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Foreword: Dual Pandemics Disproportionately Impact Minoritized Communities

The COVID-19 pandemic has laid bare what structural racism looks like in healthcare settings, workplace practices, and living conditions that disproportionately expose Black and brown communities to unfair health outcomes. Racial scholars have urged policymakers to rightfully shift their units of analysis from personal decision-making to the structural inequities that racially and ethnically minoritized communities face.[1-4]

Media narratives recycle the idea that minoritized communities do not follow COVID-19 precautions and therefore get dubbed as 'vaccine-hesitant', despite evidence that demonstrates otherwise.[5] For instance, according to the Health Equity Tracker published by the Satcher Health Leadership Institute at the Morehouse School of Medicine, the majority of populations vaccinated against COVID are of color: American Indian and Alaskan Native Americans (65,100 per 100,000), Native Hawaiian and Pacific Islander Americans (55,500 per 100,000) and Asian Americans (55,400 per 100,000) are the leading populations with COVID vaccinations followed by Hispanic Americans (52,300 per 100,000). The COVID vaccination rates of Black Americans (42,500 per 100, 000) closely trails that of white Americans (49, 400 per 100,000). [6] A multi-sector approach is well-suited to address the ongoing social, cultural, medical and geographic factors that increase exposures to HIV and COVID-19 for minoritized communities. These sectors are not limited to government entities or insurance companies but also philanthropic and industry partners. A Harvard Business Review white paper emphasizes how advancing health equity is a necessary business strategy for pharmaceutical companies but also as a corporate citizen modeling how to achieve its social mission to promote the health of the most overlooked communities.[7]

In addition, the literature offers many possible explanations for low pre-exposure prophylaxis (PrEP) uptake – a therapeutic to prevent HIV, including a lack of awareness, [8,9] misconceptions about who can use the drug,[10,11] misinformation regarding side effects,[12, 13] not having a clinician who scompassionately offers or fields questions about the risks and benefits,[14] and low self-perception or literacy concerning HIV exposure or candidacy for PrEP. [15,16] To date, few studies have addressed how public messaging about low PrEP uptake may blame and pathologize minoritized populations.[17] Given the deficit-oriented framing of many studies, racial and ethnic minoritized groups are often further marginalized in the literature that informs the clinical policies and practices for PrEP healthcare utilization.

Program Overview

It only makes sense to address the syndemic interaction between the COVID pandemic with the ongoing HIV pandemic. Both pandemics make visible the role that disparate access to healthcare and the other social determinants of health has on one's exposure to HIV and COVID-19. [18] There does not seem to be any evidence to suggest that people with HIV have a greater risk of COVID-19.[19] Instead, what the literature does point out is how the focus on COVID-19 prevention has contributed to less attention to HIV prevention.[20] As such, Gilead Sciences Incorporated funded a national training effort called "Two in One" to equally promote HIV/PrEP screening alongside COVID-19 vaccine screenings in the same primary care setting. The Two in One Model includes primary research, evidence-informed PCP training, and policy recommendations on the screening guidelines.

Given the intersectional lens of this program model, [21] it is important to identify the enduring impact of gendered racism,

mistrust, structural inequities and stigma on health behaviors and healthcare utilization. For instance, *gendered racism*[17] based on clinician assumptions can lead to microaggressions and clinician bias against minoritized communities during sexual history taking.[22] Additionally, patients of color may be survivors or witnesses of research abuse and medical exploitation that has resulted in *mistrust*[13,23-24] and question the safety and effectiveness of vaccines, testing, and PrEP. Similarly, mistrust may be extended to sexual partners who are dishonest about their HIV or COVID-19 exposures or status. [25] Yet, concerns regarding the affordability of PrEP, HIV and COVID treatments,[26] the required labs, clinic visits and transportation to healthcare sites are an ongoing reality of the *structural inequities* that lead to disparate health opportunities. Finally, the *stigma* related to HIV, PrEP/PEP and COVID-19 vaccines [27] can induce feelings of shame, embarrassment, fears of discrimination [28] or being deemed undesirable by potential partners and support systems. Studies focused on risk factors associated with PrEP and COVID-19 vaccine uptake have yet to consider the unique experiences of racial, ethnic, sexual, and gender minoritized patients by other axes of difference such as age, ability, locale, and nationality.

The goal of the "*Two in One: HIV + COVID Testing Model*" is to improve the capacity of primary care practitioners (PCP) to routinize HIV and COVID screenings for all patients and rely on culturally responsive communication with their minoritized patients. More often than not, structural inequities such as poverty, disinvestment, and discrimination are characterized within public health efforts as issues of personal responsibility. This neoliberal rhetoric is particularly detrimental to the health of historically marginalized populations. Our goal for publishing with HPHR Journal is to share a collection of scholarly papers that debunk theories that maintain people as problems as opposed to the conditions they live in as this aligns with the journal's mission to investigate biological, psychosocial, and environmental determinants of health. To truly advance the health of minoritized communities in equitable, sustainable, and reciprocal ways, our collective efforts are rooted in the following foundational truths as we believe:

- Racial, ethnic, sexual and gender minoritized patients can best speak to their humanity: It is well documented how bias can be coded into research questions, program designs and clinical algorithms.[29] These biases especially harm minoritized communities. Critical race theory [30] invites us to use counter-narratives for this very purpose and queer theory [31] points to the importance of privileging queer voices. The Two in One Model shared in this collection of papers has been designed to challenge this form of structural racism, heterosexism and gender oppression.

- Minoritized patients are complex, diverse and have full lives: The oversimplified ways data are collected flattens the realities of racism and heteronormativity for how upstream factors unfairly burdens some communities more than others. The public health surveillance data generally used to name health disparities is based on gaps between white populations and other populations. What remains unquestioned is why white populations remain the comparative reference group for every health outcome to determine norms, outliers, and disproportionality. The University of Maryland's Consortium on Race, Gender, and Ethnicity has collated a database that allows researchers to study within-group differences.[32] This is just one way to address how data is used to portray minoritized communities as perpetually at risk.

Supplement Overview

The Two in One Model does not standardize "whiteness" as the norm to which all other bodies of color are weighed. In fact, this model highlights research, policy and practice-based outcomes to emphasize how racial, ethnic, sexual and gender minoritized populations are indeed engaged in health seeking behaviors as it relates to COVID-19 vaccines, yet continue to face structural barriers to accessing preventative care. In this supplement, there is a centering of the lived experiences of the most overlooked patient populations. For this reason, a commentary entitled, "Building the capacity of PCPs to eliminate stigma through a research-informed training model" is included, describing the power and autonomy that patients have and how clinicians can recognize and tap into it during the clinical encounter. This paper is co-authored by the subject matter experts who led the Two in One training series, including patients themselves.

This supplement also emphasizes the deliberate attention that must be given to adequately prepare the health workforce to meet the challenges of health equity. In "*Culturally responsive communication: Its conceptualization and transferability*", a paradigm is offered to shift away from 'cultural competence' to 'cultural responsiveness'. Specifically, there is a call for culturally responsive communication (CRC) as a particular form of healthcare competency necessary to understand the culture of clinicians alongside the culture of patients as well as the culture of medicine and culture of racism. As academic programs consider CRC as a health competency for students and trainees, practicing clinicians can also benefit from ongoing professional development in translating their values for diversity, equity, inclusion and justice (DEIJ) into practice. The next piece describes how the DEIJ values of the Two in One team were deliberately designed in every facet of the project in, "*Codifying DEIJ values in a national research-informed training effort*"- from the language used to frame this work and research questions as well as the approach to research mentoring and the curating of a national advisory board and speakers for the training series.

Finally, this supplement ends with two articles on how to improve healthcare access in the primary care setting. In "*Making HIV, PrEP/PEP and COVID vaccination screenings the standard of care in primary care settings*", several authors describe the background and next steps for three sets of policy recommendations on how to best integrate the CDC's guidance for clinical screenings. In doing so, the primary care setting is normalized as a site for sex-positive sexual history taking and routine

screenings for HIV, PrEP/PEP and COVID-19 vaccines. To round out the discussion, this is followed by a scoping review entitled, *"Identifying the factors influencing culturally responsive HIV and PrEP screening for racial, ethnic, sexual, and gender minoritized patients: A scoping review*" that summarizes themes on culturally responsive HIV and PrEP screenings that amplify the multi-faceted conditions that either positively or negatively influence how patients and PCPs view and access screenings.

While this supplement focuses specifically on HIV and COVID-19 prevention, its theoretical frameworks, methods, research, and policy implications have transferability to a range of other disparate patient outcomes. These papers illustrate how prioritizing the values and realities of the most marginalized groups is a community-centered approach useful for eliminating discrimination and stigma.

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