

*Patient Engagement Learning Series*

# Engaging Communities to End HIV

Thursday, March 4, 2021 at 2:00 pm ET



**NATIONAL  
NURSE-LED CARE  
CONSORTIUM**  
a PHMC affiliate

# Disclaimer

*Through the Patient Engagement Learning Series, we intend to create a space where providers, community advocates, and patient representatives can engage thoughtfully on challenging topics surrounding patient care. We commit to providing evidence-based data and research to support all content presented.*

*We believe that addressing this topic aligns with the aims of the Learning Series and is therefore integral to our discussion. We welcome your feedback to continue guiding our content development.*

*Funding for this webinar has been provided to the National Nurse-Led Care Consortium through the Patient-Centered Outcomes Research Institute (PCORI) Contract Number 14507. Contents are solely the responsibility of the authors and do not necessarily represent the official views of PCORI.*

# National Nurse-Led Care Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care and public health nursing.

- Policy research and advocacy
- Program development and management
- Technical assistance and support
- Direct, nurse-led healthcare services

# Speakers



**Bridgette Brawner, PhD, MDiv, APRN**  
Associate Professor  
University of Pennsylvania School of Nursing



**Joselle Palacios, BSN, RN**  
Public Health Nurse Home Visitor  
Philadelphia Nurse-Family Partnership



**Ivy Clark**  
NNCC Board Member, Patient Representative  
Public Health Management Corporation

# Objectives

- Participants will identify strategies to better integrate care for individuals experiencing disparities in HIV care.
- Participants will explore ways that social systems can drive disparities in HIV treatment and access.
- Participants will understand the differing roles in community-based research.

# Panel Discussion



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# Pop Up Question

**What strategies have you engaged in around HIV prevention?  
Are you familiar with any specific programs, organizations,  
and/or initiatives?**



# Engaging Communities to End HIV

Bridgette M. Brawner, PhD, MDiv, APRN  
Associate Professor of Nursing  
Department of Family and Community Health  
University of Pennsylvania School of Nursing  
**Twitter: @DrBMBrawner**

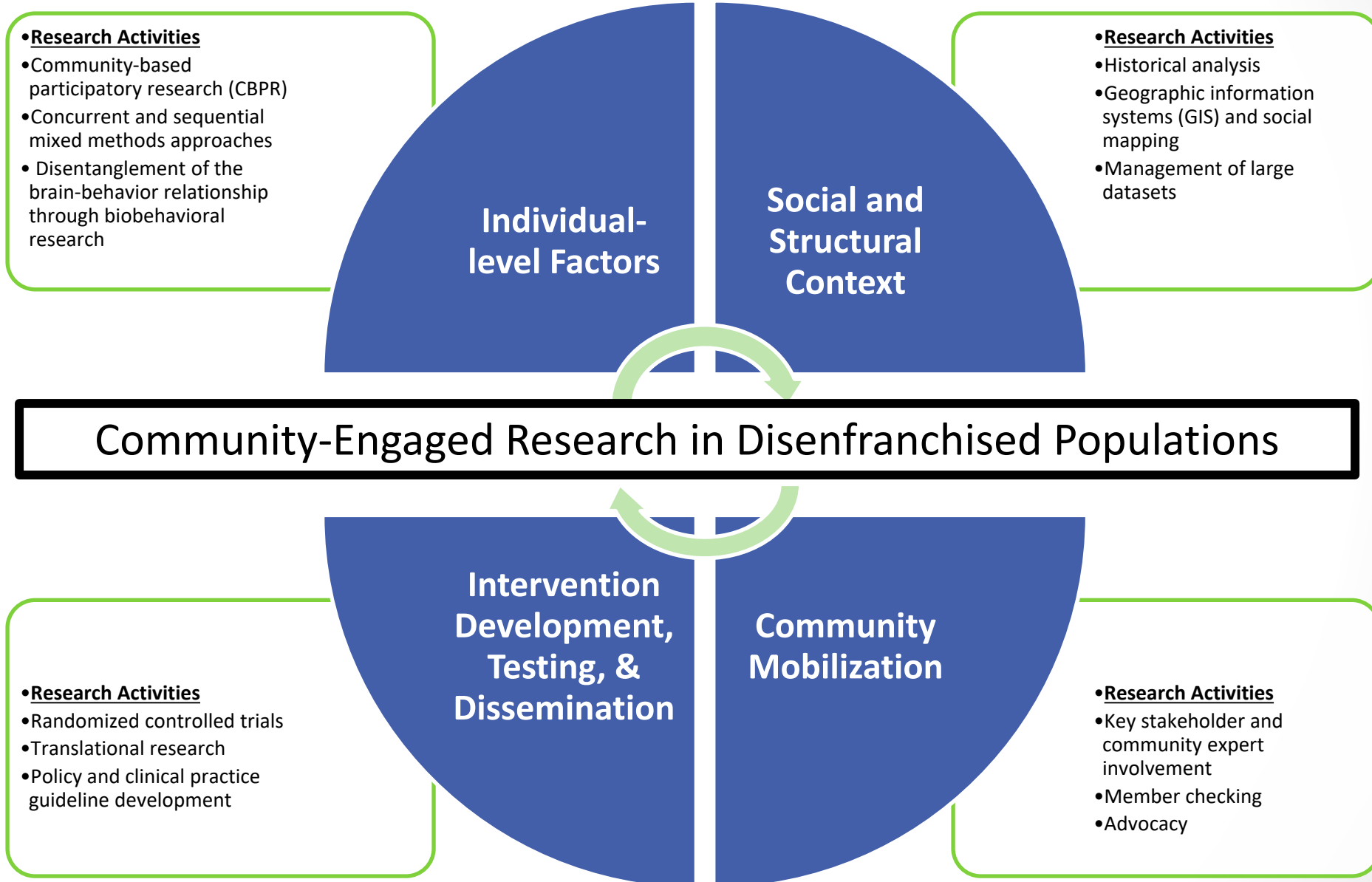




The “canary in the coal mine”



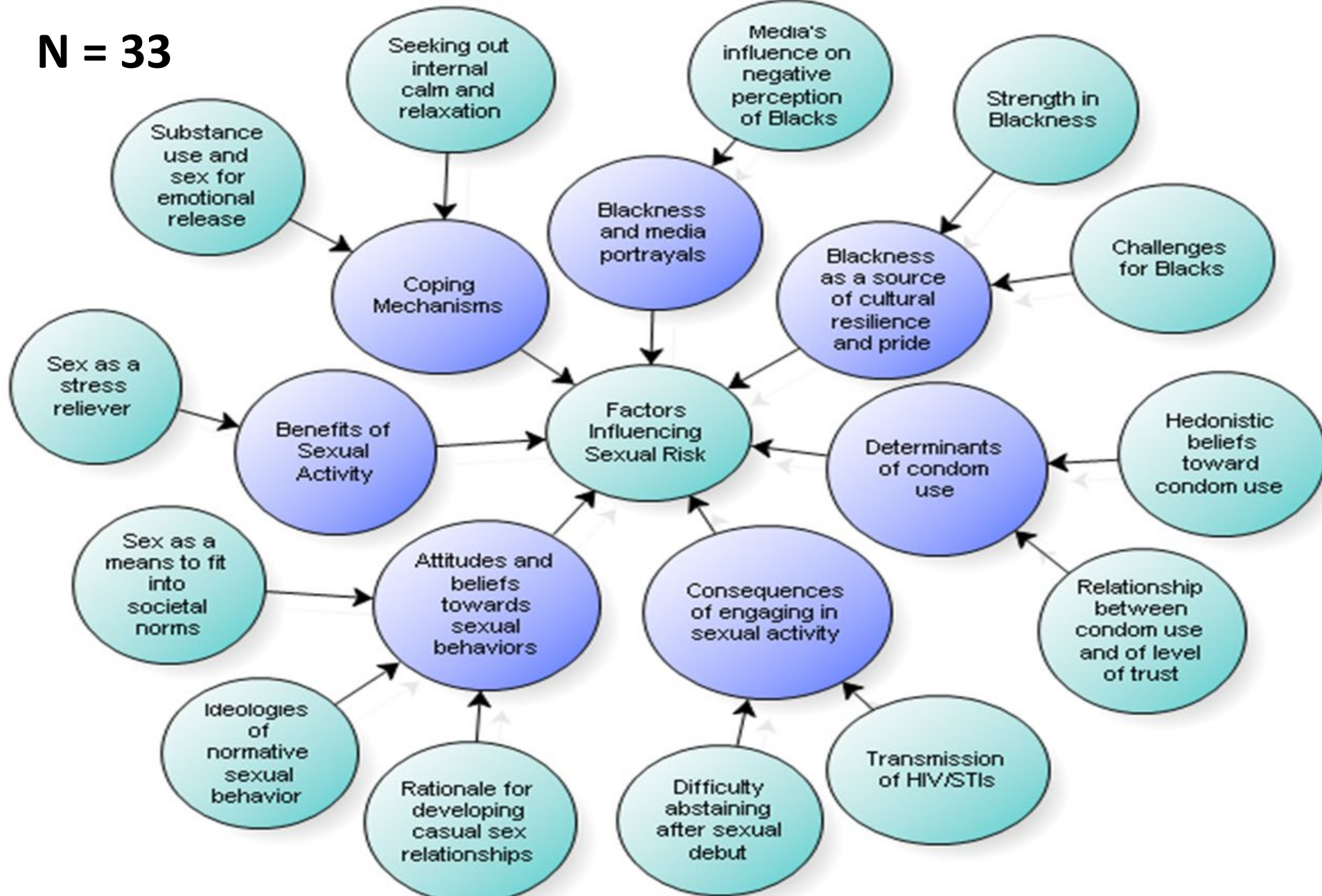
# My Research Ethic



# Overview of Findings



N = 33



Brawner, B. M., Jemmott, L. S., Wingood, G., Reason, J., & Mack, N. (2018). HIV/STI prevention among heterosexually active Black adolescents with mental illnesses: Focus group findings for intervention development. *Journal of the Association of Nurses in AIDS Care*, 29(1), 30-44. doi:10.1016/j.jana.2017.09.008

# Survey Results (N = 53)

- Reports of sexual partner concurrency were high—both while already in a sexual relationship (67.3%) and multiple sexual partners in the same day (42.3%)
- Sadness dysregulation predicted currently being in a relationship, older age at first oral sex, fewer vaginal sexual partners and fewer unprotected oral sexual encounters
- Coping difficulties predicted a greater number of vaginal and oral sexual partners, and a lower age at first vaginal sex
- Increasing depression severity was related to older age at first vaginal sex, fewer vaginal sexual partners and fewer unprotected oral sexual encounters in the past 3 months

# Wait...what?

- Anger and sadness **cop**ing were significantly associated with several sexual **ri**sks behaviors
- At first glance, this finding appears to contradict what would normally be expected (e.g., those with more adaptive methods of emotion management should have fewer risk behaviors)
- Consideration of **sexual behavior as the adaptive coping method** sheds insight on the interpretation





***"WE ARE KINGS AND QUEENS"***

Brawner, B. M., Abboud, S., Reason, J., Wingood, G., Jemmott, L. S. (2019). The development of an innovative, theory-driven, psychoeducational HIV/STI prevention intervention for heterosexually active black adolescents with mental illnesses. *Vulnerable Children and Youth Studies*, 14(2), 151-165. doi: 10.1080/17450128.2019.1567962

Brawner, B. M., Jemmott, L. S., Wingood, G., Lozano, A. J., & Hanlon, A. (2019). Project GOLD: A pilot randomized controlled trial of a novel psychoeducational HIV/STI prevention intervention for heterosexually-active Black youth. *Research in Nursing & Health*, 42(1), 8-28. doi: 10.1002/nur.21930



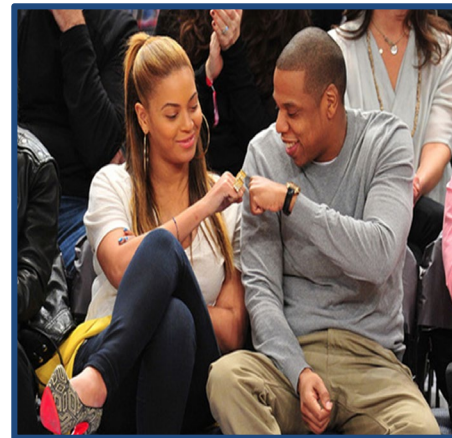
# Making Royal Decisions about Sex

Consistent Condom  
Use

Abstinence



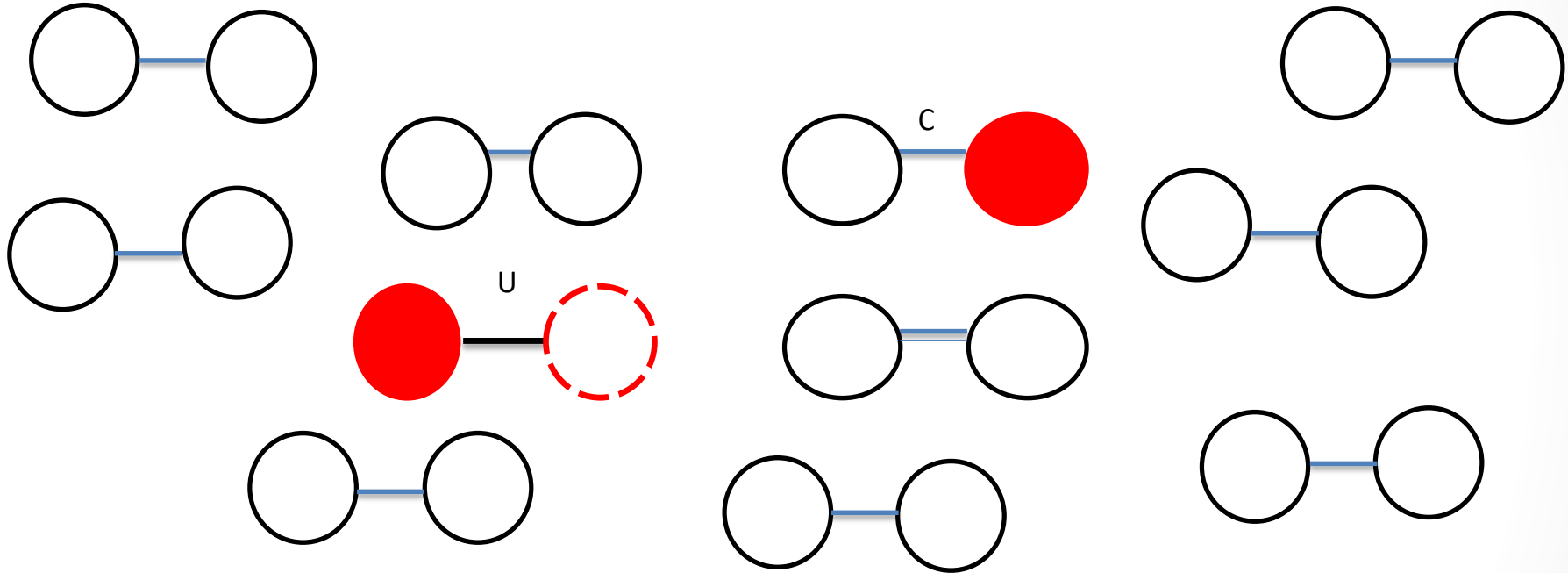
Limiting the  
Number of  
Sexual  
Partners








Getting Tested  
for HIV and  
STIs Every 3  
to 6 Months

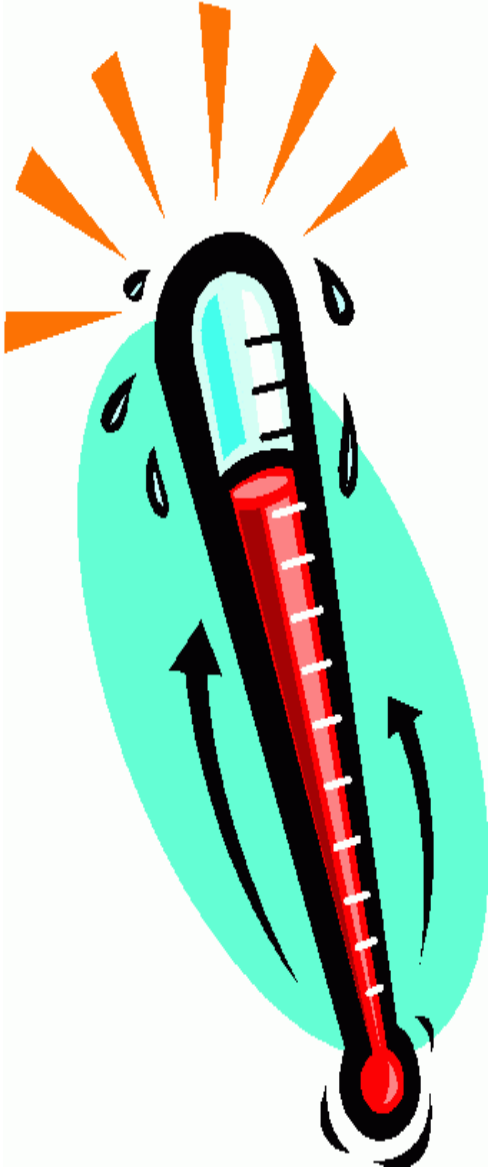


# HIV/STI Risk in Single Sexual Partnerships



KEY			
	Infected		Unprotected Sex
	Potentially Infected		Consistent Condom Use
	Not infected		

## Being My Own Thermometer:



- 1. Know your triggers/things that make your emotions escalate**
- 2. Stop, think, and recognize the emotion**
- 3. Do something positive to control the emotion (e.g., write a letter, exercise, talk to a trusted friend or adult, or walk away)**

# Results from Project GOLD Pilot RCT (N = 108)

HIV condition participants had:

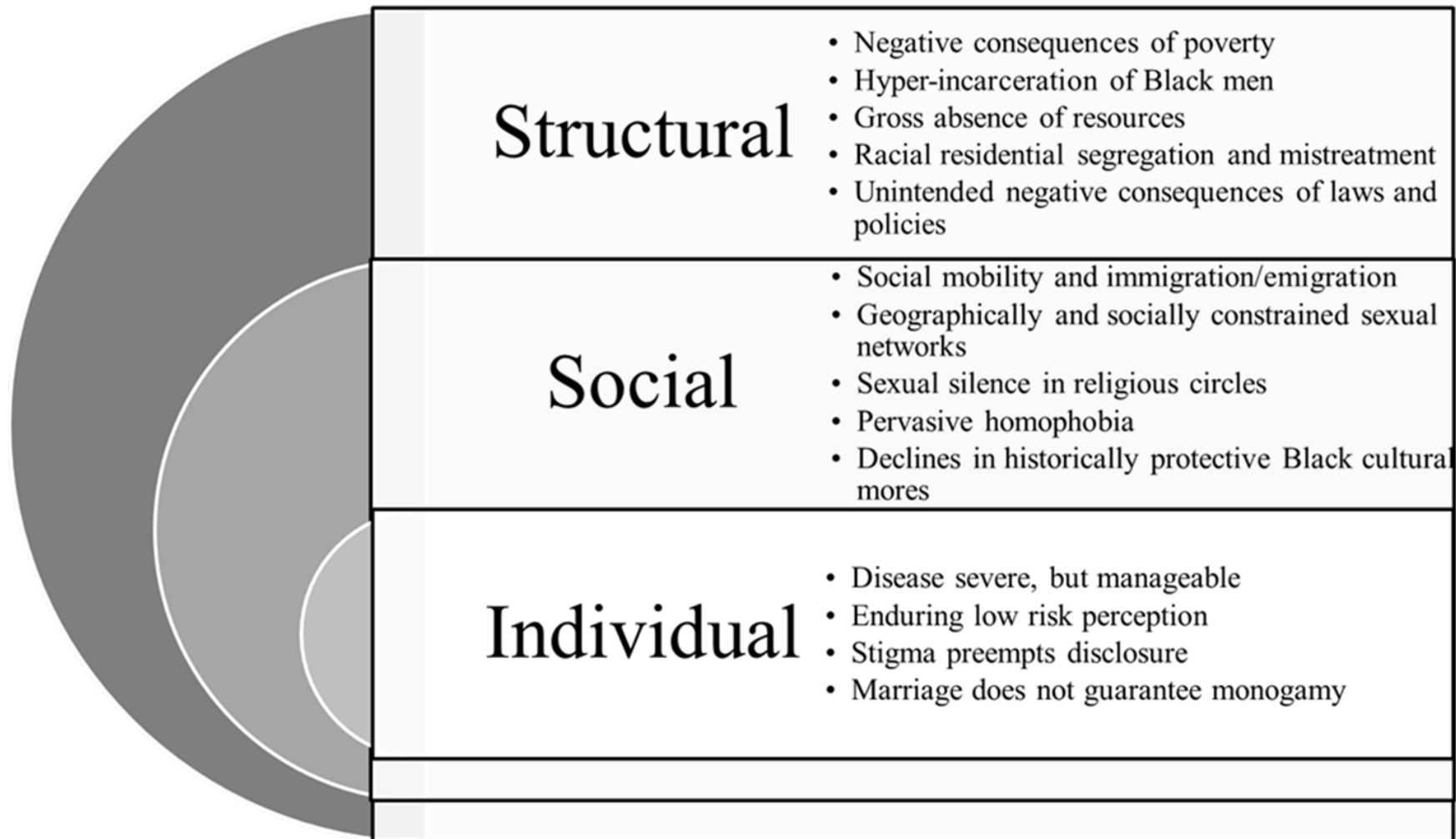
- An increased proportion of condom use for vaginal sex at 3 months (77% vs. 64%,  $M\Delta = 0.21$  vs.  $-0.02$ ,  $p = 0.20$ ,  $\eta^2 = 0.06$ )
- Fewer sexual partners at 6 months ( $M = 1$  vs.  $1.67$ ,  $M\Delta = -0.54$  vs.  $-0.57$ ,  $p = 0.24$ ,  $\eta^2 = 0.05$ )
- Less same day sexual partner concurrency at 6 months (6% vs. 33%,  $p = 0.08$ ,  $V = 0.41$ )
- Increased anger coping at 6 months ( $M = 2.47$  vs.  $2.24$ ,  $M\Delta = 0.28$  vs.  $0.06$ ,  $p = 0.15$ ,  $\eta^2 = 0.06$ )
- Change in mediators (e.g., increased condom use negotiation beliefs) sustained at 12 months
- Lower depressive symptom severity at immediate post ( $M = 2.19$  vs.  $2.80$ ,  $M\Delta = -1.06$  vs.  $0.10$ ,  $p = 0.01$ ,  $\eta^2 = 0.07$ ) and 3 months ( $M = 2.82$  vs.  $4.24$ ,  $M\Delta = -0.37$  vs.  $1.42$ ,  $p = 0.048$ ,  $\eta^2 = 0.06$ )

# *Geography = Destiny?*





# Perspectives among administrators, direct service providers and community members



# Geobehavioral Vulnerability to HIV

“...it is not just *what* you do, but also *where* you do it, and *with whom*, that increases your risk of HIV infection.”





# Communities

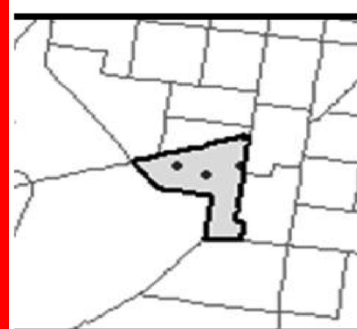
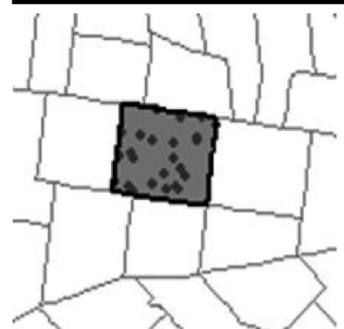
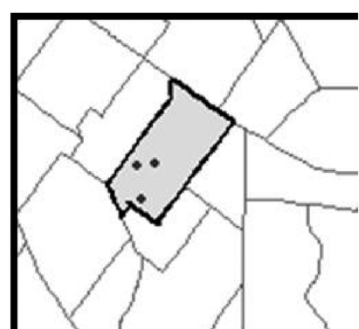
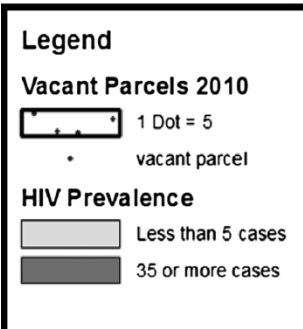
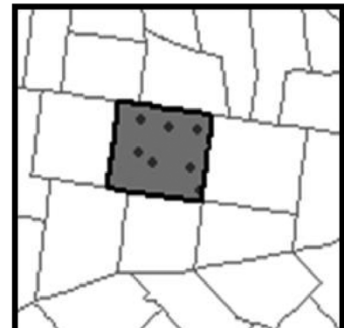
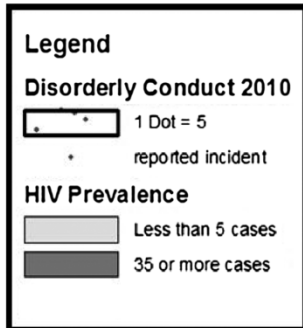
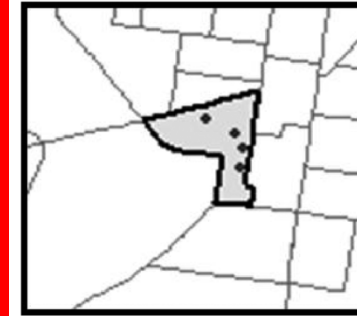
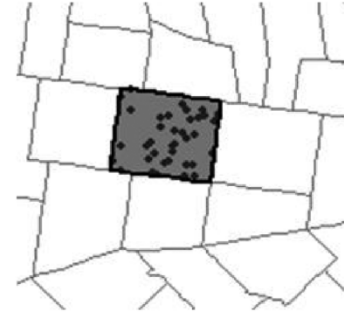
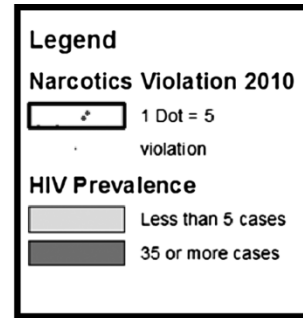
Characteristic

A

B

C

D

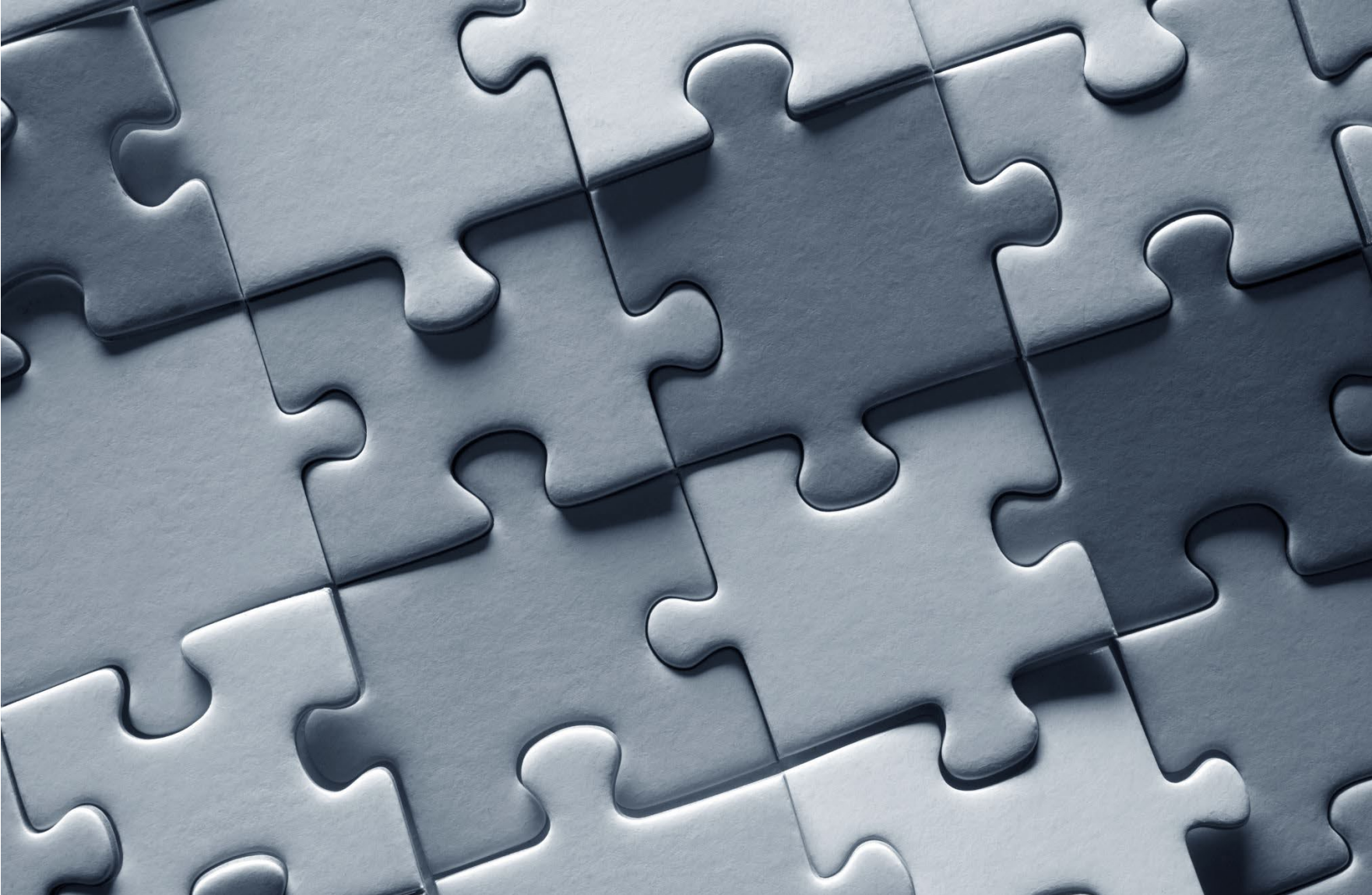


Brawner, B.M., Reason, J. L., Goodman, B. A., Schensul, J. J. & Guthrie, B. (2015). Multilevel drivers of human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS): Exploration using community ethnography and geographic information systems. *Nursing Research*, 64(2), 100–110. doi: 10.1097/NNR.0000000000000076

## Place Still Matters (N = 319; 4 Census Tracts)

- Compared to the predominantly White high HIV prevalence tract, both the predominantly Black high and low HIV prevalence tracts had greater odds of transmission via injection drug use and heterosexual contact than male-to-male sexual contact
- Black people were seven times more likely than white people to have heterosexual versus male-to-male sexual contact
- Those who had Medicaid or were uninsured (versus private insurance) were 23 and 14 times more likely, respectively, to have injection drug use than male-to-male sexual contact and 10 times more likely to have heterosexual contact than male-to-male sexual contact.

Brawner, B. M., Guthrie, B., Stevens, R., Taylor, L., Eberhart, M. & Schensul, J. J. (2017). Place still matters: Racial/ethnic and geographic disparities in HIV transmission and disease burden. *Journal of Urban Health*, 94(5), 716-729. doi: 10.1007/s11524-017-0198-2



**How can you get involved?**



# Individual-level

- Group-level interventions in nontraditional settings (e.g., shelters)
- Personalized interventions tailored to address individual risk profiles—incorporating care providers, community health workers and others
- Engage hidden, traditionally underserved populations in HIV prevention programming (e.g., youth with mental illnesses and older adults)
- Intergenerational approach to prevention services

# Social-level

- Residence and block-level campaigns
  - Some may not feel tied to the “neighborhood”, but their more immediate surroundings
- Work to restore social cohesion, mutual accountability and respect, and collective efficacy and engagement
- Promote gender equity and cultural pride
- Engage relevant social institutions (at their level of comfort)
- Infuse resources into communities to improve social life



# Structural-level

- Work to redress historically inequitable practices which have concentrated disadvantage in certain areas (e.g., mortgage redlining)
- Advocate to reform unjust laws and policies
- Deliver novel interventions such as microfinance programs in impoverished communities and post-release support structures for incarcerated populations and their families
- Create more positive media messages—and hold current systems accountable for detrimental portrayals and messages
- Better use existing structures (e.g., repurpose abandoned buildings)



Thank you!

Community



Twitter: @DrBMBrawner

# Pop Up Question

**In what ways have you engaged in community-based research?**

# Discussion



# Thank you

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