“Zero infections. Zero deaths. Zero stigma.”

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By

The UNAIDS mission of “Getting to Zero” is supported by three key goals: “Zero infections. Zero deaths. Zero stigma.” By taking up this mission, the San Francisco Department of Public Health (DPH) increased its dedication to ending the epidemic. DPH aims to realize these goals by expanding access to PrEP, ensuring RAPID (Rapid ART Program for HIV Diagnoses) linkage to care, and increasing retention in care. By all measures, the department has made significant progress toward these goals. According to the most recently published data, in 2017 there were only 221 new HIV diagnoses in San Francisco.

However, disparities remain. Of those newly diagnosed, 86% self-identify as male, and 74% men who have sex with men (MSM); a majority (51%) were between 25-39 years old; and 25% were Latino. Meanwhile African-Americans remain disproportionately represented among new HIV infections. Comprising just 6% of the city’s total population, African-Americans also represented 17% of new diagnoses. And the number of new diagnoses among this community has increased slightly in 2017. Meanwhile homelessness is also contributing to new infections. In 2017, 14% of people diagnosed with HIV were experiencing homelessness at the time of their diagnosis, and this trend is increasing (SFDPH 2018).

Among populations most affected by the virus, PrEP offers a new opportunity to decrease incidence. But the path to expanding access has been obstructed by implicit bias and the stigma that it carries. Medical students are more likely to prescribe PrEP to people who say they will continue to use condoms, and are also less likely to offer PrEP to African-American patients with multiple partners or with the intention to stop condom use than their White counterparts (Calabrese 2014, 2015). Patients at risk may also be less likely to ask for PrEP – one study found higher medical mistrust among African-American women, who were less likely to ask about PrEP in spite of higher interest (Teketse 2018).

A case in point: A San Francisco-based PrEP advocate described the experience of visiting a clinic in a predominantly African-American community and being told that they did not have a need for PrEP in their clinic because they did not have gay people:

"When I first started managing these two big clinics… things that I heard were, like, oh, well, our patients don't really need that. That's only for gay people. We don't have any gay people in our clinic; you know?"

Later that year a young man known to them from the community center adjacent to the clinic seroconverted, shocking the clinic staff. This young man had been afraid to seek care in the clinic because he didn't want to be outed in the community. We can see in this example the power of implicit biases in reinforcing risk for already marginalized populations.

In 2016, we began an interview-based study with 18 care provider interviews in the San Francisco Health Network ("health network") who had prescribed PrEP at least once. We attempted to interview providers across a diversity of clinics and patient populations, and to talk to providers who had varying experience with PrEP. Providers included: family medicine and internal medicine doctors, pediatric specialists, infectious disease-specialized nurse practitioners, and pharmacists, as well as one PrEP navigator.

In this article, we reflect on two key results from the study: first, how implicit bias influences PrEP prescription, including in the identification of people who may be at risk for acquiring HIV; and second, how implicit bias is compounded by structural factors. We intend for these findings to inform how a 'critically applied approach to PrEP' might productively inform the ongoing and important conversation about 'structural competency" (Hansen and Metzl 2016). In particular, as implicit bias poses obstacles to expanding PrEP use among those most likely to acquire HIV, these findings shine light on some of the challenges to improving structural competency. More broadly, the findings discussed here reinforce observations other scholars have made about the dominant role of standardization in clinical practice, especially concerning HIV (Benton 2018).

1. Implicit Bias & Identifying the At-Risk Subject

While guidelines from the Centers for Disease Control and Prevention (CDC) indicate providers recommend PrEP based on a risk profile and clinical safety, the criteria leave a lot of room for interpretation. Thus, decision-making remains susceptible to this individual implicit biases of providers.

For most providers we spoke with, criteria for PrEP eligibility centered on a vague notion of the "high risk" patient, which generally meant gay men, people in mixed status relationships, and men or women involved in sex work. But, of course, determining which specific patients fit into these categories was not always clear. How do you identify a gay man, someone

who sells sex, or anyone in a mixed status relationship? What if he doesn't identify himself? What if he presents differently? What if you don't ask?

While providers generally indicated that they solicited sexual histories from patients and talked to patients about risky behavior, some reported they would be less likely to do so with particular groups. In some cases, providers suggested people from immigrant communities "may not be comfortable talking about sex." Providers also expressed concerns about identifying female candidates for PrEP. Given the many assumptions about perceived discomfort, it became clear that doctors may avoid having conversations about potential risk, and may not be identifying the best candidates for PrEP.

Implicit bias also manifests through concerns about adherence. Providers hesitate to prescribe PrEP to patients who inject drugs or experience homelessness because of adherence concerns. One provider explained, "I have a few patients who are impossible to reach on the phone, who are inconsistent with their appointments, and my concern about their ability to comply to the medication regime daily and do appropriate follow-up lab-testing has, maybe, kept me from recommending it."

However, providers also reflected on their own biases. One nurse working in youth clinics explained, "I think, too, the other piece for me personally is, really, like, trying to check my own biases around who am I offering [PrEP to].. who am I really saying, this is important for you?" When providers reflected on their own biases, they identified intimate conversations between providers and patients as one key opportunity, which could be instrumental in their recommending PrEP.

Uncomfortable conversations

The combination of feeling uncomfortable initiating conversations about sex and about prescribing to people who are not having the right kind of sex for the right reasons, leads to an environment that does not encourage the disclosure of stigmatized sexual behaviors and therefore does not enable people to get on PrEP.

Contrast this with settings that specialize in sexual and reproductive health that pride themselves on creating very comfortable spaces. A provider in a sexual health clinic described this encounter:

"And so he came back in and, you know, he said to the nurse, 'I don't feel like I need to take PrEP because I'm not having sex.' And she had to be very concrete in the way that she has rapport with him, and it was like, 'Girl, you have rectal gonorrhea. Like there is no way you're not having

sex. What is going on?'…And it came to be that like he was like, 'Well, I think I'm having sex, but I've been drinking a lot and blacking out. I don't really remember if I'm having sex or when.' and so sort of that like having to be concrete and comfortable — be able to create space for somebody to tell you that."

Compounding Factors

Implicit bias is compounded by structural factors. This is evident in primary care clinics, where doctors are making quick decisions about what health needs should be addressed during a short period of time. Patients often approach providers with specific concerns or acute symptoms that need to be attended to. As one provider in a hospital clinic explained, "We don't have time to get through it all. You know, they've got endocarditis. They have poorly controlled diabetes. They've got an abscess. They have, I mean, all sorts of, you know, things that we have to deal with first." Patients who are experiencing homelessness or are injection drug users might have especially complicated and pressing medical needs, moving preventive medicine such as PrEP lower down the list.

Providers who are PrEP advocates or who work frequently with LGBTQ populations may be always on the look-out for patients who would benefit from PrEP. But given the time pressures that providers encounter in their visits, providers don't always have the time or mental space to talk about PrEP during the course of the visit.

As one provider explained, "I think the big barrier is just providers thinking about it. It's not something that I think about every single time I go into a patient encounter. And so, if it's very obvious – like someone is telling me they have multiple sexual partners, or that they do IV drugs – it's a little easier, and still I don't always think to offer it."

In settings where provider time is in great demand and they are struggling to meet basic care needs, it is easy to see how implicit bias can limit the expansion of PrEP.

Promoting "structural competency" Metzl and Hansen (2016) have called on the medical profession to address structural factors impact access to care, diagnosis, and health outcomes. Findings from our interviews among providers suggest that structural competency is firmly intact, but may have blind spots.

Competing priorities blur judgements about risk, distract from PrEP prescription, and risk reproducing existing disparities. These judgements are failing to get PrEP to communities facing stigma as well as heightened risk.

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