Re-entry experiences of Black men living with HIV/AIDS after release from prison: Intersectionality and implications for care☆

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ABSTRACT

Rationale: Both the HIV epidemic and incarceration disproportionately affect Black men in the United States. A critical period for incarcerated Black men living with HIV/AIDS is re-entry into the community, which is often associated with adverse health outcomes. Additionally, Black men living with HIV/AIDS involved in the criminal justice system are burdened by multiple, intersecting disadvantaged identities and social positions.
Objective: This study aimed to examine community re-entry experiences among Black men living with HIV/AIDS from an intersectional perspective.
Method: In-depth, semi-structured interviews were conducted with 16 incarcerated Black men in Wisconsin, at pre-release from prison and six months after re-entry. Thematic analysis guided by intersectionality theory was used to analyze interview transcripts.
Results: Seven emerged themes included Intersectional Identities and Social Positions, Family Support, Neighborhood Violence, Relationship with Law Enforcement, Employment, Mental Health Concerns, and Medical Care and Medication Management. Intersecting identities and social positions interact with factors at multiple levels to inform health and HIV care. A conceptual framework was developed to illustrate relationships among themes.
Conclusions: Findings demonstrate the relevance of intersectionality theory in HIV care with Black men involved in criminal justice system. Incorporating a social-ecological perspective into intersectionality framework could be useful in theoretical and empirical research. Disenfranchised communities may particularly benefit from interventions that address community- and systemic-level issues.

1. Introduction

It is well-established that the HIV epidemic disproportionately affects racial minorities, marginalized groups, and disenfranchised communities (Chapin-Bardales et al., 2017). In the United States, this is particularly evident among Black/African Americans, who make up 12% of the population yet account for 44% of new HIV infections (Centers for Disease Control and Prevention, 2017). The racial disparities of the HIV epidemic intersect with many vulnerability factors linked to HIV infection and inadequate health care, including socioeconomic status (Adimora and Schoenbach, 2002), incarceration (Brewer et al., 2014), and sexual identity (Millett et al., 2007). In addition, Black Americans are more likely to have delayed diagnosis and treatment, inconsistent adherence, and subsequent HIV virologic failure and medical and psychiatric co-morbidities compared to other racial

groups (Bogart et al., 2011; Gebo et al., 2005).

Black communities, particularly Black men, are also disproportionately burdened by incarceration: an estimated one in three Black men spend time in prison in their lifetime (Bonczar, 2003). Incarcerated Black men are five times more likely to be diagnosed with HIV compared to their White counterparts (CDC Centers for Disease Control and Prevention, 2015; Maruschak, 2004). A longitudinal analysis suggested that racial disparities in HIV prevalence may be explained by substantially elevated incarceration rates among Black men (Johnson and Raphael, 2009). Understanding the intersection of race, gender, and incarceration is therefore important for the development of interventions aiming to reduce the burden of HIV in Black communities.

For incarcerated people living with HIV/AIDS (PLWHA), re-entering the community is a highly vulnerable period. Lapses in HIV care occur commonly after release (Palepu et al., 2004; Springer et al., 2004) and

are associated with antiretroviral treatment failure (Baillargeon et al., 2009; Stephenson et al., 2005). The re-entry period may be especially challenging for Black individuals living with HIV/AIDS: A large cohort study with PLWHA after released from Texas prisons suggested that fewer than 30% filled their prescription within 60 days, and Black Americans were even less likely to do so (Baillargeon et al., 2009). A multi-site study (Vagenas et al., 2016) found Black men who have sex with men (MSM) were less likely to enroll in HIV care following release from prison compared to MSM of other racial groups.

These findings highlight the health inequalities for incarcerated Black men living with HIV/AIDS following release from prison and motivate the need for more research to understand processes and key factors linked to adverse health outcomes for this population during re-entry. In addition, there is a lack of research considering the context of multiple, intersecting, social disadvantages that incarcerated, HIV-infected Black men experience. Thus, we propose the use of intersectionality theory to address this gap.

1.1. Intersectionality as a theoretical approach to health inequalities research

African American legal scholar and critical race theorist Kimberlé Crenshaw first coined the term *intersectionality* (1989) as a description of exclusion of Black women in the second-wave feminist disclosure and subsequent consequences. Intersectionality theory conceptualizes multiple categories of social identities, privilege, and oppression simultaneously (Cole, 2009), as they are *co-existing* and *interdependent* in one's everyday experience. For instance, the social meaning of "an incarcerated low-income Black man living with HIV" is different from and is not the cumulative sum of being "incarcerated," "low-income," "Black," "man," and "HIV-positive". Intersectionality is contextual: An individual's experience reflects the intersection of systems (e.g., interlocking social inequality; Collins, 1991). As one context shapes the experience of privilege and oppression, intersectionality is also time and space contingent (Hulko, 2009).

Intersectionality theory is highly applicable to health research, particularly with respect to health inequalities in disenfranchised communities (Bauer, 2014; Bowleg, 2012). Often, research concerning health inequalities focus on a single axis of determinants (e.g., racial discrimination; Paradies et al., 2015), which may not fully capture the experiences of people with multiple disadvantaged identities. Intersectionality challenges the notion that social identities are additive and unidimensional, and provides a meaningful perspective in considering multiple social positions and identities for marginalized populations (Bowleg, 2012).

Because intersectionality is rooted in Black feminist scholarship, the main focus of intersectionality scholarship historically has been experiences of Black women. (Nash, 2008). Recently, scholars called for the expansion of intersectionality theory with various populations (Bowleg et al., 2013; Moradi and Grzanka, 2017). Indeed, intersectionality theory is pivotal in understanding the experiences of Black men, as the intersections of gender, race, and socioeconomic inequality are closely related to Black men's health. For instance, Bowleg and colleagues' study (2013) with Black heterosexual men regarding HIV prevention revealed the necessity to understand socio-structural issues, such as incarceration and unemployment. Another study with Black MSM highlighted the role of neighborhood factors (e.g., poverty, crimes) in stigma and discrimination (Dale et al., 2016). Brinkley-Rubinstein's qualitative study (2015) with formerly incarcerated Black men living with HIV called attention to the role of multiple, intersecting stigmas on mental health, suggesting the utility of intersectionality theory with this population. The combination of multiple disadvantaged identities and social positions is relevant to adverse health outcomes and crucial in understanding re-entry experiences among HIV-infected Black men released from prisons.

1.2. Current study

To address the gap in research related to health inequalities during re-entry for Black men living with HIV/AIDS attending to the context of multiple disadvantaged identities and social positions, this study investigates the experiences of re-entry among Black men living with HIV/AIDS from an intersectional perspective. Specifically, through the lens of intersectionality theory, this study aims to understand (1) the salient re-entry and health-related experiences among Black men living with HIV/AIDS following their release from prison, (2) how these experiences are shaped by participants' multiple, intersecting identities and social positions, and (3) how these experiences reflect larger interlocking systems of social inequality for Black men impacted by HIV/AIDS and incarceration.

2. Methods

2.1. Recruitment

The Wisconsin Transitions Study aimed to identify factors impacting HIV care following individuals' release from prison. The study was approved by the Health Sciences Institutional Review Board at the University of Wisconsin-Madison. Since 2013, HIV-infected adults receiving care while incarcerated in the Wisconsin Department of Corrections were informed and invited to participate. Inclusion criteria included that participants were (a) at least 18 years old, (b) English-speaking, (c) living with HIV/AIDS and eligible for antiretroviral therapy, and (d) intending to receive HIV care following release.

In-depth interviews were conducted twice via phone, once prior to release and once six-months' post-release. Prior to the interview, participants were asked to self-identity in terms of race and ethnicity, sex at birth, gender, sexuality, and socioeconomic status during an interviewer-administered questionnaire. Because intersectionality is embedded in day-to-day experiences (Bowleg, 2008) and such experiences reflect larger systems of oppression and privilege (Moradi and Grzanka, 2017), interviews extended beyond demographics to a broader focus on participants' everyday experiences. Pre-release interviews targeted participants' background (e.g., life history, salient identities and social positions), HIV care history, and anticipated barriers of care following release. After release, interviews focused on participants' experiences in the community, as well as their HIV care and medication management. Sample questions include "Tell me about your experience in the community" and "Tell me about your experience in HIV care." Since this study focused on experiences during re-entry, we analyzed post-release interviews as the primary data source, and utilized pre-release interviews as supplemental material to provide relevant context about participants. Interviews ranged in length from 30 to 90 min. The option of either a cellular phone or $50 monetary compensation for each month of the study incentivized participation. Either option totaled $400 per participant. Interviews were professionally transcribed and edited to remove personal identifiers.

2.2. Participants

Participants in this study were 16 incarcerated individuals living with HIV/AIDS who self-identified as Black men. The sample size was sufficient for qualitative analysis (Malterud et al., 2016). The research sample from the current study was derived from a larger dataset of 39 participants in the Wisconsin Transition Study. Individuals who did not self-identify as Black men were not included in the analysis (i.e., an intra-categorical approach; McCall, 2005). Participant ages ranged from 32 to 60 ($M = 46.3$). On average, participants had been living with HIV for 15.7 years (range = 7 to 25). Length of current incarceration (since last time in the community) was five years on average (range = 1 to 20). Most participants identified as heterosexual ($n = 12$; 75%), two identified as gay (12.5%), and two identified as bisexual (12.5%). The

average last finished grade was tenth grade; five (31.3%) had a high school diploma, five had a GED (31.3%), and six (37.5%) had no degree. Prior to incarceration, eight participants (50%) had either a full time ($n = 7$) or a part time job ($n = 1$), and eight were unemployed.

2.3. Data analysis

Qualitative methods are well-suited to incorporate an intersectionality perspective (Bowleg, 2008) and dismantle health inequality (Bowleg, 2017). Additionally, qualitative research allows for an in-depth exploration and a comprehensive understanding (Sofaer, 1999) of the experiences of Black men living with HIV/AIDS during re-entry. By utilizing voices of those within this community, we can better understand their perspective and the context of their experiences. This study used a thematic analysis method developed by Braun and Clarke (2006). We chose thematic analysis as the method for two main reasons. First, thematic analysis was developed in part to go beyond observable material to more implicit themes and tacit patterns (Joffe, 2011). Second, thematic analysis is flexible to theoretical guidance (Braun and Clarke, 2006). Therefore, analysis and the generation of themes are data-driven and guided by intersectionality theory.

The first and second authors performed coding and analytic procedures; both authors are familiar with HIV/STI research, minority health, and intersectionality theory. The first step involved the authors familiarizing themselves with the data through repeated readings of transcribed interviews. The data was individually coded to generate initial codes by identifying units of the data that were descriptive and latent regarding participants' experiences during re-entry. The authors met regularly to discuss discrepancies and reached a consensus on final codes. Together, authors organized codes into potential themes and subthemes. These meetings allowed for discussion of analysis, authenticity of coding, and thematic development, which ensured validity of analysis. With a complete set of themes, authors reviewed and refined the data codes, removed the ones lacking sufficient data, and merged themes with similar underlying meaning.

Seven themes emerged from the data; rather than remaining independent, themes interconnect and reflect a larger picture. Thus, authors performed re-reading of transcripts to seek a deeper understanding and discussed relationships among the themes. Authors worked together to create a visual presentation of the interactive nature of the themes (Fig. 1). The final step involved contextualizing analysis and presenting them in writing. Pseudonyms were used to protect confidentiality.

2.4. Research quality and trustworthiness

Our analysis met three criteria of trustworthiness including credibility, transferability, and confirmability (Lincoln and Guba, 1985). Prolonged engagement with the data and peer debriefing ensured credibility. Prolonged engagement with the data involved multiple rounds of transcript reading, as well as analysis consisting of coding, revising codes, and regular team discussion lasting a total of five months. Peer debriefing involved sharing and revising analysis and selection of quotes with research team members who were not involved in coding and from various health-related disciplines (e.g., nursing, medicine). Sufficient description of methodology and contextualized narratives of participants supported transferability of findings. We demonstrated confirmability through discussion on potential biases, as well as using peer debriefing to ensure the use of a data-oriented approach and an accurate presentation of the data. Regarding potential biases, as self-identified queer and heterosexual women of color researchers, we described concerns related to how our identities and experiences may affect analysis. We acknowledged our lack of personal experiences as Black men may be a barrier of accurate interpretations and we recognized how our own experiences of racism, sexism, heteronormativity, and the intersection of them may influence the way we

understand and interpret participants' experiences. Furthermore, we discussed how our experiences working with underserved individuals may impact our interested research questions, guiding theory, and analysis. For example, through serving as advocates with Black and LGBT communities, we had prior knowledge and understanding on how systems affect individuals' lives. Therefore, we were careful about not drawing conclusions of participants' experiences informed by prior work.

3. Results

Seven themes emerged from the data: *Intersectional identities and social positions, Family support, Neighborhood violence, Relationship with law enforcement, Employment, Mental health concerns* and *Medical care and medication management*. As all aspects of participants' experiences are shaped by intersectional identities and social positions, the first theme is incorporated into the presentation of remaining themes. A conceptual framework illustrating relationships among themes is presented and further articulated in Fig. 1.

3.1. Intersectional identities and social positions: race, gender, sexuality, HIV+, criminal history, and more

Participants shared their experiences in an intersectional sense (e.g., being a low-income, Black gay man living with HIV). Specifically, participants discussed their re-entry *in the context of their identities and social positions*. Salient identities among participants included race (being Black/African American), sexual identity, gender roles, HIV+, having a criminal record, and history of drug use (i.e., "being a drug addict"). Among participants who had more than one disadvantaged identity, some attributed difficult experiences during re-entry to one or two identities instead of others, while others discussed the layered effect of stigmas. For example, one participant attributed the lack of support to being "a sex offender", while others expressed social isolation related to a compounded sense of shame for having HIV and being gay/bisexual.

The intersection of race and gender, or more specifically, *what it means to be a good (working class) Black man*, emerged as an important identity. In our sample, Black masculinity is represented through several values and concepts, such as providing for family ("to be the provider, the breadwinner"), self-improvement ("better myself"), and self-reliance. These concepts were disclosed as a sense of expectation for oneself (e.g., "I need to better myself for my family").

Black manhood was also discussed in the context of self-responsibility regarding change and choices. For instance, when the interviewer asked Michael, a 46-year-old heterosexual Black man with a history of substance abuse, what would help him to maintain his success of abstinence from drug use, he responded, "Me. Yeah, I mean, me, period. Me." He further shared that "only [he] can convert [himself] into being a gentleman, to turn into a whole brand-new person." The self-reliance seemed to help Michael take responsibility and create change, yet also hindered him from interpersonal help-seeking (e.g., joining a support group).

When participants experienced challenges, however, self-responsibility was connected to self-blame and internalized stigma. For instance, Theo, a 53-year-old Black man, shared that he made a poor financial choice by buying an old, used car and said:

> It was just me making decisions and just plain being stupid yeah … I can't blame it on societal pressures or anything like that. It was just me, seriously. I can't blame it on anybody but myself.

The blame on self stems from the belief that individuals are responsible for their actions, yet it also contributes to shame (e.g., feeling "not worthy", "not good enough") and internalized stigma (e.g., "I *am* my bad choice"), particularly during difficult times for participants.

3.2. Family support

Participants discussed the significance of family life during re-entry. For instance, Michael shared how important it was for him to take care of his mother and children. Many referenced family support and noted how necessary it was during re-entry. For instance, Matthew, a 50-year-old heterosexual Black man released after 19 years of incarceration, stated:

The biggest success in the last six months is connecting with family, friends, step kids, nieces, nephews, and my wife … I really needed family support. I really needed my kids in my life, my wife in my life, my step kids in my life, and I really needed people that's going to pay more attention to me.

Many other Black men like Matthew also benefited from the strong cultural values in family cohesion during re-entry. Many noted support from family buffered stress when circumstances were difficult (e.g., unemployment). Even just having one person seemed to be significant. For instance, one participant noted how having his sister driving him to medical appointments was "extremely helpful".

Meanwhile, the intersection of sexuality and HIV status impacted participants' experiences of family life. For sexual minorities, this intersection appears to be a difficult aspect of identity to integrate in the context of family. Raymond, a 39-year-old Black bisexual man, shared how he managed his HIV status through concealment:

So I think, I don't know how I would feel years from now, but at this time, it (HIV) would probably be something that I would like take to my grave … I just don't, do I feel that I have any family members that are going to treat me funny or different or would they still love me, but at the same time, you're going to always have some who do not feel like others would feel and so, it's easier just, sometimes I'm just better off not spoken about.

For Raymond, to share his HIV status means risking family support. This need to conceal may reflect the stigma regarding HIV and same sex behavior among Black communities (Arnold et al., 2014). Although concealment is a coping strategy aimed at avoiding negative consequences of stigma (e.g., shame, rejection), it can backfire and become stressful. For instance, Gabe, a 53-year-old Black gay man noted he was "hiding [his] medical status and sexual preference" from his family, and he relied on drugs and alcohol for coping with concealment-related stress. Gabe ended up disclosing his HIV status to his family but not sexuality due to his family upbringing as "a very strict church-going, Christian family".

3.3. Relationship with law enforcement

The intersection of race, gender, and socioeconomic status affected participants in part by their history of multiple incarcerations. For instance, Kevin, a 49-year-old heterosexual Black man, stated:

I've been locked up eight times in prison, and altogether 27 years. So that's really half my life. It's hard because of five felonies I got and even the temp services, you know, they going to hire people that ain't really got no record first, so it's rough.

Following release, participants shared anxiety and fear over being re-incarcerated and difficulty trusting their parole officers. Many reported "staying out of jail" was their biggest success. Some were re-incarcerated. For example, Anthony, a 54-year-old heterosexual Black man, was re-incarcerated twice in the six-month period and stated:

I had made a few bad choices, one of whom is I got in an argument with my roommate two weeks after I was released from prison. I ended up doing 14 days in prison because my PO had a hold on me until she could figure out what to do … My parole officer, me and her, we don't really have a great relationship because she probably been judging me by my record instead of my actions.

Individuals like Anthony expressed feeling as though they were treated "as a category" rather than as a person. They noted the constant need to prove themselves and some were hypervigilant about reporting everything to their officer to avoid re-incarceration, which caused anxiety for many individuals. For example, Gabe, a 52-year-old Black man, shared his experience of being almost arrested twice in a day for attending an addiction treatment group:

Like I say, I was arrested last night, right when I come home from the group that my P.O. authorized me to go. They (police officers) called their station and it just happens that those officers were there and they verified with my P.O. when I came back from group, and she acknowledged and there was no problem. So, they vouched for me, and the warrant was rescinded. But then an hour and half later, two other police officers show up, we have a warrant for your arrest, again. I'm handcuffed, pockets emptied, I'm explaining to them, two other officers just came. Yes, we're taking you down to the Seventh District, you're going to be transferred from there to the county jail. I'm crying, oh, my God, man, can I make one phone call, see if I can straighten this out. No, we've already made a phone call to the monitoring people, they verified the fact the lady said the warrant is in effect.

Gabe noted that he ended up not leaving his place after this event due to the fear of getting arrested, which made him more withdrawn and socially isolated.

3.4. Neighborhood violence

Participants were released to the same or similar neighborhoods they were in prior to incarceration (i.e., low-income, segregated, Black neighborhood). Many feared for their lives (e.g., being held at a gunpoint) and desired to return to prison for safety reasons. One participant was physically attacked at home. Anthony, a 54-year-old Black man with a history of homelessness and substance dependence, was released to a shelter. Due to the toxic, drug-infested environment, Anthony shared that he violated his parole to return to prison.

Another participant, Joel, a 36-year-old Black man who was also released to a shelter, described how the lack of safety affected him:

I've been robbed more than one occasion. I know that it's bad out here and I know that the robbing season really picks up during the Christmas holiday and tax season, but when I got robbed daytime during the 2:00 hour on a weekday on a main street … I might have felt down and depressed, not to include the fact that I didn't have anything and I'm like, you know, I would just hope nothing happen, you know, including the fact that I was fortunate enough that other times that, when I was robbed that the trigger wasn't pulled on me.

The impact of violence on health was detrimental: Individuals' priority was to stay alive rather than to stay healthy. In addition to direct experiences, witnessing violence also affected one's outlook on life and mental health. We further present the effect of violence in themes of mental health concerns and HIV care and medication management.

3.5. Employment

Employment was a primary goal for re-entry among many participants, although overall they had difficulty finding a job. Few individuals who found employment described feelings of achievement and mastery that were congruent with Black manhood. For instance, Michael, a 46-year-old heterosexual Black man who found a job right away upon release, stated:

It's been good. It's been actually perfect. I haven't had no (alcohol or drugs), the only thing I had a taste for was food, food and oxygen and work.

Unemployed participants disclosed feeling hopeless, isolated, and

fearful of losing housing. Many participants noted their criminal record hurting chance of employment. Caleb, a 32-year-old Black man, discussed the salience of incarceration history in this process:

> *Sometimes, you can't find a job and the first thing I believe is you probably turn back to what you were doing before and getting locked back up … When I don't feel good, lot of things can be going on, a lot of personal situations, financial issues, all that kind of stuff, I can't, you know, get tired of looking for a job and, or my sister ran up a money issue, like she didn't have money and it make feel bad because I won't have it at the time.*

As being a provider is an important part of "being a good Black man," unemployment contradicted with the idea of Black manhood (i.e., being a provider) and could be emotionally challenging. Participants shared a sense of pressure to find a job and disclosed distress related to constantly being the provider for their family while experiencing financial hardship. For instance, Ethan, a heterosexual Black male released to his original home, stated that his most stressful experience was when his children asked him for money and he could not refuse.

3.6. Mental health concerns

The theme of mental health concerns interconnects with many themes above. Family support was a protective factor and a stress buffer. Fear of re-incarceration was linked to anxiety. Participants shared their psychological well-being affected by experiencing or witnessing neighborhood violence and feeling anxious, hypervigilant, and pessimistic. For instance, one participant disclosed that, though he never experienced violence, he was aware of the danger through witnessing it and he "was ready to go at any time." Poverty as well as social isolation associated with unemployment also impacted one's mental health.

Additionally, all participants who identified as a sexual minority reported mental health concerns. Among four of them, one reported experiencing depression, one was diagnosed with Bipolar II Disorder and Paranoid Schizophrenia, one contemplated suicide multiple times, and one had cocaine use relapse. For instance, Caleb, a 32-year-old Black gay man, stated:

> *They, they diagnosed me with bipolar type II and paranoid schizophrenic, that's what they diagnosed me with, don't know too much about that, um, it's okay. I mean, you know, I think I have a huge depression problem, so, you know, I try to get through every day, day by day. The depression … It's just the way I feel at times. One minute I'm feeling good and the next minute I'm crying about something. Nothing really helps, you know, I take my meds and go in my room and lay down.*

For Caleb, it appeared that he did not understand or was not educated about his diagnoses and experienced "a huge depression problem." Non-heterosexual Black men living with HIV may be more vulnerable to mental health issues due to a combination of factors including stress related to navigating one's identity, past experiences of discrimination, and the layered effect of multiple stigmas. Many participants like Caleb shared that they cope through becoming socially withdrawn, focusing on the present (e.g., "get by day by day"), and using alcohol and drugs.

3.7. HIV care and medication management

Similarly, HIV care and medication management also connect to other presented themes. Specifically, concealment of one's sexuality and HIV status could be detrimental: one participant shared missing medication for several days when with family due to the need to hide his HIV status (compounded by sexual identity stigma). Re-incarceration interrupted established HIV care routine in the community. For instance, Caleb had a high HIV viral load from missing a week of medication

during re-incarceration as "they [the Department of Corrections] took a week to get them". Experiences of violence also impacted medication management: participants noted their priority was to survive rather than daily medication intake in an unsafe environment. For instance, Joel, a 36-year-old Black man who experienced neighborhood violence, stated:

> *And it's like when [violence] happened I just said to myself, why? Why me? What can I possibly have done, you know? These streets are bad. Sometimes I can be so down and stressed that I'm like to hell with them, I don't care about my meds no more.*

Despite such barriers, participants in our sample overwhelmingly reported how helpful their physicians and clinics had been. Many expressed how their physicians felt like family members. For instance, despite depression, Gabe reported that he had seen his physician six times since release and missed no appointments. He further shared how he enjoyed his HIV clinic:

> *I'd find a reason to show up. It's a very helpful clinic, very helpful. Or, not to seem like a bum that just hangs out, they have a very nice lobby area, so I have come up and just spent some time in the lobby, because my life has just been difficult, you know, in fact, I have just stopped in the lobby and just sat there and gathered my thoughts, moving from one point to the other. It's been definitely like a haven, a little safe haven.*

For Gabe and many others, their clinic provided not only medical care but also a supportive, accepting, and safe environment. In addition to their medical personnel, almost all mentioned their Linkage-to-Care specialist as being helpful in providing resources and support. The Linkage-to-Care program is a community-based and individually-tailored care management program aiming to increase retention in HIV-related care for patients who are newly diagnosed with HIV, recently released from incarceration, or recently not engaged in care (Anderson et al., 2012).

Most participants reported managing their HIV medication well, though missing doses occasionally. Events of nonadherence were associated with life instability (re-incarceration), mental health issues (depression), a withdrawal attitude (e.g., "I just gave up"), forgetfulness ("I just forgot"), stress, HIV status concealment, and alcohol and drug use.

3.8. Conceptual framework

Rather than existing independently, themes interconnect and reflect larger systems of social inequalities. As illustrated (Fig. 1), our analysis revealed the relevance of a social-ecological model (Bronfenbrenner, 1977) that incorporates multiple levels in understanding the experiences of re-entry among Black men living with HIV from an intersectional lens. At the core, participants' day-to-day experiences were in the context of their intersecting identities and social positions related to being Black, male, HIV+, sexuality, and incarceration history. Meanwhile, intersecting identities interact with micro-, exo-, and macro-level factors, including interpersonal (family and social support, relationship with parole officer), community (neighborhood violence), and systemic (employment, criminal justice) level factors. Participants' health outcomes, including behavioral health and HIV care, were impacted by these interactions. Additionally, factors at the same and different levels interact with and reinforce each other and macro-level factors may manifest through exo- and micro-level factors. We further address these interactions in the Discussion.

4. Discussion

This study examines re-entry experiences among Black men living with HIV/AIDS in Wisconsin released from prison from an intersectional perspective. Utilizing thematic analysis guided by intersectionality theory, the present study demonstrates (a) how
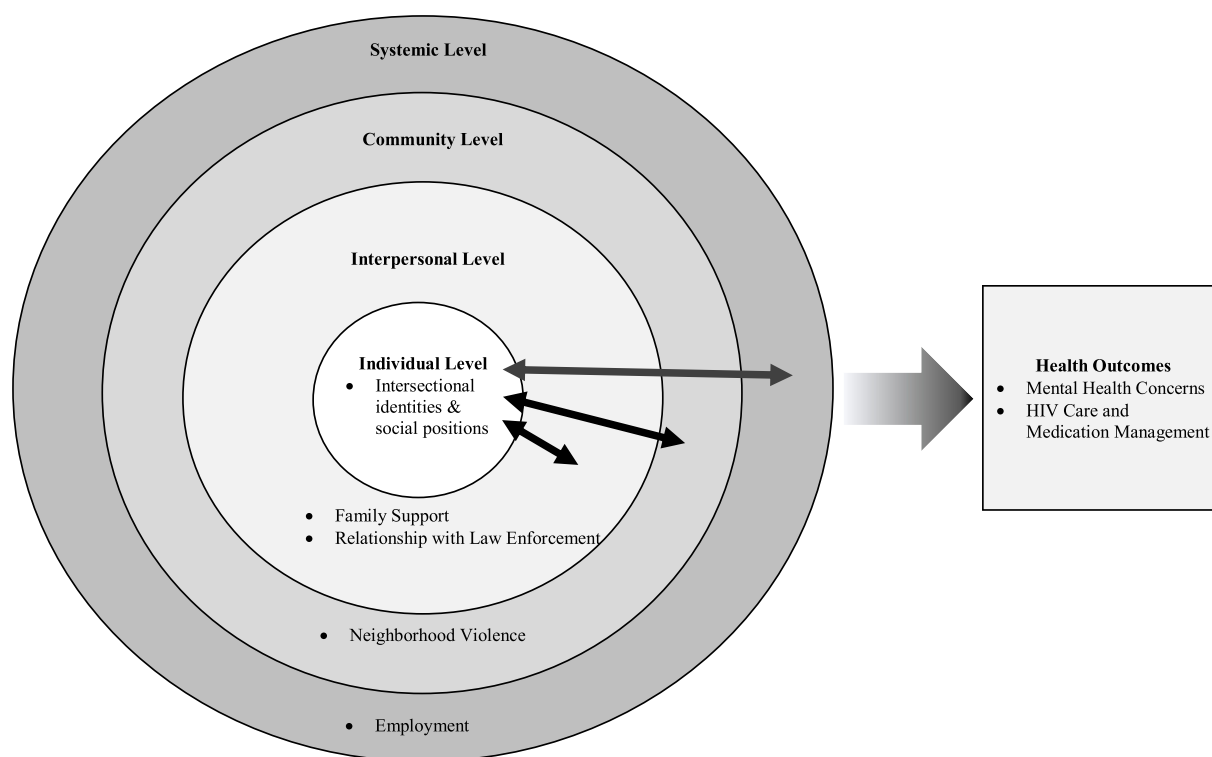
Fig. 1. Conceptual framework.

intersectionality is embedded in micro-, exo-, and macro-level interactions that affect health and HIV care and (b) how these interactions reflect the interlocking systems of inequality. Our findings reveal the relevance of intersectionality theory with incarcerated Black men living with HIV/AIDS, as well as the need to gain a comprehensive, in-depth understanding of the interactive, systemic, and dynamic nature of intersectionality in HIV care and prevention among vulnerable populations.

As shown, the intersection of identities interacts with interpersonal, community, and systemic factors of health. Macro-level factors, such as institutional racism, directly affect Black men's life through incarceration (Pettit and Western, 2004), unemployment, and poverty, creating interlocking systems of oppression. These macro-level barriers were embedded in participants' everyday life long before incarceration and were impactful during re-entry (e.g., fear of re-incarceration). Not only do factors at different levels interact with intersecting identities and social positions, but factors at the same and different levels also interact with and reinforce each other in creating an interlocking system of oppression. Macro-level factors could manifest through exo- (e.g., community) and micro-level (e.g., interpersonal) factors. For instance, institutional racism and structural injustice have been found to be largely responsible for neighborhood violence and socioeconomic inequality in Black communities (Clear, 2009; Massey and Denton, 1998), and the study's findings suggest neighborhood violence also reinforces mass incarceration among Black men (e.g., participants prefer to be in prison for safety reasons). Structural injustice could also manifest through one's relationship with parole officers (e.g., mistrust), an interpersonal level factor. Similarly, the interaction between social identities and interpersonal level factors could influence the severity of impact that macro- and exo-level factors have on an individual's health. For instance, lack of family support could lead to more adverse health consequences caused by unemployment, re-incarceration, and housing instability.

The interactions described above directly affected behavioral and mental health among participants. For instance, HIV medication was not a priority for participants who experienced violence and housing

instability and/or were frequently re-arrested. This is consistent with findings that HIV medication adherence is associated with housing instability (Harris et al., 2017), homelessness (Kidder et al., 2007), and care interruption due to incarceration or release (e.g., Palepu et al., 2004).

Thus, a critical finding is the salience of structural factors in HIV care among newly-released Black men living with HIV/AIDS. The increased risks of adverse health due to macro- and exo-level factors like neighborhood violence, homelessness, unemployment, poverty, and mass incarceration are evident. The study's findings support previous research regarding the importance of contextual factors in facilitating HIV care and health promotion with low-income Black Americans (Bowleg et al., 2013; Brinkley-Rubinstein, 2015; Wyatt, 2009). Like the criminal justice system, the health care system could also be conceptualized as a systemic-level variable. Findings indicate that specific programs and policies designed for vulnerable populations (e.g. Linkage-to-Care) could be beneficial and may even function as social and community support (e.g., participants received support from physicians and regarded their clinic as a community space). A recent study on Linkage-to-Care noted its efficacy and highlighted the value in developing a supportive relationship with the patient and personalized care (Broaddus et al., 2015).

The theme related to gender roles in the context of *being a good working class Black man* is worth noting. Values associated with Black masculinity such as accountability, providing for family, and achievement may be salient in our study due to participants' reunion with family and the need for employment, as research noted the relevance of context in the expression of masculinity (Bowleg, 2004) and intersectionality (Hulko, 2009). Masculinity and gender role conflict (when adherence to gender roles results in personal restriction) have been linked to depression and negative help-seeking attitudes (Addis and Mahalik, 2003), which could be particularly detrimental to Black men living with HIV given the lack of structural support.

Although intersectionality has been traditionally applied to Black women, our findings support Bowleg's argument (2013) on its application to other vulnerable populations. Similar to recent studies using

intersectionality theory with Black men (Bowleg et al., 2011, 2013; Griffith et al., 2013) and Black MSM (Bowleg, 2013; Calabrese et al., 2018; Vagenas et al., 2016), our study concludes the relevance of applying intersectionality theory to Black men living with HIV who are vulnerable to incarceration. The study also highlights the role of systems of oppression at multiple levels that interact with intersecting social identities, as well as the impact on behavioral health and HIV care resulting from such interactions.

4.1. Limitations

Findings should be interpreted in the context of study limitations. First, participants were incarcerated in the Wisconsin Department of Corrections between 2013 and 2015 and results may not be representative of incarcerated Black men living with HIV/AIDS in other regions of the United States. The Linkage-to-Care Program was established in 2012 and participants' experiences with HIV care were influenced by the program, as reflected in how much participants discussed the program. Second, since most participants in this sample identified as heterosexual ($n = 12$), findings may not be representative of experiences of Black men who identify as gay, bisexual, questioning, or queer. Third, most participants were from a lower social class, which is reflective of the interlocking systems of oppression around race, gender, and socioeconomic status for Black men. However, the lack of socioeconomic privilege also limits the generalizability of results.

4.2. Implications to intersectionality theory and health research

The study has important implications for health inequality research. First, the study demonstrates the relevance of intersectionality in understanding factors impacting mental health and medical care among Black men affected by HIV and incarceration. Because intersectionality research has historically focused on Black women, more scholarship is needed to expand intersectionality framework to theory, research, and health interventions on promoting health equity with Black men and other men of color living with or at risk for HIV and/or are vulnerable to incarceration.

Second, a social-ecological perspective could be incorporated into the application of intersectionality theory in health research. This perspective has been used for understanding minority health (e.g., physical activity in African American women, Fleury and Lee, 2006) and HIV prevention and care (Baral et al., 2013; Kaufman et al., 2014; Logie et al., 2011). Kaufman et al. (2014) mapped factors influencing HIV-related behavior change at multiple levels of the social-ecological model, and intersectionality framework could benefit from a similar organization to identify its mechanism at and across these levels to gain in-depth understanding of the interlocking systems of oppression for marginalized populations. Similarly, Gkiouleka et al. (2018) argued for incorporating intersectionality with institutional approaches to understand the interaction of macro- and micro-facets of health politics. The current study's findings suggest a theoretical perspective that incorporates the interactions of intersecting identities and interpersonal, community, and systemic variables could provide a comprehensive understanding of individuals' experiences. Theoretically, both intersectionality theory and social-ecological perspective emphasize context, and such integration would help contextualize and "locate" the individual's experiences of stress and resilience.

Third, as community and systemic level factors are shown to be important influences on health, future HIV prevention and care research with Black men should focus on these factors and the impact of multiple, intersecting systems of oppression. Longitudinal research efforts should be made to further investigate the impact of different systems and levels (e.g., state health policy and programs, neighborhood disorder) on antiretroviral treatment and care utilization. Meta-analytic effort and multilevel analysis could be used to address related questions. For instance, a meta-analysis on antiretroviral therapy in resource-poor facilities found that socioeconomic support (i.e., free treatment) associated with significantly increased likelihood of virologic suppression (Ivers et al., 2005). Similarly, a meta-analysis on HIV/STI behavioral interventions for heterosexual Black men indicated that interventions were more efficacious through incorporation of a variety of services compared to HIV care alone, highlighting the role of systemic factors (Henny et al., 2012). More meta-analyses on community and systemic variables are needed. For instance, as our findings noted the important role of a care management program (i.e., Linkage-to-Care), meta-analyses on such programs and policies could provide a better understanding of health promotion among vulnerable communities.

Fourth, future research should investigate the impact of one's relationship with medical staff and the medical setting on adherence and care among Black men and other vulnerable populations living with HIV. Extant literature suggests that physician-patient alliance is associated with adherence to antiretroviral therapy (Murri et al., 2002; Schneider et al., 2004), and future research should further examine this area with vulnerable populations, as well as patients' relationship with the larger medical settings (e.g., the clinic, medical team).

4.3. Implications for policy makers and service providers

Findings of the present study have implications for health policy and practice. In addition to an intersectionality-informed perspective of health policy development (Bauer, 2014; Bowleg, 2012), findings indicate the necessity to address impeding factors of care at various system levels for health promotion among vulnerable populations. It may be helpful to conceptualize the healthcare system as a broader, multi-dimensional system of well-being that goes beyond medical care (e.g., to include dimensions like housing, food, employment, incarceration). Policies that dismantle structural racism, such as the mass incarceration of men of color in the U.S., and promote economic well-being of disenfranchised communities may have a direct impact on the health outcomes of vulnerable populations living with or at risk for HIV.

Specific programs designed for vulnerable and disenfranchised communities to address their healthcare needs are in demand. Interventions should target not only individual-level factors (e.g., increase condom use) but also factors at various system levels. One way of doing so would be to develop a comprehensive program to increase housing stability, employment opportunities, treatment of mental illness, and linkage-to-care for Black men and other vulnerable communities living with or at risk for HIV/AIDS. For instance, a program designed for low-income, unemployed Black men focusing on employment and housing reduced sexual risk behaviors and increase quality of life (Raj et al., 2014). At the community level, outreach programs designed to decrease HIV stigma and homophobia and promote social support for Black sexual minority men could facilitate resilience. Such efforts may also benefit from considering sociocultural factors to shift images of stigmatized groups (Clair et al., 2016).

We recommend physicians, nurses, and mental health professionals to attend to patients' salient identities and contextual factors contributing to their distress and health. Training sessions on providing culturally-responsive care would be helpful to enhance clinicians' competencies and improve patient-physician relationships. We encourage integration of mental health services in HIV care. In addition to providing medical and emotional support in the health care system, we encourage service providers to expand their traditional role and serve as advocates (Earnest et al., 2010) for patients from vulnerable communities that face many disadvantages in the healthcare system and beyond (e.g., in community, policy involvement).

In conclusion, this research demonstrates the relevance of intersectionality theory in understanding salient experiences among Black men living with HIV during re-entry as well as the potential value of incorporating a social-ecological perspective. Intersection of identities

and social positions interacts with interpersonal, community, and systemic level factors, creating an interlocking system of inequality that affect mental health and HIV care. Black men affected by HIV and incarceration, as well as other disenfranchised communities, will benefit from interventions aiming to target various system levels and address socio-structural issues related to neighborhood violence, housing instability, mass incarceration, and economic hardship.

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