Black Men who Have Sex with Men and the HIV Epidemic: Next Steps for Public Health

Black men who have sex with men (BMSM) are disproportionately affected by HIV/AIDS in the United States. The Young Men's Survey estimates an HIV incidence rate of 14.7% among BMSM in 6 US cities, compared with 2.5% and 3.5% among White and Hispanic men who have sex with men (MSM), respectively.[1] Yet the disparity is not explained by higher rates of unprotected anal and oral sex. There are 4 possible explanations, which are not mutually exclusive: (1) bias in assessment of risk behaviors, (2) increased prevalence of HIV among sexual contacts, (3) increased infectiousness among sexual partners, and (4) increased physiological susceptibility to HIV. By exploring these possibilities more deeply, we can increase our understanding of the apparent disparity between behavioral risks and outcomes while at the same time improving the design and implementation of prevention programs that address the specific needs of BMSM.

RISK ASSESSMENT AND RISK REDUCTION

Methodological problems that may lead to underreporting of risk behaviors may also explain why behavioral messages fail to translate into safer sex among BMSM: Measures, surveys, and instruments may be culturally inappropriate for BMSM; interviewers may not be race- and gender-concordant with or may not be properly trained to interview BMSM; instruments may use language or terminology that does not resonate with BMSM; research settings may not be comfortable environments for open discussion with and responses by BMSM.

Meanwhile, BMSM research participants may (1) be unwilling

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to use certain sexual orientation labels on surveys for fear of discrimination, (2) distrust or fear researchers, (3) fear that confidential information about their sexual behavior will be disclosed, or (4) report what they think researchers want to hear.

To solve these problems, researchers must conduct more qualitative research with BMSM in environments that provide a more comfortable atmosphere in which to talk openly about sensitive sexual issues. Such research will ultimately guide the development of culturally appropriate assessment techniques. Employing BMSM as research interviewers may lead to deeper exploration of the unique social situation of being both Black and homosexual through common experiences shared by interviewer and subject.

Likewise, conducting such research away from clubs, bars, parks, and other public or sexually identified venues may yield more honest responses. Familiar locations such as participants' homes, cars, or other quiet settings chosen *by the participants themselves* may equalize power dynamics, establish trust, and create a more relaxed environment that promotes honest discussion of intimate sexual behavior.

HIV prevention initiatives based on a more accurate reporting of sexual behavior will more adequately reflect the life experiences of BMSM.

Additionally, interventions should be offered in familiar and empowering settings. For example, the African, American, Advocacy, Support-Services and Survival Institute, in Los Angeles, Calif, designed the Critical Thinking and Cultural Affirmation (CTCA) model, targeting BMSM engaging in unsafe sex. CTCA is a 6-month intervention that combines individual psychological counseling with education on Black history, critical thinking methods, concepts of self-love and respect, and an "HIV 101" course.

Thirty-two Black men from various socioeconomic backgrounds were surveyed before and after participating in the CTCA program. After completing the program, only 30% exhibited a willingness to put themselves at risk for HIV, versus 70% before the program; 80% of the men responded that they valued themselves as Black men, had a positive self-concept, and were willing to protect themselves and their community from HIV.[2] The CTCA model was community generated and maintained, and approaches HIV prevention and sexual responsibility by emphasizing the cultural affirmation of Black men, regardless of income or sexual identity. Despite the small sample size and lack of a comparison population, the outcome of the CTCA program is encouraging for new approaches to HIV prevention among BMSM.

Unfortunately, few programs and evaluations consider the role of the church and spirituality in HIV prevention for BMSM. Numerous reports of homophobia within Black churches obscure the positive initiatives and contributions of some HIV/AIDS ministries. Organizations such as The Balm in Gilead and Interfaith HIV Network hold conferences, provide capacity building to churches and pastors, disseminate HIV educational materials, and create a medium by which issues of sexuality and HIV can now be discussed in the Black faith-based community. Despite condemnation of homosexuality from many pulpits, church and spirituality play a pivotal role in the lives of many BMSM.

SEXUAL NETWORKS AND MASCULINITY

Evaluating whether BMSM select sexual partners who are more likely to be HIV-infected requires a more comprehensive understanding of how sexual partners are selected and behavioral risks are assessed. In the 6-city study mentioned previously, 93% of the HIV-infected BMSM did not know they were infected, and many felt they were at low risk for HIV.[3]

Having sex in certain settings—such as gay-identified venues, parks, and correctional facilities—and engaging in "situational sex" for drugs or money may increase risk of HIV exposure and are relevant to this discussion. However, relationships between the social construct of Black masculinity, sexual identification, and sexual behavior decisionmaking have not been adequately explored.

BMSM are more likely to identify as heterosexual or bisexual and less likely to identify as gay than their White counterparts.[4] Disclosing one's homosexuality ("coming out") has traditionally been associated with improved mental health, more responsible sexual behavior, increased awareness of HIV risk, and improved access to HIV prevention services.[5,6] Yet BMSM who disclose their sexual orientation have a higher HIV prevalence (24% vs 14%) and engage in more unprotected anal sex (41% vs 32%) than nondisclosers.[7] So if disclosure of one's sexuality is not necessarily associated with safer sexual behavior and decreased HIV risk for BMSM, pressuring these men to "come out of the closet" may be counterproductive, particularly with "down low" Black men (men who secretly engage in homosexual behavior while living "heterosexual" lives).

A deeper description of masculinity and gender roles among BMSM is needed. Homosexual desire, behavior, and identification are influenced by gender roles and expectations predicated on one's race, ethnicity, socioeconomic status, religious affiliation, and other factors. Black masculinity is described as "fragmented" owing to denial of traditional opportunities for masculine affirmation (education, employment, property ownership) by institutional and personal racism.[8] In response, Black men may adopt a "cool pose," exaggerating attributes of physical and heterosexual prowess to compensate for disempowerment in other areas.[9] Having female conquests, engaging in unprotected sex, and fathering babies are important gender role expectations that may influence sexual behavior and HIV transmission among Black men, particularly BMSM.

Do race-specific gender role and masculine expectations influence what sexual identity label BMSM choose, whether they continue to have sex with women, their sexual roles ("top"

or "bottom"), their sexual behavior choices (oral, anal, protected, unprotected), or the types of men they allow in their sexual networks? One young Black man described his sexual behavior decisionmaking process with "trade"—a masculine-appearing or -acting Black man: "A lot of time whatever trade wants is what trade gets. If that boy don't want—'Oh, it don't feel the same with a condom on'—if he feel like that then a lot of time it's like 'ok then,' 'all right then. And that alone could be it [the reason to have unprotected sex]'" (Fields EL, Fullilove RE, and Fullilove MT; unpublished data; 2001). This young man abandoned use of a condom, despite his awareness of HIV risk, in pursuing an ideal of Black masculinity in a sexual partner. Masculinity as a concept influences sexual identities ranging from "down low" to transgendered; sexual networks; perceived riskiness of sexual partners; and choices to engage in unprotected sex. Further exploration of these dynamics is needed to explain the gap between HIV knowledge and behavior.

INCREASED HIV INFECTIVITY AND ACCESS

Concurrent ulcerative (syphilis, herpes) or nonulcerative (chlamydia, gonorrhea) sexually transmitted infections (STIs) may facilitate HIV transmission.[10,11] STI prevalence has not been adequately evaluated in attempts to understand HIV incidence disparities between BMSM and MSM of other ethnicities. Whether or not undiagnosed or untreated STIs prove to be an important variable, we do know that BMSM are less likely than other MSM to know their HIV status. BMSM are therefore less able to inform their sexual partners and perhaps more likely to have acute infection or a higher viral load than other MSM. What social experiences affect BMSM's knowledge of their HIV/STI status? In 8 focus groups conducted in New York, my colleagues and I asked 81 BMSM about their health care experiences (Malebranche D, Fullilove RE, Peterson JL, Stackhouse RW; unpublished data; 2001). Many participants—already struggling with displacement from both the gay White community for being Black and from the Black community for being homosexual—said that they had experienced additional racism and sexual prejudice with all levels of medical staff in medical settings. This experience influenced their health care utilization, communication, and medication adherence behaviors. We concluded that access to and quality of health care services received by BMSM can be influenced by both the internalization of their everyday discriminatory experiences and negative interactions with medical staff.

BMSM's reduced knowledge of their serostatus and their poorer treatment outcomes if HIV-positive[12] may be related to negative experiences with medical personnel that result in fear of judgment and discrimination, which influences risk behavior disclosure, willingness to undergo HIV testing, and to return for test results, and medication adherence if infected.

Delays in HIV diagnosis and treatment can lead to more rapid disease progression and increased infectivity, ultimately increasing risk among sexual networks of BMSM.

These findings demonstrate the need for a holistic approach to addressing increased HIV infectivity among BMSM that evaluates the complex relationship between possible biological cofactors, (such as high STD prevalence and high viremia) and social variables, such as racism, sexual prejudices, and poverty, that can influence access to and adherence with medial care.

INCREASED SUSCEPTIBILITY

Psychoneuroimmunology—the study of interactions between psychological factors and immune system function—has already identified associations between mental states and disease progression. For example, for HIV-seropositive gay men, traumatic events, such as the death of a partner, or attributions of negative experiences to self can predict faster CD4 decline and progression of disease.[13,14] Exploring the relationship between stress, mental health, and immune markers of susceptibility to HIV is a plausible approach to understanding the current disparity in HIV rates between BMSM and other MSM.

While low self-esteem and the internalization of racism and sexual prejudice may influence mental health and selection of specific sexual partners and behaviors, immune system responses to these stressors may also explain increased susceptibility to HIV infection among BMSM.[15] If so, future research correlating mental health measures, immune markers, and HIV prevalence—as well as interventions emphasizing specific coping strategies to address the mental health of BMSM (and other MSM)—would be useful and could lead to future areas for intervention to empower BMSM to protect themselves from HIV, emotionally, behaviorally, and physiologically.

WHERE DO WE GO FROM HERE?

Twenty-two years into the HIV epidemic, we find ourselves at a watershed. The next steps we take with regard to BMSM will shape the evolution of prevention and intervention programs and policies in the years to come. Robust research on and effective outreach to BMSM requires the identification of diverse recruitment venues to reach and serve a population that is equally diverse in its sexual experiences and identification. Additionally, it requires methodologies that minimize biased self-reporting of sexual behaviors and research instruments that reflect culturally specific variables influencing this population.

Our assessment of risk behaviors and selection of sexual partners among BMSM needs to take into account distinct meanings of masculinity in relation to race and culture. In particular, dynamics related to protective norms among White MSM—such as "coming out"—should not be simplistically transferred to BMSM. Our understanding of infectiousness and susceptibility among BMSM must be informed

by considerations of the interactions between the immune system, psychology, culture, and social context, including the health care setting—where racial and sexual prejudice may impair delivery of services, helping to perpetuate rather than ameliorate the HIV epidemic.

David J. Malebranche, MD, MPH

About the Author

Requests for reprints should be sent to David J. Malebranche, MD, MPH, Division of Medicine, Emory University, 69 Jesse Hill Jr Dr, Atlanta, GA 30303 (e-mail: dmalebr@emory.edu).
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