the risk and protective factors of HIV which can help an individual to curtail the spread of the disease.

In terms of relationship, social system plays integral role on this level due to relationships through different affiliations or groups. The relationships formed under this level of SEM can negatively or positively impact the process. The type of relationship formed here may push adolesents or young adults living with HIV to join wrong social crowd such as gangs or prostitution. This may expose such person to more risk behaviors such as substance abuse which may constitute uncontrolled urge of multiple sex partners. Under a protective factor, adolescents or young adults living with HIV can get support through their parents, other family members or

caregivers which may help reduce their risk behaviors especially when they are being closely monitored by the mentioned relatives.

At the community level of the SEM, HIV patients face major social influences derieved from neigbhors, institutions, and built-in environmwnt. The social influences are more on the culture, norms, and stigma. Under this influence, issues such as HIV stigmatization, biphobia, or homophobia may surface (Green, 2019). Such actions occur because people live within the the same community where they often interact with each other. In a community setting and among other risk factors, the common risk behaviors can be exchange of needles, anal and viginal sex, and unprotected sex. These factors can be heightened as a result of lack of HIV awareness in the community.The social network within the community can also contribute to coping of HIV infection through social support (Qiao, Li, & Stanton, 2014), and it serves as a protective factor. While focusing on risk factors and protective factors, concentration should be on enhancing the social and physical environment as well as other avenues that may continue to disencourage risk factors (Dahlberg, & Krug, 2002).

The societal aspect of the SEM incorporates both social and cultural norms that may increase risk factors as well as provide protective factors. The societal norms include educational, economical, and social factors (Dahlberg, & Krug, 2002). Socioeconomic status (SES) plays a major role with people living with HIV. The low income status causes HIV patients to indulge in more risk behaviors such as homelessness, substance abuse, and sex for money/prostitution (Riley et al., 2007). Although activities under this level can generate risk behaviors; however, an individual can choose to maintain societal norm by practing safe sex, choosing one partner, and being tested for HIV. Protective factors or prevention measures under this level is geared towards enhancing societal norns and issues that will not promote risk factors.

Such issues include suggesting to policy makers to enact structural public policies and promote resouces (Dahlberg, & Krug, 2002). Under this level of SEM and as a protective factor, HIV patients can get help through referral of health needs, testing and counseling, and distribution of condoms (WHO, 2021).

PART 3: THEORIES OF PREVENTION

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Theory gives scholar-practitioners, practitioners, and researchers the required tools to design and assess health behaviors, health promotions, and answer research questions. The theoretical framework to be used is Health Belief Model (HBM). HBM has been extensively used for health promotions, interventions, and preventions both in social sciences and public health fields. As a framework, HBM takes account of the social context surrounding peoples' health behaviors, and it postulates that individuals can take active roles in adjusting their health behaviors to avoid unpleasant outcomes (Roth et al n.d.). This theory originated at the time free tuberculosis (TB) screening program through mobile X-ray units for chest X-ray was offered in different cities in the United States. For unexplained reason, many people did not participate. Social psychologists Irwin Rosenstock, Godfrey Hochbaum, and Stephen Kegels were then working at the U.S. Public Health Service. In their quest to discover the reason why good number of people did not attend the TB screening, they developed HBM. They implied that people's beliefs whether they were capable of of being or not being infected by a disease, and their realization of the benefits they intended to avoid impacted their keenness to act (Ganz et al, 2008; National Cancer Institute, 2005).

This theoretical framework had four concepts when it was first created namely: perceived susceptibility, perceived severity, perceived benefit, and perceived barrier. The framework was later modified, and extended to six concepts adding cues to action and self-efficacy (Janz & Becker, 1984). Perceived susceptibility is when one has the belief that one can contract a disease (Janz & Becker, 1984). At this point, the target population is identified (adolscents and young adults), risk behabaviors are explained to the target population, and tailored to the behaviors of the population. The belief at this stage helps an adolescent or young adult to understand the possibility of being infected with HIV/AIDS, and this may motivate him or her to seek preventive measures. Perceived severity is when an individual believes that the disease is serious, and that the outcome of the disease may have adverse effect (Janz & Becker, 1984). At this stage, the target population should know the consequences of being infected with HIV, and actions needed to combat the disease should be recommended. An individual knowing the seriousness and the adverse effects of HIVmay be forced to implement preventive measures by having sex with protection, or abstaining from sexual activities.

Perceived benefit is the stage when one has the belief on the efficacy of the action taken to reduce the disease (National Cancer Institute, 2005). Relating this stage to the disease (HIV), the target population will start to understand the importance of using protection or abstaining from sex. They need to know how and where to get tested, and how the actions taken to protect themselves will benefit them. Perceived barrier deals with how one sees the psychological and tangible costs associated with the recommended preventive behaviors (Roth et al n.d.). Example of this can be lack of access to care such as not having insurance. At this point, the target population will be encouaraged to take proper preventive measures. They may be given some type of incentives that will motivate them such as free HIV test . Cues to action is when life

occurrence motivates an individual to take necessary actions after having the belief that he or she can take action (Roth et al n.d.). At this time, proper awareness is implemented through information, workshops, or training. Self-efficacy is the last stage when an individual feels that he or she is confident enough to take action. This stage calls for monitoring, training, and guiding the popluation. Goal setting is also appropriate at this stags (Roth et al n.d.). Although this type of framework has limitations, it can aid me in bringing HIV/AIDS awareness and preventive measures to target population and other members of my community in Metro Atlanta and GA.

HBM is appropppriate for addressing HIV infection that has high prevalence in my community, Metro Atlanta. HBM is appropriate because it shows that a health behavior or cause of action depends on the individual's belief and perception as well as the ability to prevent the disease in question coupled with being a widely tested theory in health behavior (Schnall et al, 2015). If one sees the disease as a threat, that may trigger favorable action that may motivate one to seek preventive measures. Besides, HBM has been used by researchers to explore and better understand the risks in sexual behaviors as well as in STDs/STIs (Mckellar & Sillence, 2020). Current evidence showed that HBM has been widely used in different studies especially in adolescents and in young adult for protection against STIs (Mckellar & Sillence, 2020). Tarkang, & Zotor (2015) used HBM, and it guided them to investigate the factors associated with consistent condom use to prevent HIV/AIDS among senior secondary school female learners in Mbonge subdivision of rural Cameroon.

In terms of evidence based practice, it involves scientific evidence and clinical expertise information or data that can be used to provide good quality of care as well as make evidence based decisions (American Speech Language Hearing Association, [ASHA]n.d.). HIV infection

has attracted several evidence based programs. The Centers for Disease Control and Prevention has an evidence based program called Choosing Life: Empowerment !Action !Result (CLEAR). The purpose of the program is to aid clients in maintaining good health by reducing the transmission of HIV and STDs: thereby, enhancing the quality of their lives (Centers for Disease Control and Prevention [CDC], n.d.). This evidence based program is for males and females 16 and above living with HIV. The program is client centered, and incorporates cognitive behavioral techniques to foster behaviraol changes (CDC, n.d.). In my attempt to bring awareness and introduce prevention measures on HIV/AIDS, evidence based programs should be incorporated.

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

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It has been established that n Metro Atlanta, the high rate of HIV infection is more on the black MSM. The problem of the MSM being susceptible to HIVinfection is becoming an epidemic issue worldwide (Sullivan et al., 2012). MSM is a behavior that is known as a risk factor for the transmission of HIV/AIDS and other STIs (Geibel et al., 2010). Hixson et al (2011) conducted a study on spatial clustering of HIV prevalence in Atlanta, Geogia, and ascertained that the population highly exposed to the disease was the black MSM group at the rate of 6,998 (42%). To increase the cultural relevance prevention program among the black MSM population, community- initiated indigenous interventions designed for the population by the community that know them better should be encouraged (Pérez et al., 2018). Another option will be to

incorporate the biomedical interventions coupled with behavioral interventions that wll be tailored to the black MSM population (Martinez et al., 2016).

When working on HIV awareness and prevention strategies among diverse population such as the black MSM in Metro Atlanta, evidence based culturally prevention strategies should be included. Moreover, the society is being increasingly diverse; therefore, diversity and ethical considerations are important topics to be aware of as a counselor. Counselors go through challenges either by working with diverse population or by dealing with ethical issues surrounding their profession. They are expected to make sound ethical decisions based on the American Counseling Association (ACA)'s six moral principles of autonomy, justice, beneficience, nonmaleficence, fidelity, and veracity (Erford, 2018). When ethical dilemma or conflicts occur, couselors are also expected to review the code of ethics with multicultural consideration in mind (Forester-Miller, & Davis, 2016) besides following the aforementioned principles. The ACA (2014) code of ethics addressed diversity under research section G which stated that, "Counselors minimize bias and respect diversity in designing and implementing research". Also while working with clients, and according to the ACA (2014) code of ethics Section B.1.(multicultural/diversity considerations)"counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy".

In implementing preventive measures, counselors should be considerate of the ACA (2014) code of ethics Section A.7.b which states, " counselors obtain client consent in advocacy efforts on behalf of an identifiable client to improve the provision of services and to work toward removal of systemic barriers or obtacles that inhabit clients access, growth, and developemnet". When planning strategies for prevention, there are always some challenges. Dealing with diverse

population comes with its challenges as well, and partnering prevention strategies and culture heightens the challenges because both are important values. Evidence based culturally preventive interventions entail involving or focusing on the target population coupled with a proper culturally competent clinician who can analyze the challenges. Therefore, embedding cultural relevance while planning preventive intervention is appropriate (Reese & Vera, 2007). Reese &Vera (2007) reported that culturally relevant prevention should be implemented if they have been ascertained in two or more thoroughly conducted randomized control trials (RCTs) done by two or more independent researchers. With this in mind, any program that did not meet the criteria will pose a challenge, and not appropriate to serve as a preventive program. In a different perspective, preventive culturally embedded programs can be developed. However, there are lack of proper evaluation methods that will be empirically based, and this may present a challenge (Reese & Vera, 2007). It is imperative for counselors to be ethically and culturally grounded when working with diverse population.

PART 5: ADVOCACY

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Advocacy is a requirement for counselors on behalf of their clients, and this can be done through different levels. Advocacy in counseling started as far back as the early 1900s. It orignated with Frank Parson in his vocational guidance work among underserved communities and Clifford Beers's advocacy for his client mental health (American Counseling Association [ACA], 2018). As counselors practice counseling and advocacy intervention, barriers often do occur. The barriers associated with counseling and advocacy interventions may hinder the

positive outcome/s of the intended intervention program through community, institutional, and public policy levels if not addressed well. Therefore, it is imperative to address the barriers that may occur through community, institutional, and public policy levels. According to the ACA Advocacy Competencies, “in community collaboration, the counselor works with a group or community to identify and address systemic barriers and issues”. One barrier to discuss is stigmatization against PLWHA. Stigmatization can prevent people living with HIV/AIDS from getting needed testing and treatments. It also creates fear of being oppressed, and suppresses self-confidence that may hinder an individual from owning up (Famoroti et al., 2013). Community role in advocating against the iniquities facing PLWHA has been well documented (Miller et al., 2021).

Advocacy under community level, I recommend the awareness of HIV stigmatization and the implications. This advocacy can be done by collaborating with the target community or a group within the community by supporting an existing program or by implemting a new program/initiative. A strategy can be through structured workshops or by using evidence- based talking points. When advocacy is done well, it creates an avenue for empowerment and further advocate attempts (ACA, 2018). Community plays important role in HIV prevention and advocacy because the community as a whole brings out the norms and values that guides them. Advocacy through institutional level encroaches into the social constructs of the society in areas such as the churches, schools, and organizations. Under this level, health needs of the PLWHA can be advocated for. As a counselor working with the MSM and black MSM population, I can advocate for free cost of HIV testing. The black MSM and MSM in general are socially marginalized by the society. Levy et al (2014) reported on their systematic review that access to HIV testing and preventive services posed a barrier to black MSM in terms of not having

insurance and not being tested as recommended by CDC. To help this marginalized population in getting needed care and reduce the HIV prevalent rate in Metro Atlanta, advocacy should also be centered on HIV preventive research that will seek strategies to reduce marginalization through institutional level and other levels.

The local, state, and federal laws and regulations are integral to assist in HIV prevention programs. Evidence related HIV information is needed to aid the public policy office and public information department in guiding the government. The HIV/AIDS organizations, pharmaceutical companies, and donors should make high quality HIV treatment accessible and strive to stop the barriers that may hinder access to HIV/AIDS care (amfAR, 2021). Therefore, a way to advocate for prevention of HIV under public policy will be to either promote an existing law under HIV/AIDS or to advocate for a state uniformed law that will guide HIV testing and accessibility of care among the black MSM and all MSM in Metro Atlanta and GA in general.

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SIGNATURE: Marytherese Agwara
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