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Examining HIV Organizational Structures and their Influence on Engagement with Young Black Gay, Bisexual, and other Men who have Sex with Men in Atlanta, Georgia

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Abstract

Young Black gay, bisexual, and other men who have sex with men (YB-GBMSM) are disproportionately impacted by HIV. Structural influences on these disparities, including characteristics of the various organizations that serve YB-GBMSM living with HIV, remain understudied. We drew on Weick's model of organizing to conduct and analyze qualitative interviews with 28 HIV service providers representing healthcare and community-based organizations in Atlanta, Georgia. Enactment of HIV service provision was described as following simplified and standardized responses-defined as "rules", and/or more dynamic exchanges to formulate responses -otherwise known as "communication behavior cycles" (CBCs). Rules, including patient quotas and limited hours of operation, were viewed as rigid, out-of-touch, and inhibiting engagement with YB-GBMSM. CBCs, such as patient feedback loops and rejection of traditional hierarchies, fostered creative insights to combating the epidemic and increased levels of cultural awareness and community buy-in. Organizations should strive to enact CBCs, to foster culturally congruent approaches to service delivery for YB-GBMSM.

Keywords

HIV; Organizational theory; Black/African-American gay and biseuxal men; qualitative research; HIV/AIDS

INTRODUCTION

Young Black gay, bisexual, and other men who have sex with men (YB-GBMSM) are disproportionately impacted by HIV (Centers for Disease Control and Prevention (CDC),

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2022). In 2018, Black men accounted for 75% of HIV infections in Black populations and were impacted at eight times the infection rate among white men (CDC, 2020). Of new HIV infections in Black men, 82% occurred among GBMSM (CDC, 2020; Marano et al., 2016; Sing et al., 2015) . Among Black GBMSM, HIV among younger men is of concern for several reasons. In addition to high incidence rates in the population, young persons living with HIV (age <30 years) are less likely to be aware of their HIV status than older individuals, and represent the population with the lowest rates of linkage to HIV care after receiving a positive HIV test result (CDC, 2020). In order to effectively curb the HIV epidemic in the US, younger populations including YB-GBMSM must be tested, linked to, and engaged in care (Gardner et al., 2011), as early initiation of antiretroviral therapies leads to decreased morbidity, mortality and lower likelihood of onward transmission (Mugavero et al., 2009; Sing et al., 2015).

Current research surrounding HIV increasingly focuses on structural determinants and the impacts they have on engagement in prevention and treatment efforts (Dombrowski et al., 2015; Gant et al., 2015; Zhang et al., 2020). These structural barriers include (but are not limited to) experiences of homelessness, lack of access to health insurance or healthcare, low levels of health literacy, food insecurity, lack of access to mental health or substance treatment, poverty, education inequality, transportation issues, racism, homophobia, religious institutions, lack of social support, classism and income instability (Bauermeister et al., 2017; Dasgupta et al., 2016; Duncan et al., 2019; Latkin et al., 2013). These structural barriers, operating within the lived experiences of many YB-GBMSM, can inhibit consistent engagement in HIV medical care and viral suppression (Jeffries et al., 2017). It is virtually impossible to discuss HIV disparities impacting YB-GBMSM without acknowledging social barriers that facilitate HIV acquisition and subsequently decrease the likelihood of engagement with medical and social service organizations.

While existing research provides some perspectives on the experiences of YB-GBMSM within organizations (primarily healthcare organizations), most of these studies center around internalization of negative experiences by the patient, rather than critically examining the organizations themselves (Malebranche et al., 2004; Wilson & Moore, 2009). Some research has been conducted to discuss hiring processes, cultural competency training and presence of prejudice and racism within health systems (Levy et al., 2014) and found that these structural factors impact testing and engagement in HIV healthcare for Black GBMSM. To date, there is a paucity of research examining HIV service providers' systems and structures through the lens of organizational theory. This organizational, structural perspective has potential to inform a multidisciplinary approach to improving HIV care outcomes, that focuses on organizational reconstruction rather than pathologizing the patient populations being served.

According to Weick, organizations exist to respond to the complexity of the outside world by "making sense" of complicated problems and responding in ways that creates a sense of order (2006). *Enactment* refers to processes by which organizations define appropriate solutions to complex problems, often involving transition from chaotic problems to action-based response (Weick, 2006). Examples of enactment could include changes to a hospital's written hiring policies to address conflicts of interests, or establishment of a consumer advisory board (CAB) to increase patient involvement (Scott et al. 2016). These responses lead to development of both abstract structures (e.g., organizational culture, values, and norms), and concrete realities (e.g., official policies, practices and procedures) as shown in Figure 1. Organizations working on similar problems often interact through collaboration and/or competition. This creates a shared enactment that operates cross-organizationally, creating an interorganizational landscape that dictates a shared response to complex problems (Scott et al., 2016).

Weick (2006) describes two methods of enactment: *rules* and *communication behavior cycles* (CBCs). Rules are standardized messages used to respond to simple situations. They are concrete in nature and can be referenced quickly to decrease ambiguity. For example, doctors may provide patients with informational pamphlets when diagnosing a new illness. These pamphlets are organizationally accepted as the standard modes of health education, without opportunity for feedback or modification (Kreps, 2009). In contrast, CBCs are dynamic exchanges among organizational members that are flexible and question the efficacy and purpose of traditional organizational norms. CBCs rely on integrated processes, emphasizing communication and encouraging trial-and-error problem solving. An example of a CBC is a workgroup with multi-level employee representation that creates recommendations to increase workplace satisfaction (Ledford et al., 2016).

In this qualitative study, we draw on Weick's model of organizing to explore enactment among HIV service organizations in Atlanta, examine similarities and differences in enactment across organizations, and assess how enactment might influence engagement of YB-GBMSM in HIV care.

METHODS

This data represents a secondary analysis of qualitative data collected from interviews of key informants representing HIV clinics and community-based-organizations (CBOs) in Atlanta, Georgia between May and October 2017. The purpose of the primary study was to obtain key informant perspectives for the purpose of developing an intervention directed toward building social capital among YB-GBMSM (Hussen et al., 2018). To this end, the study team conducted qualitative in-depth-interviews (IDIs) with HIV service professionals (including but not limited to doctors, academics, activists, patient navigators and prevention workers) who discussed their experiences working with YB-GBMSM living with HIV. Participants also responded to questions regarding their organizations' strategies for meeting the needs of YB-GBMSM. The current secondary analysis focused specifically on the latter domain, in order to address our main study objective.

Participants were nominated by members of the study team and our youth advisory board (YAB; composed of eight YB-GBMSM living with HIV), based on local reputation for knowledge, experience, and competence working with YB-GBMSM living with HIV. We purposively selected participants to ensure representation of a range of settings (e.g., CBOs, academia, and medical clinics) and work roles (See Table 1). Potential participants were contacted directly by the study team via email or phone and offered participation in the interview study.

IDIs were conducted by our study team and members of the YAB, at mutually convenient and private locations for the participants. Our two primary interviewers were Black and gay-identified (one male, one female) staff members with extensive training in qualitative methods. YAB members also had the opportunity to co-conduct some interviews together with a more experienced staff member who could ensure quality and uniformity in approach. Most interviews were conducted in person, with one conducted over the phone. IDIs were digitally recorded and lasted approximately an hour and a half. Participants also completed brief demographic surveys. Written informed consent was obtained from each participant prior to the interview. The study was approved by the Emory Institutional Review Board (IRB 00088255) and the Grady Research Oversight Committee.

Interviews were transcribed verbatim by a professional company. Transcripts were imported into MAXQDA 18 (Berlin, Germany), a qualitative data management software, for coding and thematic analysis (Braun & Clark, 2006). Initial coding by two study team members (MDJ and SJM) included a combination of deductive coding (structured, predetermined codes based on major domains of the IDI guide; i.e. “cultural competence” and inductive coding (codes capturing themes that emerged organically in the interviews, i.e. “competition between organizations”). For this analysis, eight codes were selected based on relevance to our research objective: self-description, job-description, community interaction, institutional barriers to care, basic needs, funding, competition between organizations, and cultural competence.

Text comprising these organizational codes was then isolated and further sub-coded deductively by another team member (HF), incorporating constructs from Weick’s model. Specifically, text was grouped by type of enactment (rules vs. CBCs), and that data was analyzed using a constant comparison approach (Given 2008). Data matrices were constructed to further facilitate analysis of patterns emerging from the data. Once identified, these patterns were condensed into the themes found in Table 2 (below). Interpretation of coding and analysis was iterative, occurring through weekly meetings between two team members (HF and SAH). Disagreements, though rare due the diametric nature of “rules” and “CBCs” were solved iteratively through conversation and review of the definition of enactment.

We completed semi-structured interviews with 28 participants. The mean age of our participants was 36.5 years, and the majority of our participants worked in the non-profit sector, identified as male, and were Black. Table 1 (below) represents our participant demographics.

RESULTS

Participants provided rich descriptions of their experiences with organizational enactment of HIV treatment for YB-GBMSM. Based on Weick’s Theory of Organizing, we categorized these enactment descriptions as either *rules* or *communication behavior cycles* (CBCs). Enactment approaches were coded as “Rules” if they exemplified traditional problem-solving strategies typically associated with healthcare in the United States. Rules, which were often presented as the **default enactment method**, were viewed as rigid and out of touch. At times, adherence to these rules was described as directly inhibiting engagement with YB-GBMSM. In contrast, discussions of **process-based responses** to HIV care with the potential to transform rules-based approaches were coded as CBCs. Enactment was coded as a CBC if they demonstrated creative approaches to problem solving, stressed interdisciplinary decision making and communication, and/or included YB-GBMSM as key stakeholders. We found that rules-based enactment and CBC-based enactment differed most in their orientation toward several key themes: macro-level ideologies, employee value, collaboration with other organizations, patient-organization interactions, cultural competence training, bureaucratic factors, and intervention strategies. Below, we first present how each of these themes was operationalized in rules-based enactment, and subsequently describe alternative ways of operationalizing them as CBCs (also summarized in Table 2).

Macro-Level Ideologies

Rules—Participants described many institutions and organizations with hierarchical and methodical approaches to policies. We labeled these types of overarching systems and orientations as rules-based macro-level ideologies. Institutions with this type of orientation were viewed as self-serving, often at the expense of the most vulnerable clientele. Participants generally argued that medical interventions for HIV were overly prioritized, while social determinants of health were viewed as secondary concerns. As one participant stated:

> We tend to have very rigid systems. And when patients don't fit into that system, they oftentimes fall out of the system. But, again, I think that has a lot to do with just being in a rigid healthcare system. I don't think we do a good enough job of recognizing the personal struggles that these individuals are going through. And that you know unfortunately in an AIDS service, any AIDS service organization, as much as case management and counseling and other wrap-around services we have oftentimes, at the end of the day, the focus is on the medical aspect of it and the HIV and I think in that I think we're missing the boat because the HIV is the easy part to treat. I think it's trying to, we are not doing a good enough job of holistically taking care of these individuals.
>
> -Clinical professional: 35 years old, white, male

The separation of social and structural factors from the scope of "medical care" were viewed by participants to be harmful to YB-GBMSM. The result of rules-based macro-level ideologies is the perpetuation of "one size fits all" HIV systems that fail to engage YB-GBMSM, causing those with the highest social risk to fall through the cracks. As one participant summarized:

> The way we have care and services structured, may not be conducive to what works with that group. And if we keep trying to push people into this model that we think we've created that works, right? And we're not willing to change the model to accommodate the people that are most impacted then we're always going to miss the mark. So our systems weren't necessarily designed by them, all of their issues, needs, concerns weren't necessarily taken into consideration when these structures

> were created or developed. But we're trying to push people through these systems that may or may not fit."
>
> -Academic professional, 45 years old, Black, female

Communication Behavior Cycles—Macro-level CBCs sought to redefine the approach to HIV care through re-orienting approaches toward YB-GBMSM, expanding HIV care definitions, and including a call for community-based structures of care. Participants identified a need to shift focus toward de-pathologizing and embracing patients as holistic human beings operating within complex socio-ecological systems. One participant suggested a conceptual shift for health systems:

> Not like, let's start with HIV and work backwards. I think that's a completely wrong approach. But it's the approach that most people seem to take. And that's what public health does. It's like a - it's usually downstream, disease first, and then you work your way back. So that's how we do. So I think there's a lot of components to kind of making sure people understand we're part of the community … we all have a lot to learn from each other... and then not focusing on pathology as the only part of our health.
>
> -Academic professional, 48 years old, Black, male

Several participants viewed the scope of HIV care as too limited and described a role for CBCs focused more broadly on structural determinants of health for YB-GBMSM. Participants expressed a need to shift current HIV paradigms to include space for multidimensional interventions and approaches to care that involve communities.

Employee Value

Rules—Rules-based enactment often formed hierarchically structured HIV service organizations, in which people lower in the hierarchy were undervalued. Participants pointed to underpayment of front-line staff as inhibitive to quality HIV care for YB-GBMSM, arguing that low salaries keep well-qualified individuals from working in the field. Participants also reported that this poor treatment of staff could have a ripple effect that impacts customer service:

> Because the organizations aren't paying [staff] enough or valuing them enough, they, the people are walking around with chips on their shoulders the size of fucking Chicago, mad as hell and then … engaging or interacting with … this very vulnerable population, mad as hell and traumatizing them.
>
> -Non-profit professional, 38 years old, Black, male

Rules determining staff compensation and support were viewed as insufficient to provide for a reasonable quality of life. Some participants identified themselves as members of the YB-GBMSM community and experienced the same barriers to HIV care as their peers, despite working in the HIV field and paradoxically being employed to provide support to others. As one individual explained:

> I gotta worry about housing. I gotta worry about my bills. I gotta worry about going to the doctor. I gotta worry about all those things and oftentimes organizations don't give that support.
>
> -Non-profit professional, 27 years old, Black, male

Communication Behavior Cycles—CBCs often led to heightened feelings of value from employees at all levels within an organization. This value often resulted from direct inclusion of YB-GBMSM in programming and decision making. Intentional hiring and professional development of these individuals was seen to have positive effects for organizations overall. For example:

> I've seen us make some intentional hiring choices to diversify and I've also seen engagement in people who work…closest with the people that we're trying to recruit from community…that definitely helps people to be more effective, from the university perspective, when they're in the community because they know those people in the community.
>
> -Academic professional, 45 years old, Black, female

Respondents often cited personal connections to people living with HIV as an instrument in creating allies that provided quality care. As one participant explained:

> A lot of people that I work with here in, at [HIV clinic name], either have someone they've lost to HIV, somebody they know who's living with HIV…they are just passionate about the work of helping people... There's something that drew them to this work. They didn't just wake up one day and decide, 'I want to go work in HIV.' Um, something brought them here.
>
> -Medical professional, 43 years old, Black, male

Personal connections to the YB-GBMSM community and/or to HIV were viewed as productive exhibitions of humanity that should be nurtured and viewed by organizations as desirable qualities.

Collaboration Between Organizations

Rules—Rules dictated how organizations interacted with each other. Participants cited competition (for programmatic funding and numbers of patients) as directly inhibiting cross-organizational collaboration. One participant explained the tensions that emerged from emphasis on numbers:

> The government is giving them, an organization, let's say, $10,000, if you see 500 people this day. But if you don't see 500 people, I'm not going to fund you again. You know, they're [funders] not seeing these people. So, why do I have to do this for these numbers? I'm still giving them services, you know. So, why are you pushing me talking about numbers? Everybody fighting for numbers out here, you know, and it doesn't make any sense.
>
> -Medical professional, 48 years old, Black, female

Competition at the top created organizational cultures that complicated work for front-line staff. Participants highlighted how the gaps between leaders' mission and practice trickled downstream:

> I think the organizations, at a upper management level, like many executives, I think they don't play well together. I think they sit at the tables well together and they may share similar perspectives or ideas, but I don't think they naturally are like, 'Hey, let's work together and do this thing,' because it's competition, but it's not always friendly. The thing that I have witnessed my entire career is that … the rest of the staff, we play and navigate well together because we work within the community that we serve and it gets really tricky for us to not have friends or to have fallouts when we're doing it for the benefit of the community, where it should always feel good and satisfying, but it's not because the barrier usually is the, the EDs [executive directors], or the founders.
>
> -Non-profit professional, 35 years old, Black, male

Communication Behavior Cycles—CBCs presented during times when organizations worked together to combat the HIV epidemic. These interactions relied heavily on interagency trust to guarantee programmatic success. For example:

> [The Georgia Coalition to End HIV Criminalization] I think is an amazing model. I have had - it's so interesting that we're all able to kind of come together and sit at a table and have this kind of intersectional dialogue and all walk away with a task and then we accomplish a task and we're able to come back to the table and talk about it.
>
> -Non-profit professional, 39 years old, Black, male

Information sharing among organizations was also emphasized among participants as an essential part of HIV care. One participant demonstrated the ways in which data can be wielded to provide quality care:

> [The electronic medical record] generates an alert and it says, "This patient may be out of care." And so those alerts come to myself and one of the ED attendings [emergency department physicians], which if it's during working hours, we actually forward it to one of the social workers in the emergency room that is dedicated to doing HIV screening because they have a testing program in the ED. They'll approach the patient or reach out to the patient and just inform them that we learned that you might not be in care and they make an attempt at that point to relink them to care.
>
> -Medical professional, 35 years old, white, male

Generally, participants acknowledged the need for cohesive approaches to community events. CBCs presented opportunities for collaboration within structures that already existed, although organizations did not necessarily capitalize on these opportunities. One participant describes the city's Gay Pride events as one event with such potential:

> Even with Pride, like, you have everybody... you've got 85,000 parties going on and every organization is at a party versus everybody saying, 'Okay, we're going to get together and have just one big team of people and we're going to disperse and do everything we need to do from an advocacy standpoint. But we're working together.' That doesn't happen. If it did happen, a lot of things would probably be different from, um, from just an agency standpoint.
>
> -Non-profit professional, 33 years old, Black, male

Patient-Organization Interactions

Rules—Reporting metrics were seen as antithetical to compassion, often "turning patients into a number." One respondent described the tension that is created through the demands of organizational metrics:

> They want you to see more volume, they want you to see more numbers, but they don't want to, um, necessarily increase all of the stuff that you have to actually have in place to make sure that you can complete a patient visit in a timely fashion and connect them to all the resources that they need. So you hear a lot about patients, immediately once they get insurance, they want to go to that private office where they don't feel like they're an HIV patient.
>
> -Medical professional, 30 years old, white, female

Participants identified the accumulation of poor experiences with organizations as a reason for YB-GBMSM's disengagement from care. It also became evident that patients often found these interactions dehumanizing and often clouded by institutionalized prejudice. One participant describes this cycle:

> You probably just had like a big, bad experience, right? And it probably had all different sort of tentacles. Like it was probably like yes maybe someone in the elevator was racist. And maybe someone treated me like crap because I'm young. And maybe someone else was like telling me I was going to hell because I'm gay or whatever or I'm too femme or I got hit on by someone or whatever. It might have all of those facets. But it probably includes something along the lines of like, I was disrespected and … I didn't get what I needed and I didn't know what was going to happen next and I had no way of providing feedback.
>
> -Non-profit professional, 35 years old, white, female

Several participants discussed the lack of appropriate feedback mechanisms. Rules-based approaches often included customer-satisfaction surveys to gather patient feedback. These surveys were largely seen as insufficient in comparison to opportunities that promoted dialogue. One participant discusses the difference:

> These organizations will do their 'customer satisfaction surveys' or whatever. But I just, I've never felt like we get particularly good information from those. They're not done in a systematic fashion in any way. They're generally just not done in a way that I think tries to draw out the feedback that we really need, which is

> probably more done in focus groups and in environments where they're going to be very comfortable giving open and honest feedback.
>
> -Medical professional, 35 years old, white, male

These rules were generally found to have dehumanizing effects for YB-GBMSM seeking to engage in care. Most respondents acknowledged that these rules, even if they simplified the work of employees, were ultimately detrimental to quality of services.

Communication Behavior Cycles—CBCs often consisted of relationship-driven interactions between organizational staff and YB-GBMSM. These relationships provided space and autonomy for the workers and allowed individual patients to be experts on their own care. Flexibility, open-mindedness, and strengths-focused perspectives were ideal qualities for providers. As one participant explains:

> I just try and meet my patients where they are. Um, I think in the time that I've been here it's, gone over the days of sort of well, you know, how do you want to do this or do that? It's more just like, okay, well, what can we do today? Where are you with things? How are you feeling about things? And I'm like, what do you feel like you could work on? And sometimes I get patients that I know what they need, I mean, I know what I think they need. And medically I definitely know what they need. But that's just so not where they are, they need to get stable housing or come to terms with their diagnosis.
>
> -Medical professional, 30, white, female

These relationships often formed a familial dynamic, helping to fill gaps in social support for YB-GBMSM. Often, they were considered highly effective instruments for engagement.

> So, as big brother, I guess, it's weird to say in the work setting that I serve the role as the person's big brother. But for the last three years I worked in a program that was just strictly designed to support Black gay men […] the reason that in that capacity I operated mostly as big brother is because there's no way to support someone as a CEO you know? There's no way to support somebody as a director or anything like that. I think that you have to, in order to really, truly support a person and to impact their life, you have to really connect with them. So I've connected with the people within my network and outside of it on a level or try to connect with them on a level of familiar level because I feel like it's the most impactful way to really help them.
>
> -Non-profit professional, 38 years old, Black, male

CBCs that targeted relationship-building were credited with changing individual narratives around HIV status. Closeness was viewed by participants as an essential tool to constructing spaces where individuals moved from "surviving to thriving." As one participant explains:

> That's truly what we do, we transform HIV resentment. When people thought there was no hope […] and we're transforming that into some victories, it's like having the event we had not too long ago where 12 or 13 people came out about their status and they're living their truth and we had our [agency] campaign where it

> showcases individuals that made it along this journey […] and so we're sitting here coming together as a family; and I think that's one thing that's unique about our organization is that it's like a family.
>
> -Non-profit professional, 31 years old, Black, male

In addition to relationships that organizations built, participants expressed the importance of feedback loops as part of engagement with YB-GBMSM. These loops could take on several forms, including use of qualitative evaluation methods (e.g., in-depth-interviews, focus groups), development of community advisory boards, and general strategies for inclusion of YB-GBMSM clients' voices in programmatic decisions.

Cultural Competence Training

Rules—Rules for cultural competence training meant that employee education was conducted under time and priority constraints. These trainings were often one-time presentations, which were largely viewed as insufficient tools for teaching cultural competence.

> In terms of cultural competency? Nothing is going well. I mean, we have the basics in place where folks are, they go through a one-day workshop or half-day workshop on an annual basis, if their agency provides it, but that's just a baseline. That's just the very beginning of the race. There needs to be, at all levels, more in-depth training.
>
> -Non-profit professional, 55 years old, Black, male

Communication Behavior Cycles—CBCs within cultural competency training were described as ongoing, comprehensive, and dialogue based. Participants discussed that effective trainings result in complex team-based problem-solving. Often, effective organizational learning stemmed from interactive experience sharing among all levels. However, cultural competence was frequently discussed as a subject that was insufficiently discussed within organizations. When describing ideal cultural competence trainings, participants described a need for a shift in training philosophy that would lead to more of a CBC approach:

> [Cultural competency] needs to be the curriculum, I haven't seen it unfortunately. It needs to certainly be robust so that when you do know and see and identify people who identify differently from you, you know how to navigate that. You know how to create an environment that's inviting or welcoming.
>
> -Health-department professional, 29 years old, Black, male

Bureaucratic Factors

Rules—Bureaucratic rules were largely discussed as the concrete policies and procedures that organizations established to maintain order. Generally, bureaucratic rules were viewed by participants as obstacles to patient care. Examples of these obstacles included: long wait times, cumbersome referral processes, and large amounts of paperwork. Often, these processes were inconsistent and arbitrary in nature. For example:

> But there’s also, like this whole thing where you need an ID to get care at [county health department], but that’s technically not true, you can be seen without an ID. Or they tell you that you have to show proof of income for the sliding scale but, that’s technically not true, because they won’t turn you away. So what happens is I have people running around feeling helpless and like they can’t get any care because certain people who answer the phone want to make the money and not to provide the care.
>
> -Non-profit professional, 35 years old, Black, male

Similarly, rules about technologies for contact with patients often limited how and when providers could speak with patients. For instance, one participant expressed frustration with limited communication as a barrier to building rapport with their patients:

> I shouldn’t be working 8 to 4:30 because patients are not, like, functioning during those times. Or very few are. Or if they are, they are at work, so they can’t come in and see me. There should be extended hours and many of my patients aren’t even getting up until noon. So our hours and stuff don’t work. I think that the method of communication with patients is also terrible. Like, I don’t have a number that I can text from or that I can, like, I think probably technically I’m not even supposed to be like, emailing - I can’t email results or anything like that. I can just email and be like, ‘Hey, can you call me?’ Or something, but I can’t communicate with patients the way that they communicate. […] And so, I think, we lose a lot of patients because they’re just not going to pick up the phone and call us if they miss an appointment or something. They would text or send some other type of message through a messaging service. But … we’re not allowed to do that.
>
> -Medical professional, 30 years old, white, female

Communication Behavior Cycles—CBCs were found to include client-centered approaches that focused on quality customer service. Participants expressed that frequent contact with medical providers created comforting and engaging environments for YB-GBMSM. As one participant stated:

> [When patients are enrolling in the clinic] we meet with them sort of ahead of time just to sort of introduce themselves and get their baseline labs and make sure that they’re feeling okay and comfortable with everything.
>
> -Medical professional, 30 years old, white, female

Flexible communication methods were an essential part of the engagement process with YB-GBMSM. Participants generally felt that these methods should incorporate patient/client preference for highest levels of effectiveness. For example:

> I had to learn, for example, to stop emailing my patients. They don’t email. You are not going to get a 20-year-old to email you, they don’t email. So I got a Google Voice number so they could text me and they could reach me… social media is important.
>
> -Medical professional, 33 years old, Black, female

Other bureaucratic factors were that focused on care facilitation were new-patient orientations, consolidation of redundant paperwork, and “touchpoint” activities that reaffirm basic HIV knowledge:

> Um, what we do is we have a new model now, before people can even come to the events and stuff, they have to do a touch point activity of order. So that’s our admission into our events. You have to do some of the games and learn the things. So some of them can be trigger questions around HIV and AIDS, around, um, safer sex, around, um, housing, living, all these different topics we try to touch with our touchpoint activities.
>
> -Non-profit professional, 35 years old, Black, male

Intervention Strategies

Rules—HIV prevention messaging is often relegated to rules of “best practices” to provide consistent and appropriate health communications. However, participants felt the messaging practiced by organizations was outdated and inefficient. Specifically, the narrow view of sexual behaviors was limited and isolating for patients. Many participants felt that prevention was not aligned with the dynamic experiences of YB-GBMSM.

> You know there are other ways, we’re in 2017. There are other ways to have sex, everybody’s not having boring … missionary sex. Everybody’s not having penetrative sex in that sense.
>
> -Non-profit professional, 31 years old, Black, male

Similarly, respondents felt that a focus on condoms as the only prevention method failed to incorporate scientific evidence demonstrating the effectiveness of HIV treatment as prevention.

> So the individuals living with HIV [are] in treatment and taking care of themselves and finally suppressed now and undetectable. The truth is they’re not passing HIV. But all we think of is condoms, condoms, condoms, get tested and condoms, condoms, condoms. -Non-profit professional, 31 years old, Black, male

Communication Behavior Cycles—Intervention strategies in the CBC category were creative and innovative interventions geared toward YB-GBMSM. Notably, most of the CBC-type interventions were created by YB-GBMSM themselves. These interventions relied less on traditional didactic approaches to education and emphasized participant dignity. One participant points out this transformation:

> Because working with young, Black gay men, particularly positive men, it’s not transactional, it’s not just about the linkage. It’s about bolstering, you know, a person’s belief in their success trajectory.
>
> -Other Professional: 33 years old, Black, male

Participants expressed a need to emphasize the dynamic and diverse culture of YB-GBMSM. “Best practice” standards were viewed to come from traditionally white strategies and perspectives. Culturally grounded interventions were viewed as a necessary part of HIV care for YB-GBMSM. As one participant stated:

> So there is a such thing as a Black gay culture and it can never be a spinoff of something for white gay people. Honoring the fact that Black people, before they're Black, are African and, as such, have Africanisms, and especially Black gay men. We operate in a very African way. We're very, you know, gaudy and loud and expressive and communal and we're clanly. And I think it's honoring that African part of Blackness and not just seeing it as you know, Black Americanness or you know some spinoff of, you know, some shit that occurred in America but also in Africa.
>
> -Non-profit professional, 38 years old, Black, male

Additionally, traditional "support groups" were reconceptualized to incorporate social media as a means of increasing impact:

> So [organization name] sets up networks; secret, private networks around the country or highly impacted populations […] And what happens is that they get to interface in a way that just supports life regardless and not just viral suppression, not because of your HIV life but just supports life you know? You share who you are and a person that's in a same health situation as you, gets to chime in and share who they are and you get to learn and grow by just simply gleaning inspiration and information from people just like you."
>
> -Non-profit professional, 38 years old, Black, male

Participants also provided in-person examples of creative new approaches structured around CBCs:

> So, like, we do this thing called Queer Movie Nights as well, where we, um, do a screening of a film that' very queer-friendly. Um, and like last - no, a couple of days ago on Tuesday or Monday, I think, we, um, saw the screening of Kiki, it's this new documentary that takes about the Kiki scene in New York […] and making sure that, yeah, we can, you know, definitely talk about how to decrease barriers to care, um, for queer folks, but also making sure that we're affirming and addressing issues about us holistically.
>
> -Academic professional, 22 years old, Black, male

Overall, participants described a push for innovative CBCs that re-imagined and added dimension to "business as usual practices" (i.e., rules). These were viewed by participants as garnering positive feedback from YB-GBMSM and facilitating engagement and relationship building.

DISCUSSION

Our participants indicated that CBC-based responses were most likely to be appropriate for addressing the complexity of HIV among YB-GBMSM living in Atlanta. In contrast, rules-based responses were described as over-simplified, and often created additional barriers to care for YB-GBMSM. Unfortunately, rules were often presented as the default method of enactment by organizations, while CBCs were discussed as aspirational strategies. Our participants endorsed the need for further organizational investment in CBCs relative to rules, while also recognizing challenges associated with such a paradigm shift.

These results align with other uses of Weick’s theory of organizing as a framework to guide organizational design and approaches to problem-solving. In case studies involving medication adherence (Kreps, 2009) and palliative care (Ledford et al., 2016), CBCs were found to be desirable approaches to enactment and to fulfill needs insufficiently met by rules-based structures of organizing. The preference for CBCs is consistent with the complexities of public health problems. In order to be truly effective, enactment approaches and selection processes must respond with equal levels of complexity. These results add to current public health literature because they examine HIV care among YB-GBMSM as a highly complex public health issue that can be best served through CBC-based perspectives and structures.

Participants offered many concrete suggestions for CBC-based enactment of various organizational activities (see Table 2). Unfortunately, it was also made clear by participants that current funding structures (i.e., competing and reporting for grant funding) do not always support a shift from rules-based to CBC-based enactment. Realistically, organizations must maintain their funding streams to continue to employ workers and support clients. Therefore, it may be more practical to view rules and CBCs as complementary components of an organization’s toolkit, in which organizations try to prioritize CBC-based enactment strategies that can be folded in to current practices. Ultimately, these strategies move toward patient-centered care, focusing on the intersectional and unique circumstances of each client. With regard to funding requirements, our participants highlighted the point that metrics and recommended intervention strategies are frequently based on myopic and even biased “best practices” which are often developed with different target populations and may not be applicable to various minority groups such as YB-GBMSM. Additional reforms should also occur at the level of the funders; collective advocacy from organizations to lobby for changes to funding structures or metrics might be mutually beneficial and help to incentivize more creative humanistic, and client-centered approaches to service delivery.

In our focus on organizations and their structures, we contribute to the literature by addressing an understudied, but highly relevant part of YB-GBMSM’s experiences living with HIV and trying to get appropriate services. Future research could build upon these findings in several ways. First, these findings have the potential to inform the numerous implementation research efforts currently underway as part of the Ending the HIV Epidemic (EHE) initiative (Fauci et al., 2019; Mustanski et al., 2022). The EHE focus on implementation science, lends itself nicely to future attempts to operationalize the recommended CBCs and to study them within future implementation trials.

Limitations

This is a secondary data analysis; data collection was not originally intended to explore enactment styles among HIV service providers in Atlanta. Therefore, it is possible that additional insight could be gained from further research primarily focused on this topic. Additionally, organizational enactment varies by institution. A need exists for additional research on the similarities between organizations that utilize CBCs and strategies to increase buy-in from decision makers within their organizations.

Conclusions

Weick's concept of enactment provides a starting point for evaluation of current HIV service practices. This theory highlights the effectiveness of CBCs as a process of organizational enactment to address the complexity of HIV in YB-GBMSM living in Atlanta. HIV service organizations and providers would benefit from considering a shift from rules-based structures to CBCs that emphasize communication, inter-organizational information sharing and end-user input. Future research is needed to explore similarities in successful organizational structures that are CBC-informed. Additionally, HIV service providers, together with their clients, could benefit from internal process reviews and evaluations of practices and procedures to best determine how to transition from rules-based enactment to CBC-based approaches. It would be beneficial for HIV service organizations and providers to examine inter- and intra-organizational rules-based approaches to enactment and determine pathways for transformation into CBC-based styles of enactment.

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References

Bauermeister JA, Connochie D, Eaton L, Demers M, & Stephenson R (2017). Geospatial indicators of space and place: a review of multilevel studies of HIV prevention and care outcomes among young men who have sex with men in the United States. Journal of Sex Research, 54(4–5), 446–464. 10.1080/00224499.2016.1271862 [PubMed: 28135857]

Braun V & Clark V (2006). Using thematic analysis in psychology, Qualitative Research in Psychology, 3:2, 77–101, DOI: 10.1191/1478088706qp063oa

Centers for Disease Control and Prevention. Behavioral and clinical characteristics of persons with diagnosed HIV infection—Medical Monitoring Project, United States, 2020 cycle (June 2020–May 2021). HIV Surveillance Special Report 2022;29.

Centers for Disease Control and Prevention. Estimated HIV incidence and prevalence in the United States, 2014–2018. HIV Surveillance Supplemental Report 2020;25(No. 1). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2017. Part A: Census tract-level social determinants of health and diagnosed HIV infection—United States and Puerto Rico. Part B: County-level social determinants of health, selected care outcomes, and diagnosed HIV infection—41 states and the District of Columbia. HIV Surveillance Supplemental Report 2019;24(No. 4). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.

Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, & Lowery JC. (2009). Fostering implementation of health services research findings into practice: A Consolidated Framework for advancing implementation science. Implementation Science, 4(1). 10.1186/1748-5908-4-50

Dasgupta S, Kramer MR, Rosenberg ES, Sanchez TH, Reed L, & Sullivan PS (2015). The effect of commuting patterns on HIV Care attendance among men who have sex with men (MSM) in Atlanta, Georgia. JMIR Public Health and Surveillance, 1(2), e10. 10.2196/publichealth.4525 [PubMed: 27227128]

Dombrowski JC, Simoni JM, Katz DA, & Golden MR (2015). Barriers to HIV care and treatment among participants in a public health HIV care relinkage program. AIDS Patient Care and STDs, 29(5), 279–287. [PubMed: 25826007]

Duncan DT, Hickson DA, Goedel WC, Callander D, Brooks B, Chen YT, Hanson H, Eavou R, Khanna AS, Chaix B, Regan SD, Wheeler DP, Mayer KH, Safren SA, Carr Melvin S, Draper C, Magee-Jackson V, Brewer R, & Schneider JA (2019). The social context of HIV prevention and care among Black men who have sex with men in three U.S. cities: the neighborhoods and networks (N2) Cohort Study. International Journal of Environmental Research and Public Health, 16(11), 1922. 10.3390/ijerph16111922 [PubMed: 31151275]

Eaton LA, Driffin DD, Kegler C, Smith H, Conway-Washington C, White D, & Cherry C (2015). The role of stigma and medical mistrust in the routine health care engagement of Black men who have sex with men. American Journal of Public Health, 105(2), e75–e82. 10.2105/AJPH.2014.302322

Fauci AS, Redfield RR, Sigounas G, Weahkee MD, & Giroir BP (2019). Ending the HIV epidemic. JAMA, 321(9), 844. 10.1001/jama.2019.1343 [PubMed: 30730529]

Gant Z, Gant L, Song R, Willis L, & Johnson AS (2014). A census tract-level examination of social determinants of health among black/African American men with diagnosed HIV infection, 2005–2009−-17 US areas. PloS one, 9(9), e107701. doi:10.1371/journal.pone.0107701 [PubMed: 25268831]

Garcia J, Parker C, Parker RG, Wilson PA, Philbin M, & Hirsch JS (2015). Psychosocial implications of homophobia and HIV stigma in social support networks: insights for high-impact HIV prevention among Black men who have sex with men. Health Education & Behavior: the Official Publication of the Society for Public Health Education, 43(2), 217–225. doi:10.1177/1090198115599398 [PubMed: 27037286]

Gardner EM, McLees MP, Steiner JF, Del Rio C, & Burman WJ (2011). The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. Clinical Infectious Diseases: an Official Publication of the Infectious Diseases Society of America, 52(6), 793–800. 10.1093/cid/ciq243 [PubMed: 21367734]

Given LM (2008). The SAGE encyclopedia of qualitative research methods (Vols. 1–0). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963909

Hussen S, Jones M, Moore S, Hood J, Smith J, Camacho-Gonzalez A, del Rio C, & Harper G, (2018) Brothers building brothers by breaking barriers: development of a resilience-building social capital intervention for young Black gay and bisexual men living with HIV, AIDS Care, 30:sup4, 51–58, DOI: 10.1080/09540121.2018.1527007 [PubMed: 30626207]

Jeffries WL 4th, Gelaude DJ, Torrone EA, Gasiorowicz M, Oster AM, Spikes PS, Jr, McCree DH, & Bertolli J (2017). Unhealthy environments, unhealthy consequences: Experienced homonegativity and HIV infection risk among young men who have sex with men. Global Public Health, 12(1), 116–129. 10.1080/17441692.2015.1062120 [PubMed: 26251185]

Kreps GL (2009). Applying Weick's model of organizing to health care and health promotion: highlighting the central role of health communication. Patient Education & Counseling, 74(3), 347–355. 10.1016/j.pec.2008.12.002 [PubMed: 19150591]

Latkin CA, German D, Vlahov D, & Galea S (2013). Neighborhoods and HIV: a social ecological approach to prevention and care. The American Psychologist, 68(4), 210–224. 10.1037/a0032704 [PubMed: 23688089]

Ledford CJW, Canzona MR, Cafferty LA, & Kalish VB (2016). Negotiating the equivocality of palliative care: a grounded theory of team communicative processes in inpatient medicine. Health Communication, 31(5), 536–543. 10.1080/10410236.2014.974134 [PubMed: 26431077]

Levy ME, Wilton L, Phillips G, 2nd, Glick SN, Kuo I, Brewer RA, Elliott A, Watson C, & Magnus M (2014). Understanding structural barriers to accessing HIV testing and prevention services among Black men who have sex with men (BMSM) in the United States. AIDS and Behavior, 18(5), 972–996. 10.1007/s10461-014-0719-x [PubMed: 24531769]

Malebranche DJ, Peterson JL, Fullilove RE, & Stackhouse RW (2004). Race and sexual identity: perceptions about medical culture and healthcare among Black men who have sex with men. Journal of the National Medical Association, 96(1), 97–107. [PubMed: 14746359]

Marano M, Stein R, Song W, et al. HIV testing, linkage to HIV medical care, and interviews for partner services among Black men who have sex with men — Non–Health Care Facilities, 20 Southern U.S. Jurisdictions, 2016. MMWR Morb Mortal Wkly Rep 2018;67:778–781. DOI: 10.15585/mmwr.mm6728a3External3 [PubMed: 30024864]

Millett GA, Peterson JL, Wolitski RJ, & Stall R (2006). Greater risk for HIV infection of Black men who have sex with men: a critical literature review. American Journal of Public Health, 96(6), 1007–1019. doi:10.2105/AJPH.2005.066720 [PubMed: 16670223]

Mustanski B, Smith JD, Keiser B, Li DH, & Benbow N (2022). Supporting the growth of domestic HIV implementation research in the United States through coordination, consultation, and collaboration: How we got here and where we are headed. JAIDS Journal of Acquired Immune Deficiency Syndromes, 90(S1). 10.1097/qai.0000000000002959

Mugavero MJ, Lin HY, Willig JH, Westfall AO, Ulett KB, Routman JS, Abroms S, Raper JL, Saag MS, & Allison JJ (2009). Missed visits and mortality among patients establishing initial outpatient HIV treatment. Clinical Infectious Diseases: an Official Publication of the Infectious Diseases Society of America, 48(2), 248–256. 10.1086/595705 [PubMed: 19072715]

Quinn K, Dickson-Gomez J, Zarwell M, Pearson B, & Lewis M (2018). A gay man and a doctor are just like, a recipe for destruction": how racism and homonegativity in healthcare settings influence PrEP uptake among young Black MSM. AIDS Behavior 2018 Dec 18. doi: 10.1007/s10461-018-2375-z

Reif S. Whetten K, Wilson E, McAllaster C, Pence B, Legrand S & Gong W (2014) HIV/AIDS in the Southern USA: A disproportionate epidemic, AIDS Care, 26:3, 351–359, DOI: 10.1080/09540121.2013.824535 [PubMed: 23944833]

Scott WR, Davis GF, & Scott WR (2016). Organizations and organizing: Rational, natural, and open system perspectives Oxford: Routledge

Singh S, Mitsch A, Wu B. HIV care outcomes among men who have sex with men with diagnosed HIV infection — United States, 2015. MMWR Morb Mortal Wkly Rep 2017;66:969–974. DOI: 10.15585/mmwr.mm6637a2 [PubMed: 28934185]

Sullivan PS, Peterson J, Rosenberg ES, Kelley CF, Cooper H, Vaughan A, … Sanchez TH (2014). Understanding racial HIV/STI disparities in Black and White men who have sex with men: a multilevel approach. PloS one, 9(3), e90514. doi:10.1371/journal.pone.0090514 [PubMed: 24608176]

Truong M, Paradies Y, & Priest N (2014). Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Services Research, 14, 99. doi:10.1186/1472-6963-14-99 [PubMed: 24589335]

Weick KE (2006). The social psychology of organizing New York: McGraw-Hill.

Whetten K, Leserman J, Whetten R, Ostermann J, Thielman N, Swartz M, & Stangl D (2006). Exploring lack of trust in care providers and the government as a barrier to health service use. American Journal of Public Health, 96(4), 716–721. 10.2105/AJPH.2005.063255 [PubMed: 16507725]

Wilson PA, & Moore TE (2009). Public health responses to the HIV epidemic among Black men who have sex with men: A qualitative study of US health departments and communities. American Journal of Public Health, 99(6), 1013–1022. doi:10.2105/AJPH.2008.140681 [PubMed: 19372516]

Zhang C, McMahon J, Leblanc N, Braksmajer A, Crean HF, & Alcena-Stiner D (2020). Association of medical mistrust and poor communication with HIV-related health outcomes and psychosocial wellbeing among heterosexual men living with HIV. AIDS Patient Care and STDs, 34(1), 27–37. 10.1089/apc.2019.0200 [PubMed: 31755736]

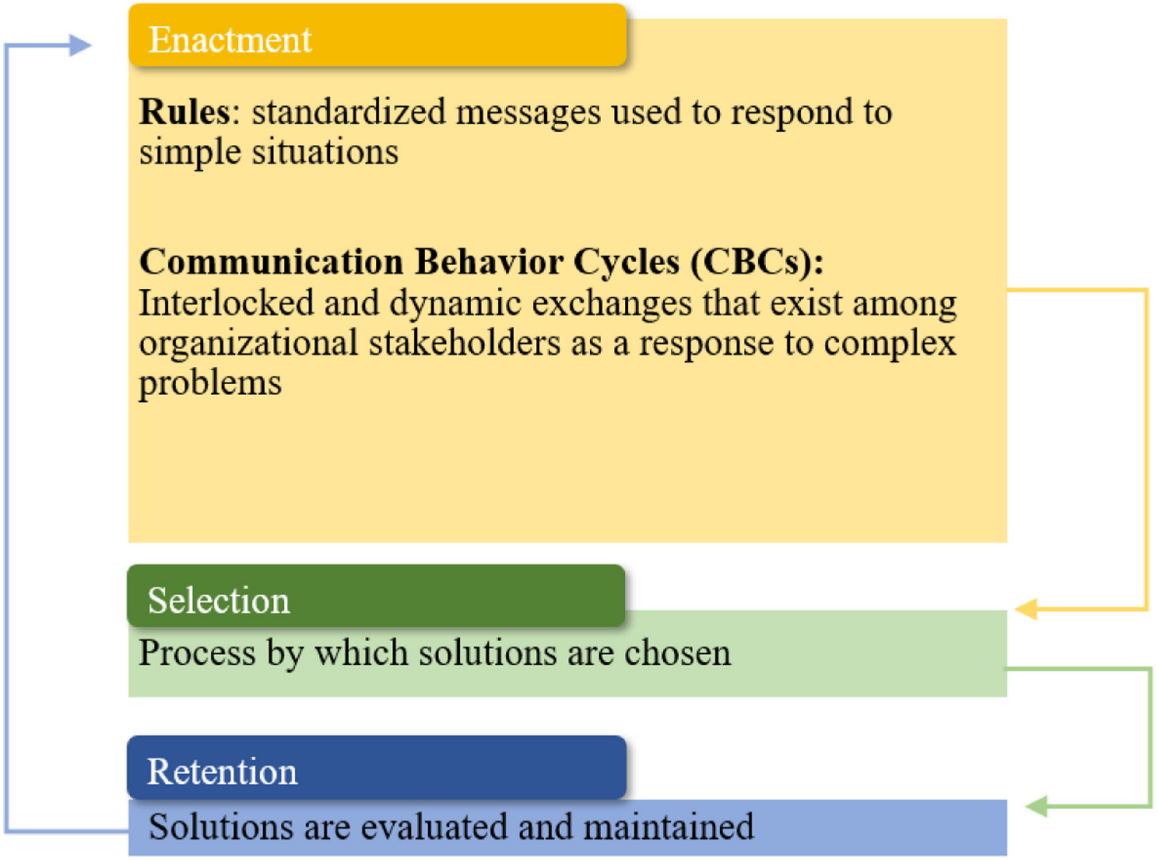

Figure 1.
Weick's Theory of Enactment

Table 1.

Participant Demographics

	Mean (SD)
Age (years)	36.5 (9.57)
	N (%)
Organizational Sector	
Medical	7 (25%)
Nonprofit	12 (43%)
Academic	5 (18%)
Health Department	2 (7%)
Other	2 (7%)
Gender	
Cisgender Male	21 (75%)
Cisgender Female	7 (25%)
Race	
Black	24 (86%)
White	4 (14%)

Table 2.

Enactment Themes as Rules and Communication Behavior Cycles

Theme	Rules	Communication Behavior Cycles (CBCs)
Macro-Level Ideologies	• Rigid healthcare systems • “One size fits all” approach to client care and services	• Holistic and patient-centered systems • Increased focus on structural issues • Community-powered
Employee Value	• Organizations undervalue and underpay staff	• Engage staff from the community and involve them in decision making • Intentional hiring and professional development
Collaboration Between Organizations	• Competition for clients • Leadership’s attitudes toward other organizations conflict with front-line staff’s reality	• Information sharing • Interagency trust
Patient-Organization Interactions	• Prejudice and discrimination • Negative customer service experiences • Limited feedback opportunities	• Construction of familial dynamic • Relationship-driven • Strengths-based approaches • Inclusion of client voice in decision-making
Cultural Competence Training	• “One-time” staff trainings	• Interactive/on-going training • Robust cultural consciousness curriculum
Bureaucratic Factors	• Long wait times for uninsured individuals • Patients must “jump through hoops.” • Referral processes • Paperwork • Hours of operation • Patient requirements (health history, zip code)	• Increased availability of providers • Access to cell-phones/reimagining communication. • Pre-appointment meetings • Touchpoint activities • New patient orientation
Intervention Strategies	• Condoms as prevention	• Emphasis on client dignity • Culturally grounded interventions • Use of social media • Innovation