Latinos Living with HIV in Lawrence, MA:
Stigma and Discrimination as Barriers to Care
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Introduction
Lawrence, Massachusetts
Lawrence was incorporated in 1847. It began as a mill town that relied on Irish and Italian
immigrant labor. At the turn of the twentieth century nearly half of the population was foreign-
born. In the 1950s-60s after the mills closed the population demographics changed. Puerto
Rican and Dominican Immigration increased, and by 2000 minorities (primarily Hispanic) were
reported to make up 61% of the population. Today Lawrence’s population is 74% Hispanic.1 2 In
2011, nearly 29% of Lawrence’s 77,000 residents were living below the federal poverty line,
compared to 11% at the MA average.3

Greater Lawrence Family Health Center
The GLFHC opened more than 30 years ago in response to local emergency departments treating rising numbers of patients for
unpaid primary care needs. It was the first health center of its kind to offer its own family medicine residency program.
Today, GLFHC has five locations and provides care to nearly 2/3 of Lawrence’s population. Comprehensive HIV care is one
of many services offered under the health center’s model of
integrated, primary care-based delivery. 4

Population of Focus
The population of focus is made up of residents of Lawrence, MA and the surrounding communities who have been diagnosed with HIV/AIDS—or who are at high risk of becoming infected with HIV— and are cared for by the Greater Lawrence Family Health Center and its affiliates. Given the population of these communities, many of these clients are also Hispanic and/or
"LEP" (of limited English proficiency).

Clerkship Objectives & Activities
- Inter-professional teamwork is fundamental to all levels of HIV service provided by GLFHC. Partnerships and connections span from preventative services to external and administrative resources, through the individual case management team and all additional medical services provided to patients. Further integration exists through overarching boards and networks such as Community Support Services (CSS). These relationships are shown in the schematic below:

Service-Learning Project
Stigma Associated with HIV in Lawrence
After meeting with several employees of GLFHC, we learned that stigma and discrimination are perceived as persistent challenges associated with HIV infection in Lawrence.

• Homophobia is still prevalent in Lawrence; homosexuals may face discrimination and be shunned by friends and family.
• Aspects of some Hispanic cultures (such as Machismo beliefs and traditions) may contribute to this.
• Sexually transmitted infections may be stigmatized and the response to patients will be more negative if the patient is associated with LGBTQ population.
• GLFHC’s patients have limitations in access to HIV testing and treatment due to various beliefs and misconceptions of HIV such as fear of discrimination.

The preventative and community-based arm provides HIV and STD testing, community education, and coordination with other community services such as soup kitchens and shelters. When an individual is diagnosed with HIV, the central case management team provides medical care and referrals and performs regular reassessment of social and medical needs to minimize potential barriers to care. The external and administrative arm provides ongoing guidance, legislature and funding, as well as linkage to social/medical services such as health insurance, SSI and housing assistance. All arms of the schematic work to minimize stigma, either at the individual, community or institutional level.

Future Directions
Since the survey was conducted only as a quality improvement project, the results cannot be disclosed here or published externally for research purposes. The results will only be used for Internal quality improvement projects by GLFHC. The survey, however, should ideally be validated, revised as indicated, and distributed more widely amongst GLFHC staff to improve sample size and QI data return. Furthermore, it would be informative to conduct a similar survey among healthcare workers. The results would characterize the stigma actually experienced in the community. By comparing such results with the preliminary data from our survey regarding provider perceptions, GLFHC can move forward with providing necessary trainings and workshops for its employees, as well as continuing to better address stigma as a barrier to care among community members and patient populations.

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