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“We hide...”: Perceptions of HIV Risk Among Black and Latino MSM in New York City

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Abstract

Black and Latino men who have sex with men (BLMSM) are disproportionately infected with HIV; they comprised 66% of HIV diagnoses among men who have sex with men (MSM) in the United States in 2015. Risk factors for HIV infection among BLMSM include a high community prevalence of diagnosed and undiagnosed HIV/STDs, and dense sex partner networks. Perceptions of HIV risk among BLMSM were explored to inform HIV prevention efforts. During 2011–2012, semistructured interviews were conducted with BLMSM in New York City. Using computer-assisted thematic analyses (NVivo), transcribed interview responses to questions regarding HIV risk for main themes were examined. Interview data were available for 108 BLMSM: 86% Black, 13% Latino, 26% aged 18–24 years, 59% self-identified as “gay,” and 33% self-identified as “bisexual.” The main emergent theme was stigma. Subthemes related to stigma included: (a) homophobia in the Black and Latino community, (b) fear of losing support from family and friends, and (c) lack of support leading to low self-esteem. Addressing the stigma felt by BLMSM may be an important strategy to facilitate improved HIV prevention efforts, HIV care and treatment, and to decrease HIV-related disparities.

Keywords

HIV, Black/African American, Latino/Hispanic, risk, stigma

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Men who have sex with men (MSM) are disproportionately affected by and infected with HIV. Despite representing an estimated 2% of the U.S. population (Purcell et al., 2012), MSM accounted for 67% of the estimated new HIV diagnoses in 2015 (Centers for Disease Control and Prevention, 2016). Black/African American (Black) and Latino/Hispanic (Latino) MSM (BLMSM) are at particularly high risk for HIV compared with other MSM. In 2015, BLMSM represented approximately 66% of HIV diagnoses among MSM in the United States (Centers for Disease Control and Prevention, 2016). It is estimated that in their lifetime, one in two Black MSM (BMSM) and one in four Latino MSM will acquire HIV compared with one in eleven white MSM (Hess, Hu, Lansky, Mermin, & Hall, 2016). Understanding factors that put BLMSM at higher risk for acquiring HIV is vital.

Data suggest that elevated risk for HIV infection among Black MSM may be explained by differences in undiagnosed HIV, access to care and treatment services, and access to antiretroviral treatment (ART) (Maulsby et al., 2014). Among Latino MSM, lack of knowledge about HIV and

STDs has been identified as a risk factor for HIV infection (Rhodes et al., 2010). In addition, among MSM, Latinos have the highest rate of unprotected anal intercourse (UAI) of any racial or ethnic group (Remien, Wagner, Dolezal, & Carballo-Diéguez, 2002); and, substance use and/or heavy alcohol consumption may contribute to UAI among Latino MSM (Dolezal, Carballo Diéguez, Nieves Rosa, & Díaz, 2000; Fernandez, 2005; Ramirez-Valles, Garcia, Campbell, Diaz, & Heckathorn, 2008).

Other studies (Adimora & Schoenbach, 2005; McCarthy, Myers, Reeves, & Zack, 2016) have reported links between HIV disparities and social and structural

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determinants of health, including incarceration, stigma, social networks with high prevalence of disease, low income, and social discrimination among BLMSM (Marmot, Friel, Bell, Houweling, & Taylor, 2008; Oster et al., 2013; Mizuno, Borkowf, Ayala, Carballo-Diéguez, & Millett, 2015). Erving Goffman (2009) defined stigma as a “profoundly discreditable attribute of a person or group that devalues their position in society.” In communities of BLMSM, stigma is often associated with homophobia (Brooks, Etzel, Hinojos, Henry, & Perez, 2005). As a result, BLMSM may struggle with their gay identity, and engage in riskier sexual behaviors (Fields et al., 2014; Jeffries, Marks, Lauby, Murrill, & Millett, 2013; Malebranche, Fields, Bryant, & Harper, 2009; Maulsby et al., 2014; Millett, Peterson, Wolitski, & Stall, 2006). Understanding factors that put BLMSM at higher risk for acquiring HIV, including social factors, is vital. This is consistent with national HIV prevention goals for the United States, which include reducing new HIV infections, increasing access to care for HIV-positive persons, and decreasing HIV-related health disparities (“National HIV/AIDS Strategy for the United States: Updated to 2020,” 2015).

HIV rates in New York City (NYC) are consistent with what is seen nationally; NYC has the second highest HIV prevalence compared with other U.S. jurisdictions, with BLMSM accounting for 60% of MSM living with HIV infection in NYC (New York City Department of Health and Mental Hygiene, 2015). Because of the disproportionate impact of HIV infection on BLMSM in NYC, it is necessary to understand the perspectives of the men themselves so that tailored HIV prevention interventions can be developed. Perceptions of HIV risk were explored among BLMSM in NYC to inform the development of culturally specific and locally tailored HIV prevention strategies.

Methods

Data were collected as part of a larger mixed methods study, Brothers Reaching Out to Talk about HIV Awareness (Project BROTHA) (Nanin, 2013). The goal of Project BROTHA was to explore the relationship between interpersonal communication about HIV prevention and HIV testing among adult BLMSM and other MSM in their social networks. The study was conducted in NYC, led by the Center for HIV Educational Studies and Training (CHEST) in partnership with Gay Men of African Descent (GMAD), a trusted, local, community-based organization that offers services for gay-identified/same-gender loving men of color. During 2011–2012, BLMSM were recruited through internet advertising (i.e., Facebook and social sites frequented by MSM) and distribution of promotional materials (i.e., pamphlets and

flyers) in NYC communities. Both purposive and respondent-driven sampling (RDS) methods were utilized for recruitment (Heckathorn, 2002).

For our RDS, the first 50 MSM enrolled into the study (seeds) were allowed to invite MSM from within their social networks using numerically coded coupons, including friends, peers, and sex partners for further recruitment of MSM into the study. Participants who were seeds received a \$20 cash incentive each time one of their referrals [“network associate” (NA)] qualified, enrolled, and completed the study. Each time an NA presented himself to participate in the study (after eligibility screening by phone), presented the numerically coded coupon, and completed the study, the initial seed received the \$20 cash incentive for encouraging the NA to participate.

Men were eligible to participate if they were (a) biologically male, (b) reported sex with a man in the previous 3 months, (c) self-identified as Black or African American or of African descent, and/or Latino/Hispanic, (d) communicated in English, (e) not undergone HIV test in the previous 3 to 6 months, (f) lived in the NYC area, and (g) able to identify two other MSM from their social network. Because Black and Latino persons in NYC are disproportionately affected by HIV infection, both Black and Latino MSM are included in these analyses. There were no exclusions based on HIV infection status. After providing written informed consent, participants completed a computer-assisted survey (ACASI) (90 min), which included questions concerning demographic (i.e., highest education level, annual income), behavioral, and psychosocial factors that may affect HIV testing decisions.

After survey completion, participants took part in a semistructured individual in-depth interview (IDI), conducted by the study coordinator (MPH graduate student), that lasted approximately 45–75 min. All interview training was conducted by the principle investigator (JN). The interview guide was developed in collaboration with colleagues from the Center for HIV Educational Studies and Training (CHEST). See Appendix 1 (Supplementary material) for part of the Interview Guide used for this study. All participants (including NAs) were reimbursed \$60 for their time after completing both the survey and interview. At both baseline and 3-month follow-up visits, all participants were offered an HIV test. Surveys were administered at baseline and during the 3-month follow-up visit. IDIs were completed at baseline. Project BROTHA was approved by Kingsborough Community College, Hunter College, and the Centers for Disease Control and Prevention (CDC) (United States Department of Health and Human Services, 2009) Institutional Review Boards (IRB).

Audio recordings of individual in-depth interviews were transcribed verbatim by the research coordinator and CDC health scientist, and reviewed for accuracy by a member of the research team. Transcriptions were uploaded into NVivo (QSR International Pty Ltd., Version 11, 2015) and structural codes were applied to the data to label each interview guide question and participants' responses (Guest & McLellan, 2003). Two qualitative analysts thoroughly read each transcript to create an emergent data-driven code list (Guest, MacQueen, & Namey, 2011). The analysts then met to discuss any discrepancies and to create a preliminary codebook. For this subanalysis led by the first author, an inductive thematic approach was applied and a preliminary list of codes was generated after reviewing the transcripts (Braun & Clarke, 2006). Next, codes were assigned to the segmented data, collated, and compared within and across transcripts using the constant comparison method with the unit of analysis as the individual in-depth interview. This iterative process continued throughout the dataset to identify similar patterns and categories. From this, a codebook and list of salient and co-occurring themes that described the risk of acquiring HIV among BLMSM were assembled, revised, and finalized by the research team.

Participant demographics are summarized using quantitative data. Themes reported below are from the qualitative portion of the study and are based on responses to four questions: (a) What is your understanding of HIV risk?, (b) Do you believe everyone looks at HIV risk the same way?, (c) What are your thoughts on studies from the CDC, which report that Black and Latino men in the United States are disproportionately at greater risk for HIV infection than other groups?, and (d) What are your thoughts on studies from the CDC that also state this population is less likely to be tested for HIV than other groups?

Results

Sample Characteristics

Of the 112 BLMSM enrolled, four were excluded due to missing data; our final sample consisted of 108 BLMSM. Participants were mostly Black ($n = 93$; 86%); aged 18–24 years ($n = 28$; 26%). Most participants self-identified as homosexual, gay, or queer ($n = 64$; 59%), followed by bisexual ($n = 36$; 33%), and “not sure/questioning” ($n = 7$; 7%). Participants were highly educated, with 73 (68%) having at least some college, associate's degree, technical degree, bachelor's degree, or postgraduate studies. Forty-nine participants (45%) reported being unemployed, and 19 men (18%) met the criteria for poverty. Almost all ($n = 99$; 92%) participants had ever been tested for HIV, and 96 participants (89%) self-reported their last HIV test

Table 1. Demographics and HIV Testing History of Black and Latino Men Who Have Sex With Men in New York City, Project BROTHA, 2011–2012 ($n = 108$).

Demographics	N (%)
Age	
18–24	28 (26)
25–32	24 (22)
33–44	26 (24)
45–64	25 (23)
Missing	5 (5)
Race/ethnicity	
Black	93 (86)
Latino/Hispanic	14 (13)
Missing	1 (1)
Sexual orientation	
Homosexual, gay, or queer	64 (59)
Bisexual	36 (33)
Not sure/questioning	7 (7)
Missing	1 (1)
Highest level of education completed	
< Grade 12	13 (12)
Grade 12 or General Education Diploma (GED)	21 (19)
Some college, associate's degree, or technical degree	44 (41)
Bachelor's degree	17 (16)
Any postgraduate studies	12 (11)
Missing	1 (1)
Current employment status	
Employed full-time	18 (17)
Employed part-time	40 (37)
Unemployed	49 (45)
Missing	1 (1)
Poverty	
Yes	19 (18)
No	89 (82)
Health insurance coverage	
Yes	78 (72)
No	29 (27)
Missing	1 (1)
HIV testing history	
Ever tested for HIV	
Yes	99 (92)
No	8 (7)
Missing	1 (1)
Result of most recent HIV test	
Negative	96 (89)
Did not get results/indeterminate	3 (3)
Missing	9 (8)

result as negative (Table 1). No participants self-identified as HIV-positive at enrollment, but four BLMSM tested HIV-positive at baseline and were linked to care as part of this study.

Qualitative Results

Seventy-one (66%) participants stated that sex without a condom put BLMSM at risk for HIV infection. The men felt that, although BLMSM were aware of the risks associated with their behaviors (e.g., sex without a condom, sharing needles, having sex under the influence of drugs and alcohol), BLMSM were at greatest risk for HIV infection primarily due to the stigma associated with being identified as gay. Responses from 38 men (35%) were related to stigma, representing the most common theme among all responses. Subthemes related to stigma included: (a) homophobia in the Black and Latino community, (b) fear of losing support from family and friends, and (c) lack of support leading to low self-esteem.

Homophobia in the Black and Latino Community

Participants shared that homophobia in the Black and Latino communities prevents BLMSM from being open about their sexual orientation and sexual behaviors. Men stated that within their community it is “*not accepted to be gay*” and that “*being gay is not cool*.” This, in turn, leads to men engaging in riskier behaviors. As one man said,

“I feel like it’s a stigma in the community and it’s like it’s a stigma with being gay, bisexual and you know our community is not really open to that. And it’s like you know if we open it up a little bit more I feel like it’s a way to prevent it [HIV].” (Age 22, Black, gay)

Men felt that homosexuality was seen as a “*weakness*” and is “*frowned upon*” in the Black and Latino communities. A participant shared:

“...There’s the whole machismo in the Latin and Black community that, and growin’ up, you know as, my grandparents are from Puerto Rico and so growing up in a Hispanic background, how dare you even [say that you are gay], it was so hard for me to even come out as gay. I didn’t even tell my mother until I was almost 30 years old....” (Age 36, Latino, gay)

Though some men were uncomfortable with using the term “*down-low*” (DL), they acknowledged men may engage in behaviors associated with a higher risk of acquiring HIV infection due to the stigma associated with being gay. The term “DL” is sometimes used to describe circumstances in which men consider themselves heterosexual and concurrently sleep with men and women (Wolitski, Jones, Wasserman, & Smith, 2006); however, men in this study used the term to further elucidate their points regarding hiding their gay identity. Men repeatedly stated that BLMSM feel that they have to “*hide who they*

are,” “*practice in the dark*,” or “*negotiate the two identities*,” (between being Black and/or Latino and being a gay man). As one man explained,

“My thought is that Black men seem to hide-I mean it’s kind of different for being a white male-white, men are more out there about their gay status or whatever. But then the Black men, they tend to hide you know-most of them you know the “DL” brothers you know what I’m saying because society doesn’t accept two males being together, so it puts them at higher risks. And Black men are supposed to be strong, supposed to be the ruler of the house you know what I’m saying, and nobody-I don’t think some Black men like to be called faggot or gay. It makes you feel belittle or whatever you know what I’m saying. So I think with society not accepting gay life or whatever, that put more Black men at risk of getting HIV because they gotta go to the park, they gotta go to places where people can’t see them and go in the dark or whatever to do that’s where you are more at risk too, we hide.” (Age 31, Black, gay)

Another participant shared:

“...It tends to be like not as accepted so for a lot of gay men of color, their sexuality is just something that they do like, and you know, like in the shadows, like on the DL. And I feel like there’s a lot of risky behavior that happens when your sexuality is always kept hidden, you know, cuz you, it’s almost something that becomes pathological in your mind as very dark and dangerous so you engage in very dark and dangerous behavior, whether it be, you know like, cruising in parks and having sex with strangers. Um, you also don’t educate yourself about the risks of sex because your sexuality isn’t something that you’ve integrated into your daily life.” (Age 28, Latino, gay)

Fear of Losing Support From Family and Friends

In addition, participants felt that BLMSM were unable to “*be themselves*” and express their sexual identity due to the fear of losing the support of their family and friends, which also causes men to practice risky “*hidden*” behaviors. Men felt that they had no one to talk to in their families about their sexuality because it is not accepted, “*...so you can’t really talk to your parents, or your family...so who do you talk to?*” (Age 27, Black, bisexual) When one participant was asked why he felt there was a disproportionate rate of HIV infection among BLMSM, he simply stated “*because people can’t talk about it*.” (Age 64, Black, bisexual).

Another participant shared:

“I think that in the Black community people are so scared to say ‘I am a homosexual,’ like, even myself I haven’t said out loud. I feel that if I say it out loud, I am going to lose so much

friends, maybe, one day...I moved across the country to be a whole different person...to be myself.”(Age 32, Black, gay)

Another participant explained:

“Black gay men I feel that if more emphasis was put on monogamy in the relationships and if the Black family was more acceptin’ of the LGBT community, the risks and the rates would be a lot lower. I feel that gay Black men have higher rates of HIV and AIDS because they have to do their things secretly and you can’t really develop a relationship with somebody that you can only see on a weekend between certain hours. So what you’re gonna do is you’re gonna find a bunch of different people and with doin’ so you put yourself at huge risk. I feel like, if, if you’re able to come out, like with myself, prior to me comin’ out to my parents last year I didn’t have too many consistent boyfriends. It would just be havin’ sex with guys and, ok I’m over you, the next guy. Because I couldn’t bring nobody to my mother’s house and I couldn’t share anything with anybody. So, it was just like, I’m not gonna get attached to you because you’re not gonna be accepted.”(Age 30, Black, gay)

Lack of Support Leads to Low Self-Esteem

Lastly, men felt that this lack of support among family members leads to low self-esteem among BLMSM. Men shared that when you do not “*care about yourself, you don’t care about what you do.*” A participant shared: “*...when I came out I went about the mindset of, like I’m gonna go fuck every boyfriend that I didn’t have while I was in the closet. And I just lost my mind, you know. And to prevent that kind of thinking I think is what’s important.*”(Age 28, Black, gay).

Another man stated:

“So, my feeling is that if you, ok so if you don’t feel really comfortable about yourself and really like things about yourself or don’t have a healthy self-esteem or whatever, you may turn to drugs, or you may turn to alcohol, or you may turn to risky sex, or you may turn to risky sex just because you want to feel connected to someone, or close to somebody...and not caring about the consequences.... there’s not a lot of respect, I think, for, you know, Black gay people amongst other Black people. And I think that’s a problem, because it does a lot of internal stuff. And then people act out.” (Age 38, Black, gay)

Discussion

Stigma was the main theme identified as an HIV risk factor during individual interviews with BLMSM in NYC. These findings inform the literature on HIV risk among BLMSM and can be used to develop culturally tailored HIV prevention interventions for BLMSM in urban areas like NYC. These findings also provide

context for targeted HIV risk behavior research among BLMSM in NYC.

Participants in the current study felt that the stigma associated with being identified as gay was the cause of BLMSM engaging in risky sexual behaviors. This is consistent with other studies regarding stigma and BLMSM (Arnold, Rebchook, & Kegeles, 2014; Fields et al., 2014; Jeffries et al., 2013; Maulsby et al., 2014). Future research should explore stigma as a risk factor for HIV acquisition quantitatively through the use of validated stigma scales.

The subtheme of homophobia has a long history among Black and Latino communities and has been shown to affect HIV prevention efforts (Brooks et al., 2005; Huebner, Davis, Nemeroff, & Aiken, 2002; Mizuno et al., 2015; Rhodes & McCoy, 2015; Stokes & Peterson, 1998). Many participants stated that they had to “negotiate identities” between being a Black or Latino man and being openly gay. Although the data for gay identity and HIV risk behaviors are mixed, the findings from the current study are consistent with studies suggesting that discrimination endured by BLMSM for their race and ethnicity, and their gay identity, directly leads to increased risky sexual behaviors (Fields et al., 2014; Jeffries et al., 2013; Malebranche, et al., 2009; Maulsby et al., 2014; Millett et al., 2006).

The men in this study referred to pressures tied to traditional gender roles and related cultural and psychosocial attitudes and expectations (e.g., men being “strong”) and the idea of *machismo*, being gay is not seen as acceptable in these communities (Rhodes et al., 2010). In Latino culture, a *machista* man is expected to demonstrate virility by having multiple sexual encounters, usually with a female, and sexual urges that are difficult to control (Diaz & Ayala, 1999; Jarama, Kennamer, Poppen, Hendricks, & Bradford, 2005; Marín, 1996). These sociocultural values may cause Latino men to engage in risk behaviors to prove their masculinity and prevent them from being open about their same-sex behaviors (Rhodes et al., 2010; Rhodes, Hergenrather, Montañó, & Remnitz, 2006; Royster, Richmond, Eng, & Margolis, 2006; Sandfort, Melendez, & Diaz, 2007).

It is also worth noting that although the majority of the men were highly educated ($n = 73$; 68%); 49 (45%) were unemployed. When one acquires better education, they expect to hold better jobs and have a higher income than those that did not attain higher education. A conflict in this belief may cause BLMSM to engage in high-risk behaviors. Ayala et al. (2012) identified financial hardships among BLMSM to be associated with unprotected anal intercourse with a sero-discordant or sero-unknown partner. This education–employment discrepancy may be important to consider for developing appropriate HIV prevention interventions and research questions asked among these groups.

Several participants noted that they did not disclose their homosexual behaviors and identities to family and loved ones from fear of losing their support. Lauby et al. (2012) conducted a study among 1,286 BLMSM in NYC, Philadelphia, and Los Angeles County, in which unrecognized HIV infection was identified in 118 men. Men who scored higher on the supportive relationship index had significantly lower odds of testing HIV-positive in the study. The researchers concluded that the association of support and HIV acquisition may be explained by the fact that men who had strong supportive relationships were more likely to have had an HIV test in the past 2 years and less likely to have engaged in high-risk sexual behaviors, which they defined as any occurrence of UAI with a non-main male partner and/or trading sex for money or drugs (Lauby et al., 2012). The current study's findings are consistent with those from Lauby et al. and highlight the possible protective role of social relationships among BLMSM.

Low self-esteem was described as a cause for engaging in risky sex behaviors among BLMSM in this study. Research conducted by Alvy et al. (2011) among a diverse sample of MSM (51% Black and Latino) examined the association between depression and sexual risk among high-risk MSM. The researchers included men who used sex as a *cognitive escape* (i.e., coping with negative mood states by attempting to escape cognitive awareness of behavioral norms and instead focusing on more immediate pleasurable outcomes) (Alvy et al., 2011; Folkman, Chesney, Pollack, & Phillips, 1992; Semple, Patterson, & Grant, 2000; Vicioso, Parsons, Nanin, Purcell, & Woods, 2005) and concluded that cognitive escape mediated the link between depression and HIV risk behavior (Alvy et al., 2011). This is consistent with the perceptions of BLMSM in the present study, that low self-esteem regarding sexual orientation increased risky sexual behaviors without regard for the long-term consequences of their actions. The interplay of psychosocial behavior and HIV risk behaviors should be considered when developing HIV prevention interventions and research studies.

Limitations

There were several limitations to this study. First, a purposive sample of BLMSM from NYC along with RDS was used. Though these are methods frequently used for sampling hard-to-reach populations, our data may not be representative of BLMSM in other areas of the United States regarding their perceptions of HIV risk factors. Second, though there were no differences found in the responses between Black and Latino MSM, this may not be the case for other regions of the country. Future studies should target enrollment of larger populations that include more diverse groups of men (e.g., by location, education,

employment status) and possibly separate analyses of Black and Latino men by location, to obtain more representative and comparative information about HIV risk among BLMSM. Based on our sample having fewer Latino MSM than Black MSM, increased, targeted efforts to enroll Latino MSM in HIV prevention research studies are warranted. Third, the sample included men who were willing to participate in research and may have had more favorable opinions of research than men who declined to participate, thereby contributing to some unmeasured selection bias. Lastly, the monetary incentive may have contributed to some selection bias and over-representation of those who may have participated due to provision of money. However, incentives and other tokens of appreciation are a routine way to thank participants for their time, and tokens help facilitate participation in research studies (Schwartz et al., 2010). Despite these limitations, the reflections from participants of this study offer important insights regarding approaches that should be considered when developing and implementing HIV risk reduction efforts in NYC.

Conclusions

Even in a large U.S. metropolitan area which is considered socially progressive, Black and Latino MSM perceived pervasive stigma. As public health professionals and researchers work to meet national HIV prevention goals, addressing stigma at individual, societal, and familial levels may be an important component of reaching successful HIV prevention and care outcomes for BLMSM. As more biomedical interventions such as treatment as prevention (TasP), test and treat, and pre-exposure prophylaxis (PrEP) are developed and implemented, it will be important to consider and intervene on social determinants of health such as stigma in order to see a more successful uptake of these interventions among BLMSM (Golub & Gamarel, 2013). The CDC's compendium of effective interventions includes two interventions for BMSM that have components for dealing with stigma and resiliency at the individual level (i.e., *d-up!* and *3MV*) and none for Latino MSM (<https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/Interventions.aspx>), indicating more work in these areas is needed. Interventions that address stigma at the macro level could include programs that work with faith-based institutions and provide support groups for family members who need assistance with accepting their loved ones' sexual orientation (Montgomery, Senat, Scanlin, Mensah, & Koffler, 2016; Sutton & Parks, 2013). Such interventions may help decrease the societal homophobia and HIV-related stigma in support of HIV prevention in many Black and Latino communities (Brooks et al., 2005).

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Supplemental Material

Supplementary material is available for this article online.

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