



NATIONAL HISPANIC/LATINX HEALTH POLICY AGENDA 2020-2024

Breaking the Invisibility!

Our Health, Our Future

Setting our Community Health Policy Agenda:

Addressing HIV, viral hepatitis,
STIs, stigma, substance use,
mental health and other critical
health issue affecting
our communities

March 2020

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EXECUTIVE SUMMARY

The Hispanic/Latinx¹ Health Leadership Network will host a health-policy-focused National Hispanic/Latinx Health Leadership Summit on March 2–3, 2020, in Washington, D.C. The National Health Policy Summit is the product of two years of work to bring together the expertise and ideas of Hispanic/Latinx leaders from across the United States and its territories, including Puerto Rico, to:

1. Fortify the Hispanic/Latinx Health Leadership Network
2. Develop the Hispanic/Latinx Health Policy Agenda 2020–2024 at the National Hispanic/Latinx Health Leadership Summit in Washington, D.C., and subsequently support setting statewide, countywide, and citywide health agendas throughout the U.S. and its territories

The overarching goal is to improve health outcomes for minorities living in the U.S. and to ensure Hispanic/Latinx participation and inclusion to erase health disparities in our nation.

Hispanic/Latinx health needs are largely invisible and often overlooked on many public health agendas in our nation. The public health establishment has responded to the Human Immunodeficiency Virus (HIV), viral hepatitis, and sexually transmitted Infections (STIs) epidemics without considering the cultural and linguistic needs of Hispanics (U.S. born and foreign born). Hispanics are disproportionately affected by poor conditions of daily life, shaped by structural and social position factors (such as macroeconomics, cultural values, income, education, occupation, and social support systems, including health services), known as social determinants of health (SDH). SDH exert health effects on individuals. [1] Hispanic/Latinx communities affected by HIV, viral hepatitis, and STIs are left out, culturally and linguistically, from prevention, treatment, and access to care programming in our nation. This situation creates an urgent need for the development of culturally competent strategies for care engagement, linkage, and retention.



¹ For the purpose of this document Hispanic/Latinx, Hispanic, Latino/a will be used interchangeably. Hispanic/Latinx is used most dominantly as a term to be inclusive of all ethnic, gender expression, etc. When referring to information from specific publications the term used in the referenced document will be used. The populations these terms describe are actually composed of various racial groups, so using them as racial categories is inaccurate. They work more accurately as descriptors of ethnicity, although not completely accurate given the diversity of peoples they represent.

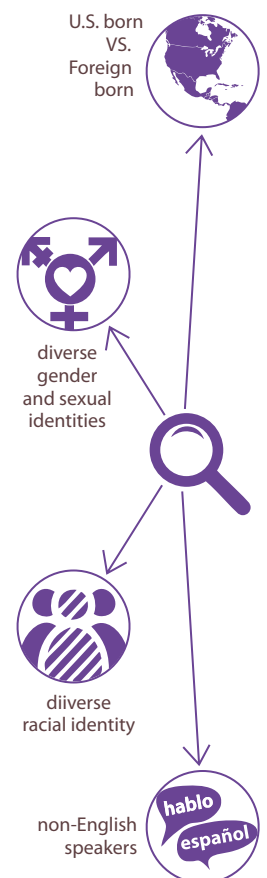
Racial, cultural, and linguistic diversity and heterogeneity are important factors to understand Hispanic/Latinx communities in the U.S. The diversity of this population should be considered in the current implementation of a standardized approach to address the impacts of HIV, viral hepatitis, and STIs in the area of prevention and treatment. We need to create comprehensive, holistic approaches to reach diverse Hispanic/Latinx populations in urban, suburban and rural areas, taking into account U.S. born and foreign-born Hispanics/Latinx, diverse gender and sexual identities, racial identities that include Black and Afro-Latinos, White/European Latinos, Native and Indigenous, Asian and many more. Approaches must also account for non-English and non-Spanish speaking communities that include Portuguese speakers, and many indigenous languages. [2]

Hispanics/Latinx represent the nation's fastest-growing minority and ethnic population, as well as the fastest-growing aging population. Older Latinos are at an increased risk of infection compared to their non-Latino white counterparts. In 2017, according to CDC Surveillance data, those Hispanic/Latinx ages 50-54 had a rate of diagnosed HIV infection more than twice the rate of non-Latino whites in the same age group. Hence, there is a pressing need to examine the sexual health and overall health care of a population that is too often forgotten. [3]

National efforts to address infectious diseases must make focused investments in four priority areas:

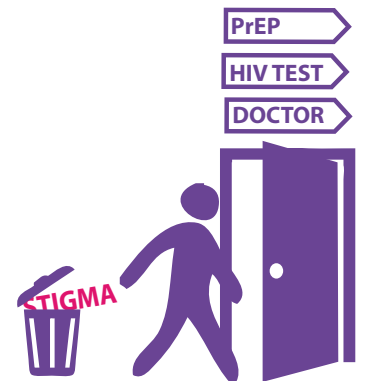
1. Mitigation of social stigma among health care and multiservice providers
2. Availability and accessibility of health care and prevention services
3. Development of behavioral interventions tailored to Hispanic/Latinx populations
4. Broader engagement of Hispanic/Latinx community leaders focused on health issues

The following recommendations were developed over the course of two years. Community leaders, organizational heads, and multi-service organizations contributed their expertise and voice to the recommendations process as members of the Hispanic/Latinx Health Network.



The National Hispanic/Latinx Health Leadership Summit's steering and planning committees convened work groups charged with articulating their perspectives on national issues, analyzing challenges, and providing recommendations on the following national issues:

1. Prevention
2. Access to health care
3. Research and data
4. The U.S. South
5. Puerto Rico
6. Stigma
7. The federal plan to end the HIV epidemic by 2030
8. Immigration and migration
9. Mental health
10. Substance use



We can change the trajectory of many health issues affecting our communities. In the case of the U.S. HIV epidemic, we can set, monitor and meet the plan's ambitious but achievable goal to end the HIV epidemic by 2030. To do this we must significantly increase access to biomedical tools for Hispanic/Latinx who are HIV negative; improve testing, care and treatment access, decrease the impacts of stigma, and take concrete actions to ensure that no population or region is left behind.

We must also immediately bring all available treatment and prevention tools to scale to achieve the necessary impacts on the epidemic. Failure to act swiftly at the required scale and across all the affected communities and populations will result in more HIV transmissions, increased HIV-related morbidity and mortality, continued health inequities, and higher health care costs.

Through the joint effort of communities, industry and all levels of government, we can harness the progress made over the past three decades to achieve this once unthinkable goal. This health agenda will actively contribute to drastically reducing new HIV infections, improving the length and quality of the lives of persons living with HIV, and effectively address the related opioid, viral hepatitis, STI, and TB crises. In doing so, this health agenda will dramatically reduce the overall costs in lives and health care spending.

INTRODUCTION

The Impacts of HIV, Viral Hepatitis, STIs, Stigma, and Other Health Disparities Affecting Hispanic/Latinx Communities

Hispanic/Latinx are the fastest-growing minority group in the U.S., accounting for more than half of the nation's total population growth between 2000 and 2010. [4] In 2019, the Census Bureau estimated that approximately 60 million Hispanics live in the U.S. [5] By July 1, 2050, the U.S. Hispanic population is projected to reach 132.8 million people, or 30.2% of the nation's total predicted population on that date. [6]

Hispanics' daily life in the U.S. is disproportionately affected by structural and social factors known as the social determinants of health (e.g., macroeconomics, cultural values, income, education, occupation, social support systems, and access to health services). [7] Health inequalities particular to Hispanics are also related to their socioeconomic status, cultural background, employment, and foreign-born and undocumented status. [8, 9] Hispanic women are a growing demographic group that faces adverse social and health conditions, and a lack of access to health care and other key social support services. [10] For economic and cultural reasons, Hispanic men are hesitant to interact with the health care system. Separate studies conducted by Kaiser Health News and the National Research Council Panel on Hispanics have shown that Latino men are much less likely than Latinas to seek treatment and are more likely to rely on emergency services for primary care. [11, 12]

Risk factors for non-communicable diseases, coupled with poor health care access, make Hispanics disproportionately vulnerable to disease and death. Hispanics face major health risks such as obesity, teen pregnancy, and tobacco use, among others. [13, 14, 15] Among foreign-born Hispanic/Latinx, significant differences in risk factors, morbidity, mortality, and health care access can also be observed by country of origin and duration of residence in the U.S.

Racial, cultural, and linguistic diversity and heterogeneity are important factors to understand Hispanic/Latinx communities in the U.S. The diversity of this population should be considered in the current implementation of a standardized approach to address the impacts of HIV, viral hepatitis, and STIs in the area of prevention and treatment. The effectiveness of national responses to the Hispanic/Latinx HIV crisis and the syndemics associated with viral hepatitis, STI, mental health, and substance use depends on efforts to target the needs of the most affected populations, specifically recent Hispanic/Latinx immigrants, cis and transgender Latina women, gay/bisexual men, and men who have sex with men (MSM).

Cultural and socioeconomic differences within U.S. Hispanic/Latinx communities affect their health outcomes and engagement in health care services. For example, among Hispanics/Latinx, subethnic groups, acculturation, demographic and socioeconomic characteristics have been shown to be associated with differential outcomes across the HIV care continuum. Greater collaboration among federal agencies, HIV/AIDS service

organizations, and diverse Hispanic/Latinx community leaders, as recommended in the 2010 National HIV/AIDS Strategy, is urgently needed to shape efforts to address specific needs of heterogeneous and geographically diverse Hispanic/Latinx constituencies. [16]

Health statistics show significant inequities and gaps among Hispanics/Latinx, who have the highest uninsured rates of any racial or ethnic group in the U.S. In 2017, the Census Bureau reported 49.0 percent of Hispanics have private insurance coverage, compared to 75.4 percent among non-Hispanic whites. [17] Health indicators demonstrate the negative health outcomes in U.S. Hispanic/Latinx communities from many preventable infectious diseases, including HIV, viral hepatitis, and STI. Additionally, these health indicators demonstrate Hispanics/Latinx disproportionate lack of access to screening, testing, prevention, treatment and care services. In the case of HIV, Hispanics/Latinx comprise 18% of the nation's population, account for 23% of all new HIV infections, and are 60% more likely to die from viral hepatitis than non-Hispanic whites, despite having lower rates of hepatitis C.

Statistics show that across the nation and U.S. territories, U.S.-born and foreign-born Latino gay/bi men experience higher rates of acquired HIV infections, increased mortality rates, delayed late-stage diagnoses, and greater barriers to accessing health care than their non-Hispanic white counterparts. Latino gay/bi men, other MSM, and transgender and cisgender Latinas have a higher risk of contracting HIV than the general population due to common risk behaviors, psychosocial factors, and a particular set of mental health vulnerabilities associated with various forms of social discrimination. Latino gay/bi men, transgender and cisgender Latinas have identified homophobia, transphobia, sexism, racism, poverty, and substance use as key factors affecting their mental health. Various studies have also shown high prevalence of suicidal ideation, anxiety. [20,21,22]

Much like HIV, barriers to viral hepatitis and STI education and access to care include language, literacy rates, patient education, incarceration history, structural violence, injection drug use, high-risk behavior, stigma, and a lack of health insurance and of lack awareness of HIV testing, HCV, and STI within Hispanic/Latinx communities. In the case of viral hepatitis, other factors that can influence disease progression include the high prevalence of obesity, diabetes, and steatosis. Health data indicate that Latinos have twofold higher likelihood of dying from hepatitis B (HBV) and HCV than whites, even though current treatment cure rates are close to 90%. Mortality rates from chronic liver disease in the U.S. has progressively declined since 2006, but this trend is not evident among Hispanics. [23] The disproportionate ethnic differences in liver disease remain poorly understood, but variations in behavioral patterns, health care access, specialist referrals, and utilization of therapeutic interventions are potential explanations for the less favorable outcomes among Hispanic/Latinx. In particular, HBV and HCV diagnoses in Hispanic/Latinx communities continue to face issues due to the low efficacy of existing disease management, treatment, and prevention efforts. These disparities require government and public health organizations to commit to strengthen Hispanic/Latinx communities' linkage to care for those living with hepatitis C, promote hepatitis A and B vaccinations to those at highest risk of infection, increase screening efforts, improve patient-centered care models to initiate therapy, and enhance monitoring of liver-related complications such as decompensated cirrhosis and HCC in those with chronic infections. This multi-pronged approach is necessary to improve negative health outcomes in Hispanic/Latinx communities, and shift toward HBV containment and HCV elimination. [24]

The tone of the ongoing national debate on immigration greatly affects public health efforts.

WHY DEVELOP A NATIONAL HISPANIC/LATINX HEALTH POLICY AGENDA?

Hispanic/Latinx are not engaged in or represented on public health agendas for many states and the federal government. The public health sector has responded to the HIV, viral hepatitis, and STI epidemics without deeply considering the cultural and linguistic needs of Hispanics/Latinx, even though they are the nation's fastest-growing population segment. Hispanic/Latinx communities impacted by HIV, viral hepatitis, and STIs are left out of prevention, treatment, and access to care programming in our nation. Culturally competent care, engagement and retention strategies must be developed and customized to respond to our diverse Hispanic/Latinx communities.

Hispanic/Latinx are invisible on many national health agendas, including, but not limited to, unequal participation in federally funded health research due to insufficient allocation of resources. As long as the inherent social, economic and cultural barriers go unaddressed, Hispanics/Latinx lack of involvement in health research will continue to hinder the development of disease prevention and treatment efforts for Hispanics/Latinx, and will limit the scope of comparative studies on the cultural and genetic factors that influence disease processes. Special attention should be given to Hispanic/Latinx communities' needs related to disease burdens, the nation's changing demographics, and the scientific opportunities inherent in the study of this population. [25]

To achieve the goals set out in Healthy People 2020 and the federal plan *Ending the HIV Epidemic by 2030: A Plan for America*, Hispanic/Latinx communities require sustainable solutions to change and improve health outcomes. Implementing change demands a tailored agenda to meet the urgent health needs of Hispanic/Latinx communities. The development of a National Hispanic/Latinx Health Policy Agenda should be rooted in a participatory, community-driven, collaborative process at the federal, state, and local levels to delineate the short-, medium-, and long-term goals, objectives, and action steps to reverse the trends in newly diagnosed infections, late diagnoses, and mortality risk. This National Hispanic/Latinx Health Policy Agenda will serve as a roadmap for a sustained health focus that will allow Hispanic/Latinx communities to mobilize their leadership to increase awareness and improve access to services and equity in resource allocations over the next four years (2020-2024).

The National Health Summit, to be held March 2–3, 2020, in Washington, D.C., will adopt the national agenda and develop an action plan for implementation at the federal level. The summit leadership will encourage the development of state-, county-, and

city-level (including the U.S. territories) agendas rooted in local realities and priority populations. Although our primary focus is HIV, viral hepatitis, and STIs, the long-term goal is to address all chronic health conditions that disproportionately impact Hispanic/Latinx communities as we strengthen our network through increased community engagement and partnerships with national organizations.

HIV, Viral Hepatitis, and STI in Hispanic/Latinx Communities

Although progress to reduce the HIV incidence and new diagnoses has been made within specific populations, increases in key demographic and age groups reflect a largely unrecognized Hispanic/Latinx HIV crisis.

CDC estimates of HIV incidence (the number of new HIV infections) continue to rise in Hispanic/Latinx communities. The overall estimated HIV incidence in the U.S. has declined by 6% since 2010, but among Hispanic/Latinx populations, it has increased significantly by more than 14%. [30] Similarly, surveillance data demonstrate that the annual number of newly diagnosed cases of HIV among Hispanics/Latinx increased by 7% between 2012 and 2016, whereas the overall annual new HIV diagnoses in the U.S. decreased by 4%. [31] The increase in estimated HIV incidence and new diagnoses among Hispanics/Latinos is best understood by considering the specific Hispanic/Latinx populations most heavily affected by HIV and AIDS: gay/bisexual men and other MSM (particularly young Hispanic/Latino gay/bisexual men and other MSM), transgender Latinas, and recent Hispanic/Latino immigrants not born in the U.S.

From data, we know that Latino gay/bisexual men and other MSM account for 27% of the total HIV cases among all MSM in the U.S. and represent more than 75% of the total HIV transmissions among all Hispanic/Latinx communities. Latino gay/bi men, other MSM, and transgender Latinas have experienced high HIV infection rates since the beginning of the epidemic. Most concerning, the Centers for Disease Control's (CDC) 2018 HIV Surveillance Report shows a decrease of new HIV infections among non-Hispanic white and a stabilization of new HIV cases among African-American MSM, but a continued increase of new HIV cases among Latino gay/bisexual men and other MSM across all ages, especially among younger men. [18]

Gay and Bisexual Men and other MSM constitute the largest affected population in the current Hispanic/Latinx HIV crisis, accounting for approximately 80% of the estimated HIV incidence rate among Hispanics/Latinx. Since 2010, the estimated number of new annual HIV infections has increased by 30% among Hispanic/Latinx gay/bisexual men and other MSM and, notably, 68% among Hispanic gay/bisexual men and other MSM aged 25–34 years. Similarly, since 2012, annual new HIV diagnoses among young Hispanics/Latinx aged 13–24 years have remained constant, but overall new diagnoses for youth aged 13–24 years have declined by 10% over the same period. [32] A pronounced HIV disparity among transgender Latinas was also reported in a recent systematic review and meta-analysis, which projected that roughly 1 in 4 transgender Latinas is HIV positive, with estimates of HIV prevalence ranging from 8% to 60%. [33] Additionally, individuals born outside the continental U.S. account for at least 1 in 3 new HIV diagnoses among Hispanics/Latinx, as of 2017, indicating a key, frequently

overlooked population affected by the Hispanic HIV epidemic. [34] Research has suggested that foreign-born Hispanics/Latinos living with HIV acquired the infection in the U.S. [35] As stated by the article *The Invisible US Hispanic/Latino HIV Crisis*, recent Hispanic/Latino immigrants face greater vulnerability to HIV infection and limited access to prevention and treatment services due to various challenges related to language barriers, immigration status, social isolation, cultural differences between their host country and their country of origin, and distinct social norms regarding health care seeking and utilization. [36]

Regarding hepatitis, Hispanic/Latinx are 60 percent more likely to die from viral hepatitis than whites. Despite lower hepatitis C rates, Hispanics are 40 percent more likely to die from that disease, as of 2015. [37] Data from the National Health and Nutrition Examination Survey (NHANES) and the Hispanic Community Health Study/Study of Latinos (HCHS/SOL) found that the hepatitis C prevalence among adult Hispanics/Latinos varies by background. Puerto Ricans have the highest prevalence, those with South Americans backgrounds have the lowest prevalence, and those with Central American, Cuban, Dominican, and Mexican backgrounds have intermediate HCV prevalence rates. On average, the HCV prevalence rate for all Hispanic/Latinos is 1.5% in the NHANES study and 2.0% in the HCHS/SOL. [38] Latinos are the largest minority in the U.S. and have higher rates of HCV infection. [39] The course of chronic hepatitis C is more aggressive in Hispanics/Latinx, who have a higher risk of developing cirrhosis than any other ethnic group or race. Available information suggests that more rapid progression of liver disease is aggravated by the decreased efficacy of the available therapies. The causes of the more aggressive progression and decreased treatment efficacy are complex. Factors related to metabolic syndrome, insulin resistance, and hepatic steatosis are important, as are genetic differences for both metabolic syndromes and immune responses to interferon. In addition, Latinos face substantial barriers to accessing medical care. [40] Linguistic and cultural differences and socioeconomic factors, including a lack of medical insurance, more frequent alcohol use, and possible medical care provider bias, are significant obstacles to diagnosis and treatment. The severity of liver disease and the association with metabolic syndrome medical conditions justify considering Latinos to be a special population in urgent need of intervention strategies. [41]

The 2018 CDC report on STIs indicates that the Hispanic population has a gonorrhea rate of 115.9 cases per 100,000 persons, 1.6 times the rate among whites. This disparity is similar for Hispanic women (1.4 times the rate among white women) and Hispanic men (1.8 times the rate among white men). The disparity in gonorrhea rates for Hispanics is highest in the Northeast and lowest in the West and South. In the same report, the chlamydia rate among Hispanics is 392.5 cases per 100,000 persons, 1.9 times the rate among whites. The rate of primary and secondary syphilis among Hispanics is 13.0 cases per 100,000 persons, 2.2 times the rate for whites. This disparity is similar for Hispanic women (1.7 times the rate among white women) and Hispanic men (2.2 times the rate among white men). As of 2018, the congenital syphilis rate is 44.7 cases per 100,000 live births among Hispanics, 3.3 times the rate among whites. For cases of congenital syphilis, race/ethnicity is based on the mother's race/ethnicity. [42]

RECOMMENDATIONS FOR BETTER HEALTH IN OUR COMMUNITIES

Breaking the Invisibility: Recommendations on Ten National Issues

U.S. innovation and leadership on HIV have laid the foundations for decisive action to end the HIV epidemic. Numerous federal government departments, agencies, and programs are involved in the domestic HIV and AIDS response. Together, they provide disease surveillance, prevention, care, support and social services, and research. The CDC leads U.S. surveillance and prevention activities, which are carried out in conjunction with state and local health departments and community-based organizations (CBOs). Federal health care programs, including Medicaid, Medicare, the Ryan White HIV/AIDS Program, and the Veterans Administration, offer care, treatment, and supportive services. The Housing Opportunities for Persons with AIDS program, as well as other safety net services offered by the Department of Housing and Urban Development, provide essential access to affordable housing for low-income persons living with, affected by, or vulnerable to HIV. The Social Security Administration's income programs for those with disabilities (SSI and SSDI) are important sources of support and financial stability. The passage of the Affordable Care Act (ACA) in March 2010 has created new opportunities to expand health care access, prevention, and treatment services for millions of people in the U.S., including many living with or vulnerable to HIV.

Programs outside the DHHS also play key roles in this work. The Department of Justice's Civil Rights Division, the Bureau of Prisons, and the Education, Labor, Transportation, Defense, and Agriculture departments, among others, play crucial roles in ending new HIV transmissions in the U.S. and supporting the health of people living with HIV, hepatitis, and STI.

We can change the trajectory of the U.S. HIV epidemic by setting and meeting the ambitious but achievable goal of creating a 95/95/95 framework. [43] By significantly increasing access to prevention services among people who are HIV negative, we can reduce the incidence of new cases, improve access to care and treatment for people who are HIV positive, decrease the impact of stigma, and take concrete action steps to ensure that no population or region is left behind. [44]

We must immediately scale up all available treatment and prevention tools to make the necessary impacts to end the HIV epidemic. This federal effort needs to address the national increase in viral hepatitis and STI. Failure to act swiftly at the required scale and across all the affected communities and populations will result in continued HIV transmissions, more HIV-related morbidity and mortality, greater health inequities, and costly financial burdens on our health care system.

Through the joint efforts of communities, government, and industry, we can harness the progress related to HIV made over the past three decades to achieve this once inconceivable goal. The Hispanic/Latinx health agenda will provide contributions needed to drastically reduce new HIV infections, improve the length and quality of the lives of persons with HIV, effectively address the related opioid, viral hepatitis, STI, and TB crises, and dramatically reduce morbidity and mortality across the country and U.S. territories.

Overall Federal Recommendations to the U.S. Congress

1. Fully fund the plan to end HIV in America by 2030
2. Give full patient protection to pre-existing conditions
3. Protect and expand Medicaid in our nation
4. Protect LGBTQ+ persons' access to health care and support services without discrimination
5. Undertake federal efforts to support and encourage states and U.S. territories to increase Hispanic/Latinx's active participation in the planning process to address the impacts of HIV, AIDS, viral hepatitis, and STI
6. Increase the CDC's overall budget, including a 15% increase in the prevention budget, and raise the Human Resource Service Administration's budget
7. Increase National Institutes of Health (NIH) funding, and request that the NIH conduct a major research study on the diverse challenges Hispanic/Latinx face to access care (highlighting resilience, challenges and realities among foreign-born and U.S.-born individuals)
8. Launch an unprecedented Federal plan to address the impact of Cancer. Cancer is the number one killer of Hispanic Americans in our nation.
9. Assign funds to the Department of Health and Human Services (DHHS) to launch an ongoing plan to eliminate social stigma in our nation
10. Designate funds to establish a federal coordinating body among all DHHS federal agencies to ensure the accessibility, utilization, and integration of mental health and substance use services for the communities most impacted by HIV, viral hepatitis, and STIs
11. Ensure that capacity building and technical assistance for providers respond to and reflect the populations most affected by HIV, viral hepatitis, and STIs

A Community-Driven Process

The process behind the development of the National Hispanic/Latinx Health Policy Agenda and each of its recommendations has been a community-driven two-year process. Our recommendations aim to address the needs of Hispanic/Latinx communities and call for a more inclusive, culturally responsive, intentionally thoughtful process by decision makers and policymakers at all levels. This process should reflect a sense of urgency to address and eliminate the HIV, hepatitis, and STI crisis affecting Hispanic/Latinx communities across the U.S., Puerto Rico, and U.S. Virgin Islands.

The ten national issues identified in the health agenda were developed by the planning groups in a process that began in the fall of 2019. Topic-specific work groups crafted recommendations on (1) prevention; (2) access to health care; (3) research and data; (4) the U.S. South; (5) Puerto Rico; (6) stigma; (7) the federal plan to end the HIV epidemic by 2030; (8) immigration and migration; (9) mental health; and (10) substance use. The leaders of this community-driven process have committed to tailor and customize these recommendations in an ongoing, live process until significant positive health outcomes are achieved in our communities.

PREVENTION

Not enough Hispanic/Latinx living with HIV are aware of their status, and too few receive the HIV care and treatment needed to help them live healthier lives. [45] It is critical that they maintain an undetectable viral load, meaning they effectively have no risk of transmitting HIV to others.

Pre-exposure prophylaxis (PrEP) has become more accessible than ever before with the FDA's approval of two different PrEP prescription medications. When used as prescribed by medical providers, both pills are highly effective at preventing HIV infections. Daily PrEP use reduces the risk of getting HIV from sex by more than 90%. Among people who inject drugs, it reduces the risk by more than 70%. Nevertheless, despite recent increases in PrEP use among Latinx, significant gaps remain throughout the diverse communities within Hispanic/Latinx communities in the U.S. and Puerto Rico. [46,47]

As we work to diagnose and treat everyone living with HIV in the U.S., we also must work to prevent HIV exposure. We know that the combined use of biomedical, behavioral, and structural interventions can successfully reduce HIV transmission. Routine, voluntary universal HIV testing is a gateway to HIV prevention for those who test negative. Effective treatment for those living with HIV suppresses viral load to very low levels, virtually eliminating transmission. HIV treatment that prevents HIV transmission has led to the development of the U=U movement (undetectable = untransmittable), which is backed by scientific data and endorsed by NIH, CDC, as well as health bodies of many other countries. This information needs to reach Hispanic/Latinx communities in a culturally and linguistically sensitive manner.

Everyone benefits from biomedical interventions, as well as interventions to address behavioral and structural factors that increase the risk of acquiring and transmitting

HIV. Additionally, HIV prevention is a gateway to primary care. Expanding access to primary care services can aid in the prevention, reduction and management of other chronic diseases, whose co-morbidities have been shown to significantly affect the health of people who are aging and living with HIV.

Viral hepatitis awareness remains very low among Hispanics/Latinx, despite the higher rates of viral hepatitis infection and the availability of treatments that can cure hepatitis C. Attention by the health and human service sector should be given to the benefits of prevention, screening, education, and related health conditions such as HIV co-infection, diabetes, obesity and behavioral health (e.g., substance use/abuse). Populations that need to be closely monitored include Hispanic/Latinx baby boomers, MSM, transgender women, and adolescents and young adults who inject drugs. There is evidence that transmissions have significantly increased among MSM living with HIV. The federal government, states, and U.S. territories urgently need to enhance efforts to address the impacts of hepatitis in our communities. [48]

There is a pressing need to develop effective interventions to prevent STIs among Hispanic/Latinx communities. Models exist to direct the design of culturally effective interventions, but recognizing the influence of specific cultural and contextual variables, building on what works, and integrating community perspectives are important elements of a comprehensive approach to address the increases of HIV, HCV and STIs nationwide.

→ Recommendations

1. Ensure all prevention initiatives consider the unique needs of populations and the intersectionality of age, gender, and sexual orientation.
2. Reduce new HIV infections through culturally and linguistically sensitive evidence based HIV prevention strategies developed with the participation of Hispanic/Latinx communities, Hispanic/Latinx researchers, and others knowledgeable and experienced in working with Hispanic/Latinx communities.
3. Utilize the strengths of peer educators and/or community health worker programs.
4. Create comprehensive HIV, viral hepatitis, and STI prevention services that deliver high-quality, medically accurate, age-appropriate, culturally and linguistically responsive education on HIV, viral hepatitis, STI, and reproductive and sexual health. Make all materials and information available in Spanish.
5. Provide routine HIV, hepatitis, and STI screening for all persons 13 years of age and older, ensuring every state and territory passes legislation in favor of opt-out HIV, hepatitis, and STI screening/testing at every point of contact with health care systems.
6. Prioritize treatment as prevention as a major component in prevention efforts.

7. Distribute HIV, hepatitis, and STI awareness and prevention (e.g., U=U) messaging and materials in Spanish and English to the most impacted populations.
8. Develop partnerships media outlets (including social media, ethnic, and Spanish-language) to improve media distribution of scientifically accurate and culturally appropriate information.
9. Broaden and provide equitable access to PrEP for those vulnerable to HIV through navigation and linkage in a culturally and linguistically sensitive manner.
10. Broaden campaigns to promote hepatitis A and B vaccinations and hepatitis C and STI treatment in urban and rural areas.
11. Develop partnerships to utilize interdisciplinary, collaborative approaches between primary care providers, larger medical systems, hospitals, and CBOs that have experience working with Hispanic/Latinx communities.
12. Give funders, funding organizations, and reviewers training in cultural and linguistic competency for Hispanic/Latinx communities and the sub-populations at risk within them.
13. Develop the leadership and sustainability of organizations that serve Hispanic/Latinx communities. Ensure that their capacity building includes data collection, program evaluation, and monitoring.
14. Provide syringe access and other harm reduction services as a form of prevention
15. Extend insurance coverage to HIV prevention, including post-exposure prophylaxis (PEP) and PrEP.

ACCESS TO CARE

Federal coordination with every state and U.S. territory is critical to increase health care access. ART for treatment of HIV infection has become increasingly effective. Hepatitis C treatment needs to be available to those living with the disease. Persistently poor health outcomes in U.S. racial and ethnic minority populations demand a closer examination of why Hispanic/Latinx are at significant risk of acquiring and dying from HIV. To improve clinical outcomes and achieve an AIDS-free generation, HIV research must address disparities in HIV outcomes among Hispanic/Latinx, the largest ethnic/racial minority population in the U.S. Immigration status and cultural factors influence HIV care utilization. [49] Together, these health determinants are critical in developing effective interventions and tailored approaches that engage Hispanic/Latinx in care.

→ Recommendations

1. Ensure all health care access initiatives consider the unique needs of populations and the intersectionality of age, gender, and sexual orientation.
2. Support broad access to care and treatment under private and public health insurance plans. Require all public plans to cover a robust formulary of treatment options for people impacted by HIV, hepatitis, and STIs.
 - a. Encourage the federal government to continue to fully fund the Ryan White Program
 - b. Continue to support the protected class policy for Medicare Part D
 - c. Protect Medicaid and promote Medicaid expansion
 - d. Support the Affordable Care Act
 - e. Do not allow pharmacy benefit management and commercial insurance plans to delay access to new HIV medications
3. Increase awareness of copay support and patient assistance programs, and ensure eligible patients are able to receive the maximum benefits from these programs. Oppose co-pay accumulator plans, which place more cost burden on patients.
4. Assign resources to create safe spaces (e.g., status-neutral and sex-positive environments) that provide comprehensive health services and public spaces for communities at risk such as LGBTQ, cis women, and substance users, among others.
5. Address the intersectionality of the social health determinants that impact specific vulnerable communities.
6. Ensure the presence of culturally and linguistically competent staff at all organizations stating their communities of focus are Hispanic/Latinx.
7. Make educational and medical information available in Spanish (e.g., posters, pamphlets, and labels).
8. Support organizations that have effectively developed culturally and linguistically sensitive sexual health programs for Hispanic/Latinx communities (e.g., urgently expand the *promotoras* or the community health care workers' model). [50]
9. Ensure Hispanic/Latinx medical and nursing organizations are involved in developing and incentivizing culturally and linguistically competent clinical providers to work in the treatment of infectious diseases (e.g., HIV, STI, and hepatitis).
10. Identify partners, such as large hospitals, to develop comprehensive health centers to de-isolate HIV as a sole issue and deliver integrated care to decrease the health disparities within Hispanic/Latinx communities. Ensure the use of patient-centered models to provide additional access to mental health, substance use and psychosocial care services.

11. Integrate CBOs into the health care systems. Create wider access to electronic medical records and include CBOs in the navigation and linkage to care processes.
12. Increase efforts to promote models of care that have demonstrated the successful integration of holistic themes beyond the classic medical and clinical models, and increase non-clinical staff's involvement in patient care. Encourage hospital systems to develop collaborations with CBO's and acknowledge their relationships with their communities.
13. Identify action-oriented strategies proven to have impacts on addressing stigma, bias and discrimination against communities of color, Hispanic/Latinx and many sub-populations at risk for HIV, viral hepatitis and STIs.
14. Demand that all training initiatives for providers include identification of how patients are affected by racial and language justice, housing, immigration and food security.
15. Develop opportunities and create access to virtual health and telehealth technologies through CBOs to ensure providers reach communities that have challenges accessing health care services.

IMMIGRATION AND MIGRATION

Immigration and migration is an important issue for Hispanic/Latinx in our nation. We are a nation of immigrants and we must honor, respect, acknowledge and understand the importance of immigrants in our nation. The following set of recommendations aim to address the growing health needs of our diverse immigrant population in the United States of America.

→ Recommendations

1. Remove immigration-status-related restrictions from HIV programs and other health services. Ensure that Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) recipients have access to comprehensive health care.
2. Conduct a national assessment of the challenges of immigration-related issues faced by new immigrants to access health care and prevention services.
3. Develop fair immigration reform that allows normalization of status for undocumented immigrants, and broaden the grounds for asylum or other legal status to include persons fleeing gender- and sexuality-based persecution, domestic violence, and gang violence and persons who cannot receive adequate health care in their countries of origin.
4. Propose changes to the definition of “public charge” that inhibits immigrants from seeking health care, including preventive care, for themselves and their families.

5. Develop a nationwide health insurance program that covers basic preventive health and primary care for all immigrants, including care associated with HIV, hepatitis, STI, tuberculosis (TB), other communicable diseases, and behavioral health conditions.
6. Establish, strengthen, maintain, and customize multilingual health services in jurisdictions along the southern border with high concentrations of immigrant communities.
7. Create meaningful oversight of immigration detention facilities to ensure adequate, respectful provision of health care, respect for the dignity and human rights of people living with HIV and LGBTQ+ persons, and protection from violence, including sexual violence.
8. Ensure immigrants and migrants receive culturally and linguistically sensitive comprehensive health services that include mental health, substance use, and humane psychosocial and trauma-informed care.
9. Implement cross-culturally informed approaches within comprehensive health services and immigration detention facilities to address the complex needs of immigrants and migrants.
10. Maximize the impact of the Federal Ryan White HIV/AIDS Program by covering mental health and ancillary services that have been proven to be associated with better health outcomes to include new immigrant communities.

MENTAL HEALTH

Although the rates of mental illness among whites and Hispanics/Latinx appear to be roughly similar, there are significant disparities in access to treatment. Compounding this problem is the gross underrepresentation of Hispanic/Latinx in drug abuse and mental health treatment research.

Hispanics/Latinx are the least likely of all the ethnic groups living in the U.S. to have health insurance, and 37% of Hispanic/Latinx have neither public nor private health insurance—roughly double the rate of their white counterparts. [51] Hispanics/Latinx are less likely than white Americans to receive needed mental health care, and when they do receive care, they are more likely to receive it from primary health providers than mental health specialists. Overall, insured Hispanics/Latinx are less likely to receive mental health care than their white counterparts.

There are several concerning health disparities related to mental health issues in Hispanic/Latinx communities: [52] Poverty levels affect mental health status. Hispanics living below the poverty level are twice more likely to report psychological distress than Hispanics whose incomes are more than twice the poverty level; The death rate from suicide for Hispanic men is four times greater than the rate for Hispanic women, as of 2017; The suicide rate for Hispanics is less than half that of the non-Hispanic white population; Suicide is the second leading cause of death for Hispanics ages

15–34 years, as of 2017. [53]; Suicide attempts for Hispanic girls in grades 9–12 are 40 percent higher than among non-Hispanic white girls in the same age group, as of 2017; Non-Hispanic whites receive mental health treatment twice as often as Hispanics in 2018; Hispanic/Latinx people living in states with more exclusionary immigration policy climates have worse mental health outcomes than Hispanic/Latinx people living in states with less exclusionary policy climates.

→ Recommendations

1. Develop opportunities and create access to virtual health and telehealth technology within CBOs to ensure we reach communities that have challenges accessing mental health and psychiatric care services.
2. Create opportunities for in-home therapy for assistance that does not require going outside the safety of the patient/client's home, including the use of culturally and linguistically competent telehealth and virtual health services in mental health care.
3. Organize mental health literacy and awareness programs specifically for Hispanics/Latinx, as well as mental health educational opportunities and informational pamphlets that are culturally and linguistically appropriate.
4. Equip non-medical providers and community health workers with the skills to recognize mental health symptoms and link clients to proper care. Incorporate mental health as part of a comprehensive health care system. Integrate clinical and community-based practices such as using *promotores de salud*, or peer or community health workers.
5. Incorporate mental health service delivery with care plans and a collective family approach (expanding the definition of mental health to include spiritual, value-based, and cultural practices).
6. Work with Hispanic/Latinx medical organizations and social worker organizations to incentivize medical residents, licensed counseling social workers, and doctors to enter the psychiatric field. Develop incentives to facilitate a path for bilingual providers to become mental health providers.
7. Establish protocols on working with Spanish-speaking clients, clients who have less mental health literacy, and populations that need services that include a trauma-focused approach for immigrants, gay/bi men, cis women, transgender and gender non-conforming (TGNC) communities, domestic violence victims, and other marginalized groups. Identify providers that have a record of accomplishments when working with TGNC and LGBTQ youth.
8. Use Ryan White Program funding to increase access to mental health services for clients living with HIV who have inadequate health coverage or lack insurance. Seek other opportunities to expand access to mental health for people at risk of HIV.

9. Improve work with Substance Abuse and Mental Health Services Administration (SAMHSA) and other federal agencies to ensure access to culturally and linguistically competent mental health services for non-English speaking communities and persons at risk or living with HIV, hepatitis, and other illnesses.
10. Expand Medicaid to all 50 states, and place an emphasis on mental health services. Allow Puerto Rico to gain Medicaid and Medicare funding based on population instead of block grants to allow equal access to mental health services.
11. Incorporate cultural assessment into regular behavioral health practices. The cultural formulation interview framework recognizes the profound impacts of patients' cultures and life experiences on their understandings of their symptoms and their attitudes toward care.

SUBSTANCE USE

Substance use is closely associated with increased HIV, hepatitis, and STI risk. Substance use may complicate the treatment needs of people living with HIV and may have negative impacts on treatment outcomes. Substance use is a long-standing health issue preceding the opioid epidemic.

ART is recommended for all people living with HIV, regardless of disease status. Substance use disorders are common barriers to successful HIV treatment. However, few studies have comprehensively explored how HIV primary care providers consider substance use disorders in the context of universal ART implementation.

Substance use rates among Hispanic/Latinx people are similar to those of the general U.S. population. Several indicators of assimilation to U.S. culture, as well as sociodemographic variables, though, predict substance use and abuse in this group. Hispanic/Latinx populations have poorer outcomes in substance abuse treatment programs. [54] However, little empirical evidence explains the problems these individuals experience in treatment, and few studies address the use and effectiveness of mutual help groups for this population. New developments in the conceptualization and measurement of acculturation may lead to a greater understanding of the role of culture in the prevalence and treatment of substance-related problems.

Recent national surveys conducted by SAMHSA continue to indicate that Hispanic/Latinx report slightly lower rates of lifetime illicit drug use than white and blacks. However, rates of past month and past year drug use equal those of other ethnic groups. Additionally, rates of alcohol dependence and binge drinking among this group are close to those of Hispanic nonwhites and slightly higher than those of blacks. Little is known about meth use among Latino gay/bisexual men, other MSM, trans Latina women, and heterosexual Hispanic/Latinx men.

→ Recommendations

1. The opioid epidemic may lead to increased risk of HIV transmission. As a result, routine opt-out testing should be made available to injection drug users.
2. Harm reduction principles, approaches, and interventions should be the principal framework for substance use services funded at the local, state, and federal levels in the U.S. and Puerto Rico. Harm reduction principles, approaches, and interventions need to further be adapted to be culturally and linguistically appropriate for Latinx communities. [55]
3. The need for culturally and linguistically responsive mental health and substance use services far exceeds the number of available bilingual and bicultural mental health professionals. These services must have appropriate cultural and linguistic capacities to fully engage and retain Hispanic/Latinx communities.
4. Decriminalizing substance use and ending arrests for possession are needed to effectively offer treatment services and/or harm reduction services.
5. Overdose prevention information, training, and interventions, both in English and Spanish, are urgent to focus on all Hispanic/Latinx communities.
6. Safe injection sites and access care services in the U.S. and Puerto Rico are an innovative strategy to prevent needle-sharing and the spread of HIV and hepatitis, and to provide wound abscess care and connect individuals with other social services, including substance use and mental health treatment services.
7. All substance use service providers should be considered safe spaces for people regardless of race, ethnicity, sexual orientation, gender identity or immigration status.
8. Increase research on substance use in Hispanic/Latinx communities and its relationship with HIV, hepatitis, and other health issues. Pay closer attention to the heterogeneity of Hispanic/Latinx communities in the U.S. The associations between various indices of acculturation and substance use merit ongoing attention. [56]

STIGMA

Sexual, gender, and minority communities continue to be disproportionately impacted by HIV, hepatitis, and STIs. These disparities are produced and exacerbated by social and structural conditions, including poverty, social-related stigma, discrimination, immigration status, anti-immigrant rhetoric, and lack of access to health care.

The discussion on stigma should be framed within an intersectional approach. The concept of intersectional stigma examines the juncture of multiple stigmatized identities that cut across categories such as co-occurring health conditions (HIV, hepatitis C,

mental illness, and substance use); sociodemographic characteristics (race, ethnicity, gender, sexual orientation, and immigration status); and behaviors/experiences (substance use, sex work, and pre-and-post migration experience). Research has documented the detrimental impacts of immigration processes on health and wellness. For sexual and gender minority immigrants, anti-immigration rhetoric is often linked with HIV acquisition and transmission and delays in HIV prevention and treatment, along with substance use, negative mental health outcomes, and isolation.

Although stigma is considered to be one of the greatest challenges to addressing the HIV epidemic, data accurately describing and quantifying stigma are often not available to program implementers and policymakers. Data are important not only to determine the efficacy of specific stigma reduction interventions but also to understand the effects stigma may have on the success of prevention and treatment programs.

→ Recommendations

1. Develop a comprehensive conceptual framework for stigma that incorporates both its socio-cognitive and its structural aspects to capture the effects of pre-existing and overlapping stigma related to poverty, race, gender, gender identity, sexual behavior, risk behavior, drug use, health conditions, and sexual orientation, among other factors.
2. Conduct research to identify appropriate tools and measures of stigma, focusing on individuals and the impacts of stigmatizing attitudes and beliefs. Support research aimed at developing valid measures of structural and institutional stigma. In addition to enabling more comprehensive assessment of stigma over time, such measures can identify and evaluate potential levers to reduce stigma at the structural and institutional levels.
3. Implement a federal stigma reduction intervention with a domino effect on health care service providers in the U.S. States and U.S. territories, which could have monumental impacts.
4. Support further research on the relationship between stigma and routine HIV testing, hepatitis, prevention, and access to care and treatment.
5. Impact laws and policies that eliminate stigma and discrimination against gay/bisexual men, other MSM, TGNC, injecting drug users, commercial sex workers, and immigrants/migrants.

PLAN TO END THE HIV EPIDEMIC IN AMERICA BY 2030

HIV continues to be a major public health crisis in the U.S., with almost 40,000 new cases each year, and it is compounded by the epidemics of opioid use, viral hepatitis, STI and TB. While more than 1.2 million people living with HIV reside in every congressional district, state, and territory in the U.S., new cases of HIV and HIV/AIDS-related deaths are increasingly concentrated in communities of color, members

of LGBTQ communities, and Southern states. Communities across the U.S. have already begun to take concrete steps to end state and local HIV epidemics, but stopping the HIV epidemic across the country will require increased federal commitment and concerted, coordinated efforts by CBOs, state and local governments, and people living with and vulnerable to HIV, along with communities, clinicians, and service providers.

The U.S. now has the tools and ability to end the HIV epidemic. It is imperative to reduce and eliminate the related epidemics of opioid use, viral hepatitis, STI and TB. We call on the U.S. government to declare that it is our goal to end the HIV epidemic in the U.S. by 2030 and to enact legislative and regulatory changes to achieve this goal.

We can change the trajectory of the U.S. HIV epidemic by setting and meeting the ambitious but achievable goal of reaching a 95/95/95 framework for HIV care (95% of people living with HIV are aware of their HIV status, 95% of diagnosed individuals are retained in care, and 95% of individuals on ART virally suppressed). As an increasing number of cities, counties, and states develop and implement plans to end the HIV epidemic in their jurisdictions, it is important that they take advantage of opportunities to re-conceptualize prevention strategies to reduce and discourage stigma across race, gender, sexual orientation, and other identities which can and should include given and chosen familial support.

→ Recommendations

1. The DHHS must ensure that all jurisdictions engage the communities most affected by HIV in the design and implementation of local plans customized to local realities to achieve the goal of the 2030 plan to end the HIV epidemic in the U.S.
2. Develop the capacity to ensure the sustainability of organizations providing services within Hispanic/Latinx communities.
3. Expanded and sustained access to Medicaid coverage in every state, as defined by the ACA and ensure the stability of the Medicaid program.
4. Reject state proposals at the federal level that would harm people living with HIV, such as rolling back benefits, restricting access to life-saving medications, imposing work requirements as a condition of continued coverage, and demanding cost-sharing beyond the federal limits on low-income beneficiaries.
5. Support the implementation of innovative care delivery and payment models through state Medicaid programs.
6. Set concrete public health goals to end the U.S. HIV epidemic by 2030. To end the U.S. HIV epidemic in Hispanic/Latinx communities, we must set and meet benchmarks and modernize our national HIV surveillance system.
7. The CDC should release new focus funding opportunities for CBOs serving Hispanic/Latinx communities outside large metropolitan areas, particularly in the U.S. South, Puerto Rico, and small cities with high rates of incidence and mortality.

8. The Health Resources and Services Administration (HRSA) should seek ways to support non-traditional clinics such as point-of-care services, mobile clinics, small neighborhood clinics, traditional medicine and healing agents, telemedicine and virtual health facilities, and integrated medical care in other social support service settings to increase access points for vulnerable populations and communities.
9. Upgrade treatment and prevention services in Puerto Rico, the U.S. Virgin Islands, and all territories to the level achieved across the U.S. states, while ensuring representation and leadership by the U.S. territories.
10. DHHS agencies should fund HIV-related stigma reduction interventions, health literacy, and health system navigation services. Prioritize communities of color and the U.S. South, and increase HIV testing awareness and access and retention in PrEP.
11. Strengthen protections from discrimination for LGBT people under both Title VII of the Civil Rights Act and Title IX of the Education Amendments Act of 1972. Provide better reporting on the health and human services needs of the entire LGBT community, with an emphasis on the transgender community.
12. Ensure consumer protections that include prohibiting insurers from denying coverage due to pre-existing conditions and premium setting based on community ratings, but include nondiscrimination protections, guaranteed essential health benefits coverage, premium and cost sharing assistance, and annual caps on out-of-pocket costs.
13. Increase funding for the Ryan White Program consistent with the growing epidemic and need, and ensure that the program's funding formulas and structure support integrated efforts to end the HIV epidemic.
14. Expand routine HIV testing to all people living in the U.S. and U.S territories regardless of immigration status.
15. Provide support for primary training and continuing education in cross-cutting cultural responsiveness for providers through the CDC and HRSA.
16. Ensure the availability and affordability of PrEP across all populations through a combination of federal funding, solutions to pricing issues for commercially available PrEP on the market, and investments in the development of new PrEP modalities.
17. Support sexual health education programs by supporting increased funding for existing programming for adolescents such as the CDC's HIV School Health efforts through the Division of Adolescent and School Health, the Teen Pregnancy Prevention Program through the Office of Adolescent Health, and an extension of the Personal Responsibility Education Program.
18. Eliminate federal funding for abstinence-only-until-marriage programs, including the Title V Sexual Risk Avoidance Education state-based grant program. Require that all federally funded state juvenile detention, foster care, substance use treatment centers, and mental health facilities for youth in out-of-home care include sexual health care and literacy in their services.

THE SOUTH

The South has the fastest Hispanic/Latinx population growth of any U.S. region. It increased by 33%, from 5.6 million in 2008 to 22.7 million in 2018 as part of a broader increase in the Hispanic population in regions across the country since the 1990s. States in the Northeast (25% increase), Midwest (24%), and West (19%), as well as the District of Columbia (57%), also experienced growth in their Hispanic populations from 2008 to 2018. [58]

As an example of this rapid growth trend in the southern U.S. region, the gap between Texas' Hispanic and white populations continues to narrow in 2019, the state gained almost nine Hispanic residents for every additional white resident. With Hispanics expected to become the largest population group in Texas as soon as 2022, new estimates released by the U.S. Census Bureau show that the Hispanic population has climbed to nearly 11.4 million—an annual gain of 214,736 through July 2018 and a rise of 1.9 million since 2010. [59]

Today, Southern states account for an estimated 51% of new HIV cases annually [60], even though only 38% of the U.S. population lives in the region. [61] In 2017, the South also had a greater proportion of new HIV diagnoses (52%) than all other regions combined. Diagnosis rates for people in the South are higher than for Americans overall. Eight of the 10 states with the highest rates of new HIV diagnoses are in the South [62], as are 9 of the 10 metropolitan statistical areas with the highest rates. [63,64] New diagnoses among Hispanic/Latino MSM in the South have increased. As in the rest of the country, most HIV diagnoses in the South occur in urban areas. However, the South has a higher proportion of new diagnoses (24%) in suburban and rural areas than other U.S. regions, posing unique challenges to HIV prevention and care efforts. [65]

→ Recommendations

1. Establish medical–legal partnerships and programs that can consistently address the realities of immigration issues, including HIV, hepatitis, and STI.
2. Update standardized data collection methods to match current subcategories for race, ethnicity, gender, sexual orientation, gender identity, and primary spoken language.
3. Advance a health agenda that considers sociopolitical issues that impact health determinants. End outdated policies such as HIV criminalization and other xenophobic, homophobic, and transphobic laws and policies.
4. Address the lack of information and myths about the public charge definition and access to health services throughout the U.S., with an emphasis on the South.
5. Support expanding Medicaid in Southern states.
6. Strengthen and establish partnerships with organizations that serve non-Latino communities and African-American and Native Americans.

7. Use telehealth and virtual health services with Spanish-speaking providers,
8. Develop organizations' capacity to achieve cultural and linguistic competency to better serve Hispanics/Latinx communities.
9. Ensure that marketing and educational materials are available in Spanish and create inclusivity.
10. Invest in youth mentorship and leadership programs. Develop LGBTQ safe spaces for Hispanic/Latinx.
11. Invest in addressing HIV, hepatitis, and STI stigma through English- and Spanish-language social media campaigns produced in collaboration with the target populations.

PUERTO RICO

Puerto Rico's population declined by nearly 4% in 2018 and has decreased by about 15% since 2008. The island's population stood at 3.2 million in 2018, down from 3.3 million in 2017, when hurricanes Maria and Irma hit. These trends will surely continue given the December 2019 – January 2020 earthquakes. The hurricanes and earthquakes led many Puerto Ricans to leave for the continental U.S., especially Florida. Even before the hurricanes, however, the island's population had experienced a steady, long-term decline due to a long-standing economic recession. [66]

Despite great advances in HIV prevention and care, insufficient progress has been made among Puerto Rican gay/bi men, TGNC communities, and people who inject drugs. Research on the HIV/AIDS epidemic among people who inject drugs has documented high levels of risk behaviors and prevalence among individuals who identify as Puerto Rican than other groups since early in the epidemic, and these disparities persist. [67] Although Puerto Ricans in the island and the continental U.S. represent about 9% of the U.S. Hispanic population [68], nearly 23% of HIV cases among Hispanics are among those born in Puerto Rico, as of 2006. [69] Early in the epidemic, injection drug use accounted for many AIDS cases in Puerto Rico, and currently, more than 20% of new infections in Puerto Rico are attributed to injection drug use, a higher rate than for any other U.S. region [70] and any other Hispanic subgroup. [71]

The number of persons living with diagnosed HIV infections in Puerto Rico is 18,117, as of 2018. The prevalence of diagnosed HIV infections among males is 2.5 times higher than in females. As of 2016, the prevalence rate of HIV in Puerto Rico is 573/100,000. [72] The prevalence of diagnosed HIV infection in the metropolitan health region is 1.6 times higher than the overall prevalence. Approximately 9% (N=1,700) of people living with HIV in Puerto Rico are not aware of their HIV infection, while 2 in 3 persons living with diagnosed HIV infection are 45 years and older. [73]

Puerto Rico faced significant public health challenges from HIV, hepatitis, and STIs before the hurricanes. The challenges have most recently been exacerbated by the earthquakes, increasing concerns about people living with HIV and hepatitis C and their

access to medicines and other support services. [74] HIV program authorities on the island continue to face intermittent communication and power challenges, but so far, no major interruptions in services have been reported, and all the Ryan White Program-funded clinics have remained open. [75]

→ Recommendations

1. Achieve greater compliance with Public Law 771, establishing the Bill of Rights of People Living with HIV in Any of their Estates in Puerto Rico, which promotes the enjoyment of a full life, access to quality care, and timely availability of new antiretroviral innovation.
2. Upgrade treatment and prevention services in Puerto Rico to the level achieved across the continental U.S., while ensuring representation and leadership by the territories.
3. Ensure that PrEP is offered and PrEP prescriptions are covered.
4. Promote implementation of PrEP and PEP protocols throughout the island with an awareness campaign to increase use and access.
5. Ensure Puerto Rico has access to appropriate lab services. Private laboratories and electronic laboratory reporting of nucleotide sequences have yet to be fully implemented.
6. Ensure all newly diagnosed individuals have quick access to treatment. Ryan White personnel cannot contact all newly identified HIV cases without a signed consent form. Ryan White in Puerto Rico does not allow patients to have access to their HIV medications during hospitalization.
7. Improve partner notification processes across prevention and treatment services.
8. Offer partner services and linkage to care to new cases identified in private health care.
9. Focus on HIV navigation services for those at high risk of HIV infection and transmission and for those not-in-care and not virally suppressed.
10. Prioritize navigation for those most likely to transmit the infections.
11. Eliminate disparities in Medicare access, which should be applied equally throughout the island.
12. Ensure equal access to Medicare and Medicaid as areas with that have expanded Medicaid. Improve billing to allow for payment of services through the Ryan White, Medicare, and Medicaid programs.
13. Build the capacity of physicians and clinical providers in Puerto Rico through the Association of HIV Physicians in Puerto Rico to expand treatment services.
14. Increase HIV awareness and stigma-related campaigns directed to people living with HIV.
15. Ensure that people diagnosed with hepatitis have access to treatment and care.
16. Develop comprehensive HIV care centers that also deliver reproductive health care and other care related to TGNC communities' needs.

RESEARCH AND DATA

Latino researchers expressed shared concerns about the future viability of CBOs serving Hispanics/Latinx, including Latino MSM, cis and trans women, and youth. [76,77] These concerns have increased as funding priorities have shifted from community-level and community-led approaches to clinically delivered interventions. In the changing AIDS landscape, communities are often relegated to getting patients to care and treatment, seriously hindering critical aspects of well-rounded, balanced HIV responses (e.g., harm reduction, peer-led approaches, and mobilization campaigns). In this context, implementation and operations research focused on developing and sustaining comprehensive HIV responses that combine behavioral, social, and biomedical approaches can secure the important roles played by communities in more robust HIV responses.

Beyond individual-level approaches, more in-depth explorations should address infectious disease risk situations and risk reduction strategies employed by Hispanic/Latinx across contexts. Theory building research should aim to understand infectious disease within the broader sexual health and wellness of Hispanic/Latinx, including those impacted by infectious disease. Research should focus on optimizing health literacy and understanding the loss of care continuum among Hispanic/Latinx.

A top priority for many investigators remains social, structural, cultural, broad lens approaches, and root causes research focused on improving measurement and understanding of stigma and immigration/migration dynamics. In particular, many have pointed to the importance of understanding the interactions between various forms of social oppression—homophobia, racism, classism, ageism, and HIV-related stigma (including internalized forms)—and their role in increasing the sexual risk of HIV, viral hepatitis and STIs among Hispanic/Latinx sub-populations. Research should be focused on geo-politically latent spaces/places such as the U.S. South and Puerto Rico.

→ Recommendations

1. A critical review to ensure that CDC materials are culturally and linguistically appropriate, and their imagery reflects the target populations. Ensure that their language resonates with subgroups at risk of HIV, viral hepatitis and STIs.
2. Rethink the CDC's molecular surveillance methodology to ensure that reports depict the overall population and leave out subgroups. Programmatic design should also leave out other vulnerable groups.
3. Train and empower community members to become integral to research (the community health research model).
4. Shift the HIV, AIDS, viral hepatitis and STIs training and research paradigm to effectively train and mentor Hispanic/Latinx researchers in the U.S. and Puerto Rico.
5. Coach senior administrative and academic staff in HIV/AIDS training programs on the needs, values, and experiences unique to Hispanic/Latinx investigators.

6. Encourage mentors to be receptive to the different sets of research questions and approaches that Latino researchers offer due to their life experiences and perspectives.
7. Create a virtual infrastructure to share resources and tackle challenges faced by minority researchers. Shifts in the research paradigm to include, retain, and promote Latino HIV/AIDS researchers will benefit the scientific process and the patients and communities who await the promise of HIV/AIDS research.

DRAFT

ACKNOWLEDGEMENTS

How did the idea to establish a National Hispanic/Latinx Health Agenda come into existence?

It started with informal discussions among community leaders about the invisibility and the lack of representation within the decision-making process in critical health care issues. Hispanic/Latinx-led organizations and Hispanic/Latinx leaders working in non-Hispanic/Latinx organizations saw the need and came together to strategize how to address the rising cases of HIV in Hispanic/Latinx communities. We came to understand that the burdens of disease and poor health, and the benefits of wellness and good health are inequitably distributed among communities of color, the economically disadvantaged, non-English-speaking communities, sexual and gender minorities, immigrants, migrants, and others vulnerable to social and health determinants, discrimination, bias, and stigma. Although biology, genetics, and individual behaviors play roles in these disparities, many health outcomes are also substantially affected by social, economic, and environmental factors.

Local and national problems such as poverty, unemployment, poor education, inadequate housing, inadequate and non-existent public transportation, violence exposure, and neighborhood deterioration (social and physical) are among the factors that shape health. They do so in unequal ways, contributing to health inequities. The historic and ongoing interplay of structures, policies, norms, and demographic/geographic patterns shapes the life of every individual across the country.

Inequities can be mitigated by policies and community action in powerful ways, so we began a conversation on developing the National Hispanic/Latinx Health Agenda which has now come to fruition.

We acknowledge the work of community leaders, stakeholders, and staff from national CBOs. (*Organizational affiliation are listed only for identification purposes.*)

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RESUMEN EJECUTIVO

La Red Hispana/Latinx de Liderazgo sobre la Salud, será la anfitriona de la de la Cumbre Nacional Hispana/Latina de Liderazgo sobre la Salud, que se enfoca en políticas de salud, y que se llevará a cabo los días 2 y 3 de marzo del 2020 en la Ciudad de Washington, DC. Esta Cumbre sobre Liderazgo sobre la Salud es el producto de dos años de trabajo para reunir las experiencias, ideas y visión de líderes Hispanos/Latinx de los Estados Unidos y sus territorios, incluido Puerto Rico, para:

1. Fortalecer la Red de Salud de Liderazgo Hispano/Latinx
2. Desarrollar la agenda de política sobre la salud Hispana/Latina 2020 – 2024 durante la Cumbre Hispana/Latinx de Salud en Washington DC, y subsecuentemente apoyar la formulación de las agendas locales a través de todos los Estados del país, y sus territorios.

La meta general es la de mejorar los resultados de salud de las minorías viviendo en los Estados Unidos, así como asegurar que la participación e inclusión de la comunidad Hispana/Latinx para así poder borrar las disparidades de salud en nuestra nación.

Las necesidades de salud de la comunidad Hispana/Latina son mayoritariamente invisibles y frecuentemente ignoradas en muchas de las agendas de salud pública en nuestra nación. Las autoridades de salud han respondido a las epidemias del virus de la inmunodeficiencia humana (VIH), hepatitis viral y las infecciones de transmisión sexual (ITS) sin considerar las necesidades culturales y lingüísticas de los Hispanos (tanto nacidos en los Estados Unidos, así como los nacidos en el extranjero, pero hoy residen en los Estados Unidos). Los Hispanos han sido desproporcionadamente afectados por las condiciones deficientes de la vida diaria, que han sido moldeadas por factores de posición social y estructurales (como la macroeconomía, los valores culturales, salarios, educación, tipo de empleo, y sistemas de apoyo social, que incluyen a los servicios para el cuidado de la salud), conocidos como determinantes de salud (SDH siglas en Ingles). Los determinantes sociales de la salud tienen efecto directo en la salud de los individuos. [1] Las comunidades Hispanas/Latinas afectadas por el VIH, la hepatitis viral, y las infecciones de transmisión sexual han sido ignoradas, tanto cultural como lingüísticamente, en la prevención, el tratamiento, y el acceso a programas de salud en nuestra nación. Esta situación crea una necesidad urgente para desarrollar estrategias que sean culturalmente apropiadas para el acceso a la salud y la retención al estar recibiendo tratamientos médicos.

La diversidad y heterogeneidad racial, cultural y lingüística son factores importantes para entender a las comunidades Hispana/Latinx de los Estados Unidos. La diversidad de esta población debe ser considerada en la implementación actual de una modalidad estandarizada para responder al impacto del VIH, la hepatitis viral, y las infecciones de transmisión sexual en las áreas de prevención y tratamiento. Necesitamos crear modalidades inclusivas y holísticas para el alcance diverso de las poblaciones Hispanas/Latinx en enclaves urbanos, sub-urbanos y rurales. Siempre tomando en cuenta la población nacida fuera de los Estados Unidos que se identifica como Hispana/Latinx, diversidad de género e identidades sexuales, identidades raciales que incluyan a los Afro-Latinos, Latinos de ascendencia europea/blanca, nativos, e indígenas, asiático, y muchos más. Estas estrategias también deben tomar en cuenta comunidades que no hablan inglés, o español y que incluyen a las personas que hablan portugués o lenguas indígenas. [2]

Los Hispanos/Latinx representan en la población minoritaria, el segmento poblacional de más rápido crecimiento en la nación, así como la población que está envejeciendo en mayor escala. Los Latinx mayores se encuentran en gran riesgo de infección en comparación con sus contrapartes no-Latinx. En el 2017, de acuerdo con el reporte de vigilancia epidemiológica de los Centros para el Control y Prevención de las Enfermedades (CDC por sus siglas en inglés), los hispanos/Latinx de edades entre los 50 y 54 años de edad han presentado un rango de diagnóstico de infección por VIH mayor que el doble de sus contrapartes masculinas blancas no-Latinx dentro del mismo rango de edad. Por lo tanto, existe una urgente necesidad de examinar la salud sexual y la salud en general de una población que regularmente se encuentra abandonada. [3] Los esfuerzos nacionales para tratar con las enfermedades infecciosas, deben enfocar su inversión en las siguientes cuatro áreas prioritarias:

1. Mitigar el estigma social entre los proveedores de servicios de salud y proveedores de servicios múltiples.
2. Acceso y disponibilidad de los servicios para la atención de salud
3. Desarrollo de intervenciones para modificar comportamientos diseñadas para las poblaciones Hispanas/Latinx
4. Acuerdos más amplios entre los líderes cívicos de las comunidades Hispanas/Latinx con enfoque más comprometido en temas de salud.

Las siguientes recomendaciones fueron desarrolladas a lo largo de dos años. Líderes comunitarios, dirigentes de organizaciones, y organizaciones que prestan una variedad de servicios, contribuyeron con sus especializaciones y con su voz al proceso de recomendaciones como miembros de la Red Hispana/Latinx.

Los comités de trabajo y de planeación de la Cumbre de Liderazgo Hispano/Latinx, se reunieron en grupos de trabajo a los cuales se les encargó el articular una perspectiva en relación a los temas nacionales más importantes, analizar los retos, y proveer recomendaciones en los siguientes temas nacionales:

1. Prevención
2. Acceso al cuidado de la salud
3. Investigación y recolección de datos informativos
4. El sur de los Estados Unidos
5. Puerto Rico
6. Estigma
7. El plan federal para derrotar la epidemia del VIH para el 2030
8. Inmigración y migración
9. Salud mental
10. Uso de sustancias

Podemos cambiar la trayectoria de muchos temas de salud que afectan a nuestras comunidades. En el caso de la epidemia del VIH, podemos implementar, monitorear y lograr el ambicioso, pero posible plan para derrotar la epidemia para el año 2030. Para hacerlo, necesitamos un incremento significativo de acceso a las herramientas biomédicas disponibles para la comunidad Hispana/Latinx que son se han expuesto al VIH, mejorar las oportunidades para hacerse la prueba de detección, así como el acceso al cuidado y tratamiento médicos, reducir el impacto del estigma, y tomar acciones concretas para asegurarnos de que ninguna población o región se queden atrás.

También debemos traer todas las herramientas de prevención para lograr el impacto necesario en la epidemia. Si fallamos en actuar de forma rápida en la medida necesaria a las comunidades afectadas, resultara en mayores casos de transmisión del VIH, un incremento en las enfermedades y muertes por VIH, la continuación de desigualdad en el acceso a la salud, y un costo mayor relacionados a servicios de salud.

A través del esfuerzo conjunto de comunidades, industrias y de todos los niveles de gobierno, podremos promover el progreso que se ha hecho en las últimas tres décadas para al fin lograr esta meta que antes era una meta impensable. Esta agenda de salud contribuirá de forma activa a la reducción drástica de nuevas infecciones por VIH, aumentar la calidad y vidas de las personas viviendo con VIH, y poder tratar de forma efectiva con las crisis de opioides, hepatitis viral, ITS, y tuberculosis entre otras enfermedades. Al hacerlo, esta agenda de salud reducirá de forma dramática el costo en general en vidas, así como gastos en temas relacionados a la salud.

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