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African American MSM and HIV/AIDS – Why It's Not Just Behavior: A Literature Review, Examining the Institutional and Structural Causes of HIV/AIDS Prevalence Among African American MSM, Situated by Social Theories

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Introduction

Several decades since the outbreak of the virus, and in spite of numerous medicinal breakthroughs in treatment and prevention, men who have sex with men (MSM) still face relatively high risks and proclivities for contracting and transmitting HIV and have had an unremittingly higher prevalence of the virus than any other high-risk group in America. While HIV incidence has declined among heterosexuals and injection drug users in recent years, MSM is the only high-risk group in the US that has seen an increase in incidences—a trend observable since the early 1990s (W. A. Hill 2011). According to the most recent release of the Centers for Disease Control and Prevention's (CDC) annual HIV Surveillance Report (2016), among a total of 722,244 males (aged 13 years and older at year end 2014), 70 percent of HIV infections and 66 percent of AIDS diagnoses were attributed to male-to-male sexual contact.

If those numbers were to be further stratified to account for racial differences, many other troubling patterns would emerge, revealing an even greater impact of the virus among African American (AA) MSM, compared to any other racial group in America. According to a 2008 report by the CDC, the HIV prevalence rate for African American men was six times greater than that of Non-Hispanic White (NHW) men. Additionally, Peterson and Jones (2009), reported that AA MSM have the highest rates of unrecognized HIV infections and the highest proportion of AIDS mortality than any other MSM racial or ethnic group. In a representative study conducted by Voelker (2008), of the MSM from 5 US Cities surveyed, AA MSM were 2.19 times more likely to be HIV+, than NHW MSM.

For decades, the primary focus of HIV preventative interventions has been limited to individual behavior change models that seek to influence knowledge, attitudes, and behaviors, such as promotion of condom use, and sexual-health education (Gupta, Parkhurst, et al 2008). Coates, et al (2008) in reviewing individual behavior change strategies, posit that

notwithstanding the success of some individually oriented interventions in reducing risk behavior, their success is substantially improved when prevention methodologies address the larger structural factors that encompass and constrain individual behavior, such as: poverty, gender, policy, and location of power; and especially the synthesis of these elements in impacting the individual.

I posit that an appraisal of the larger structural, institutional and hegemonic components, that foster HIV transmission and prevalence, will uncover the underlying issues that account for AA MSM shouldering the heaviest burden of HIV in America. For example, the poverty rate is higher among African Americans than other racial/ethnic groups. The socioeconomic issues associated with poverty—including limited access to high-quality health care, housing, and HIV prevention education—directly and indirectly increase the risk for HIV infection and affect the health of people living with and at risk for HIV (CDC 2016).

By reviewing existing research, through the lens of social science theories, and as an alternative to individual behavior change models, this manuscript will explain how structural and institutional elements can and do influence the disparate prevalence of HIV among AA MSM. I will be framing this treatise using syndemic theory, to highlight the structural elements and the confluence of multiple epidemics, that compound to affect the prospect of delimiting the burden of the virus on this specific subgroup. For the sake of clearer sociopolitical context, using critical race theory, I'll also highlight how the changing demography and political climate of the US jeopardizes the welfare state, that might otherwise be useful in tackling this epidemic. This manuscript also offers suggestions on how to address these multidimensional social blockades to treatment and prevention for AA MSM.

Background

- ***HIV/AIDS & African American Men Who Have Sex with Men (AA MSM)***

According to the CDC, though African Americans represented only 12 percent of the US population in 2015, they accounted for 45 percent (17,670) of HIV diagnoses[1] (U.S. Department of Health & Human Services 2016). In that same year, more than half (58 percent) of African Americans diagnosed with HIV were MSM. Of the total of MSM living with diagnosed HIV, 39 percent were African American[2]. Among AA MSM diagnosed with HIV in that same year, 38 percent were young men aged 13 to 24. Between 2005 and 2014, HIV diagnoses among young AA MSM (aged 13 to 24) increased 87 percent (CDC 2016). African Americans also experienced a low 3-year survival rate among persons with HIV infection diagnosed during 2003-2008. In 2014, African Americans accounted for 53 percent of total deaths attributed to HIV or AIDS (Siddiqi, Hu & Hall 2015). Geographically, HIV is highly prevalent in the Southern U.S., where more than half of all HIV infections occur, but only 1/3 of the U.S. population lives. The South accounts for 9 of the top 20 states and 9 of the top 20 metropolitan areas with the highest rates of HIV diagnoses (CDC 2013)[3].

- ***Intervention and Prevention***

The earliest response to the virus is collectively referred to as Treatment as Prevention (TasP) and includes Anti-Retroviral Therapy (ARV), and Highly Active Anti-Retroviral Therapy (HAART); – a combination of multiple medications, that work to reduce the infected (or HIV+) person's viral load to undetectable levels. In addition, there are also medications that greatly

[1] Figure 1- Source: *HIV Surveillance Report* 2016; 27.
[2] Figure 2 – Source: CDC. *Diagnoses of HIV infection by race and age group, 2015*. HIV Surveillance Report 2016; 27.
[3] Figure 3 – Source: *HIV Surveillance Report*. 2014;26.

decrease the risk, before and after potential exposure, to those who do not have the virus (HIV-); Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) respectively. PEP involves taking antiretroviral drugs shortly after being exposed to HIV. In 2005, the U.S. Centers for Disease Control and Prevention (CDC) recommended a 28-day course of highly active antiretroviral therapy for anyone who has a non-occupational exposure to blood or genital secretions from a known HIV-positive individual (Smith et al., 2005). PrEP involves a daily dose of antiretroviral drugs (currently *Truvada*; produced and distributed by *Gilead*) to reduce the likelihood of HIV acquisition from subsequent exposures (U.S. Department of Health & Human Services 2016).

In sum, Americans now have access to ART/HAART, which diminishes the viral presence in HIV positive (HIV+) men and women, PrEP, that reduces the risk to HIV negative (HIV-) Americans for contracting the virus, when taken daily, and PEP (the morning after HIV pill) offering redemptive risk reduction after a potential exposure. All treatments and medications - ART/HAART, PEP and PrEP - are encouraged to be taken/used in conjunction with condoms and other safer sex contrivances, to increase their efficacy. Though pre-exposure prophylaxis (PrEP) has demonstrated clinical effectiveness for HIV prevention, there is still much that is unknown about how factors at the individual, interpersonal, community, and structural levels impact PrEP use for AA MSM (Philbin, et al 2016).

- ***Challenges to Intervention & Prevention***

A lower percentage of AA MSM, compared to other MSM, know their HIV serostatus[4]. The CDC (2016) reported that a lack of awareness of HIV status contributes greatly to HIV risk. At the end of 2013, though African Americans accounted for almost fifty percent of everyone living with HIV in the US, 1 in 8 did not know they were infected. Low spatial densities of HIV

[4] serostatus = HIV status; *sero*: blood, *status*: HIV+/-

services where AA MSM reside, compounded with a greater incidence of undiagnosed or untreated STIs/STDs among AA MSM and reduced utilization of available care for both HIV prevention and treatment services contribute to disparities in HIV incidence and prevalence (CDC 2017; Pierce, et al 2007). Also, AA MSM have been slow and/or reluctant to patronize PrEP or PEP or are simply not aware[5] of the existence of these therapies.

Despite its noteworthy effectiveness at preventing HIV transmission and acquisition, and the positive reception by national and international health organizations, use of PrEP as a prevention strategy has been slow to take hold among some at-risk populations (Highleyman 2014). The CDC (2015) estimates that approximately 1.2 million Americans would benefit from PrEP use, based on their substantial risk of acquiring HIV (24.7 percent of which are MSM). In 2014, Gilead representative, Scott McCallister reported that only 10 percent of PrEP users were African American; compared to 74 percent White and 12 percent Hispanic (Highleyman 2016). While McCallister's report did not include a sub-categorical dissection and cross analysis for racial and sexual identities - like MSM, or AA MSM - other studies indicate that, although the usage statistics are low, the reports of willingness to use PrEP are high, especially among MSM.

Brooke Hoots, et al (2014), of the CDC, recently conducted an analysis of the willingness to use, 12-month utilization, and indications for PrEP. They submitted a multifaceted and multidimensional report that highlights insightful patterns in PrEP engagement within the US. While about 60 percent of respondents indicated that they were willing to use PrEP, only about 4 percent actually reported doing so. There was no significant difference across racial lines, in willingness to use PrEP. However, in comparative reports of actual use between AA and NHW MSM, numbers were twice as high, in favor of NHW MSM. Hoots and colleagues also found that MSM at higher risk for HIV infection are more willing to use PrEP and may use it more

[5] Figure 5 – PrEP Familiarity

consistently. Additionally, MSM who reported higher numbers of sexually transmitted infections and more casual sex partners and concurrence of sexual partners, were more likely to use PrEP.

Even more interesting, researchers made note that while more than half of respondents had CDC indications for PrEP – meaning they were most at risk for HIV and would benefit the most from PrEP use - AA MSM were less likely to have such indications than MSM of other racial/ethnic groups. Which means that although rates of HIV incidence are higher among AA MSM, they report less risky sexual behavior and drug use than NHW MSM. Overall, these researchers concluded that the racial disparity in PrEP uptake between AA MSM and others "*may be attributable to differences in health care access rather than a lack of interest*." Significant differences in PrEP use also emerged, in favor of MSM with higher levels of education, higher incomes and access to health insurance. These findings strengthen the argument that prevention models that focus solely on curtailing risk behaviors of AA MSM, are not engaging with the full crux of the issue; since there are obviously other factors at play.

Some researchers have suggested that there are other – less discussed - factors influencing the low uptake of preventative therapies among AA MSM. Research by Philbin, et al (2016) posits that factors that influence how AA MSM experienced PrEP emerged across all levels of the socio-ecological framework: At the individual level, respondents were wary of healthy people taking medication daily and of the potential side-effects related to doing so. At the interpersonal level, AA MSM believed that PrEP use would discourage condom use[6] and that PrEP should only be one option for HIV prevention, not the main option. At the community level, AA MSM described not trusting the pharmaceutical industry and described PrEP as an option for others, not for themselves and talked about HIV and sexuality-related stigmas and how they must overcome those before PrEP engagement. At the structural level, AA MSM, as is

[6] Figure 5 – PrEP & Condom use

the case for most African Americans, are less likely to be insured and thus incapable of affording the medication, without government or charitable subsidies; which come with their own levels of stigma and negative stereotypes for African Americans.

Delving further into the topic of medical mistrust, other studies suggest that AA MSM seem disinterested or wary of preventative HIV research participation. The results of a study by Shavers, Lynch & Burmeister (2002) indicate that African Americans and whites differ significantly in their willingness to participate in medical research. Gaston & Alleyne-Green (2013) reiterate the belief of many scholars that this is likely due to the poor historical reputation and legacy of abuse that medical research has had in the AA community, especially with regard to sexual health; referring to the Tuskegee Syphilis study. In essence, experiences of racism, conspiratorial assumptions and the quality (or existence) of provider-patient relationships appeared to impact engagement in treatment and prevention among AA MSM (Gaston & Alleyne-Green 2013).

Moreover, Baral, et al (2013) noted that sexually diverse populations tend to face social exclusion from families, friends, cultural, religious and health institutions. Other stigma and discrimination not related to sexual practices, may also elevate risk. For example, AA MSM face racism, and sexual stereotypes, which foster higher risks for and prevalence of HIV infection compared to NHW MSM (Quin, et al 2015). Compounding experiences of stigma may inhibit disclosure of sexual orientation and/or HIV positive serostatus – which may exacerbate HIV risks. This underscores the importance of examining the role that intersecting forms of social and structural discrimination (e.g. racism, homophobia) play in shaping health outcomes and risk (Quin, et al 2015).

Oppositely, Castro and Farmer (2005) argue that while stigma does play an assessable role in health outcomes for those stigmatized, social, economic and institutional barriers truly determine who will access treatment and testing services. Results from their research in rural Haiti suggest that stigma can be reduced, and HIV testing can be successfully encouraged when quality HIV care and prevention methodology is introduced and made accessible in affected communities (Castro and Farmer, 2005). So, the focus then should be placed on the institutional socio-ecological elements, political-economic and institutional barriers that are at play.

Theoretical Framework

- ***Syndemic Theory***

HIV acquisition and transmission risks among MSM are inarguably shaped by inequitable social and structural contexts that influence individual's sexual practices and access to HIV prevention care and treatment. As such, scholars contend that the HIV epidemic can be theoretically examined as a group of interrelated epidemics, impacting MSM on an individual, social and structural level. While no one theoretical model can adequately define or explicate all risk factors that MSM face, across these diverse domains, proponents of Syndemic Theory have come very close.

Syndemic Theory posits that health is not only influenced by individual-level characteristics but is also determined by the milieu in which one exists, and unfavorable life circumstances may result in minority groups experiencing adverse and disparate health outcomes (Baral, et al, 2013). Merrill Singer (2003), who coined the theoretical framework, defines a syndemic as "*two or more afflictions, interacting synergistically, contributing to excess burden of disease in a population*." Vulnerability to HIV among AA MSM men is increased by structural, social, and biological factors that interact, within the context of social marginalization.

AA MSM tend to experience a syndemic of HIV/AIDS, substance abuse, trauma, incarceration, and poverty (Wilson, et al, 2014). Studies have revealed that experiences of living in poverty, trauma, and incarceration, each contribute to the increased likelihood of MSM being infected with HIV (Morton, 2007; Bartholow, et al, 1994; Carballo-Diéguez & Dolezal, 1995; Diaz, et al, 2001; Galea, 2002; Singer 1994; Stine, 2007 & 2013).

There has been documented high rates of trauma (i.e., exposure to physical and sexual abuse) among AA and Latino men (Wilson, et al, 2014). Research by Doll, et al (1992) found that minority MSM were significantly more likely (52 percent of AA men and 50 percent of Latino men) than NHW MSM (32 percent) to report having been sexually abused during childhood. Further evidence showed that this and other types of community violence are more likely occur in inner-city neighborhoods - predominantly populated by AA and Latino identified youth. One third of pre-teen and teenaged youth, living in these areas have been personally victimized, while almost all youth have been exposed to community violence (Margolin & Gordis, 2000). These traumatic experiences tend to have negative consequences for minority men into adulthood (Wilson, et al 2014). These experiences often correlate with an increased likelihood of participating in risky sexual behavior, HIV acquisition, violence and being incarcerated (Morton 2007; Williams, et al 2004).

Poverty is arguably the biggest problem that disproportionately affect AA MSM and is also an associated/enabling factor for substance use, neighborhood violence, trauma, and incarceration (Adimora & Schoenbach, 2005). The most recent report by the US Census Bureau (2016) indicated that while the poverty rate for the population as a whole was 13.5 percent in 2015, the rate varies greatly by race. African Americans had the highest poverty rate at 24.1 percent and Non-Hispanic whites the lowest at 9 percent. However, separately examining the

epidemics of HIV/AIDS, poverty, trauma, incarceration, etc. among AA MSM men in isolation from one another will not fully explicate the correlation to heightened vulnerability for HIV and AIDS within these populations (Wilson, et al, 2014).

Research proves that factors individually related to HIV risk may also have complex relations with other variables. For example, Wilson, et al (2014) reiterates the point of multiple research studies, which have suggested that "the high likelihood of living in impoverished neighborhoods [facilitates] the relationship between minority race and the increased likelihood of using/injecting drugs"; which is another common method of transmitting the virus (Morton, 2007; Lillie-Blanton, Anthony & Schuster 1993; Fuller, et al, 2002). Also, given the residential density of AA communities (especially in urban areas) and the higher prevalence of HIV among them, compulsory or preferential racial exclusivity to partners within their own sexual networks place AA MSM at greater risk for being exposed to HIV with each new encounter (Newcomb, et al 2015; Hill, et al 2017).

Moreover, living in poverty almost guarantees that most African Americans rely on public education. Unfortunately, sexual education in most low income public schools has been limited to an abstinence only format for decades. Since 1998, federal, state and local governments have invested almost two billion dollars in abstinence-only and abstinence-only-until-marriage (collectively referred to as abstinence-only) education programs in public schools; the aim of which is to prevent/discourage teens and unmarried couples from engaging in all sexual activity until marriage (Advocates for Youth, 2007). Ironically, federally funded reviews of abstinence only programs have shown that youth enrolled in these programs were no more likely than those who were not to delay sexual initiation, to have fewer sexual partners, or to abstain entirely from sex (Advocates for Youth, 2007). Additionally, the most recent report of

enrollment trends suggests that, between 1976 to fall 2014, enrollment in degree-granting postsecondary institutions - which generally have curricula that are not limited to an abstinence only sexual education format - has not risen more than 14 percent among African Americans (NCES, 2016). Which means that the opportunity to become better educated about the transmission and prevention of the virus through higher education is lost on many AA MSM and members of the communities they live in.

Also, poverty contributes to increased vulnerability to HIV due to a lack of health resources. A lack of health resources may also be understood as a lack health insurance coverage, which places minority MSM at a grave disadvantage for attaining the testing, treatment, care and prevention services they need to protect themselves and others from acquiring the virus. In 2015, The uninsured rate for African Americans was almost two times higher than for non-Hispanic whites, at 11.1 percent, but lower than for Hispanics - 16.2 percent (US Census Bureau 2016). Given the exorbitant cost of PrEP – 1300 dollars per month, without subsidies, plus the added expenses of office visits and lab work (Costa-Roberts 2015; Keller & Smith 2011) - it becomes clear why PrEP use statistics for AA MSM would be much lower than others.

Similarly, Nelson, et al (2016) reported that economic, legal, and social hardships are associated with HIV risk among AA MSM. African Americans are disproportionately impacted by unemployment and underemployment. In 2015, the unemployment rate for African American men (10.3) was more than twice that of Non-Hispanic white men (4.7) and almost 40 percent higher than for Hispanic men (6.3) (U.S. Bureau of Labor Statistics 2016). Nelson and colleagues found that AA MSM with recent job loss were more likely to engage in condomless insertive anal intercourse and that those with recent financial crisis were more likely to have had

two or more male sexual partners in the past 6 months. Also, AA MSM with recent convictions were more likely to have a sexually transmitted infection at 6 months, while those who were unstably housed were more likely to have a sexually transmitted infection within 12 months. Multiple other studies correlate mass incarceration to increased poverty and unemployment (Adimora, et al 2005; Roberts 2003), experiences of violence and trauma (Roberts 2003), unprotected sex (Jones, et al 2008), and the disruption of existing sexual networks leading to increased HIV risk (Adimora, et al 2005).These multidimensional studies collectively demonstrate the importance of examining how the confluence of substance abuse, trauma, incarceration, and poverty – as social epidemics - can and do lead to increased HIV vulnerability, incidence and prevalence among AA MSM.

- ***Critical Race Theory (CRT)***

The fundamental claim of critical race theorists is that racism has been so embedded into the fabric of society that it is now an everyday experience of most people of color in this country (Delgado & Stefancic 2012). Another relevant supposition of CRT, often referred to as "interest convergence" or material determinism, adds a further dimension to the discussion on race and public health interest. This tenet of CRT asserts that because racism advances the interests of both elite (materially) and working-class Caucasians (psychically), both of which combined comprise the racial majority of American society, have little incentive to eradicate it (Delgado & Stefancic 2012). The recent political reaction to nationalistic, xenophobic and neoliberal campaign tactics and agendas, from the white working class (the majority) - based on perceived economic losses and an assumed wane in their economic interests (Beauchamp 2017) - enhances and engenders conservative and neoliberalistic disinterest in sustaining a welfare state that might be in a position to pool resources to tackle social, economic, and public health inequalities; such

as the high prevalence of HIV/AIDS among AA MSM, and the socioeconomic challenges that exacerbate it.

The welfare state can be understood as a social agreement for coping with collective risks and lessening social inequality. This function is, however, ridden with social prerequisites, since off-setting risks and diminishing social inequality often requires an unequal distribution of costs and burdens (Tucker 2016). A culturally homogenous population tend to better create and sustain a large welfare state, since it is dependent on the integration efforts by the nation state, and solidarity between its members (Mau 2007). This cultural solidarity is necessary for the state to justifiably impose the requisite financial sacrifices of redistribution upon its members (Mau 2007). One might expect then, that solidarity within the welfare state, and by virtue the welfare state itself, will be significantly weakened as a result of increasing social heterogeneity (Alesina & Glaeser 2004; Sanderson 2004; Soroka, et al 2006). As the number of immigrants in industrialized welfare states of the northern hemisphere continues to increase, so too does social diversity in these countries (Mau 2007).

- ***Conclusion & Recommendations***

Realistically, the act of sex between men is not itself inherently dangerous. Only within the context of an advanced stage of the HIV epidemic among MSM and a lack of preventive services (or awareness/uptake of services) do sexual acts of any kind become high risk exposures for infection. The interplay between the various levels of risk should also be considered; for instance, while receptive anal sex (individual risk) poses higher HIV infection rates, it only occurs through interpersonal activity (network), that is influenced by socio-cultural norms (community), and constrained by ineffective and one-dimensional public policies (public) (Baral, et al 2013). The benefits of institutional adaption of HIV care as a routine part of everyday

activities, as implemented in Botswana, are evident (Whittlesey 2005). So, the focus then should be placed on the socio-ecological elements, political-economic and institutional barriers that are at play.

The National Minority AIDS Council (NMAC) (2014) made several recommendations on how to approach the epidemic among AA MSM. The most germane of them all, one might surmise, is to increase funding for and advocacy within the Department of Education to enforce comprehensive sex education in public schools; inclusive of a discussion of homosexuality, healthy sexual practices and prevention methods across the sexuality spectrum, that gives students information to protect themselves and their partners if they choose to be sexually active. Advocates for Youth contend that only comprehensive sex education can adequately help young people to reduce their risk of potentially negative outcomes; such as unwanted pregnancies and sexually transmitted infections (STIs) and HIV transmission or contraction (2007). They also posit that comprehensive sex education can also help to enhance the quality of relationships and to develop decision-making skills for youth, that will prove invaluable throughout their lifetime (2007).

The NMAC (2014) also suggested developing an objective measure of success for comprehensive sexual health programs; such as a comparison of HIV/STI incidence before and after program implementation, to provide the most effective and evidence-based harm reduction trainings. They went even further outside of the classroom setting to suggest additional funding for programming within community-based organizations. The primary aim being to build these organizations' capacity to teach and reinforce sexual health, and to help foster community with peers and mentors for young AA MSM; as a means to reduce emotional distress and social isolation. Moreover, they included utilization of online social networks, to help disseminate

information related to sexual health needs to young AA MSM and those in rural settings and to affirm community support.

Routine/Opt-out HIV screening, which has exhibited notable success in other countries, like Botswana (Whittlesey 2006) - and is now officially recommended by the US Preventive Services Task Force (2013) - will also help reduce barriers to HIV testing based on perceived risk determination (National Minority AIDS Council 2014) and concerns about risk compensation. The CDC believes that opt-out screening for HIV holds many benefits to those within high risk groups and everyone in between. Despite unverified concerns, the method has shown preliminary success. For example, a recent study, by Rosen, et al (2015), that underscores the potential implementation and inmate perceptions of "opt-out" HIV testing in prison, reported that 89 percent of prisoners wanted to be tested, 85 percent were tested according to their wishes, and 82 percent correctly understood whether or not they were tested.

The CDC (2014) notes that this measure, if widely implemented, has the potential to increase earlier awareness of serostatus, which is conducive to better efficacy of treatment or prevention methodologies. They also suggest that this move could reduce the stigma associated with HIV testing and treatment, enable those who are infected to take steps to protect the health of their partners, as well as further decrease the number of antenatal incidence of HIV (U.S. Department of Health & Human Services 2015). Unfortunately, however, within the scope of the general public, physicians often miss opportunities to diagnose AA MSM due to a disinclination to offer screening, thereby delaying the initiation of treatment (Millett et al, 2011) and jeopardizing the potential success of an "opt-out" model. These opportunities may stem from provider bias, cost, stigma, homophobia, or poor training of providers who perform sexual health screenings (Millett et al, 2011). What's more, is that distrust of health care providers, including

real or perceived experiences of homophobia and racism within health care settings, can impede candid and honest interactions between AA MSM and the physicians they encounter (Klitzman, Greenberg, 2008). The National Minority AIDS Council (2014) suggests that open and honest communication between health care providers, especially nurses, and AA MSM men is vital in successfully diagnosing HIV and STIs, as well as counseling around risk reduction strategies.

The NMAC also added that it is crucial, for medical practitioners to be accessible and affirming with their patients and create an environment conducive to disclosure. Metzl & Hansen (2014), suggested a transition away from pedagogic approaches in medical education that emphasizes understanding issues of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. This approach, dubbed "structural competency", suggests training for medical students and practitioners in five fundamental competencies: "recognizing the structures that shape clinical interactions; developing an extra-clinical language of structure; rearticulating "cultural" formulations in structural terms; observing and imagining structural interventions; and developing structural humility" (Metzl & Hansen 2014).

The CDC's recommendation to providers and public health organizations is that, as a part of PrEP care, people who take the daily medication for HIV prevention be tested for bacterial STIs at least once every six months, even if they do not have symptoms (2017). David C. Harvey (2018), of the National Coalition of STD Directors (NCSD), is in favor of this recommendation, arguing that the HIV and STD epidemics are "inextricably linked" and there won't be an end to HIV, unless both are adequately addressed. Consequently, a joint research report by the CDC and Emory University's Rollins School of Public Health, presented at the 2017 Conference on Retroviruses and Opportunistic Infections, found that there has been a noticeable reduction in the

transmission of STIs among those who are using PrEP, since they are receiving regular STI screenings and treatment (Jenness, et al, 2017). This therefore means that if PrEP uptake were to increase, then it can be expected that rates of STI's would decrease.

The National Minority AIDS Council (2014), also made suggestions on addressing the roles of the media and cultural values in addressing the issue. The organization suggested that the media should be encouraged to better showcase supportive characters who affirm AA MSM and encourage stronger relationships between them and the general African American community. From a social interactionist standpoint, the need for positive representation is evident. Take for instance the positive response to the critically acclaimed film, "Moonlight" and TV show, "Empire", that underscore the plight of AA MSM in the African American community. Unfortunately, neither of them included an open discussion or portrayal of the impact of HIV on AA MSM. This is problematic, since there are AA made films that feature HIV as a divine punishment or result of sexual deviance; case in point, Tyler Perry's *Temptation: Confessions of a Marriage Counselor* (2013) and *For Colored Girls* (2010) respectively. Cohen (1999) posits that people exposed to frames that connect systemic issues to individual behavior (episodic frames) tend to blame individuals for their own condition.

Episodic frames influence African American attitudes about HIV/AIDS, about people associated with it, and about policy options designed to deal with it. Just as Bill Cosby (2004) blamed African American (AA) poverty on the lack of proper parenting, AA elites blamed HIV/AIDS on the deviant behavior of black men. Black organizations and elites are generally reluctant to organize around HIV/ AIDS, in part because they felt that those who contracted the disease brought it on themselves (Cohen 1999). In addition, there is also the popular idea that HIV is a 'white gay male' issue, not something African Americans need to or should have to

worry about (Williams 2007). The NMAC also highlighted the need for community support for a shift in religious ideology to encourage the reduction of queer-related stigma, and specifically address the holistic needs of AA MSM within their respective congregations.

AA MSM face significant challenges in accessing care when they also must contend with lack of transportation, food insecurity, mental health challenges, unstable housing, and inability to pay for health-related services without and even with insurance. The CDC and its partners have been diligently pursuing a high-impact prevention approach and supporting projects focusing on minorities to improve diagnosis, linkage to care, and retention in care, and to reduce disparities in HIV-related health outcomes (Siddiqi, Hu & Hall 2015). Consequently, 72 percent of African Americans diagnosed with HIV in 2014, were linked to HIV medical care within one month. Two years prior, of African Americans diagnosed with HIV in 2012 or earlier, 54 percent were retained in continuous HIV care and 49 percent had a suppressed /undetectable viral load (virus at low enough levels reduce transmission risk) (U.S. Department of Health & Human Services 2016). This is a much-needed indication of progress, that I hope will continue. And with the help other federal programs, like the Ryan White HIV/AIDS Program, there is room for even greater optimism.

The Ryan White HIV/AIDS Program provides a comprehensive system of care that includes primary medical care and essential support services, such as: providing last resort direct client services for HIV treatment and related health completion services to ensure continual care such as case management, psychosocial support, treatment adherence, temporary housing, nutritional services and transportation for medical appointments, for people living with HIV who are uninsured or underinsured. It was created to address the medical needs and supportive services of HIV-positive persons with limited resources and currently services approximately 52

percent of all people diagnosed with HIV in the United States (Health Resources & Services Administration 2016). The Program is administered by and funded through the U.S. Department of Health and Human Services (HHS), the Health Resources and Services Administration (HRSA), and the HIV/AIDS Bureau (HAB).

While the new administration's "budget blueprint" has not mentioned any cuts directly to the Ryan White Program, it has proposed an 18 percent cut for the Department of Health and Human Services overall. Dawson & Kates (2017), of the Kaiser Family Foundation, notes that If these cuts are realized, the Ryan White Program may not be able to sustain existing levels of service provision, especially if more individuals require assistance in attaining HIV related care and treatment, due to a loss of or reduction in insurance coverage. Much of the proposed changes could impact coverage for people with HIV in terms of eligibility, benefits, beneficiary protections, and enrollment requirements. It will be important to watch how further related proposals, under the recently proposed restructured healthcare bill, might impact access to programs like the Ryan White HIV/AIDS Program.

Recommendations for tackling the HIV epidemic from an economic standpoint could include a focus on the universal economic impact of aggressively, versus passively, treating the virus. Shah, et al (2015) postulate that a "*failure to improve engagement in HIV care in the United States leads to excess infections, treatment costs, and deaths. Interventions that improve not just HIV screening but also retention in care are needed to optimize epidemiologic impact and cost-effectiveness.*" Their research breaks down the national economic burden of the epidemic, in dollars and cents, and outlines the potential fiscal benefit to focusing more economic energy into eliminating or delimiting the impact of the virus. Shah and colleagues projected that, despite early ART initiation, 1.39 million new HIV infections will occur in the

US; costing approximately 256 billion dollars over two decades, given the existing levels of HIV care engagement. Their recommendation is that enhancements made to testing, with increased linkage to care, can have modest epidemiologic benefits and could reduce HIV infections by 21 percent. By contrast, comprehensive improvements that couples enhanced testing and linkage to care with improved retention would reduce HIV incidence by 54 percent and mortality rate by 64 percent, at a cost-effectiveness ratio of over 45 thousand dollars per quality-adjusted life-years (QALY) gained.

Finally, this review uncovered a notable gap in the available literature. There are currently not many researchers who investigate the impact of HIV on black immigrants in the US; most studies treat black Americans as a monolithic racial or cultural group, and do not tend to subcategorize the population by ethnicity, immigration status or cultural origin when examining structural inequalities. Within the research that does discuss the HIV related issues faced by black immigrants - who are also likely to have been counted among the statistics examining HIV prevalence among AA MSM - there are clear barriers to care and treatment. Ojikutu, et al (2014) drew attention to the fact that immigrants from sub-Saharan Africa and the Caribbean face significant barriers to HIV testing.

Their analysis revealed that having a primary language other than English, lower education levels, low income, limited access to a regular healthcare provider, and recent immigration (as opposed to earlier arrivals), were independently associated with greater barriers. It is important to note that barriers due to health care access, privacy, fatalism, and anticipated stigma were greater for recent versus longer term immigrants. Clearly, interventions to improve access to and timely entry into HIV care are crucial for these subpopulations. I posit that an examination of the significant cultural differences that exist within the melting pot of black

America, could offer some undiscovered solutions for dealing with the HIV epidemic among AA MSM.

Figures and Tables

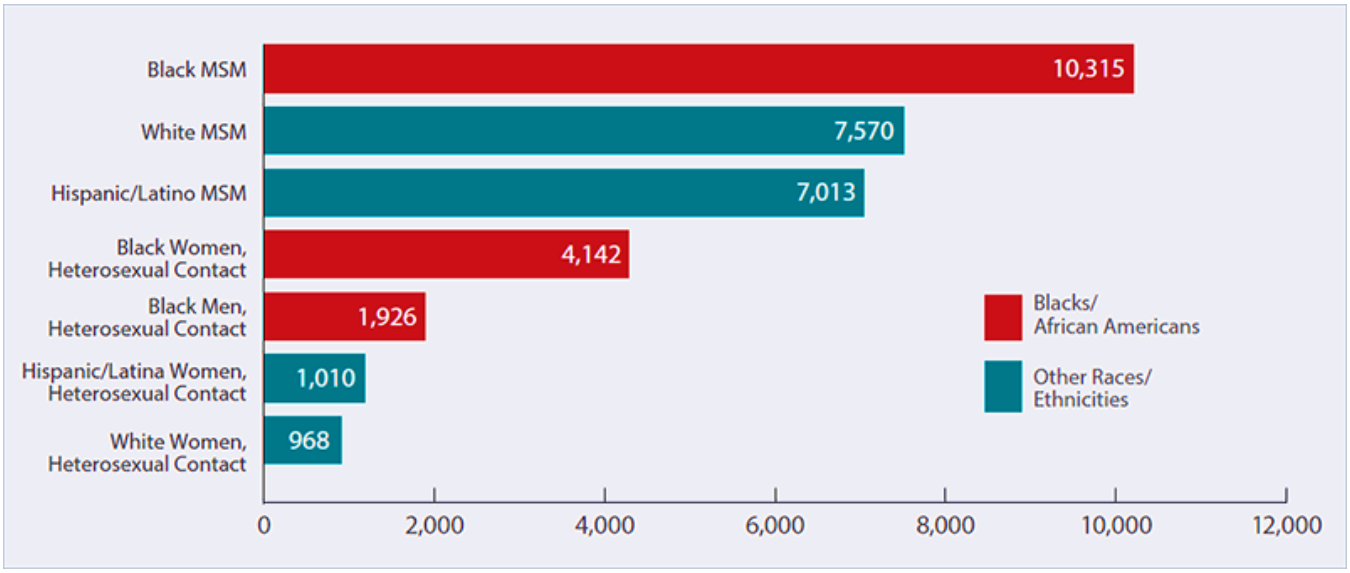

Figure 1- *HIV Diagnoses by Risk Group*. Source: CDC HIV Surveillance Report 2016; 27

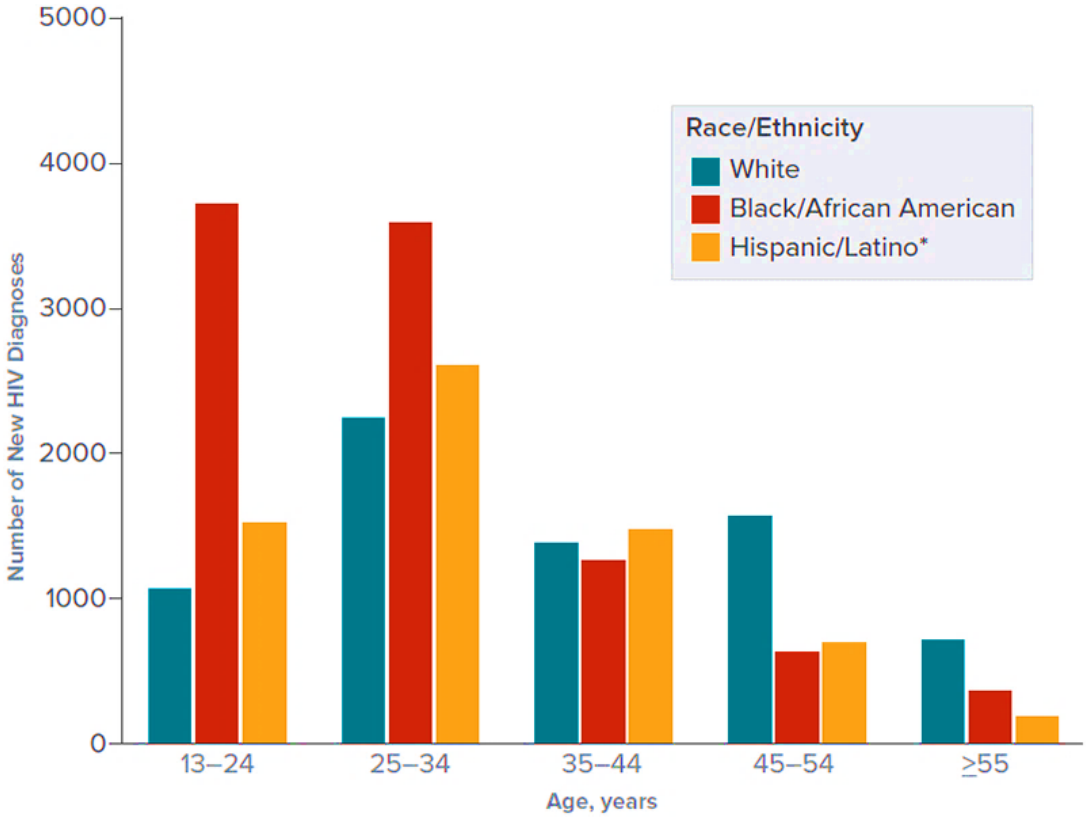

Figure 2 –New diagnoses of HIV infection in the United States and dependent areas, 2015 by race and age group. Source: CDC HIV Surveillance Report, 2016: 27

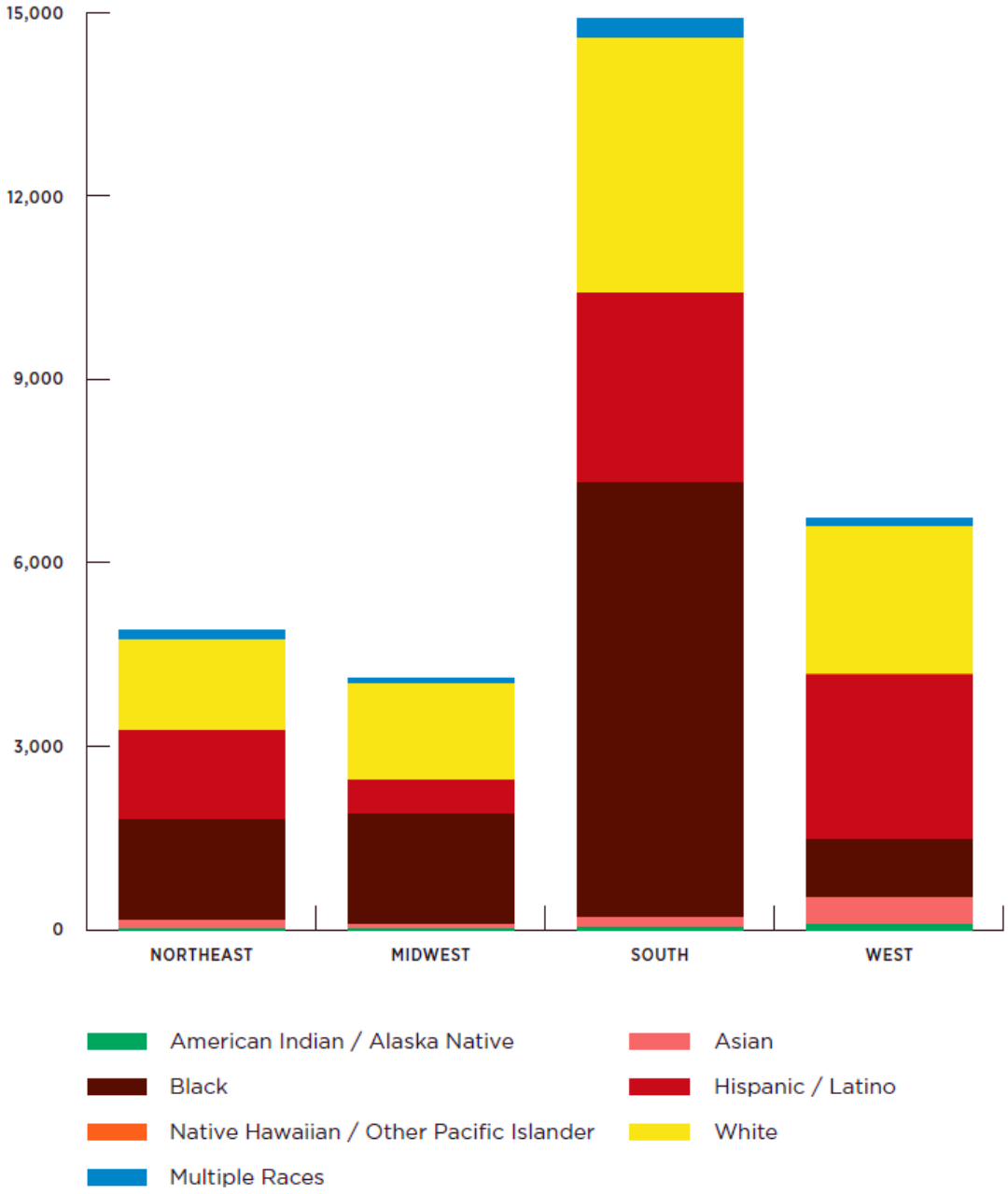

Figure 3 – *Estimated Diagnoses of HIV infection among MSM, by region or residence and race/ethnicity*, 2014. Source: CDC HIV Surveillance Report. 2014; 26.

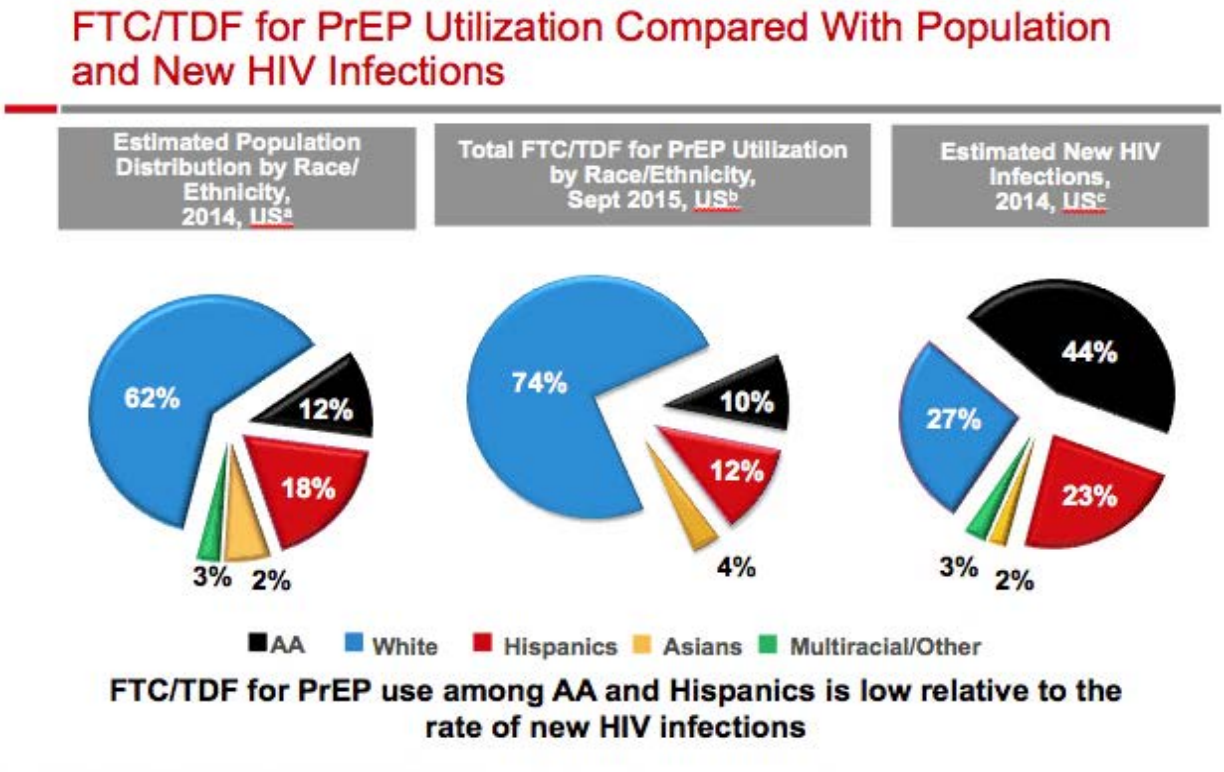

Figure 4 – *PrEP Use by Race*. Source: Southern HIV/AIDS Strategy Initiative (Ervin, et al 2016)

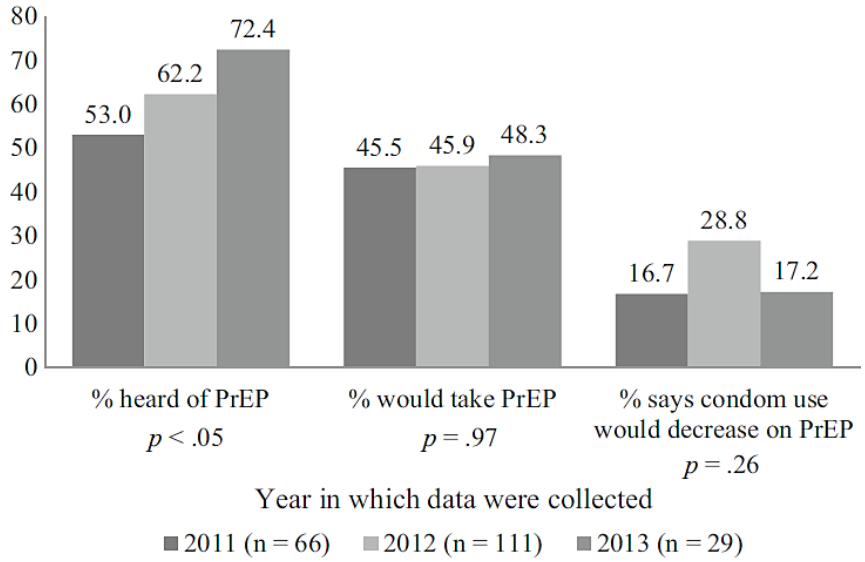

Figure 5 – *PrEP Familiarity Scale*. Source: Grov, et al 2015. Changes in PrEP familiarity, uptake, and the perceived impact of PrEP on condom use between 2011 and 2013.

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