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Community Health Worker Approach for Ending the HIV Epidemic

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Editorial

In the second half of 2019, East Baton Rouge Parish, Louisiana was selected as 1 of the 3 jump-start pilot jurisdictions for the Centers for Disease Control and Prevention–funded ending the HIV Epidemic in the U.S. Initiative. An innovative community health worker program was among the strategies developed to reduce the number of new HIV infections. In addition to testing for HIV/sexually transmitted infections in non-traditional settings, community health workers provided integrated services, including linkage for people with HIV, pre-exposure prophylaxis navigation, sterile injection supplies and referrals to syringe services programs, and other social services. The 5-member community health worker team was representative of the populations they intended to reach. They conducted outreach, from October 2019 to December 2020, within areas known to have a high incidence of new HIV infections.

The community health worker team documented 977 encounters with individuals in their communities. The vast majority of encounters were among Black clients; 9% were among White clients. In total, 48% were among cisgender women, 50% were among cisgender men, and 2% were among transgender women. People who inject drugs represented 7% of the sample. Community health workers conducted rapid testing for HIV (n=320), hepatitis C (n=274), and syphilis (n=280). In addition, they successfully linked 10 people with HIV to HIV medical care and 20 people who inject drugs to a syringe services program and assisted 19 people at risk of HIV infection with pre-exposure prophylaxis initiation. The community health worker team successfully facilitated access to HIV prevention and treatment for priority populations in East Baton Rouge Parish.

The Centers for Disease Control and Prevention estimates that 1.2 million people are living with HIV in the U.S. Approximately 15% of those individuals are unaware of their status, and 54% have not reached viral suppression. The Southern region of the U.S. bears a disproportionate burden of this, with approximately 50% of new HIV diagnoses. In 2017, Louisiana ranked fourth in the nation for HIV case rates. The Baton Rouge Metropolitan Statistical Area ranked third for HIV case rates among Metropolitan Statistical Areas nationwide. In addition to geographic disparities of HIV, specific populations are disproportionately impacted and should be prioritized for prevention efforts; in Louisiana, priority populations include gay, bisexual, and other men who have sex with men; Black women; and people who inject drugs (PWID).

In 2018, a total of 60% of all new HIV diagnoses in Louisiana were among gay, bisexual, and other men who have sex with men; the majority were Black (68%) and aged <35 years (69%). Black men comprise 15% of Louisiana's population but accounted for 52% of all new HIV diagnoses. Diagnosis rates have declined among Black women over the past 10 years but remain 7.2 times higher than the rate for White women. In the case of PWID, who make up 14% of people with HIV in Louisiana,3 priorities include expanding access to harm reduction education, supplies, and services.

Although these populations have been highlighted for intervention, these groups are often the most vulnerable and are among the most medically underserved. For example, there are many structural barriers to accessing typical health services, including transportation, child care, and basic needs such as food and housing. Other barriers to care include distrust of health systems and providers as well as persistent homophobia and stigma associated with HIV/AIDS and drug use, which can both impact quality of care as well as the probability of seeking care. As such, it is vital to utilize interventions that emphasize a comprehensive approach to understanding and addressing clients' immediate needs with a focus on both facilitating access as well as tailoring services with cultural humility.

Often, HIV prevention interventions focus on individual behaviour change rather than on structural, environmental change. However, one exception is street-based outreach, which has used outreach workers for HIV prevention efforts for >20 years. This type of community-based outreach has been shown to increase access to HIV testing and to reduce HIV risk behaviour, particularly in underserved populations. However, during the past several decades, there has been a shift in the focus of these types of HIV outreach activities to be specifically directed to recruitment for HIV testing. However, outside of the HIV prevention community there has been increasing attention to the use of Community Health Workers (CHWs), who have similar but expanded roles and functions for health promotion, particularly among underserved populations.

The American Public Health Association describes CHWs as "frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served." CHWs work with people who share similar backgrounds and life experiences to establish trusting relationships with individuals and their communities. Through those relationships, CHWs serve as a critical link between marginalized populations and healthcare resources. By effectively engaging medically underserved communities, CHWs contribute to improved health outcomes and reductions in health disparities. The stigma and fear associated with HIV infection and pervasive mistrust of the healthcare system are also diminished by the earned credibility of CHWs, who often may be members of the prioritized populations themselves. This contributes to the increased uptake of effective HIV prevention and treatment interventions.

In 2019, HHS launched ending the HIV Epidemic: A Plan for America.14 The rationale behind this endeavour is that scientific advances along the 4 pillars of Diagnose, Treat, Prevent, and Respond have made the goal of ending the HIV Epidemic possible. This initiative encourages jurisdictions to implement innovative and locally tailored interventions to reduce new HIV infections by 90% by 2030. However, as outlined earlier, the challenge remains that some communities are not easily reached by traditional interventions that require clients to travel to offices where services are provided. CHWs can serve as a critical link between members of those populations and the HIV continuum of care.

As part of the launch of the ending the HIV Epidemic in the U.S. Initiative, East Baton Rouge (EBR) Parish was selected from among the initial 57 jurisdictions as 1 of the 3 jump-start sites to implement "key foundational activities to accelerate progress toward ending the HIV epidemic in their communities."15 One program that was developed because of this funding opportunity was a locally tailored CHW program. The CHW intervention spanned the Diagnose, Treat, and Prevent pillars of the Ending the HIV Epidemic in the

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U.S. strategy. Diagnose activities included educating people on the importance of knowing their HIV status, screening for HIV risk, conducting rapid HIV tests, and distributing self-test kits. Activities in the Treat pillar included rapid linkage to care for people with newly diagnosed HIV and re-engagement for people living with HIV who are out of care. Finally, Prevent activities provided education, home health parties, community awareness events, pre-exposure prophylaxis (PrEP) promotion, condom distribution, sterile injecting supplies, and navigation to syringe services programs (SSPs).

The goal of the CHW intervention was to ensure that all individuals are aware of their HIV status, screened for other sexually transmitted infections (STIs), and linked to care and services when appropriate. HIV testing was conducted during street-based outreach using OraQuick, in-home HIV test kits, or the client would make an appointment to get tested at the CHW's office where a standard HIV rapid test was used according to state testing protocols.

During planned outreach events, CHWs engaged individuals who were unaware of their HIV status, people with HIV who were out of care, gay and bisexual men of colour, people who are transgender or gender nonconforming, Black women, and other community members. The CHW team wore uniforms during all community engagement, specifically polo shirts with an emblem that identifies them as a CHW with the Louisiana Department of Health as well as State identification badges so that they could be identified by the community as a helper. When not conducting recruitment events, staffs were located and reachable at the EBR Parish Health Unit, which is geographically located within an area of Baton Rouge with the highest incidence of new HIV infections.

Ultimately, the purpose of this pilot intervention was to reach vulnerable populations who would have otherwise not accessed HIV testing or prevention and treatment services that typically require clients to travel to medical facilities where services are provided. This paper describes the protocols for this holistic CHW approach as well as the results of the pilot demonstration, including the demographics of the clients served and the services provided, as implemented in EBR Parish, Louisiana.

The initial team consisted of 5 individuals (1 Lead CHW and 4 CHW team members) who were known to and considered members of the prioritized communities. CHWs represented the lesbian, gay, bisexual, transgender, and queer community; people with HIV; PWID; PrEP users; Black women; and heterosexuals at higher risk for HIV. Most team members had a high-school diploma or were concurrently pursuing secondary education, whereas the Lead CHW had a master's degree and was an active member of the Louisiana CHW Workforce Coalition. Each team member had a specialized skill set or specialized knowledge to engage prioritized populations. For instance, if a team member was taking PrEP, that individual would be the lead person to engage individuals regarding PrEP knowledge and uptake. However, this did not negate other members from engaging the community with PrEP referrals and information. The team was supervised by the Lead CHW and by the Prevention Unit Manager at the STD/HIV/Hepatitis Program.

Basic knowledge of HIV, STIs, and hepatitis C was required for CHWs on hiring. In addition, all team members were trained, state-certified HIV Counselors having completed Louisiana's comprehensive, 3-day HIV/STI Prevention Counseling and HIV Rapid Testing training. In addition, CHWs consistently engaged in trainings through webinars on PrEP access, community engagement, holistic referrals, and other topics that are relevant to their work. Knowledge of a broad range of HIV prevention topics allowed them to effectively educate clients whenever the opportunity arose.

The CHWs and HIV prevention staff conducted a series of community mapping exercises for EBR ZIP codes with an eye toward social determinants of health and high rates of new and existing HIV and STI infections. Before prioritizing a geographic area for outreach, the team visited each site ≥3 different times and on different days of the week to determine which location(s) would be most productive. After this preparation took place, then the team identified traditional and non-traditional community settings such as apartment complexes, shooting galleries for injection behaviour, neighbourhood storefronts, gas stations, libraries, churches, community events, and other areas where priority populations congregate within prioritized ZIP codes. The CHW team also drew on their personal experience as well as the knowledge of community gatekeepers and stakeholders to identify the venues and areas in priority communities where they could conduct outreach, including venues where community members congregate, health clinics, recreational facilities, social services, commercial businesses, police departments, and other community resources.

Potential gatekeepers and business owners were approached for permission to provide information and resources to their customers and, if needed, to set up informational tables or identify a space near the business to conduct HIV testing. In addition, the team reached out to the local police department in each community to inform them of the CHW team's presence and role and request collaboration and support. Approximately 24 target areas were identified as both appropriate and accessible (i.e., safety acceptable, permissions secured) [1-5].

Conflict of Interest

None.

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