

# NATIONAL HISPANIC/LATINX HEALTH POLICY AGENDA 2020-2024

BREAKING THE INVISIBILITY:

OUR HEALTH, OUR FUTURE

Addressing HIV, Viral Hepatitis,  
STIs, Stigma, Substance Use,  
Mental Health and Other  
Critical Health Issues

MARCH/SEPTEMBER 2020



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# EXECUTIVE SUMMARY

The Hispanic/Latinx<sup>(\*)</sup> Health Leadership Network hosted 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 ensure that we:

1. Fortify the Hispanic/Latinx Health Leadership Network
2. Finalize and reach consensus on the National Hispanic/Latinx Health Policy Agenda 2020–2024 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 in 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 and the current COVID-19 pandemic without considering the structural disparities including the cultural and linguistic needs of Hispanics/Latinx (U.S. born and foreign born). Hispanics/Latinx 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.<sup>[1]</sup> Hispanic/Latinx communities affected by HIV, viral hepatitis, and STIs and 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 in social and medical services.

Racial, cultural, and linguistic diversity and heterogeneity are important factors to understand Hispanic/Latinx communities in the U.S. The



(\*) 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.

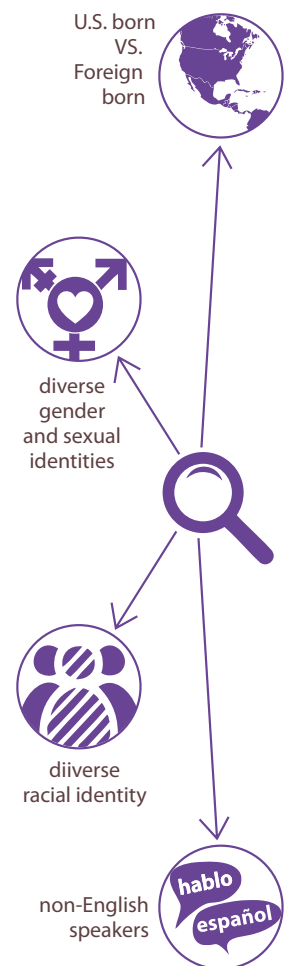
diversity of this population should be considered in the current implementation of a standardized approach to address the impacts of HIV, viral hepatitis, and STIs in the area of prevention and treatment. As a result, we need to create comprehensive and holistic approaches to reach diverse Hispanic/Latinx 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 other populations of Hispanic/Latinx experience. 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 in the U.S. Older Latinos are at an increased risk of HIV infection compared to their non-Latino white counterparts. In 2017, according to CDC Surveillance data, 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, through this network formulated recommendations, to address infectious diseases; these efforts must make focused investments in four recommended priority areas:

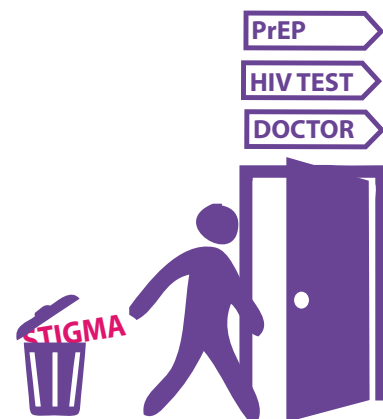
1. Mitigation of social stigma among health care and multiservice providers
2. Availability and accessibility of health care and prevention services
3. Development of behavioral interventions tailored to the diversity of the Hispanic/Latinx populations that are focused on prevention, treatment and access to care.
4. Broader engagement of Hispanic/Latinx community leaders that focus their work on health related issues that impact the health outcome disparities

The recommendations contained in this document, were developed over the course of two years. Community organizers and activists, organizational leaders from diverse Hispanic/Latinx communities and organizations contributed their expertise and voices to the recommendations and processes 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 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
11. Leadership



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 members of the Hispanic/Latinx population or geographical 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.



# COVID-19: ACKNOWLEDGEMENT OF THE GLOBAL PANDEMIC

As the National Hispanic/Latinx Health Leadership Summit was occurring, we began to receive news and receive some information around COVID-19 without having all the knowledge that we would later have. However, the leadership and the participants quickly brought the issue in the many sessions at the event. Finding that the COVID-19 virus would have an impact in many of our communities across the United States and Puerto Rico. The leadership foresaw the impact that COVID would have, and the need to use the experiences of dealing with HIV, Hepatitis C, STIs and other chronic conditions and other emerging viral diseases in our communities to ensure that our communities would have access to testing and care. Additionally, the leadership wanted to ensure that COVID-19 would have a manageable impact on the health and finances of Hispanic/Latinx communities.

We now know that the impact has been devastating among Hispanics/Latinx and African-American communities because of the already existent social determinants and health disparities that impact our communities. There are many reasons for this such as Hispanic/Latinx people are disproportionately likely to be essential workers with higher levels of exposure, levels of poverty, and more likely to be excluded from financial protections because of immigration status. Hispanics are more concerned when compared with other communities about the threat the COVID-19 outbreak poses to the health of the U.S. population, their own financial situation and the day-to-day life of their local community. [4]

The spread of COVID-19 has hit many of the nation's nearly 60 million Latinos particularly hard. Similar patterns have played out nationally. The Centers for Disease Control and Prevention reported on August 18, 2020 that COVID-19 infection rates are 2.8 times higher in the Hispanic/Latinx when compared to the rate for non-Hispanic white

people. Although the Latino unemployment rate dipped at the end of 2019 to a near record low, many Latinos work in the leisure, hospitality and other service industries – and they are less likely to have health insurance. The Great Recession hit Latinos especially hard more than a decade ago, and some workers have only recently seen their median personal incomes bounce back and exceed pre-recession levels.<sup>[5]</sup> Roughly, \$2 trillion economic stimulus sent out approximately \$1,200 to taxpayers to soften the economic blow.<sup>[6]</sup>

This survey also found that Hispanics might be financially more vulnerable than other Americans if the coronavirus forces them to stop working. Around two-thirds of employed Hispanic adults (66%) say they would not get paid if the coronavirus caused them to miss work for two weeks or more, including about half (47%) who say it would be difficult to meet expenses during this time. By comparison, 54% of employed U.S. adults overall say they wouldn't get paid if they missed two weeks of work or more, including 33% who say it would be difficult to meet expenses.

# 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. [7] In 2019, the Census Bureau estimated that approximately 60 million Hispanics live in the U.S. [8] 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. [9]

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). [10] Health inequalities particular to Hispanics are also related to their socioeconomic status, cultural background, employment, and foreign-born and undocumented status. [11, 12] 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. [13] 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. [14, 15]

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. [16, 17, 18] 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, immigration status 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 care, prevention and treatment. The effectiveness of national responses to the Hispanic/Latinx HIV crisis and the syndemic associated with viral hepatitis, STI, mental health, and substance use depends on efforts to focus on the needs of the most affected populations, specifically recent 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, immigration status and socioeconomic characteristics have been shown to be associated with differential outcomes across health care continuum. Greater collaboration among federal agencies, multi-service



organizations, and diverse Hispanic/Latinx community leaders is urgently needed to shape efforts to address specific needs of heterogeneous and geographically diverse Hispanic/Latinx constituencies. [19]

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. [20] 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 do. 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, xenophobia, racism, poverty, and substance use as key factors affecting their mental health. Various studies have also shown high prevalence of suicidal ideation, anxiety. [21,22,23]

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 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.[24] 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 communities continue to face issues due to the low efficacy of existing disease management, treatment, and prevention efforts.

All these disparities require government and public health organizations to commit to strengthen Hispanic communities' linkage to care for those living with hepatitis C, promote hepatitis A and B vaccinations, 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. [25]

# 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. 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. [26]

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, held March 2–3, 2020, in Washington, D.C., adopted the national agenda and developed an action plan for implementation at the federal level.

The summit leadership encouraged 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%. [27] 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%. [28] 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. We also know that more than one of every four Trans Latina woman is living with HIV. 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. [29]

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. [30] 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%. [31] 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. [32] Research has suggested that foreign-born Hispanics/Latinos living with HIV acquired the infection in the U.S. [33] 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. [34]

Regarding hepatitis, Hispanic/Latinx are 60 percent more likely to die from viral hepatitis than whites are. Despite lower hepatitis C rates, Hispanics are 40 percent more likely to die from that disease, as of 2015. [35] 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. [36] Latinos are the largest minority in the U.S. and have higher rates of HCV infection. [37] 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. [38] 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. [39]

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. [40]

# RECOMMENDATIONS FOR BETTER HEALTH IN OUR COMMUNITIES

## Breaking the Invisibility: Recommendations on Twelve 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. [41] 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. [42]

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 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
12. Ensure specific funding allocation to build the infrastructure of organizations most impacted by HIV, viral hepatitis, STIs, and other health disparities. These include Trans led, and LGBT Hispanic/Latinx organizations that address the unique needs of these communities.



## 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 eleven 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 that focused on HIV, viral hepatitis and STIs: (1) prevention; (2) access to health care; (3) research and data; (4) the 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 (11) leadership. 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 those live healthier lives. [43] 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 in bilingual social messaging campaigns, knowledge of primary physicians in prescribing PrEP, and programs that make PrEP available remain throughout the within Hispanic/Latinx communities in the U.S. and Puerto Rico.

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 mortality rates due to viral hepatitis infection and despite 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 and gender non-conforming people, 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. [44]

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. Governmental agencies in partnership with community-based organizations must develop and discuss culturally and linguistically appropriate HIV/Hepatitis/STI messaging and materials to Hispanic/Latinx communities and the subpopulations at risk within them via a variety of communications channels (e.g. ethnic and Spanish language media, printed and digital resources, social media, dating apps, etc.)
2. Prioritize awareness, access to and retention in HIV biomedical prevention interventions (PrEP, PEP, treatment as prevention) independent of insurance or immigration status, utilizing culturally and linguistically appropriate and community-led navigation and linkage services.
3. Develop and amplify interdisciplinary equal and fair partnerships and collaborations between community-based organizations and primary care providers, larger medical systems, hospitals, and funders with cultural and linguistic competence and proven work experience with Hispanic/Latinx communities and the most impacted sub-populations.

## ACCESS TO HEALTH CARE

Federal coordination with health care providers and community based organizations in every state and U.S. territory is critical to increase health care access. ART for treatment of HIV infection has become increasingly effective. Both antiretroviral treatment and Hepatitis C and STI treatments need to be available to those impacted. 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 issues include factors that influence HIV care utilization. [45] Addressing these health determinants is critical in developing effective interventions and tailored approaches that engage Hispanic/Latinx in care.

### → Recommendations

1. Support broad access to care and treatment under private and public health insurance plans. Require all private and 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. Lift immigration status-based restrictions on access to Medicaid and ACA plans
  - f. Do not allow pharmacy benefit management and commercial insurance plans to delay access to new HIV medications
  - g. Increase awareness of copay support and patient assistance programs, and ensure eligible patients are able to receive the maximum benefits from these programs.
  - h. Address the challenges of co-pay accumulator plans, which may place more cost burden on patients.
2. Identify action-oriented strategies that have an impact on addressing stigma, bias and discrimination against communities of color, Hispanic/Latinx and other communities vulnerable to HIV, viral hepatitis and STIs.
  - a. Assign resources to create safe spaces (e.g., status-neutral and sex-positive environments) that provide comprehensive health services for vulnerable communities such as Hispanic/Latinx LGBTQ, cis women, and substance users, among others.
  - b. Work in coalition to undo Trump Administration's rollback of Sec. 1557 anti-discrimination protections for trans and LEP folks (it's temporarily blocked by a federal judge but the rule should be thrown out altogether and 1557 protected and enforced in its entirety)

3. To develop partnerships to develop status-neutral comprehensive health and 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. Additionally, safeguard the presence of culturally and linguistically competent staff at all organizations stating their communities of focus are Hispanic/Latinx individuals.

## **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. We call for an overall reform of Immigration and Immigration Customs Enforcement (ICE). Create meaningful oversight of immigration detention facilities, including private for-profit facilities, and enforcement of existing laws concerning access to health services in detention, as well as continuous capacity building and training to ensure respect for the dignity and human rights of people living with HIV and those who are LGBTQ+ persons, and protection from interpersonal violence, including sexual violence.
2. Establish, strengthen, maintain, and customize multilingual health services in jurisdictions along the southern border and other regions with high concentrations of immigrant communities. 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, including through guaranteed and sufficient funding for safety-net health care providers such as community health centers and universal access to affordable health insurance coverage regardless of immigration status.
3. Remove immigration-status-related restrictions from HIV programs and other health services. Develop fair immigration reform that allows normalization of status for undocumented immigrants, and broaden the grounds for asylum or other legal status (persons fleeing gender- and sexuality-based persecution, domestic violence, gang violence and persons who cannot receive adequate health care in their countries of origin).
4. Address the lack of information about the public charge definition and access to health services throughout the U.S., with an emphasis on the South.

# 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. [46] 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 are.

There are several concerning health disparities related to mental health issues in Hispanic/Latinx communities: [47] 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. [48] 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. Equip non-medical and medical providers and community health workers with the skills to recognize mental health symptoms and link clients to culturally appropriate care. Incorporate mental health as part of a comprehensive health care system. Integrate clinical and community-based practices by incorporating promotores de salud (community health workers) and peers into care planning and provision, and adequately reimbursing for the services they provide. [49] Work with Hispanic/Latinx medical organizations and social worker organizations to recruit and incentivize (scholarships, student loan forgiveness, etc.) bilingual medical residents, licensed counseling social workers, nurses and doctors to enter the mental health field.
2. Mental health should be as important as primary care, and the two service systems should be more integrated and available to all people regardless of immigration status. Use Ryan White Program funding to increase access and capacity to mental health services for people living with HIV. Seek other opportunities to expand access to mental health for people at risk of HIV and other marginalized

populations. Expand Medicaid to all 50 states that is inclusive of all mental health services. Allow Puerto Rico to gain Medicaid and Medicare funding based on population instead of block grants for equal access to mental health services.

3. Incorporate mental health service delivery with patient-centered care plans, destigmatizing messaging around accessing mental health services and a collective family approach (expanding the definition of mental health to include spiritual, value-based, and cultural practices). Incorporate cultural assessment into standardized mental 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. [50] 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 non-whites 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. 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. [51] Incorporating stigma eliminating campaigns and messaging will greatly improve access to evidence-informed treatments and interventions under the harm reduction principles.
2. Decriminalizing people who consume drugs and ending arrests for possession of illicit drugs are needed to effectively offer evidence-informed treatment services and/or harm reduction services.
3. Creating and fully implementing safe injection sites and access to care services in the U.S. and Puerto Rico to prevent needle-sharing, overdosing, and the spread of HIV and hepatitis, and to provide wound abscess care, treatment of hepatitis C and connect individuals with other social services, including substance use and mental health evidence-informed treatment services.
4. Incorporate substance service delivery with patient-centered care plans, destigmatizing messaging around accessing mental health services and a collective family approach (expanding the definition of mental health to include spiritual, value-based, and cultural practices). Incorporate cultural assessment into standardized substance use 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.

## 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 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 is 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. Support further research on the relationship between stigma and routine HIV/hepatitis/STI testing, prevention, and access to care, treatment and education. Additionally, enable more comprehensive assessment of stigma over time, such measures can identify and evaluate potential levers to reduce stigma at the structural and institutional level.
3. Impact laws and policies that eliminate stigma and discrimination against gay/bisexual men, other men who have sex with men, transgender and gender nonconforming individuals, injecting drug users and others, 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, STIs 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, STIs 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—including Hispanic/Latinx HIV and LGBT-led CBOs—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. The CDC should expand 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. 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.
3. Expanded and sustained access to Medicaid coverage in every state and Puerto Rico, as defined by the Affordable Care Act (ACA) and ensure the stability of the Medicaid program. Support the implementation of innovative care delivery and payment models through state Medicaid programs.

## 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. [52]

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. [53]

Today, Southern states account for an estimated 51% of new HIV cases annually, [54] even though only 38% of the U.S. population lives in the region. [55] 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, [56] as are 9 of the 10 metropolitan statistical areas with the highest rates. [57,58] New diagnoses among Hispanic/Latino MSM and gender nonconforming communities 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. [59]

## → Recommendations

1. Advance a health agenda that considers language justice and sociopolitical issues that impact health determinants. Work on developing policies that overlap with public health such as HIV criminalization and other xenophobic, homophobic, and transphobic laws and policies.
2. Support expanding Medicaid in Southern states.
3. Invest in youth mentorship and leadership programs. Develop LGBTQ safe spaces for Hispanic/Latinx.

## 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. [60]

Despite great advances in HIV prevention and care, insufficient progress has been made among Puerto Rican gay/bi men, transgender and gender nonconforming 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. [61] Although Puerto Ricans in the island and the continental U.S. represent about 9% of the U.S. Hispanic population, [62] nearly 23% of HIV cases among Hispanics are among those born in Puerto Rico, as of 2006. [63] 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 [64] and any other Hispanic subgroup. [65]

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. [66] 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. [67]

Puerto Rico faced significant public health challenges from HIV, hepatitis, and STIs before the hurricanes. The earthquakes, increasing concerns about people living with HIV and hepatitis C and their access to medicines and other support services, have most recently exacerbated the challenges. [68] 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. [69]

## → Recommendations

1. Eliminate disparities in Medicare and specialty care access, which should be applied equally throughout the island. Ensure equal access to Medicare and Medicaid by eliminating block grants. Improve billing to allow for payment of services through the Ryan White, Medicare, and Medicaid programs.
2. Develop comprehensive HIV care centers that also deliver sexual reproductive care that is inclusive of transgender and gender nonconforming communities' needs.
3. Promote implementation of PrEP and PEP protocols throughout the island with an awareness campaign to decrease stigma and increase use and access. Raise PrEP and PEP awareness via campaigns and messaging directed at medical providers and provide continuing education on preventative treatments and HIV/hepatitis/STIs.

## 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. [70, 71] 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.

Atop 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. NIH need to conduct with broad community engagement a critical review of CDC materials to ensure they are culturally and linguistically appropriate, and make certain they are in-line with the most vulnerable communities. Ensure that their language and messaging resonates with those groups at risk of HIV, viral hepatitis and STIs. NIH need to diversify the research portfolio to understand the Hispanic/Latinx diversity in a comprehensive matter
2. Shifts in the research paradigm to include, retain, and promote Latino HIV/AIDS researchers and to ensure that researchers have the time to build community trust. This will benefit the scientific process, the patients, and communities who await the promise of HIV/AIDS research. Create a virtual infrastructure to share resources and trainings to tackle challenges faced by minority researchers. 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.
3. Train and empower community members to understand research and clinical trials so that they become integral to community and academic research (the community health impact model).



# LEADERSHIP

The Hispanic/Latinx community in the United States and Puerto Rico has a strong legacy of community mobilization, leadership, activism and a strong ability to engage diverse communities. The leaders that are founded in these circles need to be cultivated to create long-term, high-impact change within their communities. The presence of leadership is felt throughout the community. These leaders need access to educational resources, funding of leadership and professional development programs, and mentoring opportunities. A lack of leadership or leadership development can lead to burnout, no succession plan, and loss of momentum that can lead to community losses. These losses can have generational impacts if left unattended.

## → Recommendations

1. Mentoring, coaching and pairing (individuals and community-based organizations).
2. Creation of professional development initiatives and capacity building opportunities that will provide the needed skills to advance agendas and create sustainable organizations. Priority needs to be focused on Hispanic/Latinx to join the healthcare sector (physicians, nurses, physician assistants, nurse practitioners, mental health and substance use professionals, etc.), public health, and academia in research and professional business organizational management in health care.
3. Build social capital to support emerging leaders. Special focus for facilitating inter-generational spaces to strength leadership in the public health.

# ACKNOWLEDGEMENTS

**The National Hispanic/Latinx Health Leadership Network is grateful for all the individuals and entities who contributed to developing this milestone document as a first step to improve the wellness and overall health of our diverse communities.**

This process began with informal discussions in early 2018 among Hispanic/Latinx community leaders about the invisibility and the lack of representation within the decision-making process on critical health care issues. Hispanic/Latinx-led organizations and community leaders came together to strategize how to address the rising cases of HIV, viral hepatitis, STIs and other health conditions affecting Hispanic/Latinx communities. As the burdens of disease and poor health continue to disproportionately impact communities of color, we must organize ourselves and work together to change this injustice in order to achieve the benefits of wellness and good health for all.

We acknowledge our partners who have supported our vision to build the Hispanic/Latinx Health Leadership Network, organize the national health leadership summit in March 2020, and develop the implementation plan for 2020-2024.

**Thank you to Gilead Sciences, ViiV Healthcare, Merck & Co, Broadway Cares/Equity Fights AIDS, Hispanic Federation and AIDS United.**

Please visit [www.hispanicnet.org](http://www.hispanicnet.org) for the full lists of Steering and Planning Committee members, and the March 2020 National Hispanic/Latinx Health Leadership Summit attendees.

Thank you Max Hadler, MPH, MA, Director of Health Policy, New York Immigration Coalition for the final editing of the Health Policy Agenda.

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**March 1966, Dr. Martin Luther King Jr declared: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane”**

# AGENDA NACIONAL DE POLITICAS DE SALUD SOBRE HISPANOS/LATINX 2020-2024

## RESUMEN EJECUTIVO

La Red de Liderazgo en Salud Hispano/Latinx organizó una Cumbre Nacional de Liderazgo en Salud centrada en políticas de salud del 2 al 3 de marzo 2020 en Washington, DC. La Cumbre Nacional de Política de Salud fue el producto de dos años de trabajo para organizar las experiencias, ideas y voluntades de líderes Hispanos/Latinx de Estados Unidos y sus territorios, incluido Puerto Rico, para:

1. Fortalecer la Red de Liderazgo en Salud Hispano/Latino
2. Concluir y alcanzar consenso en la Cumbre sobre la Agenda Nacional de Políticas de Salud Hispana/Latina 2020-2024. Posteriormente apoyar el establecimiento de agendas de salud a nivel Estatal, condados y ciudades en Estados Unidos y sus territorios.

**El objetivo general es mejorar los resultados de salud de las minorías que viven en los EE. UU y garantizar la participación e inclusión de hispanos/latinos para borrar las disparidades de salud en nuestra nación.**

Las necesidades de salud de Hispanos/Latinx son en gran medida invisibles y, a menudo, pasan por alto en muchas agendas de salud pública en nuestra nación. El establecimiento de salud pública ha respondido a las epidemias del virus de inmunodeficiencia humana (VIH), la hepatitis viral y las infecciones de transmisión sexual (ITS) y la pandemia actual de COVID-19 sin considerar las disparidades estructurales, incluidas las necesidades culturales y lingüísticas de los hispanos (tanto los nacidos en los EE. UU. y nacidos en el extranjero). Los Hispanos/Latinx se ven afectados de manera desproporcionada por las malas condiciones de la vida cotidiana, moldeadas por factores estructurales y de posición social (como la macroeconomía, los valores culturales, los ingresos, la educación, la ocupación y los sistemas de apoyo social, incluidos los servicios de salud),



conocidos como determinantes sociales de la salud (SDH por sus siglas en Ingles). Los SDH generan efectos sobre la salud para todas las personas. Las comunidades Hispanas/Latinx afectadas por el VIH, la hepatitis viral y las ITS, dejan fuera, aspectos cultural y lingüísticamente, de los programas de prevención, tratamiento y acceso a la atención en nuestra nación. Esta situación crea una necesidad urgente para desarrollar estrategias culturalmente competentes para asegurar la participación, vinculación y retención en los servicios sociales y médicos en nuestra nación.

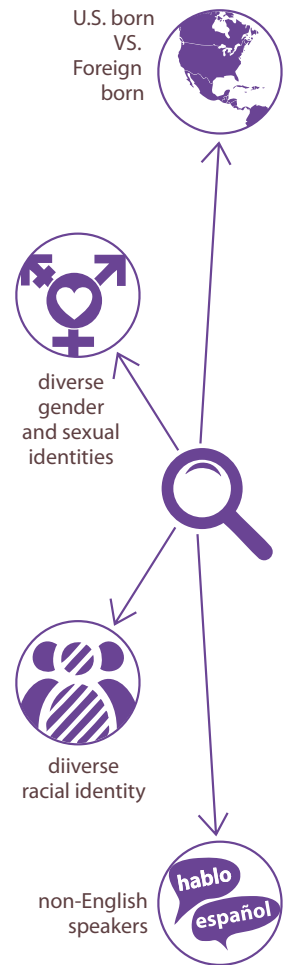
La diversidad y heterogeneidad racial, cultural y lingüística son factores importantes para comprender las comunidades Hispanas/Latinx en los EE. UU. La diversidad de esta población debe considerarse en la implementación actual de un enfoque estandarizado para abordar los impactos del VIH, la hepatitis viral y las ITS en el área de prevención y tratamiento. Como resultado, necesitamos crear enfoques integrales y holísticos para llegar a las diversas poblaciones hispanas en áreas urbanas, suburbanas y rurales, teniendo en cuenta a los hispanos nacidos en Estados Unidos ya los nacidos en el extranjero, las diversas identidades sexuales y de género, las identidades raciales que incluyen Negros y Afrolatinos, blancos/latinos europeos, nativos e indígenas, asiáticos y otras poblaciones de experiencia Hispana/Latinx. Los enfoques también deben tener en cuenta las comunidades que no entienden inglés y que no entienden español que incluyan poblaciones que hablan portugués y muchas lenguas o dialectos indígenas.

Los Hispanos/Latinx representan la población minoritaria y étnica de más rápido crecimiento en la nación actualmente, así como la población que envejece más rápido en los EE. UU. Los latinos mayores tienen un mayor riesgo de infección de VIH en comparación con sus contrapartes blancos no Hispanos. En 2017, según los datos de Vigilancia de indicadores de salud de los CDC, los Hispanos/Latinx de 50 a 54 años tenían una tasa de infección de casos de VIH diagnosticada de infección más del doble de la tasa de los blancos no Hispanos en el mismo grupo de edad. Por lo tanto, existe una necesidad crítica de examinar la salud sexual y la atención de la salud en general de una población que a menudo se olvida.

Los esfuerzos nacionales, a través de la Red de Liderazgo, formularon recomendaciones para abordar las enfermedades infecciosas; Estos esfuerzos deben realizar inversiones enfocadas en cuatro áreas prioritarias recomendadas:

1. Reducción del estigma social entre los proveedores de servicios de salud y de servicios sociales múltiples
2. Disponibilidad y accesibilidad de los servicios de prevención y atención de la salud
3. Desarrollo de intervenciones conductuales adaptadas a la diversidad de la población hispana centradas en la prevención, el tratamiento y el acceso a la atención de servicios.
4. Mayor participación de los líderes comunitarios hispanos/latinos que centran su trabajo en retos relacionados con la salud que afectan las disparidades en los resultados de salud.

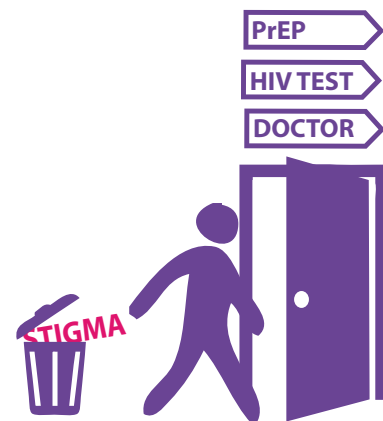
Las recomendaciones contenidas en este documento se desarrollaron a lo largo de dos años. Organizadores y activistas comunitarios, líderes de organizaciones de diversas comunidades y organizaciones Hispanas/Latinx aportaron su experiencia y sus voces



en la formulación a las recomendaciones y procesos como miembros de la Red Nacional de Salud Hispana/Latinx.

Los comités timón y de planificación de la Cumbre Nacional de Liderazgo en Salud Hispanos/ Latinos convocaron grupos de trabajo encargados de articular sus perspectivas sobre temas nacionales, analizar desafíos y brindar recomendaciones sobre los siguientes temas nacionales:

1. Prevención
2. Acceso a la atención médica
3. Investigación y colección de datos de salud
4. El sur de los EE. UU.
5. Puerto Rico
6. Estigma
7. El plan Federal para derrotar la epidemia del VIH 2030
8. Inmigración y migración
9. Salud mental
10. Uso de sustancias
11. Liderazgo en salud



Podemos cambiar la trayectoria de muchos retos de salud que afectan a nuestras comunidades. En el caso de la epidemia del VIH en los EE. UU., podemos establecer, monitorear y cumplir con las metas ambiciosas del plan para derrotar la epidemia del VIH 2030. Para lograrlo, debemos aumentar significativamente el acceso a herramientas biomédicas para los Hispanos/Latinx que son VIH negativos; mejorar las pruebas de detección, la atención y el acceso al tratamiento, disminuir los impactos del estigma social y tomar acciones concretas para garantizar que ningún miembro de la población Hispana/Latinx o regiones geográficas en particular se quede atrás.

También debemos ampliar de inmediato todas las herramientas de tratamiento y prevención disponibles para lograr los impactos necesarios en respuesta a la epidemia. Si no se actúa con rapidez a la escala requerida, en todas las comunidades y poblaciones afectadas, se producirán más transmisiones del VIH, mayor morbilidad y mortalidad relacionadas con el VIH, continuas desigualdades en el acceso a la salud y mayores costos relacionados con la atención médica.

A través del esfuerzo conjunto de las comunidades, la industria en salud y todos los niveles de gobierno, podemos aprovechar el progreso logrado durante las últimas tres décadas para lograr este objetivo, antes impensable. Esta agenda de salud contribuirá activamente a reducir drásticamente las nuevas infecciones por el VIH, mejorar la duración y la calidad de vida de las personas que viven con el VIH y abordar de manera eficaz las crisis relacionadas de opioides, hepatitis virales, ITS y tuberculosis. Al hacerlo, esta agenda de salud reducirá drásticamente los costos en vidas y el gasto global en atención médica.

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