

Alarm at the Gate—Health and Social Inequalities are Comorbid Conditions of HIV and COVID-19

Orlando O. Harris, PhD, RN, MPH, FNP* • Natalie Leblanc, PhD, MPH, RN •
 Kara McGee, DMS, MSPH, PA-C, AAHIVS • Schenita Randolph, PhD, MPH, RN, CNE •
 Mitchell J. Wharton, PhD, RN, FNP-BC, CNS • Michael Relf, PhD, RN, AACRN, ANEF, FAAN

Framing the Issue

As we are all aware, the 21st century is an era of information, especially digital information. As such, we constantly live with information explosion, maybe even overload. As the coronavirus disease 2019 (COVID-19) pandemic unfolded in the United States, there was a plethora of information intended to heighten awareness in the general population about the domestic epidemic. As with any unfolding situation, from a weather event, natural disaster, or act of terrorism to an infectious disease, such as COVID-19, it is essential for the tenets of risk communication to be followed.

“Risk communication is an interactive process used in talking or writing about topics that cause concern about health, safety, security, or the environment” (Persensky et al., 2001, p. 1). Risk communication is an essential interaction between risk analysis, risk management, and the public (Campbell & Babrow, 2004). As we have seen throughout the domestic COVID-19 epidemic, messages from different leaders of government have contradicted COVID-19 taskforce leaders, have minimized the risk and overlooked the populations being affected disproportionately, have been culturally misguided, and have sparked confusion.

Early in the emerging domestic epidemic, the U.S. government warned that older persons, persons with

high blood pressure and obesity, and persons with other chronic diseases were at higher risk for severe illness (Centers for Disease Control and Prevention [CDC], 15 April 2020). This early messaging was a form of risk communication intended to clarify who was most at risk for severe illness and death. In the major U.S. cities experiencing significant and early surges associated with COVID-19, we witnessed significant inequities in severe illness and death. Although states reported Black and African Americans comprised 13% of the COVID-19-related cases by race and ethnicity, Black and African Americans experienced approximately 35% of the deaths. In New York, Black, African American, and Latinx populations have died at twice the rate of the White population (Elving, 2020). In Chicago, Black and African American individuals have comprised more than 70% of the COVID-19-related deaths (Elving, 2020; Webb Hooper et al., 2020), despite comprising approximately 30% of the city’s population (U.S. Census Bureau, 2019). In addition, the Navajo reservation—encompassing parts of Arizona, New Mexico, and Utah—is considered the Nation’s third hot spot of the domestic COVID-19 epidemic behind New York and New Jersey (Mineo, 2020).

On April 4, 2020, the CDC identified the risk factors for COVID-19 to include “age, race/ethnicity, gender, some medical conditions, use of certain medications, poverty and crowding, certain occupations, and pregnancy” (CDC, 23 April 2020). Curiously, the CDC lists “race/ethnicity” as a risk factor. Is there a biologic factor increasing or decreasing the risk of COVID-19 for some racial and ethnic groups? Maybe in time, scientists will discover a genotypic variation that places one racial or ethnic group at higher risk or lower risk, but we do not know that today.

According to the World Health Organization, the social determinants of health (SDOH) are “the conditions in which people are born, grow, live, work and age” (WHO, 2011). The SDOH are influential factors linked to health outcomes and help provide insights on observed health inequities.

Sponsorships or competing interests that may be relevant to content are disclosed at the end of this article.

Orlando O. Harris, PhD, RN, MPH, FNP, is an Assistant Professor, Department of Community Health Systems, School of Nursing, University of California, San Francisco, San Francisco, California, USA. Natalie Leblanc, PhD, MPH, RN, is an Assistant Professor, HIV Prevention Science, School of Nursing, University of Rochester, Rochester, New York, USA. Kara McGee, DMS, MSPH, PA-C, AAHIVS, is an Instructor, School of Nursing, Duke University, Durham, North Carolina, USA. Schenita Randolph, PhD, MPH, RN, CNE, is an Assistant Professor, School of Nursing, Duke University, Durham, North Carolina, USA. Mitchell J. Wharton, PhD, RN, FNP-BC, CNS, is an Assistant Professor of Clinical Nursing, School of Nursing, University of Rochester, Rochester, New York, USA. Michael Relf, PhD, RN, AACRN, ANEF, FAAN, is an Associate Dean for Global and Community Health Affairs, School of Nursing, and Professor, Duke Global Health Institute, Duke University, and Editor-in-Chief, JANAC, Durham, North Carolina, USA.

*Corresponding author: Orlando O. Harris, e-mail: Orlando.Harris@ucsf.edu

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<http://dx.doi.org/10.1097/JNC.000000000000190>

For example, poor health or lack of education can affect employment opportunities, which in turn constrain income. Low income reduces access to health care and nutritious food and increases hardship. Hardship causes stress, which in turn promotes unhealthy coping mechanisms such as substance abuse and overeating of unhealthy foods. (NEJM Catalyst, 2017, p. 1)

Thus, the “social determinants of health are an underlying cause of today’s major societal health dilemmas, including obesity, heart disease, diabetes, and depression” (NEJM Catalyst, 2017, p. 1).

The contemporary question becomes, should the CDC’s list of risk factors from early May be amended? Should the CDC explicitly state not only poverty but also racism (instead of race and ethnicity), implicit bias, historical oppression, distrust of the government and health care system, and marginalization in the list of risk factors? Through this editorial, we will examine how health and social inequalities are the comorbid conditions of COVID-19 and of HIV. We will also offer a list of recommendations or implications to help guide nurses, policy makers, and community leaders in mitigating the negative impact of COVID-19 within communities of color.

Parallel Stigma and Intersections Between HIV and SARS-CoV-2

There are a lot of parallels between HIV and the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which is a strain of coronavirus that causes coronavirus disease 2019 (COVID-19). Let us take a moment and think about a recent clinical encounter by one of the authors of this editorial.

While working in clinic recently, I confirmed with a person who is living with HIV that they also had COVID-19. I could hear the fear in their voice. I watched them go through all the scenarios in their mind to try and figure out how they got SARS-CoV-2. They said things like, “I’ve stayed home.” “I haven’t gone to work.” “My mom was sick, and I had to bring her groceries.” They asked what they did wrong. I could hear the shame in their voice. I tried to help them understand this was not their fault. That they would be okay. I used the same approach as I did when they were diagnosed with HIV, 10 years ago. And then, we talked openly about whether the diagnosis of COVID-19 was triggering memories or feelings around living with HIV. There was a long silence. And then, “Yes, it feels awful.”

HIV-related stigma has long been one of the most troubling aspects of the global HIV epidemic. Despite advances in HIV treatment and prevention that has led to improved health outcomes, normal life expectancy, and decreases in the numbers of new HIV infections,

HIV-related stigma remains one of the most challenging aspects of living with HIV and continues to be associated with negative health outcomes (Turan et al., 2017). Since the beginning of the COVID-19 pandemic, there have been numerous reports of racism and xenophobia because attempts are made to blame certain populations for the origin and spread of the virus. Similar to many persons living with HIV (PLWH), people who test positive for COVID-19 may face fear of being stigmatized and blamed for their new illness. The parallel stigma between HIV and COVID-19 cannot be ignored.

The intersection of these stigmas can have serious negative impacts on PLWH. The intensifying shame and fear may keep people from seeking needed health care, increased risk of or exacerbated mental illness, and decreased quality of life. In addition, there is increased evidence that communities of color, specifically Black and African Americans, have increased risk of contracting COVID-19 and are more likely to die of the virus compared with their White counterparts (Barber & Barber, 21 April 2020). Black and African American people also experience higher rates of HIV infection and are less likely to receive HIV care, including treatment with antiretrovirals.

The intersections of HIV and COVID-19 disease-related stigmas and the systemic racial inequity (i.e., housing, health care access, employment, and education) experienced by marginalized communities in the United States are directly related to the health disparities seen in HIV and COVID-19. The compounding effects of disease-related stigma layered with systemic racism will have profound negative impact on communities of color living with HIV who also experience high rates of COVID-19 infection. The HIV nursing workforce is in a unique position to understand, recognize, and address the parallel disease-related stigmas and racial inequity, which is being highlighted by the COVID-19 pandemic, and advocate for the social justice responses needed to assure the health and well-being of PLWH, particularly those who experience intersecting inequities.

“It’s in the Water”: How Implicit Bias in Healthcare Contributes to Health Disparities

Another factor contributing to the intersecting inequities experienced by communities of color is implicit bias. Providers’ demonstrations of implicit biases in the clinical encounter are associated with racial and ethnic disparities in health outcomes and disparities among the LGBTQ populations. Implicit bias occurs when thoughts and feelings outside of conscious awareness and control affect judgment and behavior (Hall et al.,

2015). Observational data suggest that implicit bias plays a role in providers' clinical decision-making and in patients' experiences with their providers (Blair et al., 2014). For example, mistrust of one's provider, because of any cause, contributes to delays in care seeking, which complicates care processes and often worsens patient outcomes (Hall et al., 2015). Patients' perceptions of patient-provider communication and interpersonal style are also associated with disenrollment from health care (Hagiwara et al., 2019; Hall et al., 2015).

As we look at the domestic COVID-19 epidemic and the disparities that have been presented for Black and African Americans, Latinx, and First Nations people, we cannot overlook the role of patient-provider communication and the implicit bias that existed in our health care systems before the pandemic (Castle et al., 2018). Implicit bias layered with the SDOH and preexisting health conditions make the disparities that exist for many communities in this country extremely complex. It is not enough to focus only on the individual level and expect changes to system-level problems. In general, 50% of health disparity interventions have focused on individual-level behavior and knowledge and 30% have engaged the community, but less than 20% have targeted providers in the health system (Chin et al., 2007). This has to change if there is going to be effective transformation and elimination of health inequities.

There is ample evidence that the quality of health care delivery in the clinical encounter contributes to racial and ethnic disparities in health, even when controlling for access to care, income, and patient preferences (FitzGerald & Hurst, 2017). COVID-19 has again illustrated the critical need to expand and better equip our providers and health care systems to provide person-centered, culturally tailored, prevention, care, and treatment interventions. One place to start is the provision of racial equity training and interventions focused on recognizing individual implicit biases. As we seek to expand these opportunities, it is critical that we remove "blame." A focus on implicit bias of providers does not "blame" providers, just as a focus on poverty, education, and preexisting conditions should not "blame" people of color for the disparities that have existed for decades. It is critical that we approach our interventions, programming, and strategic plans at all levels of influence, with a lens toward equity and justice—whether at the individual, interpersonal, community, organizational, or societal level.

Another barrier to accessing quality health care specifically within Black and African American communities, which is often overlooked in interventions and programs to eliminate disparities, is medical mistrust.

This mistrust has also been overlooked in interventions associated with the HIV care continuum in diverse communities. Goparaju et al. (2017) found that women (majority of whom were African American) reported mistrust and difficulties discussing risk behaviors related to HIV with health care providers. Women recounted humiliating experiences involving providers' negative reactions to their sexual behaviors. This mistrust has implications for women of color and their use of HIV preexposure prophylaxis, which is significantly low.

Feagin and Bennefield (2014) concluded from their research that "institutionalized, White, socioeconomic resources, discrimination, and racialized framing from centuries of slavery, segregation, and contemporary White oppression severely limit and restrict access of many Americans of color to adequate socioeconomic resources and to adequate health care and health outcomes" (p. 7). This long history requires that critical conversations about race and health take place to begin breaking deeply ingrained cycles of discrimination and oppression. Bringing awareness to providers and administrators about the roles they play in this broader system, which affects the health of people of color, is essential. Awareness is the first step toward modification of provider behaviors and institutional policies that can then lead to better person-centered health outcomes (Barr, 2014). Integrating trainings on race, trust, and implicit bias into HIV programming and interventions for all stakeholders is strongly recommended. If meaningful progress is desired toward reducing disparities among people of color, focusing on health systems and providers becomes essential.

Inherent Blame, Social Construction, and Assignment of Disease

Societies blaming individuals and certain communities for their experiences of adverse health outcomes is not a new exercise (Scambler, 2020). It is rooted in biblical moral beliefs regarding the origins of sin in the historical approaches of medicine and science that reinforced racist and sexist ideologies and the individualistic lens that ceases to appreciate one's health being intimately tied to their physical and social environments (Reyes-Estrada et al., 2015; Scharff et al., 2010). One of the hard lessons that HIV prevention and treatment efforts have taught us is the role of disease in defining one's personhood, existence and worthiness, and societal (and academic) labeling of people and their behaviors.

Decades into the HIV epidemic, researchers, clinicians, and society have partially come to appreciate that the greatest challenge to ending the epidemic is the

persistent stigma against those living with HIV. Stigma, in its many forms, persists against those who are non-heteronormative because of societal “norms” around sexual behavior and gender presentation and against communities of color, specifically Black and African Americans, First Nation’s people, and Latinx persons because of a legacy of racism coupled with historical and recent antiimmigrant sentiment in the United States (Bailey et al., 2017).

The problem of stigma is rooted in a unique type of “social distancing” in which society assigns value to those deemed as being worthy of existing (Major et al., 2017). This occurs in tandem with beliefs that people bring disease on themselves or are inherently diseased because of who they are or some presumed genetic predisposition. These beliefs allow justification of policies and state-sanctioned behaviors that are oppressive to those who are vulnerable regarding health and social outcomes (Washington, 2008). In the context of HIV morbidity and mortality, the legacy of these beliefs and policies has cemented decades-long ethn racial, gender and sex-based disparities (Hagiwara et al., 2019). Similarly, the emerging ethn racial disparities in COVID-19 mortality, as experienced in the United States, has resulted once again in blaming the vulnerable for their susceptibility to infection—despite being a global phenomenon (Aleem, 2020).

In the United States, SARS-CoV-2 morbidity and COVID-19 mortality data have demonstrated that, once again, people of color—Black and African Americans, First Nation’s people, and Latinx persons—are disproportionately affected. This knowledge was only made available after political and societal pressure for demographic information to be collected and made public (Silverstein, 2020). It was found that many U.S. jurisdictions were not (and still not) collecting demographic data that could assist health care providers and public health officials in directing the resources for COVID-19 testing and treatment (Silverstein, 2020).

Initially, the COVID-19 health disparities blame narrative that emerged reflected a prevailing deep-seated belief that certain people were inherently sick or ill-bodied because of ethn racial identity. The Surgeon General, Jerome M. Adams, MD, when speaking of COVID-19 disparities, exemplified a blame narrative that targeted Black and African American and Latinx people by urging them to simply stop drinking alcohol and smoking to protect themselves and family members from the virus (Aleem, 2020). Although these recommendations may be suitable for any individual during a health visit, such targeted rhetoric directed toward vulnerable populations during an epidemic was accusatory, stereotyping,

insensitive, and lacked a risk communication perspective inclusive of the public.

This blame narrative also failed to recognize that systematic prejudice and institutionalized racism function as generational barriers to wealth and health, which are the fundamental determinants of disparities in health, including COVID-19 (Aleem, 2020). To undercut this blame narrative, other public health officials quickly responded by pivoting national attention to the SDOH in the context of chronic disease (Aleem, 2020). However, it fell short of specifically condemning the blame narrative and addressing the national public health failure toward this domestic epidemic and the pandemic overall. The extent of the U.S.-based disparities experienced should not be an excuse to blame populations already marginalized and vulnerable, but instead it should be seen as the evidence that our national public health and health care policies are insufficient to ensure a healthy society where there is equity and justice.

Cultural Nuances and “Facial Coverings”

Guidance to the American public from top U.S. health officials on how best to “flatten the curve” was marked with contradiction and controversy (Hargreaves & Davey, 2020). After weeks of discouragement from U.S. Surgeon General Jerome Adams (U.S. Surgeon General, 2020), the CDC issued a recommendation for the use of “cloth facial coverings” to decrease community-based transmission on April 3, 2020 (CDC, 2020a). This guidance explicitly stated that “the cloth face coverings recommended are *not surgical masks or N-95 respirators*. Those are critical supplies that must continue to be reserved for healthcare workers and other medical first responders, as recommended by current CDC guidance” (p. 1). Instead, the CDC recommended fashioning face coverings from low-cost household items, such as shirts and bandanas (CDC, 2020b).

The same effort to conserve critical resources for health care personnel working “on the front lines” forced Black and African Americans to choose between public health and personal safety. On an individual level, it is important to understand that people of color in this country carry an identity burden (actual vs. perceived; Ogletree, 1996). Every day, they are forced into making decisions about how they show up in the world and how it could be perceived by others; the consequences of which undoubtedly affect their health (Ogletree, 1996). For example, facial coverings in this country are signals that raise alarm and give way to implicit biases. Whether worn for religious reasons, for protection from environmental exposures, or for style, people of color and Muslims donning full or partial facial coverings are often

met with bigotry and prejudice (Bostock, 11 May 2020; Ogletree, 1996). Particularly, Black and African American men are exceptionally vulnerable to societal retaliation in the form of racial profiling—“the discriminatory practice by law enforcement officials of targeting individuals for suspicion of crime based on the individual’s race, ethnicity, religion or national origin” (ACLU, 2020).

Racial profiling of Black and African Americans is inextricably bound to the history of the United States—from precolonial slave laws to Jim Crow laws in the 19th and 20th centuries, and the “Stop and Frisk” practices of the early 2000s, leading to the 2013 Black Lives Matter movement organized to seek liberty from state-inflicted violence that continues through present day (Rickford, 2016). To many, the image of a Black man with a facial covering is associated with suspicion of criminal activity (Osborne, 2020, April 11). The experience of living through an epidemic while exercising social distancing and competing for resources has amplified implicit biases and racist reactions. Asking Black and African American men to wear a face covering (both medical and nonmedical) is asking them to make a choice between their health, and that of their family members and community, and personal safety. Ironically, in a viral video, a Black man in Philadelphia who did not wear a mask for fear of being racially profiled was shamed and forcefully removed from a city bus by police for endangering the public’s health (Osborne, 2020, April 11).

Issuing blanket recommendations to save the most lives is not the same as valuing all lives equally, and it does not erase the caustic effects of structural racism and implicit bias (Miller & Peck, 2020). Moreover, consideration must be given to how health recommendations are to be enforced, recognizing that enforcement does not look the same for all. At the structural level, six U.S. Senators wrote to the U.S. Department of Justice and the Federal Bureau of Investigations requesting immediate antibias training and guidance to law enforcement during the COVID-19 pandemic (Harris et al., 2020). In this letter, they stated,

If communities of color—especially African American communities—feel at risk of disproportionate or selective enforcement, they may avoid seeking help or adopting precautionary measures recommended by the CDC. This, in turn, could have dire public health consequences—especially given that COVID-19 is already infecting and killing African Americans at alarming and disproportionately high rates. (Harris et al., 2020 p. 1)

Social and Structural Inequalities

Since taking a foothold in the United States in 2020, the novel SARS-CoV-2 associated with COVID-19 has

exposed decades of social and structural inequalities, particularly for communities of color (van Dorn et al., 2020). Studies have shown that the health differences observed between racial and ethnic groups are often related to their economic and social conditions (van Dorn et al., 2020). However, the health differences observed among communities of color and those of their White counterparts are often hastily presumed to be based in biology instead of their social and economic conditions (Barber & Barber, 2020).

Owing to historical and contemporary experiences with discrimination, which has resulted in medical and public health distrust, the members of communities of color might be more cautious about the public health information they receive, rendering them less accepting of recommended safety measures (i.e., wearing face coverings; Van Bavel et al., 2020). Furthermore, owing to their marginalization, they are also potentially more vulnerable to disinformation (Hargreaves & Davey, 2020). For example, at the start of the COVID-19 pandemic, there was delayed and mixed messaging to the public from federal and local governments as to the presence of coronavirus in the United States and whether to use facial masks as a preventive measure (Hargreaves & Davey, 2020). As such, many did not believe that they were at risk for COVID-19 or that they could become infected with the virus, which may have resulted in a slow uptake of communities of color wearing masks or any form of facial covering after the directive was issued by the CDC (Hargreaves & Davey, 2020; Van Bavel et al., 2020).

The level of COVID-19 misinformation and slow uptake of prevention efforts in communities of color directly parallels the misinformation and perception of risk within the Black and African American community for HIV vulnerability (Hatcher et al., 2008). Effectively addressing HIV in communities of color requires collaboration with targeted groups such as faith-based institutions and other community-based organizations to educate members of the community (Wilson et al., 2011). These parallels and the lessons learned from the HIV pandemic suggest the need for more targeted public health information and collaboration between trusted indigenous community organizations and public health officials.

Contemporary economic conditions among communities of color in America are also linked to social and structural inequalities (van Dorn et al., 2020). Communities of color are more likely to work in jobs that are deemed essential during the pandemic (Van Bavel et al., 2020). Some of these jobs are in public transportation, public safety, grocery stores, sanitation, retail,

warehouses, agricultural labor, or environmental services in health care settings (van Dorn et al., 2020). Many of these individuals are hourly workers and cannot afford to miss a paycheck, which makes being able to shelter at home, self-quarantine, or purchase weeks' worth of healthy food impossible (van Dorn et al., 2020). Through these forms of employment, communities of color are disproportionately exposed to the public and hence the virus, and some work environments have not adequately instituted workplace protection against the virus (Webb Hooper et al., 2020). Many of these jobs also may not provide benefits, such as health insurance, nor provide paid or adequate sick leave, causing individuals to delay or forgo testing or seeking treatment (van Dorn et al., 2020; Webb Hooper et al., 2020). Moreover, to accommodate for a significant budget shortfall, several states have announced funding cuts to their state's Medicaid programs, which will result in an increase in the number of uninsured Americans (Booth & Frank, 2020; Lewis, 2020). This loss of state support will most likely exacerbate the negative outcomes from the disease among already vulnerable individuals.

Environmental racism, a concept of the environmental justice movement, which examines environment injustices that occur in policy and practice from a racial context (Pulido, 2000; Pulido, 2016), disproportionately affects communities of color (Turrentine, 2020). For example, redlining, a federal housing policy of the 1930s that overwhelmingly favored White Americans in the purchasing of homes, gave them access to favorable home mortgage loans in suburban neighborhoods far away from any factory or environmental pollutants (Bagley, 2020; Cusick, 2020). This policy further affects communities of color by adding to the wealth gap between White and Black and African Americans. As a result, for many communities of color, the ability to social distance, shelter at home, and self-quarantine is not as simple as what was prescribed by public health officials. Many of these families live in concentrated urban areas where reliance on public transportation is required to go to work or obtain essential items, making social distancing impossible (Ettachfini, 2020). Concentrated urban living also means that many people of color reside in small apartments or homes, which render self-quarantine difficult or simply not possible, specifically for those who live in multigenerational homes or apartments.

In addition, some communities lack access to adequate and clean water that is safe to drink (remember Flint, Michigan?) much less allow for frequent hand washing and cleaning (Pulido, 2016; Shah, 2020, April 17). Particularly, some communities in urban dwellings have not recovered from lead exposure in their water to

be safely consumed in their homes (Shah, 2020, April 17). Some families may also live near factories, other industrial areas, or busy highways that expose them to environmental pollutants (Ettachfini, 2020). These environmental hazards contribute to the high rates of asthma observed among African American and Latinx children and other chronic lung diseases among older adults of color—thus increasing their susceptibility to adverse outcomes associated with COVID-19 (Ettachfini, 2020).

Making Testing and Treatment Equitable

We have repeatedly heard that testing is key to curtailing the COVID-19 epidemic (Webb Hopper et al., 2020). But is access to testing equitable? Is there sufficient health literacy to understand how to obtain a test? Let us disentangle these questions and think about the corollaries to HIV.

First, regarding equitable testing, it is hard to know if there is equitable testing across racial and ethnic groups because only two states, Illinois and Kansas, are providing COVID-19 data by race (Hill, 2020). According to Aletha Maybank, MD, Chief Health Equity Officer and Vice President of the American Medical Association, “we need data disaggregated by race and ethnicity on who receives tests, who tests positive, who is hospitalized, who dies, and, once developed, on who receives treatment and a vaccine, along with who participated in clinical trials, which historically lack representation for Black and brown people” (Maybank, 2020). Without stratified data, it is impossible to fully understand the epidemic; to develop culturally congruent risk communication while simultaneously clarifying misinformation; to ensure equitable access to prevention, care, and treatment; and to ensure fair and just allocation of resources for not only the current COVID-19 epidemic but also HIV and the epidemics that will inevitably come in the future.

Second, regarding health literacy, only 12% of American adults have a proficient health literacy level, whereas 36% possess a basic or below basic health literacy level (Kutner et al., 2006). This means that one of three Americans may not “have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”—the definition of health literacy (as cited in Bohlman et al., 2004, p. 32). Consequently, our risk communication messages must be not only tailored to diverse communities but also sensitive to the ability of individual members of society to seek, process, and act on health information, allowing an informed decision.

Even if access to COVID-19 testing becomes increasingly available, will communities experiencing historical marginalization and distrust of the medical system (let us not forget Tuskegee) be accepting of testing? If we think about HIV, with one of seven not knowing their status (CDC, 13 December 2019), the answer is maybe not. Similarly, will economic issues—lack of employer-based health care, and lack of Medicaid expansion programs—continue to prevent equitable access to health care?

Moving Forward

There are many lessons that can be learned from the HIV epidemic and related to the current COVID-19 pandemic in the United States. Testing and treatment resources, along with misinformation around who was at risk for HIV infection, exacerbated the epidemic in communities of color, particularly among Black and African Americans (Webb Hopper et al., 2020). In addition, social and structural inequalities also worsened the HIV epidemic among communities of color by depriving them of vital resources needed to mitigate the transmission (van Dorn et al., 2020).

We hope this editorial provides insights from a socio-historical and contemporary perspective, highlighting the many parallels between the HIV and COVID-19 responses among communities of color. It is our hope that this information may help public health officials mitigate the impact of the current pandemic through the implementation of equitable public health policies and procedures. The implementation of mandatory mask wearing may help policy makers assist law enforcement and the general public to understand the cultural nuances of wearing a mask or other facial covering. This may prevent or minimize the tension between law enforcement and communities of color. Moreover, the emerging morbidity and mortality data from the CDC, and the states' health departments, have demonstrated resoundingly what many of us in nursing and the social and behavioral sciences have feared: The epidemic is disproportionately affecting communities of color, not because of biological factors but because of deeply rooted social and economic disadvantages (Van Bavel et al., 2020).

Recommendations and Nursing Implications

Here, we highlight some recommendations and implications for nurses, public health practitioners, policy makers and government officials, and community leaders to ensure equity in testing, treatment, and mitigation of COVID-19 infections among all communities:

- Public health education requires messaging that applies principles of cultural humility and risk communication.
- Public health and health care advances require an interdisciplinary approach that includes grassroots community-based perspectives.
- We need to move toward a holistic way of thinking about health and disease that incorporates the social determinants and contributors to health.
- Medicine and nursing education require moving away from thinking of disease as inherent to someone's ethnoracial group. Addressing the social determinants and contributors of health, stigma, implicit bias, and discrimination in health care early in medical and nursing school curriculum makes health care delivery more holistic and the developing provider a more humble and aware practitioner.
- It is vitally important to understand and intervene to address the intersectional stigmas experienced by PLWH around COVID-19. Health care providers need to advocate for resources and funding to prevent discrimination and assure the inclusion of key populations in designing sustainable, impactful interventions using a multilevel framework.
- Integrating trainings on race, trust, and implicit bias into HIV and COVID-19 programming for all stakeholders is strongly recommended.
- Targeted studies that improve our understanding of the social and structural impact of COVID-19 are needed to effectively mitigate the virus' negative effects on communities of color.

Disclosures

The authors do not have any perceived or actual conflicts of interest to report.

Acknowledgments

This publication was made possible with help from the Duke University Center for AIDS Research (CFAR), an NIH funded program (5P30 AI064518; Weinhold & Bartlett, PIs), and the Interdisciplinary Sexual Health and HIV Research (INSHHR) group at the University of Rochester School of Nursing. This publication was also supported by The Advancing Faculty Diversity Grant to Office of the Vice Chancellor for Diversity at the University of California, San Francisco.

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