EXISTING BARRIERS TO CARE FOR HIV POSITIVE BLACK MSM LEAVING PRISON

by

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A dissertation submitted to the faculty of
The University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in
Health Services Research

Charlotte

2017

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ABSTRACT

ERIC J. JUNIOUS. Existing Barriers to care for HIV positive Black MSM leaving prison (Under the direction of DR. DIANA ROWAN).

This study explored barriers of reintegration among Black men who have sex with other men (MSM) who are living with HIV and have histories with the criminal justice system in the state of South Carolina. This study uncovered barriers accessing HIV-related medical care and social service support among this population as they reintegrate into their communities and the larger aspects of society. The study design allowed the participants to tell their story in their own words. The study's research aims were: what is the process for accessing HIV-related medical care and social service support for Black MSM who were formerly incarcerated (BMSMFI) who are HIV positive, what are the common experiences among this sample population regarding multiple citizenships among subordinate groups as HIV positive BMSMFI, and what are some ways to improve healthcare utilization and social support for BMSMFI. The study determined the need for the development of multifaceted clinically sound approaches that consider the merging identities, and or dual citizenships, of subordinate groups when engaging populations like this focus population, ultimately contributing to the knowledge base for research and practice paradigms related to BMSMFI.

DEDICATION

To my dear Joshua Eric Junious, you have sparked a fire in me, and I am grateful to be your father. To my father, George “Go Go” Junious, thank you for your unwavering support; even when I saw you leave, you showed me what bravery is, and I feel your loving strength daily. To my little brother Lamont “Monty” Junious, I miss you every day; you made me become informed about HIV, same-sex sexuality, and the stigma experienced by men who are all of these things leaving prison. I’m still down here fighting for your voice, and I promise I will tell your story. Lastly, this dissertation is dedicated to my Father who loved me, and supported me through it all!

ACKNOWLEDGEMENTS

"Service to others is the rent you pay for your room here on earth."

~Muhammad Ali (1942-2016) The greatest fighter of all time, civil rights activist, inspirational humanitarian, and social change agent

I would love to give my humble gratitude to everyone who has been a part of my recent growth and transition both personally and professionally. The unseen acts of love and unconditional support are the very reasons I am here. More importantly, I would like to thank the "unseen essential" who has made His presence felt in many times in my life when I truly felt undeserving of His mercy. Dear God, what a wonderful craftsman you are. You knew things about me and my life that I could never imagine or dream possible.

To Darrin Johnson, thank you for pushing me and running this race alongside me. To Dr. Huet, thank you for believing in me and sticking by me. You have supported me through every trial of which you were aware these past few years; your compassion is invaluable, and I am more than grateful. Dr. Conner, I am so grateful for your listening ear and words of advice; those qualities are priceless, and I am so happy that you are who you are. Thank you Dr. Smallwood for always checking to see how I am doing; you truly care about my development. To Dr. Abrams, thank you for being a comforting voice and spirit. You are a fixer, and you have awakened new ideas in me on how to move my career forward.

Lastly, thank you Dr. Diana Rowan, there have been many times that I felt like I was drowning, and you drove several hours to be there for me. I do not know how I became

so fortunate; you have adopted me as family, and I truly appreciate you taking on the task of making me better. You have inspired me, and I am truly grateful to have you in my life.

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INTRODUCTION

During the 1970s, five young White gay men who were otherwise healthy were diagnosed with Acquired Immune Deficiency Syndrome (AIDS), giving the disease national attention (Friedman-Kien et al., 1981). The condition that preceded AIDS was eventually identified and called Human Immunodeficiency Virus (HIV); this condition was first discovered in San Francisco, California, and New York, in the 1970s among openly gay, White men during a time of excessive homophobia and bigotry (Gostin, Ward, & Baker, 1997). Since the 1970s, an HIV epidemic has occurred in marginalized populations, especially the same-sex loving community. For 40 years, the HIV epidemic has affected millions globally (Starr & Springer, 2014).

In the 1980s, the United States became an epicenter of the HIV epidemic, with infection rates growing in larger cities, such as New York and Los Angeles (Kaplan et al., 2000). These environments were prime for new cases of infection largely due to fear based on homophobia, ignorance about HIV, and lack of adequate factual information (Dieffenbach & Fauci, 2011). The lack of awareness fueled misconceptions that led to the growth of HIV, which subsequently created a vacuum of services and qualified professionals equipped to address it and help society cope and manage the new public health crises.

More importantly, those same circumstances acted as a crucible for HIV to inequitably impact vulnerable populations. According to Graham, Treadwell, and Braithwaite (2008), this new syndrome and the socially/economically deprived conditions fostered in poor communities or ghettos created a level of apathetic divide that communities of color still struggle to reconcile. During the second decade of the HIV

epidemic, the virus affected communities of color, particularly Blacks, disproportionately (Poundstone, Strathdee, & Celentano, 2004). Marginalization is typically defined as social exclusion or social disadvantage in the areas of education, employment, economics, politics, and criminal justice (Halkitis, Wolitski, & Millett, 2013). The unmet needs of vulnerable populations have influenced the rapid growth of health disparities in marginalized communities, especially communities of color. HIV has emerged as a serious chronic condition that disproportionately impacts many people who feel marginalized already by the effects of oppression because of their beliefs, sexual or gender identification, race, and/or social class (MacKellar et al., 2007).

In communities of color, HIV quickly found a fertile environment due to risky behaviors that expedited its growth (Romer et al., 1994). Blacks, who comprised 13% of the national population, were diagnosed with HIV at a disproportionate rate, accounting for more than half of new HIV infections. Unfortunately, HIV still disproportionately affects the Black community due to risky behaviors (Brizay et al., 2015). These same communities are plagued with problems in regards to the criminal justice system and often are incarcerated disproportionately (Alexander, 2011).

The widespread occurrence of HIV in the Black community and communities of color has created a vehicle for further transmission through the Department of Corrections (Hammett, 2006). The relationship of HIV and mass incarceration is symbiotic due to the nature of risky behaviors, which are significant conduits for HIV and crime, the latter being the critical factor that leads to incarceration (Wohl, Rosen, & Kaplan, 2006). The prison population growth for Blacks exploded during the 1980s and 1990s; ironically, at the same

time, HIV infection rates increased (Wohl, 2012). This aspect of HIV transmission has long occurred, without clear, effective polices to combat it within the prison system.

Background

The invisible epidemic of HIV within the prison system has been produced by structural systems of oppression that have rapidly manufactured mass incarceration (James, 2013) and HIV, in and out of prison (Meyer et al., 2017). The nuances of institutional discrimination are cumulative, intergenerational, and disproportionately impact the communities to which the formerly incarcerated return (Meyer et al., 2017). Scholars use various terms to define this process, including reintegration, reentry, and offender rehabilitation through transition (De Coster & Zito, 2017).

HIV Positive BMSMFI Offenders

Historically, the criminal justice system has offered an important point of contact for efforts to improve the healthcare utilization patterns of HIV positive BMSMFI, through testing and interventions for this vulnerable population (Swan, 2016). Research shows that approximately 25% of people living with HIV pass through the Department of Corrections yearly (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012). In 2010, 20,093 incarcerated people lived with HIV, with men comprising 91% of that population (CDC, 2015). Among that population, Black men were five times more likely than their White counterparts to have HIV. The entrenchment of HIV in prison is well documented, but the transmission of HIV is often void of contextual analyses that include the sum of factors that facilitate its growth. The common perception of HIV transmission methods is substance abuse of injectable drugs, consensual sex, and predatory sex. However, the data do not substantiate this view, despite many myths associated with prison, sexuality, HIV,

and Black men. In fact, many BMSM are infected before incarceration and unknowing participants in a vicious cycle of frequently entering in and out of correctional settings because of low socioeconomic status and high risk behaviors.

HIV positive BMSM Formerly Incarcerated and Reentry

The process of reentry is a difficult one, but persons living with HIV (PLWH) are subjected to HIV stigma and have additional barriers engaging in HIV care. The incidence and prevalence of HIV and AIDS in prison remain difficult to measure due to institutional protocols and stigma experienced by inmates (McLemore et al., 2010). The main barriers to HIV treatment in prison communities are lack of programs and negative perceptions of BMSM. Eventually, these barriers contribute to the rise and spread of HIV in this community once released (Montague et al, 2012). For many in this population, risky behaviors and crime are major conduits for HIV and lead to jail or prison. These risky behaviors mainly include situational sex or sex work, substance abuse, and crime (Epperson, El-Bassel, Chang, & Gilbert, 2010). Blacks represent more than one million of the 2.3 million people incarcerated; Black men represent 37.8% in federal institutions and 38% of state institutions; overall, Black men are 5.1 times more likely to be incarcerated than their White counterparts (Kaeble, Glaze, Tsoutis, & Minton, 2015). The disproportionality of incarceration in the Black community reflects a lack of resources and opportunity; however, it also speaks to oppression and shame due to negative self-appraisal (Sampson, 2016). Many who are a part of this population find themselves returning to the same community from which they came; when they return as HIV positive felons, they find discrimination and stigma (McLemore et al., 2010). The experience of being in prison

is stigmatizing, but for many in this community, it has been normalized and is seen as a rite of passage until they are released and have to start over (Maruna, 2011).

The formally incarcerated are a socially excluded group deemed vulnerable due to their histories of substance abuse, experiences with poverty, mental health issues, and criminal history. Many return home with significant needs that go unmet (Binswanger et al., 2011).

HIV Positive BMSMFI and Community Care Settings

The discussion about HIV inequities and care remains active in 2017. HIV is no longer a death sentence as persons are living longer due to antiretroviral treatments, yet medication cost is still incredibly high (Wohl, 2016). Aging with HIV has a unique set of consequences. For example, PLWH do not qualify for Supplemental Security Income (SSI) and must rely on community based organizations (CBO) to provide programs to link them to care (Dworkin, Fleming, & Colvin, 2015). These programs are typically grant funded and vary in size and resources.

In South Carolina, these disparities are displayed through HIV incidence collectively; in fact, South Carolina is among ten states with the most significant amount of new HIV infections totaling 391 new cases at yearend 2014 (CDC, 2015). These inequalities substantiate South Carolinas need for programs to curb new HIV infections; more importantly, it establishes the need to provide linkage to social services and HIV related care for HIV positive BMSMFI who struggle through reintegration.

Some programs identified for this study are connected to the University of South Carolina immunology center, and others are connected to CBOs in the area, such as Palmetto AIDS Life Support Services (PALSS) and South Carolina HIV/AIDS Council in

Columbia, South Carolina. These agencies often refer their clients to providers that are a part of the local collaborative, such as Healthy Connection and ECCHC Eau Claire Cooperative Health Centers for HIV healthcare. South Carolina has two frequently used corridors to coverage because of its position regarding the Affordable Care Act (ACA). South Carolina opted out of ACA's Medicaid expansion by refusing federal subsidies which would help the indigent. The first avenue to healthcare coverage, AIDS drug assistance program, is sponsored through the South Carolina Department of Health and Environmental Control (Sprague & Simon, 2014); the second is 340 B pharmacies, designed to serve PLWH with medication and treatment (Tseng et al., 2012). Each of these programs is used to serve PLWH who are poor or cannot afford treatment. These resources are subject to variation because of funding and political-institutional climates that influence resource allocation (Whetten & Reif, 2006).

Many who qualify for programs such as Housing Opportunities for Persons with AIDS (HOPWA) find trouble gaining access due to policies regarding criminal history set by the US Department of Housing and Urban Development (HUD) (Smith, 2016). This reality perfectly illustrates the importance of housing as a social determinant of health and discrimination at the government level (Bowen & Mitchell, 2016). These same regulations prevent BMSMFI from returning to loved ones who live in low-income housing because of the location often being in crime riddled areas, which is against conditions of probation. If family or friends live in Section 8 housing, the released inmate cannot live with them because it against housing policies for people residing in these communities (Goodridge & Strom, 2016).

Housing as a Barrier to Care

HIV positive BMSMFI face obstacles to gaining access to housing once they return to society. In fact, they typically have five choices for housing: community based, transitional housing, homeless shelters, federally subsidized housing, and private housing (Harding, Morenoff, & Herbert, 2013). Community based housing is a form of transitional housing associated with federal incarceration; the state of South Carolina primarily uses homeless shelters such as Alston Wilkes, which is a non-profit agency (U.S. Government Accountability Office, 2012). These organizations provide temporary housing but do not provide long term solutions to housing instability; residential instability often increases the chances of re-incarceration (Leasure & Martin, 2016). Some offenders eventually access federally subsidized housing under the Fair Housing Act, depending on their crime; however, the formerly incarcerated are not a protected class (U.S. Government Accountability Office, 2012). More importantly, the US Department of Housing and Urban Development (HUD) prohibits public housing agencies (PHAs) from admitting people who have been charged/convicted of a drug or sexual crime (U.S. Government Accountability Office, 2012). Under the 24th Code of Federal Regulations section 960. 203© (3) and 960.204, public housing assistance PHAs have the right to reject applicants with a history of criminal activity (U.S. Government Accountability Office, 2012). These policies make it almost impossible for people who have been formerly incarcerated to gain access to this type of housing.

Housing Opportunities for Persons with AIDS (HOPWA) is a program that helps persons living with HIV gain access to housing; however, BMSMFI are usually barred due to the aforementioned policies regarding criminal history, leaving them vulnerable to

private markets and complex subjective regulations upon the owner's discretion (Smith, 2016). In one study, 196 property managers were surveyed; 67% stated they would inquire about criminal record with 43% rejecting criminal applicants of any kind due to personal morals (Ouellette, Applegate, & Vuk, 2016).

ACA Insurance Health Programs

Currently, the battleground for healthcare is at the feet of the Affordable Care Act. On March 23, 2010, the Affordable Care Act was signed and set into place to help ensure that every American has secure, stable, affordable health insurance. The ability to obtain healthcare insurance poses potential challenges to BMSMFI in the workforce due to unemployment and underemployment (Vogenberg et al., 2017).

According to the Center for Disease Control and Prevention (2015), the Affordable Care Act (ACA) helps people living with HIV/AIDS. Historically, people living with HIV and AIDS experience barriers to obtaining private health insurance and seek care under programs such as Ryan White. People vulnerable to the insurance industry need a clear pathway to coverage that removes obstacles due to medical history. In regards to access, 17% of people living with HIV have private insurance while 30% are uninsured (CDC, 2015). The Medicaid expansion, which is a state-federal program, covers people living with disabilities from a low-socioeconomic status who are categorized as people who fall at 13% of the national poverty level (CDC, 2015).

Medicaid is a major source of funding for people living with HIV in addition to other programs. Under the Medicaid expansion, many HIV positive BMSMFI can access care once released from prison; however, in South Carolina the governor decided not to engage in this program. The 11th amendment supports South Carolina as well as other

southern states who have rejected the Medicaid expansion (Mason and Stephenson, 1993); ultimately, this decision advances the disenfranchisement of people who have been formerly incarcerated (Maher & Pathak, 2015).

Since the ACA was constructed to protect vulnerable populations, it created a decline with Ryan White awards (CDC, 2015). By design, The Ryan White HIV/AIDS Program is an important source of funding for persons living with HIV. Under the ACA, people do not have to wait for diagnosis to enter into care, which eases the process to attain coverage (CDC, 2015). Since the Medicaid expansion, the changes improve access to insurance for many people living with HIV and help them retain the coverage (CDC, 2015). A critical part to the implementation of the Affordable Care Act is how it broadens Medicaid eligibility, which for this discussion includes childless adults who suffer from HIV/AIDS. These adults, who were not previously eligible for Medicaid, no longer have to wait for diagnoses to engage in care (CDC, 2015).

People who fall into the category of childless adults are HIV positive BMSMFI being released from the criminal justice system (Hall, Wooten, & Lundgren, 2016). These men typically are poor, indigent and able to take advantage of expanded coverage through Medicaid (De Coster et al., 2017). However, with ACA implementation unfolding differently in every state, many are left without coverage, including BMSMFI who are HIV positive (Hall et al., 2016). Under the Medicaid expansion of the Affordable Care Act, felons receive access to care; however, South Carolina does not engage in this aspect of care. Consequently, BMSMFI in South Carolina are not eligible due to state policy. Ultimately, the Medicaid expansion provision is needed to connect this vulnerable

population to healthcare insurance, meeting their need for assistance (De Coster et al., 2017).

Healthcare Utilization

Currently, the barriers to accessing healthcare for HIV positive BMSM leaving prison are created by their experiences of exclusion and internalized once they re-enter society (McLemore et al., 2010; Wildeman & Muller, 2012). The experience of exclusion is drawn from the prison experience; it also is advanced through reintegration. However, it certainly impacts treatment or medication adherence (Frank, Linder, Becker, Fiellin, & Wang, 2014). More importantly, recently released HIV positive BMSMFI are associated with increased hospital and emergency department utilization, which indicates lack of having a primary care provider (Frank, Linder, Becker, Fiellin, & Wang, 2014). The criminal justice system offers an important point of contact for efforts to improve the healthcare utilization patterns of ex-offenders; however, the FI are often locked out of care when they return home due to national and local agency policies that exclude or disqualify them due to criminal history (Swan, 2016).

Research suggests that HIV positive BMSMFI who actively engage in healthcare typically report positive health results (Meyer, Qiu, Chen, Larkin, & Altice, 2012). Additionally, a segment of the population who is a part of this unique population re-offend by 48%, with 75% of that group who reoffends expressing the need for medical care they feel is impossible to acquire (Ejike-King, 2014). HIV positive BMSM who exit prison are plagued by policies affecting linkage to overall healthcare. An example is states opting out of the Medicaid expansion, which influences access outcomes (Robinson & Moodie-Mills, 2012).

Conceptual Framework for the Study

The multidimensional model of minority stress and intersectionality explores the experiences of accessing social services (public assistance) and healthcare among HIV positive BMSMFI in Columbia, South Carolina. Specifically, the model examines the relationship between several instances that promote stigma from institutions that advance structural barriers that indirectly/directly impact these group of men trying to find some since of stability. The journey of reintegration is a difficult one filled with stress generated through subtle forms of oppression that the day of release from incarceration. By definition, health services research is the interdisciplinary field that evaluates how people gain access to healthcare holistically. However, in this study, minority stress and intersectionality were meshed to evaluate the perceptions of the focus population and the impact of macro and micro aggressions that spawn stigma.

Minority stress is the description of higher levels of stress experienced by members of a stigmatized population (Meyer, 1995). The term primarily applies to marginalized populations, such as LGBTQ and communities of color, but what about men who are HIV positive BMSMFI? HIV positive BMSMFI feel they are stigmatized and belong to several subordinate groups. This belief is where minority stress and intersectionality congregate for this group of men in South Carolina, creating a disconnection with their immediate community and personally leading to poorer health outcomes (Higginbotham, 2017).

Historically, intersectionality is the study of the intersections among methods and/or institutions of oppression that are systemic and prevalent among women and marginalized groups (Crenshaw, 1991). Kimberly Crenshaw first applied it to Black feminism. In this study, the construct highlights the experience of HIV positive BMSMFI

(Higginbotham, 2017). The reoccurrence of minority stress in these circumstances are symbolic and impactful, yet are experienced in various ways due to the intangible intersecting social identities of being Black, MSM, HIV positive, and a former criminal (Quinn et al., 2017).

Purpose of the Study

This study documents the evolution of barriers to social services and HIV related care for HIV positive Black men who have sex with men who were formerly incarcerated in Columbia, South Carolina. The focus is on structural barriers regarding public assistance programs, stigma, and the way stigma impacts these men who attempt to gain access to the services they need while reintegrating into society. Reentry means many things to different people; however, the functional definition of reentry is all activities and or programs that prepare HIV positive BMSMFI to return to their communities as law abiding citizens (Visher, & Travis, 2011).

The process of reentry is more than being released back into the community; it encompasses the sociological and psychological journey of transitioning back to society (Listwan, Sullivan, Agnew, Cullen, & Colvin, 2013). The journey often includes the need for acceptance, forgiveness, community connectedness, and basic fundamental rights measured in broader terms than the basic needs of housing, healthcare, and employment (Maruna, 2011). The context of reentry presented in this study is housing, employment, healthcare, community connection, minority stress, stigma, and poor healthcare outcomes as they pertain to services that connect and influence engagement and retention in healthcare (Visher & Travis, 2003).

Specific Aims

This dissertation focuses on the relationship between HIV positive BMSMFI and the structural institutions that create barriers to HIV related care in Columbia, South Carolina. Additionally, this study examines the facilitators of minority stress and intersectionality of stigma at the various identity intersections of this group. Therefore, the primary aim of this qualitative phenomenological study is to gain an in-depth understanding of the experiences of Black men having sex with men (BMSM) living with HIV who were formerly incarcerated as they transition back into the community and access care. The study gives this vulnerable population a voice to express their experiences living with HIV by exploring their journeys to access healthcare, structurally and individually.

Specific Aim 1. Determine the process for accessing HIV-related medical care and social service support for formerly incarcerated BMSM who are HIV positive.

Specific Aim 2. Identify common experiences among this sample population regarding patient-provider relationships.

Specific Aim 3. Identify different ways to improve healthcare utilization and social service support for BMSM through recommendations made from this group of participants.

Organization of Study

Paper one explores then describes the nature of the sample population being invisible in South Carolina due to multiple memberships within the stigmatized populations of HIV positive, BMSM, and formerly incarcerated. In this paper, being invisible in South Carolina explains the negative experiences of HIV positive BMSMFI and structural barriers that are seemingly oppressive.

In paper two, participants' perceptions of barriers shape the discussion. The conversation begins by reporting structural obstacles that consist of system level barriers in South Carolina then transcends into an explanation the individual level barrier of stigma.

Lastly, paper three moves the discussion in the direction of public assistance in the form of housing and Medicaid as conduits for individual level stigma. These two structural level barriers are the most influential factors for HIV positive BMSMFI and ultimately lead to stigma. Housing and healthcare are reported as the important facilitators to better health outcomes, and by the group's own admission, the hardest services to acquire.

Chapter: 1 THE INVISIBLITY AMONG HIV POSITIVE BMSMFI IN SOUTH CAROLINA

The Invisible Man is a novel about a Black man living in the South during the beginning of the twentieth century who feels that his racial identity makes him invisible (Ellison, 2010). This novel, written by Ralph Ellison, addresses social and intellectual issues that dissected the connection of Marxism and Black men (Ellison, 2010). The novel's discussion as well as many others is the reason for the debate regarding what is fair and just pertaining to current populations considered vulnerable. Research once explained vulnerable populations as target populations but now considers them to be marginalized or subordinate groups, such as people who have been formerly incarcerated (Mazza, 2015).

Conflict exists among research professionals who attempt to examine these communities without fully appraising their experience critically through the lens of criminal convictions as a tool of discrimination (Tonry, 2017). The members of society who live in these circumstances often feel divorced from inclusion and citizenship that policies state they were never married to or a part of. Historic acts, such as the 13th Amendment, and Supreme Court decisions, such as Plessy vs Ferguson and Brown vs Board of Education, only make people who are Black and marginalized feel more excluded in America. Recent policies, such as the war on drugs, project exile, and No Child Left Behind, reflect acceptance or inclusion in many communities they target. Research suggests that these policies ignore social capital and the human condition through the attempt to merely identify the population or the problem that does not establish nor reinforce the personhood due to stigma (Sampson, 2016). Institutions that form policy influence these areas of stigma, making many in the communities of color feel excluded

and invisible due to their lack of voice within governmental structures that shape the way marginalized populations are viewed and live their lives.

Negative characterizations create and promote an aspect of invisibility that saturates people in these subordinate groups, making them feel essentially invisible (Purdie-Vaughns & Eibach, 2008). Since the origin of the human immunodeficiency virus (HIV) epidemic in America, populations deemed vulnerable have experienced rates of infections at a disproportionate rate (Worobey et al., 2016). The 1970s and 1980s provided a national auditorium for dueling epidemics in communities of color, which are historically classified as vulnerable populations. HIV has formed a nexus with communities of color and subordinate groups for a very long time (Bluthenthal et al., 1999; Wohl, 2016). Subordinate groups, such as men who have sex with men specifically BMSM, have been severely impacted by HIV.

The Centers for Disease Control and Prevention (CDC) applies the technical term Black men who have sex with men (BMSM) for the purpose of categorizing behavior that transmits infection (CDC, 2011). Often, overlap exists among population results regarding the data collection procedures among Blacks; the term BMSM helps reduce stigma or conflicting answers given by participants by stating the type of sex they have had instead of how they may see themselves (Preston et al., 2004). Categorizing specifically as MSM (men having sex with men) helps the CDC to quantify the population by race (Sheehan et al., 2016). Unfortunately, the term includes trans-woman persons without truly addressing their population size and perception of themselves and suppressing their sexual identity (Calabrese, Rosenberger, Schick, & Novak, 2015).

BMSM who have been formerly incarcerated (BMSMFI) have the same challenge of others due to their unique status as a subordinate group among several vulnerable populations who often are left voiceless in terms of accurately describing who they are and what challenges they face on multiple fronts (Sheehan et al., 2016). These men hold multiple identities in multiple groups, including Black, Black male, BMSM, Black felon, and HIV positive. Currently, the literature separates this group by race, gender, HIV status, and criminal history and does a good job reporting the amount of disparity regarding access to services. However, the literature does not report the perception of this population in regards to social and cultural factors that impact the way they seek care. Nationally, healthcare looks differently for vulnerable populations pertaining to resource allocation. Regionally, politics currently look very similar pertaining to social programs that impact the underserved.

Currently, BMSM in South Carolina experience the social and cultural politics of being in the South; however, BMSM who were formerly incarcerated may be disproportionately oppressed because of their previous crimes against the state. The conflict is due to social programs in regards to reentry. The formerly incarcerated deal with the irony of being qualified and disqualified at the same time; this irony usually happens around programs that deal with housing, insurance, and food (Newton, 2016). The qualified/disqualified quagmire would be best described as structural barriers that impact social programs that would benefit them as persons living with HIV (PLWH) in the South but are out of reach due to their criminal history and regional politics regarding healthcare (Garfield, Damico, Stephens, & Rouhani, 2014). This paper focuses on the Affordable Care Act, or Obamacare, and South Carolina's role in creating a barrier to health insurance

for HIV positive BMSM who are formerly incarcerated and feel invisible due to multiple subordinate statuses (McLemore, Winter, Walker, & Ray, 2010).

HIV Positive BMSM

Human Immunodeficiency Virus (HIV) is a chronic illness that weakens the immune system by attacking and destroying cells that combat disease and infection. This chronic illness has impacted marginalized communities and communities of color for more than 40 years (Young et al., 2017). Many impacted by HIV are from low socioeconomic statuses and find themselves reliant on many social welfare programs, from healthcare to housing, to aid in their struggle of living with HIV (Young et al., 2017). In fact, gay and bisexual populations categorized as MSM are the most impacted by HIV in America (CDC, 2015). MSM are estimated to be 2% of the total population in America but make up 55% of PLWH. At the current growth rate, BMSM have a 50% chance of future HIV diagnosis due to trends in the data (CDC, 2015). In 2014, MSM represented 83% (29, 418) of new infections, MSM ages 13-24 accounted for 92%, and BMSM represented 57%. BMSM accounted for 44% of all new infections nationally while the South represented 37% all new infections nationally (CDC, 2015).

The South has the poorest health outcomes regionally, and South Carolina is in the top four nationally (Cima et al., 2016). The areas or measurement for poor health outcomes are diabetes, heart disease, and obesity (Cima et al., 2016). When considering sexual health, the South leads the way for chlamydia, gonorrhea, and syphilis, which certainly offers explanations for higher HIV incidence due to the documented norms of risk behaviors and HIV transmission (CDC, 2015).

Poverty and lack of resources facilitate the growth of HIV. The economic burden of living in the South creates barriers to employment and health insurance, which in turn contribute to higher rates of infection (Oldenburg, Perez-Brumer, & Reisner, 2014). The South has six of the ten states with the highest levels of poverty, with South Carolina being number eight (Adimora, Ramirez, Schoenbach, & Cohen, 2014). Poverty is deeply connected to lack of education, which is related to poorer health outcomes (Adimora et al., 2014). The South leads the nation in educational disparities with the bulk of its children in public schools categorized as low income; also, it reports some of the highest dropout rates (Oldenburg, Perez-Brumer, & Reisner, 2014). Ultimately, poor educational outcomes influence the unemployment rates, which explain the high levels of poverty. The poverty rate among Blacks is at 25.7%, which is more than twice the amount of their White counterparts; these statistics present the factors that comprise healthcare and reflect the disproportionate representation of HIV in the Black community (Eberhart et al., 2015).

Black men and women were diagnosed with HIV disproportionately at the rates of 8 and 19 times to their White counterparts. Black men and women represented 50% and 71% of new infections in the South in 2012 (Reif, Pence, Hall, Hu, Whetten & Wilson, 2015). In 2013, the largest populations of individuals living with HIV were in the South at 57.6% (Reif et al., 2015). The majority of new AIDS diagnoses were also in the South (60%) among Blacks, which was significantly more than any other region. Hispanics accounted for 13.4% of the population and 18% of new HIV infections during that calendar year (Reif et al., 2014). Seventy percent of these people of color were of lower socioeconomic status and reported poorer health outcomes were attributed to barriers due to lack of public assistance regarding health insurance and housing (Eberhart et al., 2015).

CDC surveillance data indicated that 61% of new infections were among Black men who reported having male to male contact, 9% injection drug use (IDU), and 3% engaged in MSM/IDU forms of risk behavior (CDC, 2014.) Many in this population received late diagnosis, and the CDC surveillance reports that 1/3 of HIV diagnosis were late diagnosis (CDC, 2014.) According to the CDC, "late diagnosis is defined as receiving an AIDS diagnosis one year after being diagnosed with HIV (CDC, 2014.) It also reports that South Carolina is one of four states with the highest rate of late diagnosis (Rief et al, 2015).The data suggest that late diagnosis occurs in areas limited in resources and the individual diagnosed with HIV is not able to access regular medical care (CDC, 2014).

Mass Incarceration and HIV

America has the highest rate of incarceration globally, with more than 2.3 million people in prison or jails, equating to 750/100,000 residents, representing 3.2% adults (Mears & Cochran, 2014). Over the past 30 years, there has been a 239% increase in incarceration due to drug related arrests (Mears, Cochran, & Lindsey, 2016). Research indicates that minorities are overrepresented in the criminal justice system; Black males are seven times more likely to go to jail than Whites, Hispanic males are two times more like than Whites, equaling 38% and 20% of the prison population while accounting for 13% and 12% of the population in America (Seim, 2016). With 2.3 million people in America in correctional environments, the impact or rate of HIV infections among inmates is five times greater than people not incarcerated per capita (CDC, 2015). Ninety one percent of the 20,093 of the HIV infections were men, and among that population, Black men were five times more likely to acquire HIV than their White counterparts (CDC, 2015).

People in prison are the most difficult to diagnose and treat for HIV; however, they would benefit the most from prevention education, treatment, and linkage to care through discharge planning because of ancillary barriers (Travis, Western, & Redburn, 2014). These barriers can be structural, such as regional, cultural, and political environments that impact access to healthcare, and financial. They also can be individual, such as housing, employment, insurance, physiological, mental health, and HIV related care (Belani et al., 2012).

The United States Supreme Court ruled that all prisoners in America will have access to healthcare under Estelle vs. Gamble, (429 U.S.C. 97, 105); however, many returning to the community are still under the Department of Corrections in the form of probation and parole, leaving them disconnected from care because of barriers to communication and coordination to community services post release. Since this ruling, medical care has improved; however, the delivery of health services has faced challenges because of high turnover (Dyer, & Biddle, 2013). Many in the population participate in the revolving door of prison and are affected by mental health/substance abuse, infectious diseases like HIV, and sexually transmitted infections (STI) (Herbert, 2014). A study of a HIV jailed population in New York estimated that 5%-9% of its inmate population was infected, and 25% were undiagnosed. In 10 other studies of the HIV infected, minorities had a history of injection drug use (IDU), history of STI, and reported having sex with men. They also report having Hepatitis C (29%-80%), Chlamydia (2.4%), Gonorrhea (1%) which is higher than the general population (Ross, Liebling, & Tait, 2011).

Typical ways of HIV transmission in prison are through high-risk behaviors, such as unprotected sex, substance abuse by way of IDU, and tattooing (Jürgens, Nowak, &

Day, 2011). A 2005 study conducted by Georgia Department Corrections reported that HIV transmission in prison occurred and that 25%-30% were discovered through HIV testing (Thomas, Spittal, Taxman, & Kinner, 2015). Some educational programs, such as project START and project CLEAR (Boyd, 2002), reach out to HIV infected prisoners; however, many feel that programs like these promote stigma and discrimination, ultimately impacting the willingness of prisoners to engage in testing (Ball, 2014).

HIV testing policies are different per institution; inmates are typically tested through intake, upon inmate request, and offered during release for the inmate. The CDC recommends routine testing of jails and prisons; however, HIV testing is not offered in all facilities (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012). Routine opt-out testing has unique advantages, such as earlier diagnoses and linking infected people to care earlier (Beckwith, Zaller, Fu, Montague, & Rich, 2010).

HIV care in prison can facilitate access and delivery for effective treatment, and access to highly active retroviral therapy (HAART) is more available to inmates as compared to the general population (Rosen et al., 2009). HAART is a combination drug therapy used to suppress viral activity by effectively stopping HIV from replicating itself during different stages of its life course through a multidrug approach. In 2012, a national survey of correctional facilities indicated that 71% of state and federal systems provided HAART to inmates with elevated CD4 counts more than 300 (Iroh, Mayo, & Nihhawan, 2015). When taken adequately, HAART reduced opportunistic infections, and many reported achieving undetectable viral loads at the time of release (Rich et al., 2016). Typically, staff/personnel in charge of discharge and planning are familiar with HIV-related services within the community (Shrage, 2016).

No national programs for prison reentry specifically exist, only legislation such as Second Chance Act, Ban the Box, and models that incorporate housing for the formerly incarcerated, such as Austin Wilkes. Programs for reentry are typically faith based or operated through entities such as Goodwill (Solomon, 2004). These programs often focus on workforce readiness, life skills, and substance abuse (Shrinkfield & Graffam, 2007). Faith based programs are a large fixture within reentry; however, many BMSMFI feel a conflict with their sexual identity and the beliefs of faith based programs (Mears, Roman, Wolff, & Buck, 2006). Historically, the church has been a place of refuge for people of color; however, these men feel engaging with the church provides one more place to be judged within the community where they are trying to reintegrate (Lassiter, 2015).

The aforementioned programs help with transitioning those released from prison back to the community holistically; however, they do not fit every aspect of the formerly incarcerated. They provide assistance in several areas, but not HIV, just as HIV programs are not always inclusive of the formerly incarcerated. HIV programs address sexual orientation, but do not address the overlap or intersection of various identities (Wallace, 2007). These issues underscore the need for tailor made approaches that serve this population specifically. Case management and interventions improve linkage and retention to care through collaboration (Rich et al., 2001). These programs help develop social support, reduce risky behaviors, and prevent HAART disruptions, ultimately leading to viral suppression (Baillargeon et al., 2009). An example is Project Bridge in Rhode Island, where 90% registered in the program for 18 months, 75% needed primary medical care, 100% received HIV-related medical care from community providers, and 67% engaged in treatment programs (Springer, Spaulding, Meyer, & Altice, 2011).

Reentry and Minority Stress

The historic relationships between Blacks and institutions of power have created Black mistrust of the justice system and healthcare systems within the communities they serve. Health disparities among communities of color can be attributed to a life course overly impacted with stress, often creating mental health and physiological issues (Meyers, 1995). Minority stress is defined as high levels of stress that marginalized groups live under and can be caused by environmental factors, such as low socio-economic status (SES) and discrimination in the form of racism or prejudice (Meyers, 2013). Minority stress is described as "death by a thousand cuts" due to micro-aggressions which many in vulnerable populations face daily (Meyer, 2010); these micro-aggressions have been proven to lead to poorer health results. To understand risk behaviors and these related social stressors, Minority Stress Theory (MST) has been used to underscore the stress that minorities encounter consistently.

Historically, stress is conceptualized among the general public through the lens of environmental factors that are either acute or chronic (Hobfoll & Freedy, 1993); furthermore, social stress is used to understand the events that occur in a social environment (Turner, Wheaton, &Loyd, 1995). Social stress is the template for viewing health repercussions due to social conditions; however, minority stress emphasizes that individuals who are a part of minority groups are subjected to greater amounts of stigma. According to Myers, minority stress is "the incongruence between the minority person's culture, needs, experience, and societal structures" (1995, pg. 39). This stress stems from social processes, institutions, and structures of power that impact the individual psychologically (Meyer, 2013); direct examples of the impact of minority stress have been

well documented in physical health (Denton, 2012), substance abuse, and high-risk behaviors, which has harvested huge interests as an outcome of minority stress (Bryan, Kim, Fredrikson-Goldsen, 2017).

During the beginning of the HIV epidemic in America, ethnic, racial and or sexual minorities quickly became the face of the chronic illness (Masur et al., 2014). This image fueled negative connotations about Blacks' sexuality and criminality because of the increased incidence of HIV within the Black community (Masur et al., 2014).

Despite all the efforts in prevention and testing, the disparity has been salient in communities of color, specifically Black men (Bogart et al., 2016). While Black men account for 13% of the population, they also account for a disproportionate amount of HIV/AIDS infection at all stages, including mortality (Frye et al., 2015). Currently, HIV is the ninth leading cause of death among Blacks in America, and the third leading cause of death for Black men in America (CDC, 2014). According to the CDC, one in 51 men will receive a HIV diagnosis in their lifetime, one in 16 Black men will be diagnosed with HIV. Blacks accounted for 73 % of all new HIV infections while Black men in the South accounted for 44% of the new HIV infections at yearend 2014. One in two BMSM will contract HIV during his lifetime; BMSM were estimated at 57% of 73% new infections nationally (CDC, 2015).

Furthermore, the incidences in BMSMFI are substantially higher than Black or MSM populations which create a different more profound experience of stigma due to their criminal history (Rice et al., 2016). According to the CDC, BMSMFI are disproportionately impacted by HIV, even among other vulnerable populations such as intravenous drug users and sex workers (CDC, 2014); what is not clear is the infection rate

among members of society who are formerly incarcerated and the stigma encountered as BMSMFI who are deemed ineligible for social or HIV related healthcare services. Certainly, they experience the same barriers or social determinants of health, such as (SES), housing, employment, insurance and limited access to healthcare. They also experience discrimination, racism, homophobia, and stigma (McLemore et al., 2010). HIV positive BMSMFI are clearly a marginalized group and stigmatized population, even in the LGBTQ community (Meyers et al., 2017). The connections of stigma faced are race, sexuality, HIV, and criminal convictions (Meyer, 2013).

The Invisibility of Reentry

The epidemic of invisibility has been birthed from structural inequality around public assistance in the areas of housing, insurance, and healthcare (Meyer, 2017). Shades of structural inequalities have long lived under the tenure of political forces that decide who and what is important based on regional and cultural politics (McLemore, 2010). Invisibility takes place in the form of policies that leave portions of society locked out of opportunity, creating barriers as they try to gain access to the aforementioned factors that aid reintegration (De Coster & Zito, 2017). BMSMFI in South Carolina face these specific barriers in a politicized environment and amidst a perfect storm because of ideologies that are natural adversaries to social welfare and sponsored programs due to stark opposition to big government (Brown, 2016). The depiction of minorities as the burden of America ignites fires among many who may be just as poor; however, they are not the face of poverty and mass incarceration like Blacks are (Beckett & Western, 2001; Schoefeld, 2016). Some support reintegration investment; however, existing longstanding laws around public assistance hinder the process at the state and federal level (Brown, 2016).

Living under a criminal conviction is challenging and becomes exhausting when seeking housing. Each person released from prison is typically released to community supervision and need a home address to be granted release. If not, they are sent to a halfway house or shelter (Campagna, Foster, Karas, Stohr, & Hemmens, 2016). Housing is typically accessed through family members, such as parents or siblings. If these HIV positive BMSMFI and their family members come from poverty stricken areas, like public housing, they are not be return and reside there because of their formerly incarcerated status. Therefore, the first barrier the formerly incarcerated face is probation or parole; under the conditions of most probation or parole, felons cannot live in red-zones, which are defined as high crime areas (Hester, & Sevigny, 2016). This condition is ironic because many formerly incarcerated come from these areas, and their support systems live in these areas.

The next barriers are the US Department of Housing and Urban Development (HUD) and section 8 (Helms, Costanza, & Gutierrex, 2016). Felons cannot live in subsidized housing if they have a drug related conviction or a conviction within the last five years (Brown, 2016). As it pertains to HIV positive BMSMFI, they are locked out of housing assistance for which they do not qualify, such as HOPWA, which is defined as Housing Opportunities for Persons with AIDS (Bowen, & Mitchell, 2016). This program is key to helping persons living with HIV (PLWH) gain access to housing through federal funding; since felons do not qualify for this program, they often live in shelters or where ever they can, including rooming houses that often are not safe (Bowen, & Mitchell, 2016). These areas are just outside of red-zones and acceptable to department of safety officers; however, they are out of reach of felons' support system.

Another policy that influences health outcomes is Medicaid expansion in regards to the Affordable Care Act (ACA). By design, the ACA covers the nation's indigent, including the formerly incarcerated (CDC, 2015). Medicaid expansion is the federally sponsored programs that provide states with subsidies to help treat the chronically ill and chronically poor. Since South Carolina does not participate in this program, it creates a barrier for the formerly incarcerated, especially HIV positive BMSMFI; another example of this is neighboring North Carolina, which until recently, rejected the Medicaid expansion as well and has very similar results (Buot et al., 2014).

Ideally, social services and healthcare for PLWH are financed through several funding streams, such as Ryan White, Medicaid, Medicare, and other federal sources that include Substance Abuse and Mental Health Services Administration (Bradley et al., 2016). In 2012, state and federal funding for Medicaid represented 51% of HIV healthcare funding, 29% of Medicare, and 13% of Ryan White (Bradley et al., 2016). However, variation in resource allocation produces different results and health outcomes by state (Bradley et al., 2016). Since August, 1990, Ryan White has provided medical care and support services for PLWH for people without insurance as a way to cover the indigent through several funding mechanisms, such as Part A (direct funding) and Part B (funding for AIDS Drug Assistance Programs, or ADAP) (Bradley et al., 2016). The bulk of the people on these programs are Blacks at 72%; however, in Southern states, the funding is much less due to resource allocation (Bradley et al., 2016).

Other federal funding, such as Housing Opportunities for Persons with AIDS, were given the same funding nationally but received substantially less with regard to AIDS Drug Assistance Programs (ADAP); they often reported a waiting list for PLWH trying to gain

access to funding for federally FDA approved meds (Hatcher, Pund, & Khatiashvili, 2016). In fact, 99.5% of PLWH were on the waiting list while 21.4% were enrolled in Medicaid and could gain access to prescriptions (Hatcher et al., 2016). Medicaid in America appears to be similar among the criteria for eligibility for single people who are disabled; however, Medicaid in South Carolina does not qualify HIV as a disability and does not provide for the indigent.

More importantly, people who are indigent in South Carolina fall into the category of childless adults and are not eligible for aid under the South Carolina state guidelines (Hatcher et al., 2016). The South has a lower percentage of people enrolled in Medicaid at 21%. South Carolina was identified as one of the most restrictive states regarding Medicaid. With the exception of South Carolina, most states that fall into the highest rates of infection have medically needy programs for people who earn too much for Medicaid but cannot afford treatment or insurance without some form of assistance. However, these programs do not help PLWH who are indigent (Maher & Pathak, 2015). Since Medicaid is the highest form of funding in America, rejection of the Medicaid expansion for South Carolina has had terrible effects on HIV positive BSMSFI. This policy decision created barriers to overall healthcare services for this population leaving them barred from access to services they desperately need; due to their felony conviction which reinforces their invisibility with in policy implications.

The Multiple Intersections of Minority Stress

Minority Stress in defined as the stigma that stigmatized populations live under. The minority stress model provides the framework that theoretically dissects oppressions that impact sexual minorities, from homophobia to racism (Meyers, 1995). While

intersectionality complements the nuances of discrimination for subordinate populations regarding health outcomes, it ultimately serves another purpose for this study. Minority stress focuses on stigmatized groups and their relationship with social support, socioeconomic status, prejudice, and discrimination that are scientifically measured through chronic stress (Meyer, 1995). Intersectionality seeks to examine the overlap of intersecting social identities and the relationship to related systems of oppression, domination, and discrimination (Crenshaw, 1991).

Merging these two theoretical frameworks is necessary to address the multiple ideas that create an unabridged reality very different from the factors that are components or characteristics of people often marginalized (Crenshaw, 1991). Commonly known intersecting identities are gender, race, social class, ethnicity, nationality, sexual orientation, age, religion, mental disability, and physical disability (Crenshaw, 1991), all of which are integral but not mutually exclusive and essential to understanding one's identity (Schneider et al., 2017). Marrying minority stress and intersectionality together aids the research by dissecting multidimensional systemic injustices and social inequalities that occur frequently through classical conceptions of oppression within society and do not act independently of each other (Bird, Eversman, & Voisin, 2017). The multidimensional nature of oppression is the cardiovascular system among coordinating organizations or institutions that work interdependently for one common cause. Since policies and laws typically address marginalized communities linearly in a specific nature, such as race, sex, and socioeconomics, people oppressed on multiple fronts and with intersecting identities are commonly overlooked, thus advancing the cycle of oppression (Schneider et al., 2017).

All aspects of identity need to be examined as concurrent phenomena that cannot be scrutinized separately. This overarching approach to power hierarchies provides insight into the fluidity that takes place in the lives of communities of color, Black men, Black men who are MSM, HIV positive Black men, and Black men who have been incarcerated at least once in their life and bare the invisible scars of their experience by way of collateral civic consequences, social inequalities, and stigma (Mclemore, 2010). This paradigm is important to explain the results of socially constructed categories that elevate social class and create a socially invisible underclass of people which policy often does not consider (Lang & Bird, 2015).

Policies that prevent housing and admission into public housing or section 8, such as those barring drug related felon as residents in these communities, have been well documented as well as barriers to supplemental nutrition assistance programs. Though needed, these resources are not necessary for survival. However, healthcare is something the formerly incarcerated living with HIV cannot live without; many face multifaceted barriers either due to location or insurance (Schnittker, Uggen, Shannon, & McElrath, 2015). These challenges present a complex network of legal and administrative regulations that take form in the matters of community connectedness and civic access, such as housing, employment, insurance, healthcare, and voting (Campagna et al., 2016).

Until recently, the federal government has not given attention to this emerging crises, and states are still starting to get on board in more liberal areas. South Carolina has some programs for the basic needs regarding reentry; however, there an assortment of other elements (Cullen, Johnson, & Mears, 2017). These features can be addressed through

creating a more robust referral process, identifying a true point of entry for reentry services, and teaching reentry to public safety officers and community based organizations.

Methods

A phenomenological qualitative research method was used to explore the experiences of BMSM who are HIV positive ex-offenders in a metropolitan area in South Carolina. Specifically, the study examined the facilitators/influencers and barriers to healthcare for HIV positive BMSM who were formally incarcerated in South Carolina. The participants shared their lived experiences engaging healthcare, whether directly or indirectly, that impacted engagement or retention in care. Semi-structured interviews were administered to uncover their unique experience. The exploration of the study captured the participants' experiences of re-entry, accessing care, barriers, and facilitators and the various forms of discrimination they experienced (Bhushan, Brown, Marcus, & Altice, 2015). The study process obtained rich information from the participants' points of view pertaining to aspects of invisibility through various interactions while accessing care and treatment while seeking care. Also, the study provides clarity regarding the need for culturally grounded approaches while receiving care or seeking services.

The study participants were recruited from Project EMPACT, a local program connected to the South Carolina Department of Corrections. Project EMPACT, defined as Empowering Men through Prevention Action Community Collaboration and Training (EMPACT), is a community-based intervention used to prevent the spread of HIV/AIDS, STIs, tuberculosis, and hepatitis among BMSM who were formerly incarcerated through education and training. The program has a tailor-made approach to addressing the needs of these extremely vulnerable men as they return to society. Study participants graduated from

the locally sponsored program called Project Empact and participated in the program several times during their tenure of incarceration; more importantly, they continue to engage in and seek care. This specific community represents the best litmus test for engagement and retention because they engage in the system constantly in the Columbia, South Carolina area. Lastly, this study was conducted according to the protocol approved by the University of North Carolina at Charlotte IRB.

Sample

The program manager of the HIV/STI risk reduction program in Columbia, South Carolina, referred 10-15 potential participants from Project Empact. The community members selected to be participants were informed about the research and volunteered to participate prior to the study. The participants gave verbal consent at the time at the interview, which was recorded. The participants were given $25 Walmart gift cards as an incentive for participating. The inclusion criteria for participants were as follows: 1. Self-identify as Black men, 2. Assigned male gender at birth, 3. Report having sex with men, 4. Have been previously incarcerated and recently released, 5. Are HIV-positive, and 6. Reside in the identified area of South Carolina. Exclusion criteria were if they self-identified as a race other than Black or were assigned female gender at birth. The small, purposive sample of 10 to 15 individuals was a best fit to allow for an in-depth examination of the experiences from the sample population and the detailed analysis required for individual transcripts (Creswell, 2009).

Procedure

The participants were given a number based on the order of the interview; the interviewee/participant stated his number during the recording and verbally gave informed

consent as prompted by the script. The script stated that each individual understands the purpose of the research, knows he is anonymously participating in the study, and has no direct threat to his privacy from the researcher and or team. The interviews were conducted in person by the researcher with the baseline being one hour in a private office. Each interview was recorded and transcribed.

Data Analysis

Interpretive Phenomenological Analysis (IPA) is a qualitative approach to research that focuses on the experience, which aims to offer insight into how people, in a given context, make sense of a given phenomenon (Smith, 1996). Theoretically, IPA is rooted in health psychology and provides context to problems or issues through critical realism (Smith, 2015). The population being studied often has physical problems, mental health problems, and addiction disorders at rates greater than the general population.

When they return home, formerly incarcerated living with HIV may be affected by other conditions (Marlow, White, & Chesla, 2010). IPA is the best way to consider the context in which participants live, their histories, and their concerns (Marlow et al, 2010). The data was coded thematically from the transcript, and the most significant codes were organized by what interviewees indicated as most important through the interview process. Flow charts were created to examine answers given to create clarity regarding themes from the transcripts, observations, and field notes. Sociodemographic questionnaires were administered to collect information about education, employment, insurance, housing, and age. An audio-recorder was used to collect information while interviews were transcribed. A software program also was used to assist with transcription of the information recorded. This software is commonly used when writing notes; however, the extra step was used to

ensure that the interviews were transcribed accurately verbatim. The transcripts were analyzed in conjunction with original audio recordings to capture potential themes, and the program manager reviewed material to build consensus, adding rigor/trustworthiness to the process. Field service notes were used as a guide to ensure the integrity of the data and protect the research from assumptions or bias. The materials were read throughout the interview and analysis; the notes and observations added relevance to the process by providing context to how the participants responded physically as well as verbally. The physical cues added perspective to what the participants felt at the moment of the interview, which is very relevant to the process by providing signals about comfort level (Larkin et al., 2006).

Findings

The South is known for being the Bible belt with conservative family values and Republican politics; it is also known for the highest incarceration rate and HIV rates nationally (Cohen, Gray, Ocfemia, Johnson, & Hall, 2014). Failures to adequately allocate resources have had dire consequences for southern states such as South Carolina in terms of incidence rates and viral suppression (Chakrabooty et al., 2015). In 2014, Black men exiting the South Carolina prison system totaled 5,121 (Stirling, 2016). Since South Carolina does not engage in the Medicaid expansion, every newly released prisoner does not qualify for coverage, unless they have the resources to buy into the exchange.

South Carolina policy pertaining to Medicaid expansion and the category of childless adults in which they fall creates barriers to direct care and further stigmatizes the group who lives in these conditions (Rief et al., 2014). HIV positive BMSMFI feel this reality is discrimination because of race and homophobia. They reported feeling some, if

not all, of these forms of oppression due policies that disqualify them from basic services that they would normally be eligible for. Additionally, they feel like they are living with an unfair amount of stigma because of their criminal history, which is often internalized. The data collected from the participants were combined and categorized into five major categories of **(a)** Discrimination, **(b)** Racism, **(c)** Homophobia, **(d)**, Perceived stigma, and **(e)** Internalized oppression.

Table 2.1 Characteristics of Population (N=10)

Category	Description	N (%)
Employment	Employment status	0 (100%) unemployed
Education	High School diploma	6 (60%) High School/GED
Age	Range 26-55	37.2 AVG years
Incarceration (length of Stay)	Length of Stay	5.5 AVG years
Marital Status	Single or Relationship	2 (20%) Significant Other
Insurance	Medicaid/ACA	2 (10%) Had insurance
Healthcare	Medical visits	7 (70%) regular monthly visits
Medication management	Take medication as instructed	5 (50%) reported compliance
Housing	Housing of own	1 (10%) Apartment 3 (30%) Relatives 6(60%) Homeless shelter or transitional housing

Table 2.2 Experiences of Population (N=10)

Theme	Description	N (%)
Discrimination	Community/Church	10 (100%)
Racism	Institutions State/Federal	7 (70%)
Homophobia	Probation/Provider	6 (60%)
Perceived stigma	Society/Community	8 (80%)
Internalized oppression	Negative self-perceptions	10 (100%)
Community connectedness	Closed	3 (30%)

Discrimination

Participants described discrimination in terms of how they are received by society and within their community as well as facing negative experiences due to their criminal history and sexuality that create a heightened since of stress. Minority stress suggests that minority populations experience and perceive oppression and discrimination because of their minority status (Meyer, 2010). One example would be homophobia regarding sexual minorities, such as Lesbian, Bisexual, Gay, Transgender, Queer (LBGTQ), or a portion of this population defined as MSM by the CDC (CDC, 2014).

Minority stress also can be explained through the experience of discrimination (Meyers, 2013). These events can take place from a distance or within close proximity; however, they are equally important in their impact (Meyers, 2010). They can be understood as conditions where stress can be experienced through personal processes that involve the subjectivity of appraisal, which influences the perceptions of those specific experiences (Meyer, 2010). The main factors in processes identified by minority stress are discrimination, racism, homophobia, and internalized oppression (Meyers, 2013). These factors operationalize minority stress through the previously listed and its impact on the perception of stigma and psychological distress, which several of the participants stated they experienced.

In fact, most participants expressed problems with discrimination while still incarcerated and stated that it followed them when they returned home in the form of relationship barriers with family, parole officers, and healthcare providers. Overall, all ten of the participants expressed these feelings regarding discrimination; however, the data

reported captures a snapshot of their shared experience. Two participants were very candid about the discrimination they faced:

"It's okay, I was only inside for a couple of years, but I always felt like I won't nothing to the staff or security, hell my parole officer don't treat me no better. He ain't never say nothing crazy, but you can just tell. He ain't really trying to be bothered, with me on no level. Even when I first got out, he put me in shelter, because he didn't hear from my people but then gave me grief because I was trying to transfer to somewhere closer to where I can get some help at. But then again, ain't nothing jumping, he don't even take me serious for real. He know I got sugar in my tank, actin all upitty and stuff, I swear they be working my reserve nerve" (Participant Age 34).

"I'm just trying to hold on, for right now. I can't get nothing down here, can't leave here neither. Can't get housing, can't get insurance, and can't get no damn food, shit crazy. It's like they say here $75 clown - start over. What the hell am I supposed to do with that? My people took me in, if not I would have been on the streets, ass out. Them folk don't care bout no jail birds, we ain't citizens, we ain't white, we don't vote" (Participant Age 37).

These responses ultimately paint a portrait of frustration and believed discrimination of institutions, highlighting the link of poverty and socio economic status (SES) among HIV positive BMSMFI and social welfare programs in South Carolina. HIV positive BMSMFI are men who have the unique experience of being members of multiple subordinate populations. They often fall into the category of vulnerable populations and are categorized by CDC as MSM (CDC, 2015). The CDC has used this term to describe behavior regarding the sexual act with the intent to include men who do not feel or identify

as homosexuals or bisexuals. This classification is intended to remove stigma from the participants who engage or participate in surveys used to determine health disparities.

Research illustrates the growth of human immunodeficiency virus among Black MSM as well as Black men who are incarcerated (CDC, 2015). The men who fall into this category typically have faced life circumstances that left them predisposed to poverty, facing barriers to education, social dislocation, behavioral risk, crime, and civic consequences. Many of the participants truly believe this cycle is continued and or worsened due to their criminal history, sexual identity, and HIV status; minimizing their needs is another form of racism (Harris & Hodge, 2017).

Racism

Defining racism has been a persistent challenge within the discourse; however, it is currently defined as "institutional and individual practices that create and reinforce oppressive systems of race relations whereby people and institutions engaging in discrimination adversely restrict, by judgment and action, the lives of those against those whom they discriminate" (Kreiger, 2003, pg.195). According to Mathews, Smith, Brown, & Malebranche (2016), racism, not race, should be considered the major contributor to poor health outcomes regarding racial/ethnic minorities, such as MSM. Furthermore, the consequences of racism, including low SES or barriers to economic opportunity, are the true culprits of HIV growth in America (Watkins-Hayes, Pittman-Gay, & Beaman, 2012).

The tools used to identify racism and its impact on health outcomes in America are: institutionalized racism, personally mediated racism, and internalized racism (Boone, Cook, & Wilson, 2016). Institutional racism is best described as opportunity and access being distributed differently by race because of race; personally mediated racism is where

ability, intention, and actions are a result of prejudice and discrimination, and internalized racism is where the members of the stigmatized group develop negative self-appraisal and have a lack of self-worth (Shoshana, 2017). In terms of sexual health, these factors greatly influence risky behavior and, ultimately, the growth of STI and HIV (Meyers, 2013).

Participants in this study reported negative experiences regarding their reintegration while trying to access services and feel since they are the face of poverty and social welfare programs, the government of South Carolina is not willing to allocate resources to help them live suitably with HIV. All ten of the participants expressed these encounters with racism; however, the data reported captures a snapshot of lived shared experience. The participants reported barriers to housing and Medicaid and believe that everything is connected to race and politics. One older participant of the study stated that he spent 10 years in prison for drugs and explained:

*"Yes, I stay in my hood but I don't mess with nobody. I can't live nowhere else, because I was selling dogfood (*heroin*). I ain't got a lot of education, and really can't get hired any place besides McDonalds or Burger King. I can't do nothing but hustle, I don't qualify for no program besides ADAP. I don't want people in my business, so I don't ask for help. I know I am poor, but it's different down here, being sick, poor and Black just looks different down here" (Participant Age 46).*

Homophobia

Just like racism, homophobia is an essential function and contributor to poor health outcomes (Robinson, 2016). Originally, homophobia was defined by Dr. George Weinberg in 1972 as the discomfort or fear of being near gay men or lesbians (Fraïssé, & Barrientos, 2016). Within the context of social oppression, this definition fits as an addition to the

earlier outlined argument of racism and its nuances: institutional, personally mediated, and internalized forms of homophobia. In the world of BMSM, homophobia and racism have had a longstanding relationship; this relationship is seemingly far more complex among BMSMFI (Garcia et al., 2016).

Since there is some variation of how many men see themselves as being MSM, the formerly incarcerated conversations, including jail sex, sex work, and situational sex, should be dissected more. The state of confinement and the urge to have sexual needs met behind bars further explains the anxiety that BMSMFI have about disclosure, unfair treatment, and reluctance to get tested or seek treatment (Mackenzie, Rubin, & Gomez, 2016). Many MSM feel victimized due to their sexual orientation, especially in prison, whether from other inmates or the guards who are sworn to protect them (McLemore et, al., 2010).

Furthermore, homophobia has been found to impact self-esteem among BMSM and contribute to psychological distress because of the experience of discrimination. The homophobic experience influences the perception of the individual and continues to develop stigma among BMSM, especially those who are formerly incarcerated. Some of the participants in this study expressed negative feelings about disclosing their preference and or status to family and friends. Some also reported feeling awkward being out of the closet because of the cliché of "being gay for the state/stay," which is directly connected to being incarcerated and having sex with other men. The cliché is attached to men tagged as "undercover brothers" regarding their sexual preference, either during their time in prison or upon returning home. When asked how this (sexuality) affected their approach to health, many participants felt it influenced their self-perception negatively, ultimately

impacting relationships within the community as well as with their providers. Several of the participants mentioned that community connectedness influenced them to stay healthy, but they were scared to engage and disclose. Ten of the participants expressed feelings of discrimination by way of homophobia; however, the data reported captures a portion of their shared experience. Three participants were very vocal about this experience:

"Sometimes you have to realize who you talk to and their threat level, and the very main reason why people try to get to know you and make sure you do not disclose. Them women be smiling, but they don't know that I am sweeter than a bag of sugar. And no I don't tell them, I ain't got time for that or church. No, I don't attend church a lot, if I do, I see the church man talking about homosexuality and sinning and see the people jumping up and down, but I ain't feeling the holy ghost, they don't feel nothing, I feel HIV daily" (Participant Age 33).

"*I don't get with church or my community because-they understand Sunday but Monday they don't give a damn. Them damn doctors the same way, I am just a paycheck, nothing more and nothing less. When I come in they be smiling, but when I call they act like they ain't the same damn person that they was hahaha and geegeeing with the other day in the office. Hell some of them see me in 60 seconds or less, like it's a race or something. I think that I make them feel a certain kind of way" (Participant Age 40).*

"I'm still a human being, and I am still a man. It's like they don't see me, they only see what I have done or what I do. It should not matter what I have done, I didn't do it to them and it shouldn't matter who I screw, I ain't screwing them! I just need help getting better, and I don't want to be judged while I do it, I am just trying to live" (Participant Age 35).

The above statements reference homophobia and indicate some perceived sigma by the participants that impact them daily. During the interviews, these concepts surfaced consistently and led the researcher to believe that this is the nature of having multiple stigmatizing identities. Unfortunately, the statements reflect a common experience among the group; it was apparent from start to finish of the study.

Perceived stigma

Black MSM fall outside many social norms regarding sexual orientation, and their lifestyle and sexual identity have become stigmatized; these members of society tend to engage the world around them with caution, insecurity, and anxiety (Goffman, 2009). Ultimately, their experiences impact interactions with the broader culture in terms of psychological and sociological stressors and coping mechanisms (Finzen, 2017, pg. 29-42). Research has indicated that BMSM, among other members of minority groups, have a high level of perceived stigma and often maintain expectations of rejection and discrimination (Meyer, 2013). Perceived stigma also creates an environment of hyper vigilance with regard to intersections of their identity and interaction with society (Finzen, 2017, pg. 29-42), which is brought on by perceived stigma, stress, and the effort used to meet the constant expectations placed on them by their community (Finzen, 2017, pg. 29-42).

The anxiety regarding social rejection based on sexual orientation has been more predictive of psychological distress than the actual events of discrimination that occur. This consciousness of stigma influences health outcomes and is paramount regarding BMSM who are HIV positive. Stigma consciousness is largely associated with lower self-esteem, facilitating psychological distress and creating high risk behaviors (Quinn et al., 2017).

These high risk behaviors are directly linked to HIV, HIV related stigma, and ultimately, negative health outcomes (Quinn et al., 2017). All but two participants believed they only were accepted among their close circle, by people who know them. This reality reflects the complexity of jail culture, where notions of masculinity and femininity play out more prevalently than in the larger population of MSM.

Stigma impacts outreach (education/prevention) and retention to treatment. The effects of stigma were rooted deeply within the sample group. Many participants expressed the belief that the world does not accept their preference, criminal status, and social class, even among other Black MSM. They moved past the discussion of jail stigma or gay stigma to a place where they were extremely vulnerable. The stigma of poverty or extreme poverty was relevant to this study because it ultimately decreased individuals' social network. All of the participants were unemployed, and most of them stated that they only interact with PLWH and others just like them. Overall, all ten of the participants expressed these feelings of perceived stigma; however, the data reported is a snapshot of their shared experience. One participant captured the essence of this issue as he explained his lived experience:

"I don't say nothing, I usually don't worry about it unless I see children dying around me. I only deal with people who are living with HIV like me. I ain't about to mix it up, you know the virus change up so I don't mess around. You can mess up and get some bad shit, I don't care how fine they are. I don't need nobody who can't get with me like I am, I ain't fancy, I am just regular but I got a good heart. As a matter of fact, I don't even need no man right now. Because I ain't bout to explain myself. I feel like no one wants to really deal with you, and it is just too much right now. I can't be with just nobody" (Participant Age 46).

Internalized Oppression

Though people grow up in a society that states it values diversity and inclusion, through experience, communities of color or sexual minorities typically feel stigmatized due to race or sexuality (Rao, Pryor, Gaddist, & Mayer, 2008). Due to these experiences, many participants and members of this subordinate group developed negative beliefs about their sexuality and HIV status (Rao, Pryor, Gaddist, & Mayer, 2008). These beliefs promote internalized homophobia because of negative past or present encounters with a larger portion or dominant segment of society (Meyer, 1995), which is commonly compounded due to a prison experience (McLemore et al., 2010). Additionally, internalized homophobia has been connected to mental illness and substance abuse (Quinn et al., 2017).

The aspect of self-blaming among this population has created an environment where internalized homophobia and internalized racism create harmful effects on health outcomes, sometimes more than external discrimination that facilitates these conditions (Quinn et al., 2017). Furthermore, the outcome of these factors not only influences risky behaviors, but it also impacts how HIV positive BMSMFI interact with their community and society at large, shaping the way they access HIV related healthcare (Voisin, Quinn, Kim, & Schneider, 2016). Research has suggested that experiences of discrimination by way of racism and homophobia ultimately increase perceived stigma that develops internalized oppression (Voisin et al., 2016). Overall, four of the ten participants expressed feeling some type of internal oppression; however, the data reported is a snapshot of their shared experience. The participants of this study that indicated this experience; a few stated that they struggle with this issue. A younger participant of the group stated:

"First the people have to want to get help, stigma and pride can only bring you down. You have to never put yourself into a situation in which you go into potentially negative situations where you are made to feel that way. You also have to make your own community, where you can be accepted. Community as a HIV positive person---does not feel the same as the larger community, we know that in ours we are accepted and it is receptive, but the larger community is biased, we ain't got nothing coming from them. It is pretty scary. You know white MSM who ain't poor or felons do not have our type of life, I am used to it though. I grew up like this, it's going to probably be like this forever because, well just because the important people who make the laws ain't farting at us, so we gotta do for self" (Participant Age 31).

The disconnection described in this participant's response is emblematic of what many disenfranchised feel pertaining to negative self-perception. In this specific instance, the participants refer to sexual identity, HIV status, and criminal background; however, many of these men can use poverty and educational attainment as a surrogate because they create very similar feelings that develop the same internal oppression.

Interplay of Intersectionality

Intersectionality is how all the features of a person is impacted by oppression various or multi-dimensional creating a paradigm experienced by the oppressor and the oppressed. In this study the experiences are tease apart for clarity; however, many of the participants experienced the aforementioned encounters simultaneously. All ten of the participants reflected duality concerning their experience with multiple encounters with oppression; however, the data reported is a snapshot of their shared experience.

"I am a poor HIV positive Black man who sleeps with men. I am a felon, I am unemployed, and I don't have nowhere to stay. I live in South Carolina, where this just don't fly" (Participant Age 44).

" I ain't got nowhere to live, I ain't got no money, I ain't got no damn education. What the hell am I supposed to do? My people think I ain't shit, and so does the people who supposed to help my Black ass" (Participant Age 37).

Discussion

These participants reported a variety of problems that made them feel invisible and were conveyed through the areas of discrimination, racism, homophobia, perceived stigma, and internalized oppression which ultimately impacted their collective health. Health disparities are the product of social inequalities and their relationships with gender, race, ethnicity, sexual orientation/identity, and poverty. HIV has grown disproportionately among communities of color, especially in the South and particularly in BMSMFI (CDC, 2014). These barriers exemplify the social construction of oppressive systems that impact BMSMFI, who are shaped by a history of descending from slaves, a class/caste position regarding poverty, and their personally lived experiences (Schnittker et al., 2015). These factors, combined with HIV and criminal history, influence stigma and often are normalized within the community as well as the broader society (Wohl, 2012).

The criminal justice system, among others, has advanced the growth of HIV; however, criminal justice is just an instrument. The true culprits are fear and hate that flourish in the minds and spirits of people who are rich, poor, powerful, or weak. The power of oppression is facilitated through various forms of discrimination, not limited to race, gender, sexual preference, and HIV. Discrimination runs much deeper; it is a river that

carries all possible forms of social injustice on a raft of indifference. Indifference is the worse form of discrimination; it ignores the circumstance of BMSMFI due to the lack of social capital needed to be heard and have a voice. This reality has been explained by the participants as a need to be seen, heard, and connected in order to eliminate the void in social support.

Social support is simply defined as the perception and actual fact that you are cared for, that your existence matters, and that you are valuable. It also is reflective in the amount of social support available from your social network/community, including information, financial help, and companionship (Morandini, Blaszczynski, Dar-Nimrod, & Ross, 2015). A sense of belonging is key to improving positive health related outcomes, especially regarding HIV (Young & McLeod, 2013). This sense of belonging is also critical to healthy coping strategies and a mechanism to deal with HIV and, for this population, reentry (Young & McLeod, 2013; Patterson & Wildeman, 2015). The unique combination or intersectionality of experiences complicates the already complex process of reentry and accessing healthcare for participants of this group and, for many, seems out of reach or without merit due to barriers regarding acceptance (Patterson & Wildeman, 2015).

Conclusion

In summation, the participants were very candid, and the interview process yielded answers in several areas regarding discrimination. Through probing questions, themes were developed around discrimination, racism, homophobia, stigma, and internalized oppression. All of the participants were recruited from Palmetto AIDS Life Support Services and had engaged in Project EMPACT at a local correctional center, so they had very similar experiences regarding reentry. HIV positive BMSMFI all reported that

structural barriers before, during, and post prison shaped the way they engaged in care and eventually impacted how they felt about themselves. These feelings essentially created another barrier to treatment due to the development of stigma.

Health services research has become normalized in big data and outcomes evaluating how people gain access to healthcare, cost of care, approaches to care, and disparities regarding care (Brown, Chui, & Manyika, 2011); however, the field is sparsely populated with the shared experience from the people who receive this care. The issues revealed in this study are layered and very complex. Yet, if researchers hope to fully understand the nuances to HIV positive BMSMFI, they must examine all of the attributes that contribute to behavioral risk. Currently, researchers approach HIV and STI's risk in terms of sexual behavior/identity and HIV or criminal history/behavior and HIV; however, none of them adequately captures the multiple categories that this specific group faces.

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Chapter: 2 PERCEIVED BARRIERS TO HIV CARE AMONG HIV POSITIVE BLACK MSM IN SOUTH CAROLINA

The perception of barriers for persons living with HIV is an experience which creates conditions that act as obstacles to engaging or remaining in care. Belief can be more critical to health outcomes than the actual process of seeking treatment. Many Black men who are HIV positive have a different worldview due to experiences in which they have felt inadequate. HIV positive Black men who have been formerly incarcerated have similar experiences that are heightened because of their criminal history. Health outcomes for people living with human immunodeficiency virus HIV (PLWH) continue to be a topic of public discourse and have sparked debates among healthcare professionals, researchers, and politicians (Du, Camacho, Zurlo, & Lengerich, 2011).

Healthcare for PLWH has vastly improved holistically due to anti-retroviral therapy (ART) and interventions to promote testing and engage people into care (Wynberg, Cooke, Shroufi, Reid, & Ford, 2014). Treatment efforts such as ART have transformed HIV from an historically believed terminal illness to a very manageable chronic condition. The change is due to the widely available treatment in America; however, treatment looks differently geographically (Govindasamy, Ford, & Kranzer, 2012). Each part of the country varies in HIV incidence and prevalence rates and is very different regarding mortality/morbidity because of structural barriers and facilitators to and for treatment (Rief et al., 2014).

Many persistent barriers to HIV treatment are due to policies and resource allocation saturated with politics that are defined regionally and executed then protected constitutionally under the provision of states' rights (Adimora, Ramirez, Schoenbach, &

Cohen, 2014). These rights to drive policy have seen the influx of HIV for 30 years, specifically in the South, communities of color, among Black men, and especially among BMSM (Lieb et al., 2011). According to the Centers for Disease Control and Prevention, Black MSM accounted for the highest number of new HIV diagnoses 38%, with Whites 31%, and Hispanics/Latinos 26% at yearend 2014. Additionally, 39% of those newly infected were Black MSM, reflecting disproportionate rates of infection (2016).

The racial disparities of HIV infection have been observed in the South alongside complex, macroeconomic social factors, such as poverty, discrimination, and disproportionate incarceration of Black men, which provide context to the social determinants that ultimately influence HIV transmission (Kaufman, Cornish, Zimmerman, & Johnson, 2014). These factors also impact vulnerable subgroups, such as HIV positive Black MSM who were formerly incarcerated (Wohl, Rosen, & Kaplan, 2006). In 2010, the CDC reported 20,093 PLWH in federal or state prisons CDC, 2015). Daily, two million people are incarcerated in America; among that population, research suggests the rate of HIV infection is five times larger among Black men than the general population (CDC, 2015).

In 2014, there were 20,093 inmates with HIV/AIDS in state and federal prisons with 91% being men. Among this population, Black men were diagnosed with HIV at a rate of 5 to 1 as compared to their White and Latino counterparts (Kaeble, Glaze, Tsoutis, & Minton, 2015). Blacks represent 13% of the population, yet Black men represent 48% of the incarcerated population (Kaeble et al., 2015); Black MSM represent nearly 50% of PLWH (CDC, 2015), and Black MSM in the South represent 44% (CDC, 2016). In South

Carolina, Black MSM account for 56.8 % of new infections, with 11% categorized as ex-offenders and or formerly incarcerated (SCDHEC, 2015).

Members of this vulnerable population are subject to many barriers when returning to their communities (Berg, & Huebner, 2011). Simply examined, barriers for this population are housing, employment, insurance, healthcare, and civil liberties (McLemore, Winter, Walker, & Ray, 2010). However, many personal barriers are more impactful to reentry or reintegration pertaining to this population, such as engagement into care, retention in care, and medication adherence (Harawa, & Adimora, 2008). Structural barriers are salient to the discussion of HIV and vulnerable populations (Levy et al., 2014); however, so are individual experiences in reintegration, such as racial discrimination, sexual discrimination, discrimination regarding criminal history, and HIV status (Bowleg et al., 2013).

Despite the evidence illustrating barriers to access to care for Black MSM, specific barriers for this population have not been examined fully from the perspectives of the men who are a part of this unique group who lives in the South. The purpose of this study is to explore the (1) perceived process for accessing HIV-related medical care and social service support for formerly incarcerated BMSM who are HIV positive, and (2) identify common experiences among this sample population regarding patient-provider relationships.

Background

Currently, the defining characteristic of the South is the high rates of HIV, among other health disparities (CDC, 2011). The growth of new infections is disproportionate in the South and accounts for 44% of PLWH in America (CDC, 2015). Research suggests that the disparities faced by the South are due to population geography and occur in

metropolitan areas; however, limiting disparities to geography without considering social, cultural, and political ecology would not capture the unique challenges experienced by this very vulnerable population (Travis, Western, & Redburn, 2014). The South is known as the Bible belt, or the epicenter of religion and conservatism, to many and has a complicated history with minorities. The history of slavery, equal rights, and mistrust of institutions has been well documented (Friend, 2009) as well as historic rates of mass incarceration and growth of HIV (Wohl, 2012). The South can be defined as the states of Alabama, Mississippi, Louisiana, Georgia, North Carolina, and South Carolina, which all have participated in slavery and mass incarceration (Levy-Pounds, 2013). Incarceration in the South is disproportionate, and the rate of incarceration among people of color overwhelmingly impacts Black men.

Black men are disproportionately incarcerated, representing 60% of the male prison population while only representing 13% of the total population (Iroh, Mayo, & Nijhawan, 2015). In 2016, Black men in South Carolina accounted for 12,319 (63%), Whites 6,622 (34%), and other 550 (3%) of the total population of the 19,491 people housed in South Carolina Department of Corrections. The average age of Black men was 37.7, average education level of Black men 10.6, and 10,085 (52%) of the Black men incarcerated in South Carolina were without a high school diploma or GED. The total population released from the SC Department of Corrections was 9,147, and the only mention of health was mental illness, which reported 2,658 (14%) who sought treatment (Stirling 2016). South Carolina was reported to have the 11th highest rate of HIV infection among the states with high rates of incarcerated persons living with HIV (Maruschak, & Beavers, 2009); 5,121

inmates of color were released at year end 2015, including various types of probation and parole with 2,290 under some condition of post release (Stirling 2016).

Many of the indigent who were formerly incarcerated qualify for assistance in other states because of the provisions of the Affordable Care Act that expands Medicaid eligibility to all people 65 and younger whose income is 133% of the federal poverty level. These provisions benefit the formerly incarcerated once they are discharged by facilitating care and transitioning inmates to community providers without a break in treatment, thus improving the continuity of care (Teitelbaum and Hoffman, 2013). Since the provisions are not federally mandated, it is the discretion of South Carolina to accept or reject the funding (Wang et al., 2012). The state discretion is critical because once released, offenders may need to wait several weeks to access healthcare following their discharge from prison, breaking established regimens of healthcare services and potentially impacting medication adherence (Feaster et al., 2013). South Carolina does not engage in Medicaid expansion; therefore, newly released prisoners do not qualify for coverage (Adimora, et al., 2014).

Many who were formerly incarcerated have varying experiences gaining treatment. While some homogeneity exists among this group regarding sociodemographic and socioeconomics, there is heterogeneity pertaining to access, resources, and experience (Altice et al., 2010). The experience is the subject of focus for this study because psychological distress, depression, stigma, and discrimination impact engagement and retention in care (Binswanger et al., 2011). HIV related stigma and discrimination have been well established in the research for Black MSM who are HIV positive regarding testing, disclosure, and disclosing (Matthews et al., 2016). Research also has documented

stigma among the incarcerated and formerly incarcerated (Muessig, et al., 2016); however, an overlap of experiences is under examined pertaining to Black MSM who are HIV and ex-offenders in South Carolina. The relevance of mistrust of healthcare providers or systems, high cost of care, barriers to insurance, higher levels of poverty, and the perception of being alienated from access to healthcare are much needed steps to identify barriers, dissect them, and develop/implement interventions that enhance the quality of life for this vulnerable population (Brinkley-Rubinstein, & Turner, 2013).

Methods

A qualitative phenomenological approach was used to explore the lived experience of HIV positive BMSMFI in Columbia, South Carolina. An examination of facilitators and barriers to social services and HIV related healthcare was conducted to gather, dissect, and later disseminate information to inform policy, research, and practice among professionals. The lived experience, whether external (system-level) or internal (individual-level), was collected through loosely semi-structured interviews to uncover the perception of barriers to reintegration for HIV positive BMSMFI. The exploration of this study captured the experiences of reintegration from the people most qualified to make the assessment and give an authentic voice to the collective problems they encounter during the process. Lastly, this study was conducted according to the protocol approved by the University of North Carolina at Charlotte IRB.

Sample Selection and Recruitment

Palmetto AIDS Life Support Services (PALSS) is among the leaders of HIV/STI reduction in Columbia, South Carolina. The program managers, along with the leadership of PALSS, gave full support and agreed to refer potential participants for the study.

Program managers described why the study was being conducted, detailed the process for participating, and informed any potential participants that their confidentiality would be protected fully. Fifteen participants agreed to participate; however, the actual sample population capped at 10 due to saturation. Each person who signed up to participate was given a $25 Walmart gift card. The inclusion criteria for the participants were: 1. Self-identify as Black men, 2. Assigned male gender at birth, 3. Report having sex with men, 4. Have been previously incarcerated and recently released, 5. Are HIV-positive, and 6. Reside in the identified area of South Carolina. Exclusion criteria were if they self-identify as a race other than Black or were assigned female gender at birth.

The participants were graduates of a tailor made program in Columbia, South Carolina, named Project EMPACT. Project EMPACT is well defined as Empowering Men through Prevention, Action, Community Collaboration, and Training. The program was created and delivered for several years at a local correctional institution as an intervention to prevent the spread of HIV/STIs, tuberculosis, and hepatitis among HIV positive BMSMFI through education, training, and action. The program was enacted due to budget cuts in South Carolina and the lack of adequate service delivery to combat the rate of new HIV infections while informing HIV positive BMSMFI on treatment and medication management. Many members in this group participated in the program several times during their tenure of incarceration and felt it was the best pathway to get engaged and remain engaged in healthcare.

Interviews

Each one of the participants was given a number based on the order of the interview for coding; the interviewee stated his number during the recording while giving verbal

consent. There was a script used for consent as well as some semi-structured questions during the application process that was approved by the Institutional Review Board (IRB) of the University of North Carolina at Charlotte. The face to face interviews lasted between one hour and one hour and 45 minutes in a private office located at PALSS. The interviews were recorded by two recorders, one located close to the participant and the other located just arm's length from the researcher. The interviews were transcribed during the process by the program manager and reviewed later with the files (recordings) for accuracy. Transcripts, field notes, and sociodemographic forms provided primary data, and descriptive statistics were used to describe the sample's sociodemographic characteristics. Field service notes were used to make sure the researcher avoided assumptions or bias, and the researcher read them during the analysis. The notes and observations, just like any reflections, are relevant to the process (Larkin et al., 2006). The notes included reoccurring phrases or comments and descriptions of emotions (Larkin et al., 2006)

Participant Characteristics

HIV positive BMSMFI participants were used. See Table 3.1 below. They all identified as Black men, born male, identified as MSM, HIV positive, and formerly incarcerated longer than a year at least once in their life. Participants were all graduates of Project EMPACT in a correctional facility located in Columbia, SC. The average age was (37.2). Everyone in the group was unemployed (100.0%), and (60.0%) had a GED/High school diploma. Participants reported substance abuse at (100.0), crack at (80.0%), and heroin at (20.0%). Participants reported living with relatives (30.0%), homeless shelters (30.0%), and one reported having his own apartment through a Veterans Affairs Supportive Housing VASH/HUD program that accommodates disabled veterans with housing

assistance. Two members of the group had insurance either through Veteran Affairs or Medicaid. Eight men did not have insurance (80.0%), and they all reported using community based organizations that were a part of local collaborating partners that facilitate HIV healthcare in Columbia, South Carolina.

Table 3.1 Characteristics of Population (N=10)

Name	Description	N (%)
Employment	Employment status	0 (100%) unemployed
Education	High School diploma	6 (60%) High School/GED
Age	Range 31-55	37.2 years AVG
Incarceration (length of Stay)	Length of Stay	5.5 years AVG
Substance Abuse	Crack Heroin	8 (80%) crack 2 (20%) heroin
Marital Status	Single or Relationship	2 (20%) Significant Other
Insurance	Medicaid/ACA	2 (10%) Had insurance
Healthcare	Doctor Visits	7 (70%) regular monthly visits
Medication management	Take medication as instructed	5 (50%) reported compliance
Housing	Housing of own	1(10%) Apartment 3(30%) Relatives 6(60%) Homeless shelter

Data Analysis

Interpretive Phenomenological Analysis (IPA) was used as a method to focus on the participants' lived experience. IPA is a qualitative approach that aims to gather insight and make sense of a certain phenomenon (Smith, 1996). Deeply rooted in health psychology, this approach provides context to problems experienced by the population through critical realism (Smith, 2015). HIV positive BMSMFI often face ancillary issues that are difficult to record, so this approach allows for the development of data that gives the full discussion and identifies the experience, not just the outcome (Marlow, White, & Chesla, 2010). IPA is the best way to take "into consideration the context in which

participants lives, their histories, and their concerns" (Marlow et al, 2010 pg.2). The data was coded thematically from the transcript, and the most significant codes were organized by what participants felt was most important through the interview process. The researcher then uploaded codes from the transcriptions into ATLAS ti, a qualitative data management program. The transcripts were analyzed in conjunction with original audio recordings while focusing on themes. This approach was systematic and multi-phased to accurately capture the lived experience of the participants, validated by the participants, and triangulated with the program manager, literature, and transcripts to ensure the accuracy of themes regarding data collected. The process ensured that each participant's voice was heard.

Results

The data collected from the participants were combined and categorized into the two major categories of (a) system level barriers, and (b) individual/personal level barriers. Each barrier is discussed in full detail in the following sections as reported from the lived experience of the participants. The participants identified barriers specific to their transition in regards to housing, insurance, and healthcare; however, the statements provided, when coded, unveiled a stigma regarding lack of access to those services. The manifestation of stigma from structural barriers, such as housing and Medicaid, filtered down to the fear of rejection, internalized homophobia, and personalized stigma of being indigent. In this study, it is important to note that the participants expressed a reluctance to share and expressed self-stigma through nonverbal cues.

System Level Barriers

System level barriers for this group were identified by the things the participants cannot get or do because of their criminal background. Race, HIV, and incarceration have

intersecting identities that come with specific realities; however, being a convicted felon comes with a different reality (Brinkley, 2015) that makes it difficult to attain housing, insurance, employment, probation/ parole, and healthcare (Haley et al., 2014). Many members in the group returned with a criminal conviction and chronic illness to areas void of opportunity (McCarthy, Myers, Reeves, & Zack, 2016). The technical name for this status is "carceral citizenship", which is defined as the relationship between individual rights and incarceration (Miller, & Alexander, 2015). The criminal disposition or background indicates the amount of rights or access to civil liberties the individual has as a citizen (Gottschalk, 2016).

In the South, over policing and the expansion of mass incarceration have created an underclass who are without rights and have lost a portion of their personhood (Deckard, & Heslin, 2016). The divorce of constitutional rights creates a political climate that constructs policies that impact persons returning or reintegrating into society (Maynard-Moody, 2016). This process is called reentry, and most experienced barriers indicated by the population were Medicaid, Supplemental Security Income (SSI), and Housing, which triangulated with the literature (Lerman, & Weaver, 2015).

Housing Barriers

Participants described the system level barriers in terms of what they did not qualify for, such as section 8 or low income housing. Participants described how their felony status prevented them from gaining access to programs that had a contingency regarding criminal background, such as the Housing Opportunities for Persons with AIDS (HOPWA) Program which provides grants to states, cities, and nonprofit community based organizations to provide housing assistance for PLWH. HOPWA also provides HIV related support services

for indigent PLWH as well as their families; however, HOPWA regulations are under HUD's section 8 guidelines, which disqualify applicants with drug offenses and felony convictions within 60 months (Hamilton, Kigerl, & Hays, 2015). Seven participants reported living with their family, two respondents reported living at Alston Wilkes while one lived on his own. When asked about living arrangements, the responses were as follows:

"Yeah, I stay with my people. I can't get nowhere on my own, it's hard out here. It ain't what I want but at least I ain't in the streets, it could be bad you know?". (Participant Age 37)

"I guess, it depends on how much money I got when she need it. I ain't really got nowhere to be at if she get nasty. I am just trying to main'tain." (Participant Age 35)

"I stay with my mama, mama ain't never let me down. Me and mama make it work, we don't have a lot but we got us." (Participant Age 41)

"I am living at Alston Wilkes; it's a homeless shelter over in west cola, it's just too damn far. It ain't near nothing, but I am good sometimes I feel like I don't need to be near nothing."(Participant Age 40)

"I got my own, finally, I am tired of being put out. I am tired of having to cater to folk who ain't trying to cater to me." (Participant Age 56)

These quotes from the participants acknowledge that their criminal history prevents them from gaining access to housing under HOPWA and demonstrate that they feel this lack of access is unjustified. HIV positive BMSMFI in the study expressed a lot of frustration. Several participants were simply happy to have a place to live, considering their circumstance.

Healthcare Barriers

The healthcare system has been well defined historically as the structure-organization of people within the institution that works interdependently to meet the needs of the population holistically (Donabedian, 1988). Conversely, healthcare's definition and the perception of some of the population receiving it are divided. Many marginalized groups, especially people of color, have been at odds with the healthcare system from the very beginning. The unique combinations of trauma pertaining to slavery, segregation, and racism have caused many to develop a different pattern of behavior and perception pertaining to healthcare (Randall, 1995). The experience has impacted the definitions, standards, and expectations that many of these men have due to their past involvements with systems, such as welfare or criminal justice, as they return to impoverished environments. They also present socioeconomic status as a barrier to opportunities and or social services (Venkataramani, Chatterjee, Kawachi, & Tsai, (2016). The connection of experiences is deeply rooted in mistrust shaped by fear from past life experiences, which are reoccurring themes that ultimately shape healthcare engagement, retention, and outcomes. More importantly, this collection of experiences impacts the way a lot of these men live their lives because of the negative experience with the system and how healthcare takes on the appearance of being closely related to the quality they received behind bars.

Participants described several barriers to healthcare. The common barrier among the group was coordination or organization, which created an additional burden regarding length or waiting time at appointments. This experience ultimately impacted transportation; many of the participants without transportation used the University of South Carolina (USC) immunology center because of its wrap around services. All ten of the participants reported

barriers acquiring adequate healthcare; however, the data reported is a snapshot of their shared experience. Some noteworthy responses by the participants were:

"I can't get no Medicaid. I got a felony. I use Healthy connections to be seen, and they hook me up with my drugs". (Participant Age 37)

"I go to USC immunology center, every time I try to get Medicaid they turn me down". (Participant Age 41)

"I use Euclaire to get treatment because I don't qualify for anything else". (Participant Age 46)

"I wish-they got it so I have to be damn near dead to get Medicaid. I got to have the AIDS to qualify".(Participant Age 37)

"They say HIV don't qualify for Medicaid, but I am sick as hell and I don't understand this shit. Excuse my French but the virus is real and they playing with my life". (Participant Age 33)

In these quotes, the participants acknowledged their criminal history bars them from gaining access to Medicaid, and some expressed the belief that it is justified while others do not. The participants expressed mixed emotions and a lot of frustration because of this specific barrier.

Individual Level or Personal Barriers

External stigmas include race, gender, SES, and HIV status. Though these set of experiences begin socially at the structural level, they certainly become personalized and experienced individually through many of the participants' lived experience. HIV positive BMSMFI face discrimination and prejudice even within their cultures (Meyer et al., 2017). Minority stress suggests that society creates the connection of indirect social stigma that

directly impacts minorities and health outcomes (Meyer, 2013). In this study, some participants found trouble engaging in their community and often created their own community of people who are just like them. This is an example of difficulty with trust and having a fear of rejection.

Internalized Fear of Rejection

Rejection sensitivity is best explained as being anxious because of perceived stigma (Feinstein, Goldfried, Davila, 2012), which many of the HIV positive BMSMFI feel consistently in their community. This sensitivity directly correlates to past and current experiences and often impacts how the men engage with the rest of the world (Meyer, Ouellette, Haile, McFarlane, 2011). The internalized fear of rejection is typically generated and formed from institutions; however, it also can streamline into issues like internalized homophobia (Meyer et al., 2011). All of the ten participants reported encounters regarding rejection; however, this information reported is a glimpse of their shared experience. Participants gave various answers that indicated this experience: "*I don't date nobody unless they have HIV. Sometimes you have to realize who you talk to, and talking to people who ain't positive is a problem. At least if they are positive we got something that we can do together, we can look out for each other, and I don't have to discuss why we using condoms". (Participant Age 33)*

"I'm still a human being, and I am still a man. I get hard like everyone else, yeah I step out, but I only step out with familiar folks, who know how to carry it" (Participant Age 37).

"It's okay, I don't see nobody seriously. I ain't up for that because when I give myself to someone it's real. I ain't just gonna be round here douching for just any damn

body, if I give you some it's real, and if you cross me, hmmp hmmp {pause} I will beat that ass! {Leans back crossing arms}". (Participant Age 34)

"No, I never disclosed to my family because I don't want them to know, my worry is my kids and don't want to be a burden. I also don't want to say how I got it. GOD grace got me this far and he will and can make it on through".(Participant Age 56)

"No. I quit, no more men. I have done it all, so there is nothing I can get back from it. I done sold this good cotton candy and have had the very best. I am more worried about that other stuff out there, like Hepatitis, it is more a threat than HIV".(Participant Age 46)

These statements illustrate the varying opinions of disclosure and monogamy; some participants feel like relationships are precious and hard to come by. They also indicate their preference is dating people who have a positive HIV status because they do not want to have to do a lot of explaining, which means they have problems or anxiety regarding disclosing.

Internalized Homophobia

Internalized homophobia is present within the group and connected through societal and religious prejudice (Abara et al., 2015) regarding sexual identity and personal beliefs. The participants have been reared with the experience of religiosity, which ultimately impacts how they feel about themselves (Coleman, Gaddist, & White, 2016). Ten of ten participants expressed some form of internalized homophobia; however, the information provided is just a very small picture of their shared experience. When evaluating internalized homophobia, the participants reported:

"No, does not want the headaches. Last relationship was last year (Thanksgiving). Man, I was the major issue, we met in church while I was dating a woman in the same

church. It was a damn mess. I spent a lot of time in denial of what I wanted. I was raised in the church you know. I sung on the choir and stuff, but I kept having these feelings. I felt trapped. I felt like it wasn't me, I like women, but there ain't nothing like a man. {Sigh} I need that feeling. I know that they say it's wrong, sometimes it feels like it is but only after. I hate hiding. Columbia is not progressive enough, I got my family but that's it". (Participant Age 31)

"I don't get with church or my community because they understand Sunday, but Monday they don't give a damn".(Participant Age 40)

"Church, {sigh- pause} ain't no damn need. They be trashing homosexuality. Ain't nobody gonna put me on front street".(Participant Age 33)

Participants in this study recognized and expressed feelings of inadequacy because of their sexuality. On a superficial level, they reported it is the discrimination they experience as MSM; however, they never indicated verbally that they feel negative about their preference, even though physically they seem uncomfortable discussing it.

Internalized Stigma of Poverty

Being poor in South Carolina has a set of consequences that creates barriers regarding employment, housing, insurance, and healthcare (Hall, Wooten, & Lundgren, 2016). Stigma at this level is a manifestation of experiences owned by the participants from negative structural interactions. Being homeless and being poor are debilitating for many returning home after incarceration; once released, they go from being restricted by barbwire and fences to a freedom that brings anxiety (Wilkinson, Glover, Probst, Cai, & Wigfall, 2015). The anxiety comes from being in a situation where the only concern is freedom; shelter, clothing, food, and healthcare are all just about free to them while

incarcerated; however, upon release, they experience a new world where money is the key to everything they need (Wilkinson et al., 2015). Due to their criminal history, this population faces ancillary barriers initially, such as housing and healthcare (Hubbard, 2014); employment is the key to gain access to the latter when it comes to overall opportunity (Wolfe, 2014). HIV positive BMSMFI face these collateral consequences, ultimately leaving them poor and without a way to adequately support themselves. Many participants shared these experiences; however, these noteworthy statements provided an illustration of what this collective group of ten HIV positive BMSMFI encounter constantly:

"It's okay, I was inside for a couple of years, but I know how to hustle. I sell clothes, shoes, anything I can get my hands on. I have applied for some things but they don't pay me no attention".(Participant Age 34)

"I ain't got a lot of education and really can't get hired any place besides McDonalds or Burger King. I can't do nothing but hustle".(Participant Age 46)

"Sometimes you have to realize that you ain't got nothing coming, that's why I really don't mess with nobody. I ain't got nothing to offer. I can barely pay the little bills I got".(Participant Age 33)

"I don't get with my family because everybody smart and perfect. I'm really having a rough time right now. I go from the shelter to Goodwill, but I can't catch a damn break". (Participant Age 40)

"JOB, I wish. My jacket says steal shit and smoke crack! Ain't nobody got no time for that. I am what you call a liability as soon as I walk in the door". (Participant Age 33)

These responses illustrate the frustration of not having a place to live, an opportunity for employment, and/or options to find a significant other because of the participants' background. More importantly, they describe the stigma of being poor and feeling pessimistic about the freedom they have. Based on collective statements, the freedom that the participants have longed for seems gloomy and without many choices.

Discussion

A synergy exists among various influencers that drives barriers to HIV related care in South Carolina. Whether directly or indirectly, HIV positive BMSMFI feel the brunt of regional and culturally driven policies. These conditions act in concert and place these men at greater risk. The study participants are a sample of an extremely vulnerable population within a well-documented vulnerable population within a larger marginalized population that has been historically oppressed. The participants' narratives reveal the effects of reintegration on PLWH, specifically HIV positive BMSMFI in South Carolina. It also unveils the moderating variable of stigma, which sets the foundation on which theoretical conclusions can be drawn, such as minority stress and intersectionality.

The participants' narratives detail an experience with multiple stigmas that begin structurally and impact them personally. HIV positive BMSMFI who live in these chronic, stress filled life circumstances are impacted psychologically as well as socially. The conflict between who they are and what mainstream society deems acceptable is a battle that seems waged daily (Meyer, 2013). The experience of being formerly incarcerated has concrete circumstances that make many in this population feel disenfranchised, excluded, and out of reach of housing and healthcare primarily (Meyer et al., 2017). Individually, HIV positive BMSMFI fears of rejection, demonstrates internalized homophobia, and deep

feelings of stigma due to poverty. These results have critically important implications for the intersectionality of stigma regarding these men (Crenshaw, 1991; McLemore et al., 2010). Intersectionality is the acknowledgement and study of intersections of oppression among institutions that are prevalent among marginalized groups, not limited to women (Crenshaw, 1991).

The participants operationalize stigma and describe how and where it manifests while accessing HIV healthcare in South Carolina (Higginbotham, 2017). The reoccurrence of stigma is more than impactful for this group of men; it permeates all areas of their life and is reinforced constantly because of corresponding social structures that create multiple instances of rejection. This coinciding set of experiences develops negative self-appraisals and indirectly promotes depression, anxiety, and risky behaviors that lead to poorer health outcomes, especially regarding HIV (Wohl, Rosen, & Kaplan, 2006). HIV positive BMSMFI are disproportionately impacted by mental and physical illnesses that enhance one another and work concurrently (Eldahan et al., 2016). This stigmatized group has an assortment of complex social stressors that is a cohesive combination of the various types of stigma deeply connected to their race, sexuality, criminal history, and HIV status (Meyer, Ouellette, Haile, and McFarlane, 2011).

Therefore, policy makers, practitioners, and researchers must work to understand multiple stigmas. They also must understand various lenses hat examine intersectionality because it should be evaluated on different levels in collaboration with the groups who experience social inequalities and health disparities that create barriers to healthcare and complete wellness. A need for collaboration exists among practice professionals and researchers to address the issues that HIV positive BMSMFI experience to develop an all-

inclusive template to help this population of men specifically. Collaboration will raise a consciousness among professionals to ease some of the burden experienced by professional and client alike to (1) alleviate internalized stigmas that impact engagement and retention, (2) and theoretically add to the discussion of treatment and advance advocacy of culturally grounded policies that consider all people.

Limitations and Future Research

One major limitation to this study was the length of time spent with participants. Though participants were very engaged, it was difficult to get them in and keep them in the interview process. The concern about personal problems was a source of disconnect. Additionally, some participants were more comfortable than others, which added time to the interview process. It took time for some participants to relax to be fully willing to disclose; some struggled to let the researcher completely into their world.

Thinking forward, it would serve the field to engage this population in workshops that afford more openness about the process of living as a HIV positive BMSMFI. Disclosure certainly looks differently for each participant; the degree of difficulty reliving these experiences poses different challenges that may invoke internal conflict. In the future, any research with groups with multiple subordinate identities or multiple stigmas, like HIV BMSMFI, needs to be long and ongoing and include an intervention to improve openness with the intent of addressing the trauma experienced from prison and HIV.

Conclusion

HIV positive BMSMFI experience stigma structurally and personally that intersect and exacerbate overall health outcomes for this extremely vulnerable sub population of MSM. These conditions impact linkage to care and retention to care during the post release

process. Stigma and its conceptualization often occurs in silos, creating a miscalculation of the amount of burden, which leads to policy that does not consider the accumulation of these various life circumstances that perpetuate the cycle of risky behaviors, comorbid conditions, and poor health outcomes. More importantly, the social-historical context of past and current events regarding the complicated status of being Black, MSM, HIV positive, and formerly incarcerated may deliver new methods of research and practice to shape the landscape of future HIV research.

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Chapter: 3 STRUCTURAL BARRIERS OF PUBLIC ASSISTANCE AS A CONDUIT FOR STIGMA

The HIV epidemic in people with criminal justice involvement expresses the urgent need for public assistance and HIV related healthcare services; however, research has focused specifically on prison or jail experiences (Barskey, Surendera Babu, Hernandez, & Espinoza, 2016). Even though HIV has grown rapidly in correctional environments and persons living with HIV (PLWH) who are people of color are disproportionately represented within this group, many with dual citizenship among these groups are not represented qualitatively (Schwitters, 2016).

Much of the current research central to HIV and criminal justice focuses on pre and post incarceration behaviors that are high risk while establishing a connection of risky behavior in prison as a conduit for transmission, quantitatively (McCarthy, Myers, Reeves, & Zack, 2016). These behaviors typically focus on intravenous drug use (IDU), tattooing, sex, and sexual violence as a pathway for HIV infection as well as other sexually transmitted diseases (STIs) (Grodensky, Rosen, Hino, Golin, & Wohl, 2016). Additionally, policies such as opt out/in among institutions may facilitate the growth of HIV infections through lack of awareness, leaving many undiagnosed and untreated in prison (Rosen et al., 2015). Furthermore, these policies contribute to late diagnosis due to the stigma associated with HIV, homosexuality, and incarceration (Rosen et al., 2015). However, research has not adequately addressed the widespread disparity of HIV among participants of society who have been formerly incarcerated; more importantly, many questions about racialized policy, collateral consequences of being felons, and unanswered issues around coordination complicate reintegration to society (Knighton et al., 2016).

Policy that creates socially imposed stigma due to HIV status is critical to the broader conversation of healthcare access in terms of public assistance, especially in this population in the South (McLemore, Winter, Walker & Ray, 2010). More importantly, aspects of socio-demographics and access and their role affect populations differently regarding access to public assistance and healthcare; some populations are predisposed to stigma and live under these conditions constantly (Meyer, 2013). Black men who have sex with men (BMSM) who have been formerly incarcerated (BMSMFI) encounter an unprecedented amount of stigma by way of discrimination, prejudice, racism, and socialized stress, within and out of their communities. Ultimately, this stigma impacts how BMSMFI engage in healthcare and remain in healthcare once they return home due to ancillary conditions, such as housing, access to food, insurance, and medication costs (Brinsdon, Abel, & Desrosiers, 2017). These circumstances create stigma through system level barriers regarding public assistance, ultimately comprising the civil rights desperately needed and that should be afforded under the law (Rubenstein et al., 2016).

Background

America has an estimated 1.5 million people who are incarcerated and 4.8 million on probation or parole, many of whom need housing (Schneider et al., 2017). Blacks are disproportionately impacted by mass incarceration, especially among the ages 25-39 (CDC, 2015). Seventeen percent of Black men have had the experience of re-incarceration, and of that population, 31% have reported being MSM (Doshi, Malebranche, Bowleg, & Sangaramoorthy, 2013). Blacks account for 44% of all new HIV infections nationally, 49% are categorized as MSM, and the prevalence of HIV in prison is 2.5 higher than the general

public (CDC, 2015). In America, approximately 1 in 7 people living with HIV are incarcerated and are released back into the community annually (Vagenas et al., 2016).

HIV positive BMSMFI return to places impacted by elements of sociodemographic risk, such as poverty, housing, unemployment/under-employment, and crime (Mazza, 2015). However, overlapping social-cultural and politically driven policies regarding public assistance create these environments that advance social isolation among this population in the South (Edun, Iyer, Albrecht, & Weissman, 2016). In 2014, South Carolina ranked thirteenth nationally for the number of new HIV cases, with a total of 391 (South Carolina Department of Health and Environmental Control [SCDHEC], 2015). Historically, HIV incidence rates in South Carolina occur at an alarming rate of 70% among marginalized groups, especially in Black MSM (men who have sex with men) communities 56.8% (SCDHEC, 2015). HIV positive BMSMFI recently released from prison face more challenges than their criminally convicted counterparts regarding access to quality care (McLemore, Winter, Walker, & Ray, 2010). The process of reentry is a difficult one, but persons living with HIV (PLWH) have the added pressure of finding care and warding off stigma.

Currently, BMSMFI account for a disproportionate burden of prison sentences and HIV infections nationally, especially in the South (Rich et al., 2016). However, to completely understand the present situation of this population, the duality of history regarding this population and civil liberties accessing public assistance must be dissected to report the complicated multidimensional structural barrier that has acted as an oven for oppression. The strength of the connection between poverty, low socio-economic status, incarceration, and health began during the period after slavery, called the Reconstruction

era; constitutional rights were subject to revocation upon criminal conviction as per the fine print of the 13th amendment, essentially divorcing Blacks from their citizenship (Kennedy, 2016). Equal rights have been the subject of discussion for more than 150 years, especially in the areas of equal protection (McGowan et al., 2016). BMSMFI released from detention centers nationally have high rates of unemployment, barriers to housing, food insecurity, and chronic health conditions but minimal engagement in primary medical care (Wohl, 2016). According to Westergaard, Spaulding, and Flannigan (2013), communication and coordination about reentry or reintegration can facilitate early access to treatment, streamlining the transition for HIV positive BMSMFI from prison to community-based care.

In this paper, the overarching goal is to examine the system level barriers regarding public assistance for HIV positive BMSMFI that create stigma, ultimately providing context to the complicated picture of this population that lives with HIV, are formerly incarcerated, and currently access healthcare in Columbia, South Carolina (Haley et al., 2014).

Public Assistance

Public assistance is defined as the benefits provided by the government, either federal or state, to people who are poor/needy, disabled, and or aging in the form of cash vouchers (Reeves, Rodrique, & Kneebone, 2016). This aid is ultimately provided by the federal government and largely dispersed by state and local agencies to assist governments, organizations, and people in the areas of housing, healthcare, insurance, and general public welfare including food programs (Reeves et al., 2016). The annual national average for public assistance is nearly 400 billion dollars and is administered through federal

agencies/federal assistance programs such as the departments of Health and Human Services (DHHS) as well as Housing and Urban Development (HUD) (Blumenberg, & Pierce, 2016).

Federal Public Assistance Programs

Federal Public Assistance Programs is defined as the organization method by which the federal government delivers aid through its agencies. This format is a well-managed way to facilitate the dispersing of federal funds for utilization among the nation's indigent. Beneficiaries or recipients of aid are typically states, hospitals, and families; the facilitators are states, counties, cities, and non-profits also known as community based organizations. These facilitators provide a number of services not limited to food or medicine; each program was conceived for a particular purpose that is closely scrutinized/regulated (Nuemann, 2016).

Some examples of federal assistance programs that would benefit HIV positive BMSMFI are: Alcohol, Drug Abuse, and mental health, Supplemental Nutrition Assistance Program, Section 8 Housing Choice Voucher/HOPWA, and Medicaid (Nuemann, 2016). All of these programs are income based, and persons 138% below the federal poverty level are eligible in most states; however, felony convictions deem many who need these services ineligible in states such as South Carolina. This inequality has existed for decades in communities of color and currently has been politicized nationally and regionally, creating opposition to social welfare programs in South Carolina, especially pertaining to housing and Medicaid (Grabb, Curtis, Grabb, & Guppy, 1984).

Housing

HIV positive BMSMFI have numerous obstacles regarding housing during reintegration. They encounter barriers to any type of federally subsided housing; they also experience hurdles in the private housing market. These obstructions to stable housing are due to their criminal history (Harding et al., 2013). The limited options they have are homeless shelters and transitional housing, such as Alston Wilkes; however, these places do not offer long term solutions to housing dilemmas. Drug related crimes, such as distribution and possession, almost guarantee future barriers to federally sponsored housing and most private housing because of Section 8 (U.S. Government Accountability Office, 2012).

The US Department of Urban Development (HUD), under the 24th Code of Federal Regulations section 960. 203© (3) and 960.204 public housing authority, has the right to reject potential applicants due to criminal history (U.S. Government Accountability Office, 2012). These guidelines create barriers for the formerly incarcerated; more importantly, they create barriers for those who are HIV positive and indigent in South Carolina. Persons living with HIV (PLWH) who are impoverished typically can access housing assistance through Housing Opportunities for Persons with AIDS, also known as HOPWA. This program helps PLWH gain access to housing; however, the aforementioned regulations bar HIV positive BMSMFI from gaining access to these services because of their criminal history.

Medicaid

Another public assistance program that is out of reach of HIV positive BMSMFI is Medicaid. In South Carolina, Medicaid does not cover the indigent who do not have children. The Affordable Care Act (ACA) has Medicaid expansion to cover poor adults who fall beneath the federal poverty guidelines and qualify for the program; however, South Carolina does not participate in the expansion of Medicaid, leaving many in this group uncovered. This right provided by the state under the 11th amendment gives the South Carolina legislature and Governor absolute autonomy in this issue, ultimately socially excluding HIV positive BMSMFI in need of the program (Maher, and Pathak, 2015).

Minority Stress and the Intersectionality of Stigma and Structural Institutions

Due to the wide range of health disparities among communities of color and their life course of stress, many health professionals have employed theories that explain the chronic conditions with which vulnerable populations suffer (Meyer, 1995). HIV positive BMSMFI are clearly a subordinate group and stigmatized population of the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community (Meyer, 1995). The intersections of stigma they face are race, sexuality, HIV, and criminal history, which are typically layered in discrimination (Meyer, 2013). The historically turbulent relationships between Blacks and institutional entities have created a distrust between the criminal justice system and research/healthcare systems and the communities they serve.

Minority stress is defined as high levels of stress with which marginalized groups deal with that may be caused by environmental factors, such as low socio-economic status (SES) or discrimination in the form of racism or prejudice (Meyers, 1995). Minority stress is described as “death by a thousand cuts” due to micro-aggressions which many in

vulnerable populations face daily (Meyer, 2010); these micro-aggressions lead to poorer health outcomes. To understand risk behaviors and these related stressors, Minority Stress Theory (MST) has been used to emphasize the stress of minorities.

Intersectionality is the intersection of identity and categories; it is most often used in the context of women and feminism (Crenshaw, 1991). Intersectionality refers to the layers of who a person is and all of his or her experiences. Through careful inspection, the individual psychology of HIV positive BMSMFI can be examined in relation to structural barriers that resemble oppression (Moradi, 2017). An examination of barriers that represent oppression are married to the subjectivity of all the institutional encounters that subordinate groups such as HIV positive BMSMFI face, leaving them feeling divorced from their citizenship and creating stigma through various forms of policy that appear discriminatory. These factors ultimately shape the way HIV positive BMSMFI live in South Carolina (Barrick, 2017).

The living conditions for HIV positive BMSMFI in the South are different because of the level of poverty experienced. Nationally, the unemployment rate was 4.7% at the end of 2016. South Carolina's unemployment rate was 4.4%; however, the annual income of those in poverty was $6,275, with the formerly incarcerated four times more likely to be unemployed (Minor, Persico, & Weiss, 2016). Citizens who wear a scarlet letter due to their felony conviction are complicatedly impacted by barriers to employment and public assistance (Wildeman, 2016) because they cannot move beyond their criminal history, in many cases, to help themselves regarding health benefits (Montague et al., 2012). South Carolina is among the 10 states with a significant amount of new HIV infections and at greater risk of HIV related morbidity/mortality (Barskey et al., 2016).

Research suggests that geographic variations of HIV infection are contingent upon state infrastructure and cultural politics that influence resource allocation (Blake et al., 2016). In South Carolina, HIV care is financed through various funding streams that consist of Ryan White, Medicaid, and Medicare. These conduits for HIV related healthcare are state allocated programs. In 2012, Ryan White programs were 13%, Medicare was 29%, and Medicaid was 51% of the funding sources in South Carolina (McLemore et al., 2010). The Affordable Care Act was designed to provide a bridge to care for vulnerable populations, such as HIV positive BMSMFI (Edun, Iyer, Albrecht, Weissman, 2016). The rejection of Medicaid expansion by some states impacted all poor citizens, but more importantly, it impacted HIV positive BMSMFI who live in South Carolina (Doshi, Malebranche, Bowleg, & Sangaramoorthy, 2013).

Socio-demographics

The sample population for this study consisted of 10 (or 100.0%) Black men who were born male, identified as MSM, diagnosed HIV positive, and formerly incarcerated. All participants were a part of Project EMPACT in a correctional facility located in Columbia, South Carolina. The average age for the sample was (37.2), the exact age range was from 31-55 years. No one in the group was employed 0 (0.00%). There was a (60.0%) general education degree or high school completion rate among the sample. The average length of stay in prison was 5.5 years. Substance abuse issues at one time were prevalent among (100.0%) of the sample, (80.0%) reported the use of crack and (20.0%) reported use of heroin. Participants of the study reported a large amount of homelessness, living in transitional housing, or living in shelters (60.0%), (30.0%) reported living with relatives, and one participant had his own apartment through VASH/HUD, a program that

accommodates veterans with housing assistance through the department of Veteran Affairs. Two participants had some form of insurance (VA), and one through Medicaid. The only Medicaid recipient received SSI due to a heart attack experienced during the 1990s; he was the elder statesmen within the group. A total of (80.0%) of the group was without insurance and relied on community based organizations as well as community health collaborative through local providers and the University of South Carolina's (USC) immunology center. Across the sample, (70.0%) reported they had regularly scheduled doctor's visits within the last 12 months at USC, healthy connections, and Eau Clair, all located locally in Columbia, South Carolina.

Table 4.1 Characteristics of Population (N=10)

Name	Description	N (%)
Employment	Employment status	0 (100%) unemployed
Education	High School diploma	6 (60%) High School/GED
Age	Range 31-55	37.2 years AVG
Incarceration	Length of Stay	5.5 years AVG
Substance Abuse	Crack or Heroin	8 (80%) crack 2 (20%) heroin
Marital Status	Relationship status	2 (20%) Significant Other
Insurance	Medicaid/ACA	2 (10%) Had insurance
Healthcare	Medical visits (regularly)	7 (70%)
Medication management	Compliance	5 (50%) compliant
Housing	Housing of your own	1 (10%) Apartment 3 (30%) Living w/ Relatives 6(60%) Homeless or transitional housing

Methods

A qualitative phenomenological research method was used to report the experiences of HIV positive BMSMFI in South Carolina. The study examined the relationship of the structural barriers to healthcare for HIV positive BMSMFI. Semi-

structured interviews were constructed and administered with HIV positive BMSMFI. This study was conducted according to the protocol approved by the University of North Carolina at Charlotte IRB. Data was collected using semi-structured interviews to allow the atmosphere for BMSMFI to share their lived experience. The participants were recruited from Project EMPACT, a local program connected to the South Carolina Department of Corrections. Project EMPACT, which is defined as Empowering Men through Prevention Action Community Collaboration and Training (EMPACT), is a tailor made community-based intervention with the goal of preventing the spread of HIV/AIDS and STIs through education and promotion at a local correctional facility. All participants graduated from the program and remain in contact with the community based organization that conducted the intervention while they were incarcerated.

The leadership of a HIV/STI risk reduction program in Columbia, South Carolina, referred 10-15 potential participants to the researcher from project EMPACT. Ten participants were interviewed due to saturation. Twelve participants received $25 Walmart gift cards as an incentive; two received payment for showing up though they were not interviewed. Inclusion criteria for participants were that they: 1. Self-identify as Black, 2. Assigned male gender at birth, 3. Report having sex with men at least once, 4. Formerly incarcerated and recently released within five years, 5. Have a HIV positive status, and 6. Reside in midlands/Columbia, South Carolina. The exclusionary criteria were if they self-identify as a race other than Black, were not HIV positive, or assigned female gender at birth.

The participants gave verbal consent, which was recorded; they were given a number based on the order of the interview. The interviews were conducted face to face

with the medium time being one hour and 45 minutes in a private office. Interviews were recorded and immediately transcribed. Each interview lasted approximately one hour; however, the length varied per person and subject matter. This type of interview flexibility allowed for more probing questions, which helped to confirm the findings. Interpretive Phenomenological Analysis (IPA) was used to focus on participants' lived experience, which provided context, making sense of their experience. HIV positive BMSMFI often have more than physiological problems; they also have mental health/substance abuse disorders in greater percentage than the general population. IPA was the best method to record their lives, their histories, and their concerns.

Transcripts, field-notes, and sociodemographic forms provided primary data used to describe the population and tell each story. Dragon software was used to assist with transcription of the information recorded. This extra step was used to ensure that the interviews were transcribed verbatim. Themes were constructed from the participants' dialogue and organized by significance by the participant first and the researcher next. The transcripts were analyzed in conjunction with original audio recording. Memo-ing or field notes were used to avoid assumptions or bias and read while asking follow-up questions and during the analysis; the notes included reoccurring phrases or comments as well as the descriptions of emotions. These notes and observations, like any reflections, are relevant to the process. The answer themes were coded by researcher and team member and organized in ATLAS ti, then discussed in a team meeting, which consisted of a program manager.

Results

An exploratory qualitative design, by way of semi-structured interviews, was used to dissect the common or shared lived experiences of the participants as they attempted to gain access to public assistance program/HIV related care in Columbia, South Carolina. The journey of HIV positive BMSMFI detailed the barriers they felt were more significant as they reintegrated into society from prison. The data collected from the participants were combined and categorized into the four categories of (a) housing, (b) employment (c) insurance, and (d) healthcare. These categories were funneled into one major category, which was the relationship between stigma and institutions of oppression.

Public Assistance Stigma

Public assistance and stigma seem interconnected to many Black MSM who are HIV positive, and for HIV positive BMSMFI it, seems traumatic (Kay, & Litchtenstien, 2016). Gaining access to healthcare and insurance involves testing (primarily) and being linked to care, which includes disclosure about status as well as other potentially embarrassing information (Kay, & Litchtenstien, 2016). Many participants of the group had not fully opened up about their infection or the level of poverty in which they live. To detail sexual history, criminal background, and present condition of indigence is overwhelming for this population. The disclosing process brings shame and creates an environment where portions of their life they want to forget are relived (Stringer et al., 2016).

Stigma is a very real experience that is more prevalent in a place or environment like South Carolina that offers its own perspective about HIV or criminal justice (Shrage, 2016). Race, health disparities, and incarceration are seemingly politicized in South

Carolina and create antagonistic barriers subject to advance structural inequalities that many of these men report they face daily. Race, incarceration, HIV, and stigma are intersecting symbols emblematic of the social inequalities associated with this epidemic (Kerr & Jackson, 2016). Research suggests that stigma can be another stimulant among minorities (Meyer et al., 2017); there is lack of investigation that marries incarceration, HIV, sexuality, and race (Bos, Pryor, Reeder, & Stutterheim, 2013). In all, ten of the ten participants reported the experience of stigma in the area of public assistance. Many of the participants expressed the belief that no one cares about them because of all of these factors or categories in which they belong:

"*I am Black, HIV positive, I sleep with men, and I'm criminal. This is all they see when they look at me*". *(Participant Age 41)*

"*When I try to get help, they be whispering under their breath. They don't want to help me, and all they do is judge me, or at least this is how they make me feel"*. *(Participant Age 37)*

"They always act like I don't need nothing. They say you know you have drug charges, so why are we doing this". *(Participant Age 33)*

Racial Stigma

Race was the first category examined because it cannot be changed or covered. Race is determined by phenotype in biological taxonomy and is an informal way to rank hierarchy. Race can be genetically distinct phenotypically; it also can be defined geographically or physiologically; however, people are genetically isolated (Gracia, 2016). The subject of race has posed trouble for medical researchers as well as social scientists because of the complicated nature in which people see and interact with the concept of

race. The concept of race is uncomfortable and can be slippery because it forces the conversation of racism in America, past and present, either subtle or blatant, which ultimately impacts all parties involved due to divisions among people in America (Kelly, 2016). During several instances, participants expressed that the barriers to public assistance they experienced were due simply to race, and these feelings were undisputed among the group. All ten stated concretely, that this was there experience:

"*When I try to get help, all they see is Black, fat, and greasy. I sit and fill out paper work, only to have some little White girl smile at me as she tells me I don't qualify". (Participant Age 31)*

"I think they think I am just trying to work the system. Shit, the system been working me my whole life, I just need some benefits". (Participant Age 35)

"Oh, they think Imma slow leak. Got me completely twisted, she willing to go the extra mile for her own". (Participant Age 37)

These responses speak to the pervasiveness of racial stigma. The answers given regarding race from these men have exacerbated the whole process of gaining access to public assistance as well as reentry and/or reintegration in its entirety. This perspective reported by the participants has been crafted through the participants' life course, either through barriers to education, employment, or frequent negative contact with police, who, to many, not only operate at the discretion of institutional racism but are a tool that represents the oppression which leads to their incarceration.

Incarceration Stigma

The stigma acquired from incarceration can be long standing and enduring, leaving a permanent stain on the identity of anyone on the reintegration journey. Incarceration

stigma can produce life changing events and have implications for HIV positive BMSMFI that can only find rest and closure in truth and self-forgiveness (James, 2013). People released from prison face diminished opportunities regarding all aspects of life; this reality is especially felt among Black men or ethnic minorities (James, 2013).

A certain sense of invisibility is experienced by the formerly incarcerated because of the divorce of their union with civic rights, thus creating a magnitude of structural barriers (Cooper, 2016). All the participants were familiar with this experience, invisibility begins with the loss of the right to vote and, more importantly, be heard, a form of political capital that is lost. One participant addressed this sense of invisibility: *"Them folk don't care about no jail birds, we ain't citizens, we ain't white, we don't vote" (Participant Age 37).*

More importantly, incarceration stigma can directly impact health. It starts physiologically, or HIV related, and crosses into mental or substance abuse areas of health (Muessig et al., 2016). HIV and incarcerated discrimination often elevate levels of stress and impacts the wellbeing of the people who live in these circumstances (McLemore et al, 2010). Furthermore, even if people who have this experience can overcome structural barriers, they still face the constant branding of being a criminal for the rest of their life course and have a diminished social status, reconciling little to no social capital to indicate worth (McCarthy et al., 2016). HIV positive BMSMFI feel this, know this, and live this consistently and are overwhelmingly impacted by the culmination of all of these mentioned factors. The disempowerment creates an environment in which many feel a decreased sense of control over their life trajectory (McCarthy et al., 2016). Several participants (eight) reported having these issues; three noteworthy responses were:

"I can't get nothing down here, can't leave here neither. Can't get housing, can't get insurance, and can't get no damn food, shit crazy. It's like they say here $75 clown start over". (Participant Age 37)

"I am just here trying to hold on, the only fortune I have is misfortune. No job, no place, no money, and it is only getting worse. Who wants to give an old queen like me a chance". (Participant Age 56)

"I am home now, but it like what's next? Here is a bus ticket, and $65 money off your commissary books if you lucky to have it, and I will get with. As a matter of fact, they say I'll mail you the rest. Damn mess, damn messy ass shit".(Participant Age 31)

The uncertainty about life and HIV creates an affinity among the formerly incarcerated because of the same experience. Thinking reflexively, the concept of reentry/reintegration is too familiar for many who have had this experience, one shared with the participants; those who do not have this experience need to cross the empathetic divide.

HIV Related Stigma

Racial and incarcerated stigma converges on HIV positive BMSMFI to create negative living conditions (Meyer et al., 2017). The HIV rate of infection is about five times higher among people incarcerated or a part of the criminal justice system in some way (CDC, 2015). The inescapabilty of stigma has a complicated relationship with HIV positive BMSMFI and their everyday life experiences (Wildeman, 2016). Research indicates a significant need to evaluate stigma as a structural barrier to HIV, especially concerning race/ethnicity (Earnshaw, Bogart, Dovidio, Williams, 2013). Societal stigma has manifested intersectional forms of stigma (race, incarceration, HIV status), which

impacts HIV positive BMSMFI individually and leads or contributes to more HIV disparities (McLemore et al., 2010).

Those who experience increased levels of stigma report higher levels of anxiety, lower self-esteem, and poorer health outcomes (Earnshaw et al., 2013); the responses of several participants, which was seven of the ten confirmed this truth:

"Yes, I stay in my hood, but I don't mess with nobody. I can't live no-where else". (Participant Age 41)

"I don't want people in my business, so I don't ask for help. I know I am poor, but it's different down here, being sick, poor and Black just looks different down here". (Participant Age 46)

"I'm still a man. They don't see me nor do they see what I am doing just to stay healthy. It should not matter who I lay up with or how I do it. I am still a good person. I ain't screwing them! I live with HIV every day, and I know how to keep my stuff down (viral loads)". (Participant Age 33)

"I'm like you know you can't get nothing from me just being here. I am just trying to live". (Participant Age 37)

These responses indicate that issues with engagement are often influenced by stigma. Stigma or perceived level of social acceptance is often viewed as an individual barrier (Levy et al., 2014); however, stigma often starts at a system level. The compounded individual level barriers for this group were criminal background, race, sexual preference, and HIV status; these multiple identities create a complex reality that impacts the way these men see themselves in relation to the rest of the world (Brinkley-Rubinstein, 2015).

Self-Stigma

Long-term and relentless socially imposed stigma can lead to a phenomenon identified and known as self-stigma (Collett, Pugh, Waite, & Freeman, 2016). Self-stigma is defined as "the reduction of an individual's self-esteem or self-worth caused by the individual self-labeling her or himself as someone who is socially unacceptable" (Vogel, Wade, & Haake, 2006 pg. 325). This form of stigma is connected to self-esteem, self-efficacy, and behaviors conducive to seeking help (Vogel, Wade, & Hackler, 2007). More importantly, research suggests that internalized self-stigma influenced by society is directly related to the conceptualization that medical care is unimportant for many who have this experience (Vogel, Bitman, Hammer, & Wade, 2013). Many participants stated that they experienced some negative self-perceptions, which has severely impacted how they take care of themselves on a consistent basis. In fact, eight of the ten participants reported some form of self-stigma:

"It's okay, I was only inside for a couple of years, but I always felt like I won't nothing to the staff or security, hell my parole officer don't treat me no better, maybe I deserve it". (Participant Age 34)

"I ain't got a lot of education and really can't get hired any place besides McDonalds or Burger King. I can't do nothing but hustle, I ain't smart enough to do nothing else". (Participant Age 46)

"Sometimes you have to realize who you talk to and their threat level, and that the very main reason why people try to get to know you, and make sure you do not disclose, I don't want nobody all in my business you know. My life is my life, and I ain't really trying to share it". (Participant Age 33)

"I know I'm a damn sinner, but that's my cross to bear with Jesus. I have done everything to shake this feeling when I was young. I even prayed, but I finally realized I like cocaine and men, and that's just the sum of it. I don't get with church or my community because they understand Sunday, but Monday they don't give a damn". (Participant Age 40)

"*No I don't attend church a lot, all they do is down homosexuality. If it comes from the pulpit they swear its true, hell even I think it is sometimes. I guess it is my truth, my sorry ass truth that I have to live with just like HIV". (Participant Age 33)*

The intersectionality of stigma explains the transactional view the participants have pertaining to their value and lends itself to the model of minority stress and intersectionality because of the simultaneous impact they have on HIV positive BMSMFI (Brinkley-Rubinstein, & Turner, 2013).

Discussion

The participants report substantial barriers to public assistance that ultimately become layers of stigma they are forced to encounter and live with during reintegration. This is a common problem, so there is a need to examine structural barriers as stressors that become conduits for stigma. In 2014, South Carolina released 5,121 Black men from prison; some of them were HIV positive and potentially more were unaware of their status; however, they were aware of their indigent status and need (Lieb et., al.,2012). This study revealed structural barriers to public assistance that include housing, insurance, and healthcare access. Many participants of this group returned to shelters; the others returned to their families in areas void of opportunities and considered poverty stricken by many.

This “carceral citizenship” is when incarceration officially divorces the individual from access and a status that grants constitutional rights in America (Miller, & Alexander, 2015).

The overarching themes in this study were public assistance, discrimination by way of stigma which creates barriers to care, and an identity construct layered in negativity. The narratives from the participants reflected the role of stigma in the South, especially in South Carolina. The state of South Carolina and tough policies on crime seemingly promote a caste/class system that these men are stuck in as unwilling participants (Gottschalk, 2016). They feel that the multiple stigmas they encounter are not limited to HIV and impact how they seek treatment or ultimately remain in care. As residents of South Carolina, the participants feel they do not have the pathway to reintegration, essentially denying HIV positive BMSMFI complete personhood (Deckard, & Heslin, 2016). The theoretical framework for this study rested on the foundation of minority stress/intersectionality, which focused on stigma applied to stigmatized members of society and the intersection of identity, politics, and inequalities experienced among subordinate or marginalized groups (Meyer, 1995; Crenshaw, 1991). In this study, intersectionality of minority stress was applied to HIV positive BMSMFI and reintegration and triangulated with other literature in regard to the data uncovered by the group about their lived experience.

Implications for Health Services Research

Health services research evaluates several different areas from health econometrics to health disparities determined by utilization or access, which is more than closely linked to social determinants of health. Furthermore, differences in race and SES are also illustrated and typically well documented in research; however, further inspection of minority stress, intersectionality, HIV, criminal background, and external forms of stigma

via cultural/regional politics will impact the discussion of race and many social injustices this specific group as well as others who resemble this group face consistently.

Conclusion

HIV positive BMSMFI in Columbia, South Carolina, face numerous structural barriers upon reintegrating into society. In fact, nearly 25% of PLWH enter/exit prison annually, and 1.8% are a part of the state prison system (Wohl, 2016). US prisons and communities of color have higher rates of crime and HIV infection. These members of society also typically reintegrate into home and neighborhoods located in poorer areas, among poorer people in environments that are geographically vulnerable to these societal ills (Buot et al., 2014). These two challenges to public health are deeply rooted in drug related crimes and other risky behaviors (Stepanikova, & Oates, 2017). The significance of HIV transmission is influenced by structural and cultural disparities that take place across society several aspects of society regarding this population (Elopre, Kudroff, Westfall, Overton, & Mugavero, 2017). The disparities among BMSMFI take place in the form of discrimination pertaining to public assistance (Priester, Foster, & Shaw, 2017), insurance by way of Medicaid (Chakraborty et al., 2016), community connectedness (Powell, Herbert, Rischwood, & Latkin, 2016), and patient-provider relationships (Batey et al., 2016). All of the aforementioned issues impact this population, providing them with multiple potentially negative interactions on an individual level that begin at a system level and promote bias and distrust (Lam et al., 2016).

In South Carolina, public assistance seems almost out of reach for many of the men and women who return home from prison; more importantly, HIV positive BMSMFI find it even more difficult due to the lack of programs specific to men who are HIV positive,

MSM, and convicted felons. Healthcare is usually defined by the actual system or disparities; however, ancillary barriers are just as important, if not more. Ancillary barriers are usually categorized as housing, employment, transportation, location, or distance; however, in this study, stigma was the actual ancillary barrier due to external conditions created through public assistance and insurance programs, such as Medicaid, in an environment ripe for stigma that has impacted each every participant of this sample group. In summation, there is no value or judgment more decisive to a person's psychological development and behavior than the ultimate judgment he places on himself (Howard, Flennaugh, & Terry, 2012). Self-judgment is the rational or irrational way that he (they) interacts with the world, impacting not just behavior but outcomes. With this sample group, HIV related healthcare outcomes regarding treatment were at the intersection of public assistance and insurance programs that cultivate the relationship with stigma.

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CONCLUSION

HIV positive BMSM who were formerly incarcerated (BMSMFI) experience numerous, overlapping forms of stigma. As examined in this study, these intersecting stigmas can have a profound influence on health, engagement, and or retention to HIV related care services as well as the reintegration process in Columbia, South Carolina. Participants often expressed feeling structural forms of stigma that naturally created barriers that impacted them individually as it pertained to public assistance and healthcare access. The barriers reported were related to their disqualification from services primarily because of their criminal history and indigent status, which many expressed as a symptom of being formerly incarcerated. Conceptualization of minority stress and intersectionality are often discussed in isolation; together, these concepts potentially lead to a compounded burden of reintegration for HIV positive BMSMFI in Columbia, South Carolina. Additionally, the socio-historical context enlightens and forms one's understanding about the lived experience of BMSMFI and must be considered when evaluating minority stress and the intersections of the people who have this uniquely difficult task of reintegration with HIV.

Black and White racial disparities regarding HIV and the criminal justice system have plagued America for more than 40 years. The United States incarcerates nearly 1% of the adult population in jail or prison (Wohl, 2016). Mass incarceration stimulates the growth of the transmission of Human Immunodeficiency Virus (HIV), especially among Black men (Wohl, 2016). Black men represent nearly 13% of the national population but are roughly six times more likely to be incarcerated than their White peers (Carson, 2014). In fact, research suggests that one in three Black men will be incarcerated once in his life

time (Alexander, 2011). This rate of disproportionate incarceration has been a trend for the past 30 years, and HIV has grown in this population at a similar rate (Levy et al., 2014). According to Wohl, Rosen, and Kaplan, the growth in each area has been facilitated by structural barriers born from stigma and transfers this perception to an individual level (2006). The stigma experienced on an individual level creates minority stress, which is the condition under which many in this population live (Peterson & Jones, 2009).

In response, this project dissects the nuances of stigma pertaining to social services in the area of public assistance and HIV related healthcare. This dissertation begins with reentry/reintegration and discusses HIV positive BMSM who were formerly incarcerated and what post-release looks like as they try to engage in HIV related healthcare. The discussion of linkage and retention in care is culturally grounded in theoretical concepts that address the intersectionality of minority stress while accessing HIV related healthcare and ancillary barriers pertaining to various forms of public assistance as felons who are HIV positive in desperate need of housing and Medicaid in Columbia, South Carolina.

In chapter two, which is the first article, the role of multiple citizenship within subordinate marginalized groups was explained by describing the characteristics of being invisible in South Carolina. Through various experiences that socially exclude and create feelings of stigma that become internalized, HIV positive BMSMFI encounter structural barriers facilitated by institutional systems of oppression that create devastating collateral consequences. The social context of invisibility that fosters minority stress and the intersectionality of stigma experienced by HIV positive BMSMFI is vast and widespread among communities that are culturally and regionally constructed similarly. The sociological approach of providing a whole picture of HIV would be contingent on health

outcomes; the social determinants that play the leading role of facilitators on the stage of injustice, incarceration, and HIV resonate psychologically regarding the multidimensionality of discrimination (Adimora et al., 2014). The classic triangle of HIV transmission and progression are host, agent, and environment (Hargreaves et al., 2016). A relationship exists among men, their experience, socio-economic status (SES), and barriers to opportunities; furthermore, the aforementioned is also a gate way to alternate market economies, drug related crimes, and high risk behaviors that lead to incarceration and HIV (Wohl, 2012). The challenges of being poor and disenfranchised while living in these circumstances are the reported conduits to HIV and prison; however, they do not serve the discussion of the experience and multiple identities that illustrate a portrait of HIV positive BMSMFI (Sykes, & Piquero, 2009).

Moving from the description of invisibility of HIV positive BMSM who were formerly incarcerated in paper one, the second paper, or chapter three, focuses on the perceived barriers faced by HIV positive BMSMFI in Columbia, South Carolina. This population has been impacted by social determinants of health their entire lives so what they report as barriers engaging HIV related healthcare is more than just direct access (Bauman et al., 2013). The dual epidemic of accessing healthcare and reintegration impacts HIV positive BMSMFI mostly in the areas of housing, employment, insurance, healthcare, and transportation. Members of this unique group typically come from disadvantaged backgrounds and live in very similar environments once released from prison. The difference in experience in barriers adds richness to the discussion regarding needs.

The group identified that their barriers were deeply connected to public assistance, particularly at the system level, such as housing and healthcare insurance. However, these

expressed system level barriers impact them individually, creating stigma because of the stigma filled conditions. The structure of inequality and policies keep institutional oppression alive and breathing; they are partisan and can appear racially devised and applied through selective resource allocation (Bonilla-Silva, 1997; Wilson, 2016). Broken homes and fractured families create neighborhoods that struggle economically, underfunded schools that are considered unimportant and, explaining the correlation between poverty, education, and prison (Tejeda, 2016). These factors facilitate the growth of risky behaviors in place and space of urban and rural environments that are gateways to prison and HIV infections (Wilson, 2016). This specific framework of poverty is a constant reminder of the continuous dysfunction that fosters societal ills and perpetuates stigma socially that ultimately impairs HIV positive BMSMFI psychologically.

The stigma experienced by HIV positive BMSMFI through the instrument of oppression in the United States has been a constant, frequently reoccurring experience for many marginalized populations either by race, social class, gender, and or sexual orientation (Wilson, 2011). This experience is a painful one and is often overlooked because of the desensitizing or normalization of these stigmatizing events that many associate as a part of life (Smith et al., 2014). Life and what many consider to be normal behaviors create an environment in which second class citizenship, poverty, and the stigma of being in several subordinate groups only exacerbates the experience gaining or remaining in HIV healthcare (Xia et al., 2016).

Chapter four, or the third paper, focused on the structural barriers of public assistance as a conduit for stigma. The argument is made regarding people shaped by the various classifications in which they identify, believe that they belong to and with which

they are connected. Socially, their negative categorizations are commonly related to social and economic disparities. The purpose of the third paper was to provide more context about public assistance and the stigma experienced by HIV positive BMSMFI through their shared lens. The multidimensional forms of stigma encountered explain engagement and retention in HIV related healthcare. Numerous participants reported that system level barriers linked to public assistance, such as housing, food programs, and Medicaid, provided difficulty during their process of reintegration. They attributed this to their social status and criminal convictions, which left them out of reach of opportunities or the ability to take advantage of socially sponsored programs that influence health outcomes either directly or indirectly.

In this chapter, public assistance is well defined as benefits provided by the government to people who are indigent, aging, and or disabled in the form of cash or vouchers largely distributed through state agencies (Reeves, Rodrique, & Kneebone, 2016). These federally sponsored programs come with a specific set of criteria, such as indigent status, criminal convictions, and what the state defines as chronically ill, which are managed with varying levels of oversight and regulated on a state level. Some program examples are Alcohol, Drug Abuse, and mental health, Child and Adult Care Food Program, Supplemental Nutrition Assistance Program, Section 8 Housing Choice Voucher/HOPWA, and Medicaid (Nuemann, 2016). All of these programs are income based, and persons who are 138% below the federal poverty level would be eligible in most states in America; however, felony convictions deem many who need these services ineligible in states like South Carolina. This inequality has existed for decades in communities of color and has been currently politicized nationally, creating opposition to

social welfare programs. However, HIV positive BMSMFI are now victims of these policies and experiencing what they feel is discrimination (Grabb, Curtis, Grabb, & Guppy, 1984).

The wide range of disparities among HIV positive BMSMFI impacts their life course. Collectively, health service research professionals have moved research toward SES and social determinants of health, which are typically chronically stressful. Research on stigmatized or vulnerable populations also has been conducted for several decades; furthermore, race and SES have merged to describe and categorize health disparities quantitatively. However, more is needed qualitatively regarding HIV positive BMSMFI in order to examine minority stress and intersectionality in terms of the individual experience of the person and within the intersections of the person that often get compartmentalized and secured away from the rest of the world. The intersections include physical health, mental health/substance abuse, poverty, educational attainment, community connectedness, stigma, and internalized stigma. The reasons for stigma may vary; however, the outcome is the same for many in this unique population of HIV positive BMSMFI in Columbia, South Carolina.

Deductions Drawn from HIV Positive BMSMFI

The conclusions drawn from the study of HIV positive BMSMFI is that this population suffers from external stigma that impacts them internally as well as from minority stress consistently throughout their life course. Minority stress is the description of higher levels of stress experienced by members of a stigmatized population (Meyer, 1995). The term is primarily applied to marginalized populations, such as Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) and communities of color; however, what

about ex-offenders who are greatly stigmatized in society? The research reports that prison is a major facilitator of HIV due to the various ways of transmission, such as unprotected anal intercourse, intravenous drug use, and tattooing (Matthews et al, 2016). These factors act in concert creating synergy and ultimately influencing the transmission of HIV in prison (Dumont, Brockmann, Dickman, Alexander, & Rich, 2012). The experience of prison and reintegration assists stigmas experienced by HIV positive BMSMFI in Columbia, South Carolina, because of social and cultural perspectives that reinforce a different type of shame and oppression.

Significance of HIV and Reintegration Research for Helping Professionals

The importance of this study is centered on societal stigma that has produced individual level stigma through institutional barriers. In addition, policies/protocols, such as opt-in/opt-out in various prison settings, have created a vacuum in testing and treatment due to stigma, and many refuse testing against their own interest (Rubenstein et al., 2016). The stigma is experienced on several levels and creates different health outcomes for this population, especially HIV positive BMSM in the South (McLemore, Winter, Walker, & Ray, 2010). Fourteen percent of people living with HIV (PLWH) were released from some form of incarceration (Bhushan, Brown, Marcus, & Altice, 2015). Eighty percent have substance abuse illnesses and 50% have some mental illness diagnosis. Within the scope of HIV, the prison population is 3 times more likely to contract HIV than the general public; however, they typically are more successful at viral suppression because of greater achievements at medication adherence while in prison (Bhushan, Brown et al., 2015).

Once released, HIV positive BMSMFI report difficulty staying engaged in care, resulting in poorer health (Binswanger et al., 2011). The benefits of antiretroviral therapy

(ART), which is the combination medicines used to treat and slow the rates of infection in the body, is often lost during the transition from prison to the community (Wohl, 2016). Current scholarship often dissects minority stress and intersectionality regarding BMSM, HIV, and prison; however, the overlap does not reflect the specificity of the population. The homogeneity of the population may be in direct conflict with their heterogeneity as individuals. Each person has a different lived experience, and each experience is layered with that person's life story from prison to the community. The subtle nuances are all of the aspects regarding structural, social/environmental, and individual factors that either act as facilitators or barriers to care, which create either positive or negative health outcomes (Meyer, 1995).

Despite rapid decline in HIV and incarceration rates overall (Kaeble, Glaze, Tsoutis, & Minton, 2015), Black men still face disproportionate rates of infection and incarceration (Wohl, 2016). Nationally as well as regionally, BMSM are deeply impacted by incarceration and HIV (CDC, 2015), and their transition or reintegration is filled with stress and some kind of stigma due to the numerous challenges they face as members of multiple marginalized groups (McLemore et al., 2010). In South Carolina, their stigma is deeply rooted in polarized opinions that stem from cultural opinions of politics, religion, and societal norms within the communities to which they return (Cook, Calebs, Perry, & Hopkins, 2017). Research suggests that "HIV disproportionately impacts prisoners. Though incarceration provides an opportunity to diagnose and initiate therapy, treatment is frequently disrupted after release" (Montague et al., 2012 pg. 319). This disruption is connected to various levels of stigma that inmates encounter before, during, and post prison experience. It may begin at home, in their communities, as children and young adults;

however, it certainly is found within the prison setting and persists after release because of HIV status and criminal history (Swan, 2016).

HIV positive BMSM who were formerly incarcerated are labeled with several stigmatizing characteristics that leave them socially and culturally devalued (Swan, 2016). Many are impacted by substance abuse and mental illness; they all are affected by their collective criminal backgrounds and multiple minority statuses in a very dominant culture (Montague et al., 2016). The aspect of criminal history has been well documented in the literature regarding employment, under employment, homelessness, and barriers to public assistance, ultimately contributing to the revolving door of reoffending (Travis, Western, & Redburn, 2014).

The intersection of these stigmatizing characteristics only complicates reintegration for HIV positive BMSMFI. The prevalence of HIV and incarceration is twice that of the general public (CDC, 2015), making PLWH who are BMSMFI more susceptible to complicated intersections of minority stress (Swan, 2016); stigmatizing characteristics experienced within this group are uniquely different, even though they are perceived as homogeneous. This assumption does not appreciate the individuality of the shared experience of HIV, prison, and reintegration in Columbia, South Carolina (Vagenas et al, 2016).

A Pathway forward for Health Services Research

By definition, health services research is the interdisciplinary field that evaluates how people gain access to healthcare holistically through various passageways of engagement, such as facilities and or practitioners. Health services research examines costs and outcomes of individuals who receive care; furthermore, the community based side of

health research explores policies and social determinants of health and the people predisposed to barriers to care due to socioeconomic status. However, there is a need to include moderating variables other than sex, ethnicity, and class. Racial and sexual identities are well researched; however, a key task to understanding many of the disparities that research professionals discover is delving deeper into the experiences of the focus population and their life, hopefully beginning at adolescence where emerging adults begin to develop and understand who they are and how they fit into society. This approach will involve questions about identity development that pertain to sex as well as specific ecology and what it (environment) may look like for them. Other questions to consider are: what are their cultural norms and how do they contrast or conflict with dominant culture in America where the expectations of citizenship and masculinity look differently than the great advertised American reality.

The range of negative experiences encountered by HIV positive BMSMFI has been described as contempt, prejudice, and or some kind of hatred stemming from fear or religious beliefs which impact the way people view the world and themselves, particularly regarding sex, sexual identity, and God (Abara et al., 2015). Although this study contributes to the knowledge base regarding the epidemics of HIV, mass incarceration, and the process of reintegration, much more work still needs to be done qualitatively. More research is needed on minority stress and intersectionality of HIV positive BMSMFI and structures that present challenges because of socioeconomic status and criminal history; the work needs to move past reporting the disparity to focus on the inequality from the voices of the people impacted by the structural inequities that they are born into, live with,

and die in. HIV positive BMSMFI are disproportionately impacted by chronic physiological and mental health conditions that activate anxiety (Eldahan et al., 2016).

Limitations

The small sample size and limited generalizability of this group of participants in Columbia, South Carolina is a limitation to this study. All of the participants were recruited through PALSS a HIV organization in Columbia, South Carolina. All the participants were graduates of project EMPACT, which is an intervention conducted in one specific correctional institution in Columbia, South Carolina. All of these conditions limit the variability of the participants, thus creating a large amount of homogeneity among the group.

Although this study contributes to the knowledge base regarding the epidemics of HIV, mass incarceration, and the process of reintegration, there is still much more work to do qualitatively. More research is needed on minority stress and intersectionality of HIV positive BMSMFI and structures that present challenges because of socioeconomic status and criminal history; the work needs to move past reporting just the disparity to focus on the inequality from the voices of the people impacted by the structural inequities that they are born into, live with, and die in.

Conclusion

According to current research, mental health disparities among sexual minorities facilitate chronic illnesses, including HIV; long term exposure to minority stress impacts socially disadvantaged members of society, especially HIV positive BMSMFI (Meyer et al., 2010). Stigmatized minority groups are consumed with these groups of stressors because of their sexual preference, socioeconomic status, and HIV status that complexes

life and compounds general stress that everyone experiences (Livingston, 2017). The group within this study specifically presented all of these problems, and during this project, their struggle was very obvious. More importantly, they expressed growing concern for party-political shifts and how the shifts will impact how, when, and where they will be able to get help. Furthermore, the socio-cultural climate was another barrier because of the added social stressor and its potential impact on how they eventually will be perceived or treated. The group of HIV positive BMSMFI expressed concern about the rights they have and what they will lose under the current politically charged circumstance in South Carolina because of their status and sexuality.

The stigma experienced is like a scarlet letter, and quite a few of these men feel impacted by this bad public or community characterization. Stigma influences negative self-perception and is a byproduct of pre-prison experiences, such as poverty, and post prison experiences, which are their shared experience and potentially their connected future. The shared lived experience produces a panoramic view due to their various experiences that ultimately orchestrate how sub-culture mores are established and affixed to cultural rules/morals derived by those living that life specifically. This type of life course experienced by the most vulnerable influences decision making through risk versus rewards processes and often justifies decision making and high risk behaviors from their (HIV positive BMSMFI) perspective and or appraisal of themselves in relation to the rest of the world.

Race is very salient to the discussion of public health in numerous ways; however, the complexity of structural barriers that appear racist influence health and the production of research that is eventually disseminated regarding health disparities. Methodologically,

it is well documented that structural forces drive inequalities and research, and interventions alike over emphasize individual mechanisms disproportionately (Newsome, Davis, & Dinac, 2015). More importantly, overconfidence in research objectivity can subject the scientific investigator to unintentional influences regarding priori assumptions of the actual research.

Health services research is the interdisciplinary field of scientific inquiry that evaluates access and or utilization related to structure, process, and outcomes (Engelhard et al., 2016). There is an emerging consensus that a new direction is needed to advance the fight against social inequalities regarding health in which society can cross the empathetic divide. This station is where research professionals can fully recognize our platform to focus on race as an influencing factor that mitigates or exacerbates health outcomes. Anderson focused on population characteristics such as race (Lee, Matejkowski, & Han, 2017); however, to center the margin, as researchers, we must immerse ourselves in the experience and perspective of that population we investigate, evaluate, and disseminate information regarding health disparities (Mackenzie et al., 2016). There is a need for a shift in paradigm and methodologically integrated theoretical conceptualizations that are race conscious to suppress inequities that form the inequalities that many marginalized communities experience.

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