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Ending the HIV Epidemic for All, Not Just Some: Structural Racism as a Fundamental but Overlooked Social-Structural Determinant of the U.S. HIV Epidemic

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Abstract

Purpose of review—We review recent theoretical and empirical literature on structural racism, social determinants of health frameworks within the context of HIV prevention and treatment, and criticism of the national responses to the U.S. epidemic.

Recent findings—In line with growing mainstream attention to the role of structural racism and health inequities, recent editorials and studies cite ending structural racism as an essential step to ending the U.S. HIV epidemic. Recent studies demonstrate that barriers rooted in structural racism such as incarceration, housing instability, police discrimination, neighborhood disadvantage, health service utilization and community violence, and poor or no access to social services, transportation and childcare, are barriers to HIV prevention. Recent articles also criticize national responses to HIV such as the Ending the HIV Epidemic (EHE) and National HIV/AIDS Strategy (NHAS) plans for failing to address structural racism and prioritize community-engagement in EHE efforts.

Summary—Collectively, the articles in this review highlight a growing consensus that the U.S. has no real chance of ending the HIV epidemic for all, absent a meaningful and measurable commitment to addressing structural racism and intersectional discrimination as core determinants of HIV, and without more equitable engagement with community-based organizations and communities disproportionately affected by HIV.

Keywords

Structural racism; social determinants of health; syndemics; HIV

Introduction

Four decades into the U.S. HIV epidemic, there are key HIV prevention and treatment successes to celebrate. The absence of a vaccine or cure notwithstanding, access to antiretroviral treatment (ART) has expanded life expectancy for people living with HIV (PLWH) and preexposure prophylaxis (PrEP) significantly reduces HIV transmission. Alas,

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Conflicts of interest

The authors have no conflicts of interest

with Black and Latino people still disproportionately represented among those living with and newly diagnosed with HIV [1], racial equity in HIV prevention and treatment remains elusive.

HIV inequities among racialized groups in the U.S. are staggering. Black people represent just 13% of the U.S. population, but accounted for 45% of new HIV cases in 2019 [1]. This disproportionate burden exists at every intersection of gender, with Black cisgender gay, bisexual and other men who have sex with men (BGMSM), cisgender and transgender women, accounting for 26% [2], 91% [3], and 49% [4] of new HIV diagnoses, respectively. Similarly, Latina/x/os, who can be of any racial group, represent 17% of the U.S. population, but accounted for 21.5% of new HIV diagnoses in 2019 [1]. Latino GBMSM, cisgender Latinas, and Latina/x transwomen accounted for 85% [5], 87% [3], and 33% [4] respectively of new HIV diagnoses. The epidemic is especially dire for Black and Latino GBMSM. Recent analyses of national surveillance data from 2010–2019 document that although HIV has declined among White GBMSM, there has been no decline for Black and Latino GBMSM [6]. Moreover, National HIV Behavioral Surveillance data document similar inequities in PrEP use, with just 27% and 31% of Black and Latino GBMSM respectively using PrEP compared with 42% of their White counterparts [7].

By contrast, although White people in the U.S. represent 60% of the population, they accounted for just 25% of new HIV diagnoses in 2019 [8]. And yet, White people represented 60% of those on PrEP in the U.S. in 2019, compared with just 14% and 8.2% of their Latino and Black counterparts, respectively [9]. Underscoring the need for racialized data to analyze and document racialized health inequities [10], the Centers for Disease Control and Prevention (CDC) noted that roughly 60% of racial/ethnic data on prescribed PrEP was unavailable [9]. These realities underscore the stark racialized inequities that persist in HIV prevention and treatment.

In May 2020, the confluence of the murder of George Floyd by police, widespread national and international Black Lives Matter protests against police brutality, and the stark racialized inequities of the COVID-19 pandemic unleashed a slew of editorials that highlighted what COVID-19 revealed about structural racism and health in the U.S. [10–22]. Structural racism describes how “racism … is produced and reproduced by laws, rules, and practices, sanctioned and even implemented by various levels of government, and embedded in the economic systems as well as in cultural and societal norms” [12, p. 768]. In the wake of these monumental events, even U.S. health institutions such as the CDC [23] and the National Institutes of Health [24] now acknowledge that structural racism is a critical barrier to health equity. Notably, the CDC called structural racism a precursor to social determinants of health (SDOH); a marked shift from traditional SDOH and public health perspectives that have historically neglected structural racism as a determinant of health [13, 25, 26].

The Curious Omission of Structural Racism as Social Determinant of Health in the U.S.

Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, the Institute of Medicine’s 2003 landmark report [27] and the World Health Organization’s seminal

2008 report on SDOH and health equity [28] undergird the use of SDOH frameworks in U.S. public health policy and practice [26]. The SDOH framework includes five key areas: economic stability, neighborhood and built environment, health and health care, social and community context, and education.

In a recent article celebrating 30 years of their popular SDOH framework, the Dahlgren-White model (often called The Rainbow Model) [29], Dahlgren and Whitehead defended it against criticism that it is a model of health inequalities. They clarified that it is a model of main determinants of health, noting that it "conceptualizes the main determinants of health for the *whole* [italics added], which may differ from the most significant determinants of the social inequalities in health observed in that same population" [29, p. 21]. But structural racism affects the whole; both those oppressed by it and its beneficiaries. Structural racism confers on White middle and upper-class people SDOH-dividends that are denied people of color regardless of their socioeconomic position. Dahlgren and Whitehead also explicitly addressed the absence of structural racism in their model by arguing that structural racism should be "… conceptualised as an important driving force" that influences "almost all determinants of health in the model" [29, p. 23], but not be included as a determinant of health. Yearby offered a stark counterpoint with a reconfiguration of the SDOH framework that prioritizes structural racism as a fundamental cause of health inequities [26]. Similarly, other authors have advanced conceptual models that center structural racism in minority health research [14, 19].

SDOH Frameworks and HIV

SDOH frameworks feature prominently in recent articles on HIV prevention and treatment [30–34] and national responses to HIV [35–37]. SDOH approaches that center structural racism as a social determinant of HIV prevention and treatment, by contrast, are rare. This absence is puzzling for at least three reasons. First, in the U.S., the historical legacies of slavery and structural racism explain racialized inequities in *all* five SDOH areas. Second, the relationship between racism and racialized people's negative physical and mental health is well-documented in a vast empirical [38–40] and theoretical [41, 42] literature base. Third, structural racism and intersectional discrimination — racism *and* heterosexism in the case of Black sexual minority men [43], and racism *and* sexism or gendered racism in the case of Black and Latina women [44] for example — are antecedents to every structural barrier to HIV prevention and treatment documented in recent research: incarceration [45, 46]; housing instability [46]; police discrimination [45]; neighborhood disadvantage [47]; health service utilization [48, 49]; and community violence, poor or no access to social services, transportation and childcare [50].

Pursuant to our focus on structural racism as an overlooked core determinant of HIV in many SDOH frameworks, we review recent articles (i.e., May 2020-October 2021) that highlight or advocate a need for greater attention to structural racism as a core determinant of HIV; argue for the revision of SDOH frameworks to include structural racism [26, 51, 52]; and empirically document how barriers rooted in structural racism and syndemics are associated with HIV incidence and risk and PrEP uptake among Black cisgender women [50], and Black GBMSM [49]. Moreover, because SDOH frameworks are the foundation

of national responses to HIV, such as those by the CDC [53], and those reflected in the National HIV/AIDS Strategy (NHAS) [35] and the Ending the HIV Epidemic (EHE) plans [36, 37], we also review recent articles that criticize these plans for failing to address structural racism, center the population and intersectionally-specific needs of racial/ethnic communities disproportionately affected by HIV, and prioritize community-engagement.

Structural Racism as a Core Determinant of HIV: Recent Literature

Most of the recent editorials explicitly name ending structural racism as an essential step to ending the U.S. HIV epidemic [54–58]. For example, Godley, Schoenbach, and Adimora highlighted how targeted structural reforms within U.S. criminal justice and healthcare systems could profoundly improve HIV outcomes for Black and other people of color [54]. Wharton and colleagues asserted that dismantling the social and structural inequities that result from racism and intersecting forms of discrimination must be prioritized if the U.S. is to reach its EHE goals [56]. Similarly, Doshi and colleagues, in response to a study from Khazanchi et al. [59], argue that the U.S. HIV epidemic will not end without dismantling the effects of structural racism and that researchers must prioritize structural interventions to end the HIV epidemic [55].

A recurrent theme in most of the recent editorials is that structural racism is the unifying link between the HIV and COVID-19 epidemics [22, 57, 58]. To Blackstock, structural racism is the nation's third pandemic [58] and along with COVID-19, will likely thwart the advances made toward ending the U.S. HIV epidemic [58]. In an insightful commentary, Millett illustrated nine structural racism pathways that contribute to both HIV and COVID-19, and argued that failure to target the SDOH in the national HIV response compounded COVID-19's spread [57]. He posited that syndemics and structural racism likely explain the disproportionate burden of both diseases on communities of color in light of empirical evidence that these communities engage in more preventive behaviors than their White counterparts [57]. Godley, Schoenbach and Adimora [54] highlighted interventions within two critical areas for structural reform — the criminal justice system and health care — that could profoundly improve HIV outcomes for Black and other people of color in the U.S.: (1) policing reforms; (2) implementation of decarceration policies; (3) elimination of the collateral consequences of incarceration; and (4) access to high quality healthcare for all.

Although most of the articles on this topic were editorials, we also identified a handful of studies. Among them are a qualitative study with low-income women in New Haven, CT, that showed how living in segregated neighborhoods was a HIV risk factor, and argued that participants' efforts to maintain relationships with incarcerated partners constituted HIV prevention work [46]. Rejecting the SDOH framework in favor of a "social determination of health" framework, Blankenship and colleagues illustrated how mass incarceration and housing vulnerabilities are tied to HIV transmission at the individual level, and argued that HIV reduction efforts require structural interventions that confront systemic racial, gender, and class inequities [46]. Another qualitative study with Black women living in low-income housing in the southern U.S. found that structural racism, discrimination and medical mistrust were key barriers to participants' utilization of health services and, in turn, HIV prevention services [48]. Using Bronfenbrenner's socioecological model to frame

a prospective cohort study in Atlanta, GA, Sullivan and colleagues posited that structural racism and barriers to care, such as lack of Medicaid expansion, may explain lower viral suppression among Black men who have sex with men (MSM) [49]. Finally, a multivariable analysis of a cohort of adult PLWH in the midwestern U.S. showed that neighborhood deprivation and low income may better explain lower HIV viral suppression rather than racial group alone. The authors concluded that HIV interventions must transcend individual-level only factors and address systemic neighborhood-level factors grounded in structural racism [59].

Syndemics, Structural Barriers, and Structural Violence

Syndemic approaches that focus on the interaction between co-occurring individual-level risk factors and the broader social and structural systems that shape them [60], offer important insights about how factors such as structural violence are implicated in the HIV epidemic [50, 60–63]. Accordingly, a qualitative study with Black women at HIV risk reported multiple social and structural barriers to PrEP uptake including intimate partner and community violence, substance use, and lack of access to social services, transportation, and childcare [50]. Another study found that racism, incarceration, intimate partner violence, depression, and binge drinking were co-occurring issues for Black MSM at high HIV risk [61]. A literature review on the effect of continuous traumatic violence on HIV outcomes among young Black MSM highlighted the need for more research on these concurrent conditions [63]. Another literature review found that structural and institutional factors such as societal and health system stigma and discrimination, punitive laws and criminalization, poverty, and violence and victimization are key drivers of HIV risk among U.S. MSM [64].

Although a recent literature review underscores that syndemic approaches may be useful for reducing HIV among MSM [64], Sangaramoorthy and Benton, in an important commentary on intersectionality and syndemics cautioned against prioritizing syndemic approaches — which emphasize social and environmental conditions of *pathogens* — over intersectional approaches, which by contrast center interlocking structural oppression as a core focus of analysis and intervention [62].

National Responses to the HIV Epidemic

Contemporary national responses to the HIV epidemic such as the 2019 EHE plan [36, 37] and the updated 2022–2025 NHAS [35] have complementary goals; both aim to reduce HIV incidence in the U.S. by at least 75% by 2025 and 90% by 2030. The EHE plan represents a collaboration between the U.S. Department of Health and Human Services and “local, state, tribal federal, and community partners to achieve the NHAS’s goals” [35, p. 2]. Although both plans acknowledge social and structural factors as major barriers to HIV prevention and treatment, the NHAS recognizes “racism as a serious public health threat that directly affects the well-being of millions of Americans” [35, p. 47].

Despite their impressive targets and the NHAS’s acknowledgement of social-structural determinants grounded in the historical legacy of racism, critics assert that these plans are likely to fall short of their goals for at least two key reasons: (1) they focus primarily on

biomedical solutions and ignore the fundamental root causes of racialized HIV inequities [56, 57, 65]; and (2) they have traditionally failed to engage equitably and ethically with communities most disproportionately affected by HIV [66, 67].

The latter point is especially important given the emphasis in recent articles on community-engagement as one of the most promising and essential routes to ending the HIV epidemic for people of color in the U.S. [66, 73]. Notable examples of effective community-based collaborations include the integration of services provided by community-based pharmacists with those of medical providers to improve retention in care, rates of viral suppression, and adherence to antiretroviral medications among persons with HIV (PWHIV) [68–70]; community-engaged development of mobile HIV prevention apps for Black women [e.g., 71] and Black sexual minority men; clinic-based strategies to improve care outcomes among PLWH experiencing homelessness and unstable housing [72], and concept mapping of multi-level resilience resources among adult Black PLWH in the Southern U.S. [73].

Recognizing the invaluable role of community-based stakeholders in implementing EHE [66, 74] and the need for "multifactorial approach[es] accounting for the social, cultural, economic, and environmental factors that drive transmission of HIV" [74], HIV advocates and other EHE implementers have begun to advocate for the addition of 'Community Engagement' as an integral fifth EHE pillar [75]. Moreover, bolstering the notion that communities benefit most from interventions borne from community advocacy, organizations such as the Black AIDS Institute [76] and United We Rise [77] initiatives promote community-based EHE programs that prioritize attention to inequitable social-structural realities, and that address persistent and disproportionate HIV inequities among Black U.S. communities.

Conclusion

Collectively, the articles in this review spotlight the growing consensus among HIV researchers, practitioners, and community activists that the U.S. has no real chance of ending the HIV epidemic absent a meaningful and measurable commitment to addressing structural racism and intersectional discrimination as core social and structural determinants of HIV. Until then, it is more realistic to envision an end of the U.S. HIV epidemic primarily for those who have historically benefited from structural racism, but not those who continue to be oppressed by it, and its intersections with heterosexism, sexism, and cisgenderism. On this trajectory, the epidemic will end for some, but not all.

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References and Recommended Reading

Articles of particular interest published within the annual period of review have been highlighted as:

■ Of special interest

■■ Of outstanding interest

1. Centers for Disease Control and Prevention. Diagnoses of HIV infection in the United States and dependent areas 2019: National profile 2021 [updated May 27. Available from: https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-32/content/national-profile.html#Diagnoses.
2. Centers for Disease Control and Prevention. HIV and African American gay and bisexual men: HIV diagnoses 2022 [updated January 11. Available from: https://www.cdc.gov/hiv/group/bmsm/diagnoses.html.
3. Centers for Disease Control and Prevention. HIV Surveillance Report, 2019; Vol. 32 2021 [updated May. Available from: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2018-updated-vol-32.pdf.
4. Centers for Disease Control & Prevention. HIV and transgender people: HIV diagnoses 2021. Available from: https://www.cdc.gov/hiv/group/gender/transgender/hiv-diagnoses.html.
5. Centers for Disease Control & Prevention. HIV and Hispanic/Latino people: HIV diagnoses 2021. Available from: https://www.cdc.gov/hiv/group/racialethnic/hispanic-latino/diagnoses.html.
6. Pitasi MA, Beer L, Cha S, Lyons SJ, Hernandez AL, Prejan J, et al. Vital Signs: HIV infection, diagnosis, treatment, and prevention among gay, bisexual, and other men who have sex with men — United States, 2010–2019. MMWR. 2021:1669–75.
7. Kanny D, Jeffries WL IV, Chapin-Bardales J, Denning P, Cha S, Finlayson T, et al. Racial/ethnic disparities in HIV preexposure prophylaxis among men who have sex with men — 23 urban areas, 2017. MMWR. 2019;68(37):801–6.
8. Centers for Disease Control & Prevention. HIV in the United States and dependent areas 2021 [updated August 9. Available from: https://www.cdc.gov/hiv/statistics/overview/ataglance.html.
9. Centers for Disease Control & Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data United States and 6 dependent areas, 2019: National profile 2021 [updated May 27. Available from: https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-26-no-2/content/national-profile.html#7.
10. Krieger N. Structural racism, health inequities, and the two-edged sword of data: Structural problems require structural solutions. Front Public Health. 2021;9(301).
11. Agénor M, Perkins C, Stamoulis C, Hall RD, Samnaliev M, Berland S, et al. Developing a database of structural racism–related state laws for health equity research and practice in the United States. Public Health Rep 2021:0033354920984168.■■ This article descibes one of the first projects to compile a database of structural-racism-related laws in the U.S. to inform health equity research and practice.
12. Bailey ZD, Feldman JM, Bassett MT. How structural racism works — Racist policies as a root cause of U.S. racial health inequities. N Engl J Med. 2021;384(8):768–73. [PubMed: 33326717]
13. Alvidrez J, Tabor DC. Now is the time to incorporate the construct of structural racism and discrimination into health research. Ethn Dis. 2021;31:283–4. [PubMed: 34045828]
14. Dennis AC, Chung EO, Lodge EK, Martinez RA, Rachel WE. Looking back to leap forward: A framework for operationalizing the structural racism construct in minority health research. Ethn Dis. 2021;31:301–10. [PubMed: 34045832]
15. Gee GC, Hicken MT. Structural racism: The rules and relations of inequity. Ethn Dis. 2021;31:293–300. [PubMed: 34045831]
16. Lynch EE, Malcoe LH, Laurent SE, Richardson J, Mitchell BC, Meier HCS. The legacy of structural racism: Associations between historic redlining, current mortgage lending, and health. SSM Popul Health. 2021;14:100793–. [PubMed: 33997243]
17. Priest N, Williams DR. Structural racism: A call to action for health and health disparities research. Ethn Dis. 2021;31:285–8. [PubMed: 34045829]
18. Shelton RC, Adsul P, Oh A. Recommendations for addressing structural racism in implementation science: A call to the field. Ethn Dis. 2021;31:357–64. [PubMed: 34045837]
19. Volpe VV, Hoggard LS, Willis HA, Tynes BM. Anti- black structural racism goes online: A conceptual model for racial health disparities research. Ethn Dis. 2021;31:311–8. [PubMed: 34045833]

20. Anyane-Yeboa A, Sato T, Sakuraba A. Racial disparities in COVID-19 deaths reveal harsh truths about structural inequality in America. J Intern Med. 2020;288(4):479–80. [PubMed: 32452046]
21. Ortega AN, Roby DH. Ending structural racism in the US Health care system to eliminate health care inequities. JAMA Internal Medicine. 2021;326(7):613–5.
22. Bowleg L. We're not all in this together: On Covid-19, intersectionality, and structural inequality. American Journal of Public Health [Internet]. 2020; 110(7):[917 p.]. Available from: 10.2105/AJPH.2020.305766.
23. Centers for Disease Control & Prevention. Racism and health 2021 [updated November 24. Available from: https://www.cdc.gov/healthequity/racism-disparities/index.html.
24. Collins FS, Adams AB, Aklin C, Archer TK, Bernard MA, Boone E, et al. Affirming NIH's commitment to addressing structural racism in the biomedical research enterprise. Cell. 2021;184(12):3075–9. [PubMed: 34115967]
25. Castle B, Wendel M, Kerr J, Brooms D, Rollins A. Public health's approach to systemic racism: A systematic literature review. J Racial Ethn Health Disparities. 2019;6(1):27–36. [PubMed: 29729001]
26. Yearby R. Structural racism and health disparities: Reconfiguring the social determinants of health framework to include the root cause. J Law Med Ethics. 2020;48(3):518–26. [PubMed: 33021164] ■■ This commentary discusses structural racism as a root cause of the social determinants of health (SDOH) and racial health disparities, and revises the SDOH framework to include structural racism in order to more effectively achieve health equity.
27. Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2003.
28. World Health Organization. Closing the gap in a generation: Health equity through action on the social determinants of health 2008. Available from: https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf.
29. Dahlgren G, Whitehead M. The Dahlgren-Whitehead model of health determinants: 30 years on and still chasing rainbows. Public Health. 2021;199:20–4. [PubMed: 34534885]
30. Barrington C, Rosenberg A, Kerrigan D, Blankenship KM. Probing the processes: Longitudinal qualitative research on social determinants of HIV. AIDS Behav. 2021;25(2):203–13.
31. Menza TW, Hixson LK, Lipira L, Drach L. Social determinants of health and care outcomes among people with HIV in the United States. Open Forum Infect Dis. 2021;8(7):ofab330. [PubMed: 34307729]
32. Greenwood G, Gaist P, Namkung A, Rausch D. Methodological and measurement advances in social determinants of HIV: View from NIH. AIDS Behav. 2021;25(2):127–32. [PubMed: 33782880]
33. Sprague C, Simon SE. Ending HIV in the USA: Integrating social determinants of health. Lancet. 2021;398(10302):742–3.
34. Beyrer C, Adimora AA, Sullivan PS, Fields E, Mayer KH. Ending HIV in the USA: integrating social determinants of health – Authors' reply. Lancet. 2021;398(10302):743.
35. The White House. National HIV/AIDS Strategy for the United States 2022–2025 Washington, DC2021 [Available from: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf.
36. Fauci AS, Redfield RR, Sigounas G, Weahkee MD, Giroir BP. Ending the HIV epidemic: A plan for the United States. JAMA. 2019;321(9):844–5. [PubMed: 30730529]
37. Giroir BP. The time is now to End the HIV Epidemic. Am J Public Health. 2019;110(1):22–4. [PubMed: 31725312]
38. Pascoe EA, Richman LS. Perceived discrimination and health: A meta-analytic review. Psychol Bull. 2009;135(4):531–54. [PubMed: 19586161]
39. Williams DR, Mohammed SA. Racism and health I: Pathways and scientific evidence. Am Behav Sci. 2013;57(8):1152–73.
40. Krieger N, Sidney S. Racial discrimination and blood pressure: The CARDIA Study of young black and white adults. Am J Public Health. 1996;86(10):1370–8. [PubMed: 8876504]
41. Mays VM, Cochran SD, Barnes NW. Race, race-based discrimination, and health outcomes among African Americans. Annu Rev Psychol. 2007;58:201–25. [PubMed: 16953796]

42. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. Lancet. 2017;389(10077):1453–63. [PubMed: 28402827]
43. English D, Carter JA, Boone CA, Forbes N, Bowleg L, Malebranche DJ, et al. Intersecting structural oppression and Black sexual minority men's health. Am J Prev Med. 2021;60(6):781–91. [PubMed: 33840546] ■ This study demonstrates the effects of structural racism and heterosexism on health behaviors such as HIV testing frequency, among a sample of Black sexual minority men at increased HIV risk.
44. Rosenthal L, Lobel M. Gendered racism and the sexual and reproductive health of Black and Latina Women. Ethn Health. 2020;25(3):367–92. [PubMed: 29447448]
45. English D, Carter JA, Bowleg L, Malebranche DJ, Talan AJ, Rendina HJ. Intersectional social control: The roles of incarceration and police discrimination in psychological and HIV-related outcomes for Black sexual minority men. Soc Sci Med. 2020;258:113121. [PubMed: 32590189]
46. Blankenship KM, Rosenberg A, Keene DE, Dawson AJ, Groves AK, Schlesinger P. Social determination of HIV: Women's relationship work in the context of mass incarceration and housing vulnerability. AIDS Behav. 2021;25(2):190–201. [PubMed: 33796957] ■ This qualitative study applies a "social determination of health" framework to evaluate the impact of structural inequalities and their effects on incarceration and housing instability on a sample of heterosexual women's HIV sexual risk.
47. Khazanchi R, Sayles H, Bares SH, Swindells S, Marcelin JR. Neighborhood deprivation and racial/ethnic disparities in Human Immunodeficiency Virus viral suppression: a single-center, cross-sectional study in the United States Midwest. Clin Infect Dis. 2021;72(10):e642–e5. [PubMed: 32845985]
48. Randolph SD, Golin C, Welgus H, Lightfoot AF, Harding CJ, Riggins LF. How perceived structural racism and discrimination and medical mistrust in the health system influences participation in HIV health services for Black women living in the United States South: A qualitative, descriptive study. J Assoc Nurses AIDS Care. 2020;31(5).
49. Sullivan PS, Taussig J, Valentine-Graves M, Luisi N, Del Rio C, Jones J, et al. Disparities in care outcomes in Atlanta between Black and White men who have sex with men living with HIV: Protocol for a prospective cohort study (Engage[men]t). JMIR Res Protoc. 2021;10(2):e21985. [PubMed: 33320821]
50. Nydegger LA, Dickson-Gomez J, Ko TK. Structural and syndemic barriers to PrEP adoption among Black women at high risk for HIV: A qualitative exploration. Cult Health Sex. 2021;23(5):659–73. [PubMed: 32212993]
51. Egede LE, Walker RJ. Structural racism, social risk factors, and Covid-19 — A dangerous convergence for Black Americans. N Engl J Med. 2020;383(12):e77. [PubMed: 32706952]
52. Bluthenthal RN. Structural racism and violence as social determinants of health: Conceptual, methodological and intervention challenges. Drug Alcohol Depend. 2021;222.
53. Sharpe TT, Harrison KM, Dean HD. Summary of CDC consultation to address social determinants of health for prevention of disparities in HIV/AIDS, viral hepatitis, sexually transmitted diseases, and tuberculosis. Pub Health Rep. 2010;125(4_suppl):11–5. [PubMed: 20626189]
54. Godley BA, Schoenbach VJ, Adimora AA. Racial justice and HIV in the United States: Now is the time. J Int AIDS Soc. 2020;23(10):e25625–e. [PubMed: 33078585]
55. Doshi RK, Bowleg L, Blankenship KM. Tying structural racism to human immunodeficiency virus viral suppression. Clin Infect Dis. 2021;72(10):e646–e8. [PubMed: 32845976]
56. Wharton MJ, Harris OO, Chapman Lambert C, LeGrand S. "The more things change, the more things remain the same": It's time to dismantle structural inequalities of racism, discrimination, and health disparities. J Assoc Nurses AIDS Care. 2021;32(4):413–7. [PubMed: 34115721] ■■The authors outline the first steps to addressing the structural inequalities resulting from intersecting forms of discrimination to end the U.S. epidemic, including confronting the historical and contemporary legacy of discrimination in social and health institutions and combatting medical mistrust.
57. Millett GA. New pathogen, same disparities: Why COVID-19 and HIV remain prevalent in U.S. communities of colour and implications for ending the HIV epidemic. JAIDS. 2020;23(11):e25639.■■This commentary explains the pathways through which structural racism

perpetuates both the U.S. HIV and COVID-19 epidemics, driving the disproportionate burden of these syndemic conditions in communities of color.

58. Blackstock OJ. Ensuring progress toward Ending the HIV Epidemic while confronting the dual pandemics of COVID-19 and systemic racism. Am J Public Health. 2021;111(8):1462–4. [PubMed: 34464197]
59. Khazanchi R, Sayles H, Bares SH, Swindells S, Marcelin JR. Neighborhood deprivation and racial/ethnic disparities in HIV viral suppression: A single-center crosssectional study in the U.S. Midwest. Clin Infect Dis. 2020.
60. Godley BA, Adimora AA. Syndemic theory, structural violence and HIV among African–Americans. 2020;15(4).
61. Dyer TV, Turpin RE, Stall R, Khan MR, Nelson LE, Brewer R, et al. Latent profile analysis of a syndemic of vulnerability factors on incident sexually transmitted infection in a cohort of Black men who have sex with men only and Black men who have sex with men and women in the HIV Prevention Trials Network 061 Study. Sex Transm Dis. 2020;47(9):571–9. [PubMed: 32496390]
62. Sangaramoorthy T, Benton A. Intersectionality and syndemics: A commentary. Soc Sci Med. 2021:113783. [PubMed: 33642069] ■ This commentary emphasizes the importance of using an intersectionality lens in syndemic approaches to health equity research.
63. Quinn KG, Spector A, Takahashi L, Voisin DR. Conceptualizing the effects of continuous traumatic violence on HIV continuum of care outcomes for young Black men who have sex with men in the United States. AIDS Behav. 2021;25(3):758–72. [PubMed: 32944841]
64. Mayer KH, Nelson L, Hightow-Weidman L, Mimiaga MJ, Mena L, Reisner S, et al. The persistent and evolving HIV epidemic in American men who have sex with men. Lancet. 2021;397(10279):1116–26. [PubMed: 33617771]
65. Guilamo-Ramos V, Thimm-Kaiser M, Benzekri A, Chacón G, López OR, Scaccabarrozzi L, et al. The invisible US Hispanic/Latino HIV crisis: Addressing gaps in the national response. Am J Public Health. 2019;110(1):27–31. [PubMed: 31725313]
66. Rodriguez-Diaz CE, Davis W, Ellis MV, Cameron MS, Donastorg Y, Bowleg L, et al. Disrupting the systems: Opportunities to enhance methodological approaches to address socio-structural determinants of HIV and end the epidemic through effective community engagement. 2021.
67. Ellis MV. Forty years of fighting for equitable partnering in HIV research: We are not there yet. Am J Public Health. 2021;111(7):1249–51. [PubMed: 34111357] ■ The author critiques efforts to ensure that people living with HIV (PLWH) are meaningfully and equitably engaged as partners throughout the research process, and outlines the structural and cultural shifts that are necessary in order to achieve equity in research.
68. Koester KA, Saberi P, Fuller SM, Arnold EA, Steward WT. Attitudes about community pharmacy access to HIV prevention medications in California. J Am Pharm Assoc. 2020;60(6):e179–e83.
69. Lopez MI, Grant RM, Dong BJ. Community pharmacy delivered PrEP to STOP HIV transmission: An opportunity NOT to miss! J Am Pharm Assoc. 2020;60(4):e18–e24.
70. Schommer JC, Garza OW, Taitel MS, Akinbosoye OE, Suzuki S, Clay PG. Work system and process designs for community pharmacy-medical clinic partnerships to improve retention in care, antiretroviral adherence, and viral suppression in persons with HIV. Pharmacy. 2020;8(3).
71. Chandler R, Hernandez N, Guillaume D, Grandoit S, Branch-Ellis D, Lightfoot M. A community-engaged approach to creating a mobile HIV prevention app for Black women: Focus group study to determine preferences via prototype demos. JMIR Mhealth Uhealth. 2020;8(7):e18437. [PubMed: 32706723]
72. Ochoa AM, Paneda CC, Wu ESC, Maxwell KE, Garth G, Smith T, et al. A community-developed, web-based mobile app intervention addressing social work and legal needs of Black sexual minority men living with HIV: Protocol for a randomized comparison trial. JMIR Res Protoc. 2021;10(1):e19770. [PubMed: 33404514]
73. Dulin AJ, Earnshaw VA, Dale SK, Carey MP, Fava JL, Wilson-Barthes M, et al. A concept mapping study to understand multilevel resilience resources among African American/Black adults living with HIV in the Southern United States. AIDS Behav. 2021;25(3):773–86. [PubMed: 32940827] ■■This research study, which utilized a community-engaged approach, presents findings from ongoing measure development and longitudinal examination of multilevel resilience

resources among African American/Black people living with HIV in the southern U.S., in relation to advancement through stages of the HIV care continuum.

74. Burns PA, Williams MS, Mena LA, Bruce MA, Bender M, Burton ET, et al. Leveraging community engagement: The role of community-based organizations in reducing new HIV infections among Black men who have sex with men. 2020;7(2):193–201.
75. AIDS United, Act Now: End AIDS Coalition. Ending the HIV epidemic in the United States: A roadmap for federal action 2020 [Available from: https://blobby.wsimg.com/go/dc5e4a5f-b921-45e4-8eb7-c96a9f556f6e/downloads/Ending_the_HIV_Epidemic_in_the_United_States__.pdf.
76. Black AIDS Institute. We the people: A Black strategy to end HIV 2021 [Available from: https://blackaids.org/we-the-people/.
77. Body EB. United We Rise 2021 [Available from: https://www.everyblackbody.org/.

Key Points

- Although structural racism is a key social-structural determinant of HIV incidence and prevalence in racial/ethnic minority communities disproportionately affected by HIV/AIDS in the U.S., research on structural racism and HIV/AIDS is relatively rare.
- In the wake of the COVID-19 pandemic and the police killing of George Floyd, a growing theoretical and empirical HIV literature now highlights the relationship between structural racism and widespread inequities in HIV prevention and treatment experienced by groups at historically marginalized intersections (e.g., racialized status, sexual and gender minority status, low socioeconomic position, drug users), and criticizes national responses for failing to attend to structural racism and engage more equitably with community-based HIV and health organizations.
- To be successful in ending the U.S. HIV epidemic for all, national responses must address structural racism and intersectional structural discrimination as barriers to HIV prevention and treatment, and prioritize community-based engagement and leadership to end the epidemic for intersectionally diverse Black and Latino communities disproportionately affected by HIV.