

The HIV care continuum in black MSM in the USA

In *The Lancet HIV*, Eli Rosenberg and colleagues¹ report their reconstruction and population of the HIV care continuum from publicly available and nationally representative data of men who have sex with men (MSM) in the USA. Viral suppression, the penultimate desired effect on the continuum, is achieved in 16% of black and 34% of white MSM. After modelling various scenarios of how differences in viral suppression could affect the future course of the epidemic, the investigators reach the disappointing conclusion that even in the best-case scenario racial disparities in HIV prevalence will sustain a higher incidence in black MSM for decades to come.

These disheartening conclusions show the long-term consequences of historical neglect. Immediately after the first epidemiological investigations of HIV infection in MSM in the USA started in 1984, Samuel and Winkelstein² not only reported racial disparities in HIV seroprevalence and incidence, but also that, contrary to their expectation, these disparities could not be accounted for by race-associated differences in HIV risk behaviour.

Similarly, after all US states and territories had implemented AIDS case reporting in 1986, Bakeman and colleagues^{3–5} analysed and reported the AIDS Public Information Data Set from US Centers for Disease Control and Prevention (analogous to the rationale and approach used by Rosenberg¹ to obtain and report the data presented in the current study) demanding interventions to stop the emerging and widening HIV/AIDS epidemic in black Americans.

The racial disparity findings in HIV/AIDS have been repeatedly corroborated in HIV case reporting, surveillance, and research. However, the first US federally funded evidence-based HIV prevention intervention designed specifically for black MSM was not published⁶ until 2009—a quarter of a century after racial disparities in HIV infection were first noted between black and white MSM.²

The increased federal investment in HIV prevention in black MSM is promising. However, the focus on HIV testing and biomedical interventions is unlikely to have the effect needed to end disparities in care. Black MSM are already as likely as or more likely than are white MSM to use condoms, to get tested for HIV, and even

to use pre-exposure chemoprophylaxis.⁷ However, these preventive behaviours have not reduced racial disparities along the care continuum, nor have they reversed the increasing trend in HIV incidence. Indeed, Rosenberg and colleagues note that the same structural barriers affecting the HIV care continuum are likely to affect access to and use of any other biomedical HIV prevention measure.

The researchers leave us with the dire prediction that short of “transformational biomedical advances”, such as an effective HIV vaccine or a cure, racial disparities in MSM will persist for the foreseeable future. While we wait for scientific process to take its course in delivering biomedical advances, the structural interventions and changes needed to facilitate affordable, effective, and unrestricted access to the new preventive methods can be started today.⁸

Positive structural changes in the organisation of the health-care system of the USA will help to improve overall access to quality health care in the country. However, this might not benefit black Americans generally. Black MSM have lower rates of health insurance than do white MSM, starting with reduced access to health-care services. The Affordable Care Act has increased access to care for people who live in states that have elected to expand Medicaid. However, most states in southern USA (where most black Americans with HIV live) have rejected Medicaid expansion. A mandatory Medicaid expansion would likely increase health-care access for many black MSM who live in the south. However, even when such access would become available, structural interventions and change will still be needed to provide unrestricted and unhindered access to this expansion.

High rates of poverty, incarceration, unemployment, and low education are driven by historical and current policies that disproportionately affect black people in the USA. These policies can be changed in ways that improve life circumstances that put black MSM at higher risk for HIV. For example, elimination of policies such as stop and frisk that target young black men would serve to reduce the number of black men in the criminal justice system, allowing them to spend more time on education, expanding employment opportunities, and reducing exposure to HIV in prison.

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The inclusion of all MSM living with HIV infection in this analysis (and not only those who have been diagnosed) led to substantially different estimates of the HIV care continuum from those in federal reports. For example, Singh and colleagues⁹ reported in September, 2014, that 46% of black MSM are retained in care, whereas Rosenberg and colleagues found only 24% are.¹ Likewise, Whiteside and colleagues¹⁰ reported 37% of black MSM were virally suppressed, whereas Rosenberg and colleagues found only 16%.¹ These differences show the need for consensus about the timing of initiation of the continuum. In view of the effect that undiagnosed HIV infected people have on the HIV epidemic, their inclusion in our understanding of transmission dynamics and appropriate interventions is crucial.

Both the methods and the findings of this study show that the USA cannot reduce new infections without addressing structural factors and attending to social justice. Data that provide road maps to begin addressing the structural issues that surround disparities in HIV prevention, care, and treatment in black and white MSM are becoming available. It might be wise to follow where they lead; however, since the roots of racial inequality and injustice in the USA run deep, much more depth and a much greater toolbox will be needed to uproot and eradicate causes definitively.

Tonia Poteat, Jordan White, *Frits van Griensven

Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, USA (TP, JW); Thai Red Cross AIDS Research Center, Bangkok, Thailand (FvG), and Division of Preventive Medicine and Public Health, University of California, San Francisco, CA, USA (FvG)
frits(svg@gmail.com)

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