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“Honesty, Communication and Trust Are What Bring Peace of Mind”: Narratives of HIV Risk Among Hispanic/Latino Men Who Have Sex with Men in the Southern United States

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Abstract

For Hispanic/Latino MSM (HLMSM) in the South, HIV burden remains high, and HIV elimination is a national priority. Between July and September 2016, using a strengths-based approach informed by resilience theory, we conducted qualitative interviews with HIV-negative HLMSM in five southern cities in the United States with elevated HIV prevalence. We analyzed data using a qualitative content analysis approach, assessing for interrater reliability. A brief behavioral survey was also conducted. We enrolled 51 HLMSM (mean age = 33 years, range = 15–63). HLMSM discussed the climate of fear about HIV and homosexuality impeding HIV prevention, including the impact of stigma and taboo. Three main strengths-based strategies emerged for preventing HIV: assessing partner risk, establishing boundaries for sexual interactions, and self-education. Future HIV prevention efforts may benefit from balancing risk-based approaches with those that emphasize resilience, address partner trustworthiness and safety, and focus on providing novel outlets for HIV prevention education.

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Ethics Approval This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Emory University Institutional Review Board (IRB00077517) on March 2, 2015.

Consent to Participate Informed consent was obtained from all individual participants included in the study.

Competing Interests The authors have no relevant financial or non-financial interests to disclose.

Keywords

HIV; Hispanic; Latino; MSM; HIV prevention; Resilience; U.S. South; Qualitative methods

Introduction

Despite overall improvement in HIV prevention and treatment outcomes and reduction of HIV incidence and mortality across the United States, Hispanic/Latino persons, persons who live in the U.S. South, and men who have sex with men (MSM) continue to experience a disproportionate burden of HIV [1–5]. For Hispanic/Latino MSM (HLMSM), intersectionality and minority stress theory explain how having a “dual minority status” can further elevate HIV risk and thus exacerbate disparities in HIV trends among HLMSM as compared with trends seen in other racial/ethnic and sexual orientation groups. In addition, HLMSM living in the southern United States must contend with socioeconomic factors like poverty and unemployment or cultural factors such as HIV stigma that have been found to affect HIV prevention and treatment in the region [3, 6–10]. Studies have also identified behavioral factors such as higher rates of condomless sex, not using pre-exposure prophylaxis (PrEP), and lower PrEP awareness (as compared to White MSM) [1, 11]. Qualitative interviews with HLMSM identified low knowledge about HIV prevention, transmission, and treatment [12] [1], increased likelihood of engaging in sexual behaviors associated with HIV acquisition, and low-risk perception [13, 14] as contributors to disparities among HLMSM.

Our research questions were guided by a strengths-based approach in which we posited that individual and community strengths and assets contribute to HLMSM remaining HIV negative, and these self-identified protective factors provide unique opportunities for preventing HIV. We used resilience theory [15–18] to understand how experiences of adversity (increased likelihood of exposure to HIV) might result in protective health outcomes (prioritizing behaviors that prevent HIV transmission) for sexual minority men [19–21].

To meet the goals of the Department of Health and Human Services’ multi-agency national initiative, *Ending the HIV Epidemic* (EHE) [22], prevention efforts must focus on the Hispanic/Latino community [23, 24], specifically HLMSM vulnerable to HIV infection [25]. To eliminate HIV disparities among HLMSM, it is imperative to understand how HIV-negative HLMSM who reside in high HIV burden areas, such as the U.S. South, remain HIV negative despite challenges that increase exposure to HIV [19], and perceptions of what is considered a transmission risk among HLMSM who engage in behaviors associated with HIV acquisition [26]. The purpose of this study was to understand how HLMSM not living with HIV who reside in the southern U.S. understand and prevent HIV, and to identify factors HLMSM attribute to remaining HIV negative.

Methods

Between July and September 2016, we conducted in-depth interviews with 150 HIV-negative adolescent and adult cisgender Black/African American ($N = 99$) and Hispanic/

Latino MSM ($N = 51$) in five cities in the southern U.S. with elevated HIV prevalence among racial/ethnic minority MSM at the time of data collection: Atlanta, GA; New Orleans, LA; Baton Rouge, LA; Jackson, MS; and Miami, FL [2, 27, 28]. Eligibility criteria were 13–17 years of age for adolescents, and ≥ 18 years of age for adults; evidence of an HIV-negative test result in the past 6 months [self-reported negative/unknown status accepted for those < 18 years of age]; self-identify as cisgender male; self-identify as Black/African American or Hispanic/Latino; reside in one of the five cities listed above; report oral or anal sex with another man at least once in the past 6 months or (if a minor) indicate physical attraction to other males; and be proficient in either English or Spanish. Respondents were screened by phone or in person. Participants were recruited through referrals from local community-based organizations, health departments, clinics, HIV testing sites, and via word-of-mouth referrals and flyers from local service-providing agencies. Respondents were screened for eligibility and provided a \$40 cash incentive for participation. A purposive sampling strategy was used to ensure that quotas were met based on city, race/ethnicity, and age group to achieve qualitative data saturation for subgroups. Study procedures were approved by the Emory University Institutional Review Board (#IRB00077517).

Interviewers were trained social scientists diverse in gender, race/ethnicity, age, and ability to speak Spanish with experience conducting interviews with MSM, including HLMSM and Spanish-speaking MSM. Participants were recruited through community sites and interviews conducted at the community-based venue or at a private location convenient to the participant. Participants provided voluntary informed consent (those aged 13–17 provided voluntary informed assent and parental consent was waived by the IRB due to potential risk to minors of disclosure of sexual attraction or behaviors to parents or guardians). For this analysis, we focused only on data collected from HLMSM participants. Findings from this study specific to Black/African American MSM participants are published elsewhere [27].

Eligible MSM were invited to complete a brief sociodemographic questionnaire and a 1-h in-person in-depth interview (IDI). Sociodemographic questions covered age, race/ethnicity, sexual identity, education, employment, housing status, health insurance coverage, sex-seeking behaviors, number of sex partners, relationship status, and internet use. IDI questions included perceptions and experiences of HIV prevention, including sexual behaviors, PrEP use, and condom use. Interviewers were trained to ask probing questions to elicit greater depth and reflection in participant responses [29], especially related to perceived protective factors. Interviews were digitally audio recorded, translated, and transcribed verbatim. Transcripts were not reviewed for accuracy by participants prior to analysis. Findings were not reviewed or validated by participants but were shared with community-based organizations assisting with recruitment.

Interview transcripts were coded for themes present in the data using a qualitative content analysis approach [30]. The coding process was facilitated by Lumivero *NVivo* qualitative data analysis software (version 11, released 2015). An initial codebook was created based on a review of the interviews. To ensure reliability in the coding process, four study team coders independently coded the same interviews with the codebook and assessed agreement using pairwise comparisons of coders (A vs. B, A vs. C, etc.) and the coder group (A

vs. combined codes of B, C, and D). Agreement was measured by calculating Cohen's Kappa [31]. Differences in coding were resolved via consensus until final agreement reached a Kappa score of ≥ 0.8 [32, 33]. The coded data were further analyzed using NVivo's cluster analysis tools to identify codes that frequently occur together and form a narrative to describe the experiences of HLMSM) [34, 35]. Behavioral scientists, including Spanish speakers on the team, reviewed the interviews for context related to the cultural experiences of HLMSM, including those MSM not born in the United States. This method resulted in themes frequently associated by HLMSM with remaining HIV negative. A detailed description of the analytic methods has been reported elsewhere [27].

Results

The sample included 51 HLMSM with recent HIV-negative test results. Table 1 depicts descriptive sociodemographic characteristics of respondents. Most respondents lived in Miami, FL (73%, $n = 37$) or Atlanta, GA (18%, $n = 9$), and the mean age was 33 years ($SD = 15$, range: 15–63). One-fifth of respondents were < 18 years of age (20%, $n = 10$). Nearly half (45%, $n = 23$) of respondents had attended some college, and half (51%, $n = 26$) were employed at the time of the interview. A quarter (26%, $n = 13$) of respondents reported staying on the street, in a shelter, or temporarily in someone's home because they did not have a regular place to live or stay in the 12 months prior to the interview, and 14% ($n = 7$) reported being homeless at the time of the interview. Over a third of respondents (35%, $n = 18$) were uninsured; however, 84% ($n = 43$) had seen a doctor or nurse for care in the past 12 months. Most respondents tested for HIV every 3–6 months (61%, $n = 31$), although five (10%) reported having never been tested, and only 3 (6%) respondents report using PrEP. Over half of the respondents (59%, $n = 30$) reported having more than 11 sexual partners in the previous 6 months, and 43% ($n = 22$) reported using the internet recreationally to meet other men for casual sex. However, 59% of respondents reported being in a relationship at the time of the interview ($n = 30$), 88% ($n = 45$) felt there was a community of men like them in their city, and 67% ($n = 34$) reported feeling somewhat or very connected to the community of HLMSM in their city. More than half of the respondents were born in the U.S. (53%, $n = 27$), and sixteen interviews were conducted in Spanish (31%).

Why I Am HIV Negative? HLMSM Journeys Through HIV Risk in the Southern U.S

HLMSM interviewed in our study discussed their HIV-negative status against a landscape of HIV-related fear, reinforced by stereotypes and stigma related to increased HIV prevalence among gay or bisexual men, and included taboo or silence around HIV. These factors served as barriers to starting conversations about HIV risk or prevention among HLMSM, and contributed to stigma, and fear of rejection by association. Against this backdrop, HLMSM attributed their ability to remain HIV negative to strategies that included assessing partner risk and HIV status, establishing boundaries for permissible sexual interaction based on perceived partner trustworthiness, and educating themselves about HIV prevention. "Slip-ups" and exposure to HIV were perceived to occur when conditions were not optimal for assessing risk and trustworthiness of partners or sex acts, such as when alcohol and/or illicit drugs were used.

More than half of the HLMSM in our study associated HIV with fear, terror, danger, death, and anxiety. When asked about what they think of when they hear the word “HIV,” an HLMSM currently using PrEP and condoms with his partner speaks about his HIV fear,

And then I was in a relationship with a young man that I really cared about. And about two months into our relationship, we discovered that he was HIV-positive. And it brought back this flood of feelings. We stayed together for two years after that, right. But after that relationship was over, I lived in just absolute terror of contracting HIV. I was terrified the entire time we were together. And I was terrified and ultimately was the reason for our relationship falling apart because I don't think I had the emotional maturity or vocabulary to express the fear that I was feeling and how it was deeply seated in my own psychobiography and how I understood my sexuality and how I suddenly had to like face it daily.

(Age 35, Miami)

Nearly all HLMSM in the sample responded that they knew people living with HIV and were aware that it is psychologically stressful and stigmatizing to live with HIV infection,

I think of how depressing that is. How, how much you have to go through in life living with HIV and like I can imagine, like, other people being afraid of you once you tell them that you have HIV. It must be the scariest thing in the world to think of when you have it.

(Age 17, Miami)

Some HLMSM shared that sex, HIV, and homosexuality are forbidden or taboo topics, and thus prevented having discussions about their sexuality and preventing HIV,

Well, though, like my circle of friends and family, we don't discuss that because we, maybe we all think it's a gay thing...And we don't have reasons to talk about being gay.

(Age 50, Miami)

But I think that is based on my upbringings, from where I was born. That comes from third world countries; it happens a lot in the third world Latin American countries. Sex is a taboo. To openly talk about... My mother never sat with me to explain or say anything, and my dad even worst. When my father found out that I was gay, he told me that he rather see me dead.

(Age 47, Miami)

When asked about how they prevented HIV, almost half the HLMSM in the sample described requesting the HIV status of partners, assessing who is “clean,” assuming or trusting partners to be HIV negative, and staying away from the “wrong crowd,”

I firmly believe that I am able to discern whether someone is HIV-positive. I have remained negative, thank God, and developed some sort of sixth sense that tells me when to stay away from someone.

(Age 30, Miami)

A condom certainly protects; it is a barrier. A stable partner, though, is more important to me. It is not about stability alone, but about trust. I could be in love and therefore faithful. However, it would make no difference if my partner were to cheat on me. Honesty, communication, and trust, are what bring peace of mind.

(Age 35, Miami)

Based on assessments of partner trustworthiness, all HLMSM in the sample used condoms ($n = 51$), and some engaged only in oral sex, practiced monogamy, and waited longer to have sex with new partners,

Well, definitely limiting my partners...Knowing who you're sleeping with. You know...Not just picking them up on the web. I think there's a lot of fake people out there lying or whatever. And if you're infected, you could kill us, you know? I think it's gonna be for them an easy ticket. Just say, whatever. I'm just gonna do and have fun and...Well, I get to know them a lot better. You know, their principles, their goals, their morals and so forth...And not just having one-night stands.

(Age 50, Miami)

What's keeping me HIV negative, I think, it's my life-style, the way I control my sexual partners, and the way I control my sexual activity, the way I control how, who do I interact with, you know. So I think that has a lot to do with a lot of it.

(Age 22, Atlanta)

In addition, most HLMSM believed staying informed about HIV and challenging old fears and stereotypes helped them prevent HIV,

One doesn't see a person that has HIV as a sick person anymore, as someone who is going to die, as someone who will not get cured. And, I don't look at it with fear because I believe one can protect himself. I believe one can have safe sex and, the best way, if one were to have it, is to go to a doctor and have a test done, and get a treatment, and with treatment one will not die. It is like having a cold, like having asthma, like having diabetes. It is an illness that is chronic but is kept at bay, but you will not die, it is not scary anymore.

(Age 50, Miami)

HLMSM in the sample believed that they stayed HIV negative by adopting a prevention strategy focused on educating themselves about HIV and challenging cultural and societal norms and stereotypes by talking openly about HIV prevention with peers, supportive family members, and sex partners (almost three-quarters of HLMSM). Nearly all HLMSM engaged in one or more prevention behaviors with partners: shared their HIV status with sex partners, discussed HIV prevention and condom use, and vetted potential sex partners,

I ask a lot of questions with guys especially when I am about to...I'll be like I'll just talk to them I'll be like 'you don't HIV or AIDS or anything?' and... I'll just do it really direct and just ask them like 'you don't have that right?'...I'll be like 'no?' and they'll go 'okay' and we can continue then.

(Age 15, Atlanta)

While HLMSM in our sample described a variety of strategies to prevent HIV, few reported using PrEP ($n = 3$), most frequently stating they did not need PrEP:

...I don't feel like I need to get on a program if I'm in a safe relationship

(Age 50, Miami)

HLMSM discussed where their HIV prevention strategies failed, especially when using alcohol and substances and being in situations that encourage inhibition,

Uh, like, getting drunk, partying. I mean, it's a fun, it's fun out there. You can go out to clubs, meet people, do it every weekend, especially if you have the means and the friends and taking, you might start taking more, more risks, or if, you're definitely putting yourself into more risk...Because those situations encourage you to, to make bad decisions very easily.

(Age 27, Miami)

Yes, when I was drunk...when I was drunk at the night clubs, at the dance clubs, after you have drank too much you don't care what happens.

(Age 59, Miami)

Discussion

For this study conducted in urban areas in the southern U.S. with high HIV prevalence among racial/ethnic minority MSM, we sought to understand the context of HIV for HLMSM and to identify perceived prevention practices. It has been widely reported that stigma and taboo impede access to and acceptance of HIV prevention tools and services among HLMSM [12, 13, 24, 26, 36–45]. HLMSM in our study perceived they were not able to openly discuss HIV and homosexuality within families and the wider Hispanic Latino community. In response to the HIV epidemic in their communities, HLMSM developed strategies they believed protected them from HIV infection in environments where homosexuality and HIV are stigmatized and tabooed, demonstrating potential resilience when faced with adversity [15–18]. We learned that HLMSM in our study use condoms, but also employ personal prevention strategies not inherently associated with traditional HIV prevention approaches, such as assessing partners for their HIV status both with and without directly asking them, engaging in sex practices based on perceptions of trustworthiness, and taking the initiative to learn about HIV. As with the cohort of Black MSM in this study [2, 27], HLMSM choose to trust each other as self-protection when familial and social/structural systems fail, possibly in pursuit of agency or control over their circumstances. Using condoms, requesting the HIV status of partners, assessing the risk of new partners, and trusting partners to be negative to reduce potential of HIV acquisition are prevention practices that were also identified in another study of HLMSM in the U.S. South [3, 46], but otherwise, are not widely noted in the literature. Few participants in this study reported PrEP use and over a third were not aware of PrEP; low PrEP awareness and uptake among HLMSM are associated with stigma, medical mistrust, and *machismo* [40, 45, 47], indicating a topic for further research and intervention.

Social relationships are protective against HIV for HLMSM [48]. A study of HLMSM in San Antonio found that HIV-negative HLMSM were more likely to have a prominent mother-son relationship and a strong sense of family support and acceptance, compared to those with HIV infection [37]; other studies indicate that HLMSM with a higher affinity for *familismo* are more likely to engage in sexual behaviors that mitigate HIV acquisition [49, 50]. Among the HLMSM in our study, more than three-quarters reported having a friend or family member they can trust to talk with about HIV, felt somewhat or very connected to other HLMSM in their community, and felt there was a community of men like them in their city. These relationships allowed men to navigate social environments otherwise perceived as restrictive and HLMSM may need more opportunities for social connectedness and relationships where conversations about HIV and other topics that might be taboo can occur. Rhodes et. al. recommend “safe spaces” for HLMSM to have supportive dialogue [12], which can be prioritized by community organizations serving HLMSM (as part of HIV prevention programming), and in online settings and other venues supporting well-being and health.

Our analysis identified that HLMSM in our study experience prevention failure when they are in environments that encourage disinhibition, especially when drugs or alcohol are used. Previous research among HLMSM regardless of HIV status found that substance abuse may be related to decreasing sexual inhibitions and social connection [38, 51–53]. PrEP can be promoted for HLMSM using substances to navigate sociocultural stressors, even when there is less than optimal uptake and barriers that impact PrEP access, use, and adherence for HLMSM [54]. Our findings related to PrEP are discussed in greater detail elsewhere [47].

Strengths-based approaches have emerged as important constructs in HIV research [19] and LGBTQ health overall [55]; however, public health messaging has prioritized a risk narrative to prevent HIV. When assessed against the backdrop of cultural and socio-political barriers to HIV care, health communication highlighting disparities may have unintended consequences for HLMSM [19, 56]. Given the reports of HIV fear and anxiety among the HLMSM in our study, and that almost all respondents know someone with HIV, HIV messaging can focus on strengths and support prevention behaviors in which MSM are already engaged, such as developing personal HIV prevention strategies based on partner trust and the desire to openly communicate about HIV with peers [27, 57].

There are important caveats and limitations to note in how participants were recruited to the study. First, the purposive sampling design used to ensure HLMSM were recruited from each of the participating cities, and the effort to include young MSM aged < 18 years introduce sampling biases. In addition, MSM were recruited from sites or agencies which conduct targeted, free HIV testing. Generalization of findings should thus be undertaken with caution; findings from this study may not be transferable to other HIV-negative HLMSM, or to other HIV-negative populations in the southern U.S. However, for a qualitative data collection effort, the large sample, and the wide range of ages of participants do provide rich data on the diversity of experience. Likewise, the cross-sectional nature of the study design does not allow us to fully identify the temporal elements for how the respondents’ vulnerability to HIV infection evolves over time. Also, as is typical with face-to-face interviews, social desirability bias may have been a factor in how participants

responded to interview questions. Our analysis is not a comprehensive review of all potential factors that might affect HIV risk; for example, we did not include data on urban versus rural, community-level or societal-level economic, cultural, or political conditions that form the contextual background to the respondents' lives and HIV exposure. Instead, our results relied on personal experiences. The self-reported nature of our data is an important strength because it allowed the respondents to provide clear reasons for how and why they were or were not utilizing HIV prevention strategies. Finally, we acknowledge the age of the data and the potential limitations to interpretation. We believe these findings are still relevant to the literature and intervention development but should be confirmed with more recent data if available.

Implications for Future Research

HIV prevention efforts that support resilience and assets-based approaches, and that build on important priorities for HLMSM, such as assessing partner trust and safety and building supportive relationships and communities, can be utilized in HIV prevention efforts with HLMSM in the U.S. South. National efforts to end the HIV epidemic can address stigma and promote PrEP and condom use for HLMSM via Spanish-language television and radio and other linguistically appropriate venues [11, 26]. Research is needed on how HLMSM in the southern U.S. can effectively communicate their HIV prevention needs to potential partners and prioritize trust, emphasizing resilience and strengths over deficit-based approaches. Further, assessing prevention efforts can provide HLMSM with prevention messages and tools that build on existing strategies, such as adding using PrEP as a factor in assessing partners. Finally, it is important to remember that the HLMSM community is not homogeneous, and as in recent findings from a study of HLMSM in Atlanta regarding HIV care, prevention efforts should not take a one-size-fits-all approach but must reflect the strengths and diversity of HLMSM experiences in the United States [54].

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Data Availability

The data that support the findings of this study are available from the Centers for Disease Control and Prevention, but restrictions apply to the availability of these data, and so are not publicly available. The data are, however, available from the authors upon reasonable request and with the permission of the Centers for Disease Control and Prevention.

References

1. Crepaz N, Mullins MM, Higa D, Gunn JK, Salabarría-Peña Y. A rapid review of disparities in HIV prevention and care outcomes among Hispanic/Latino men who have sex with men in the United States. *AIDS Educ Prev*. 2021;33(4):276–89. 10.1521/aeap.2021.33.4.276. [PubMed: 34370568]
2. Centers for Disease Control and Prevention. HIV Surveillance Report, 2021. 2023;34. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Accessed 12/28/2023.
3. Reif S, Safley D, McAllaster C, Wilson E, Whetten K. State of HIV in the US Deep South. *J Community Health*. 2017;42:844–53. 10.1007/s10900-017-0325-8. [PubMed: 28247067]
4. Sullivan PS, Johnson AS, Pembleton ES, Stephenson R, Justice AC, Althoff KN, Bradley H, Castel AD, Oster AM, Rosenberg ES, Mayer KH. Epidemiology of HIV in the USA: epidemic burden, inequities, contexts, and responses. *The Lancet*. 2021;397(10279):1095–106. 10.1016/s0140-6736(21)00395-0.
5. Johnson AS, Song R, Hall HI. Estimated HIV incidence, prevalence, and undiagnosed infections in US States and Washington, DC, 2010–2014. *JAIDS J Acquir Immune Defic Syndr*. 2017;76(2):116–22. 10.1097/qai.0000000000001495. [PubMed: 28700407]
6. Balsam KF, Molina Y, Beadnell B, Simoni J, Walters K. Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. *Cultur Divers Ethnic Minor Psychol*. 2011;17(2):163–74. 10.1037/a0023244. [PubMed: 21604840]
7. Crenshaw KW. Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine. *Univ Chic Leg Forum*. 1989;1989(8):139–68.
8. Diaz RM, Ayala G, Bein E, Henne J, Marin BV. The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. *Am J Public Health*. 2001;91(6):927–32. 10.2105/ajph.91.6.927. [PubMed: 11392936]
9. McConnell EA, Janulis P, Phillips G 2nd, Truong R, Birkett M. Multiple minority stress and LGBT community resilience among sexual minority men. *Psychol Sex Orientat Gend Divers*. 2018;5(1):1–2. 10.1037/sgd0000265. [PubMed: 29546228]
10. Rueda S, Mitra S, Chen S, Gogolishvili D, Globberman J, Chambers L, Wilson M, Logie CH, Shi Q, Morassaei S, Rourke SB. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ Open*. 2016;6(7):e011453. 10.1136/bmjopen-2016-011453.
11. Trujillo L, Chapin-Bardales J, German EJ, Kanny D, Wejnert C. Trends in sexual risk behaviors among Hispanic/Latino men who have sex with men—19 urban areas, 2011–2017. *Morb Mortal Wkly Rep*. 2019;8(40):873–9. 10.15585/mmwr.mm6840a2.
12. Rhodes SD, Hergenrather KC, Aronson RE, Bloom FR, Felizzola J, Wolfson M, Vissman AT, Alonzo J, Boevig Allen A, Montañó J, McGuire J. Latino men who have sex with men and HIV in the rural south-eastern USA: findings from ethnographic in-depth interviews. *Cult Health Sex*. 2010;12(7):797–812. 10.1080/13691058.2010.492432. [PubMed: 20582764]
13. Murray A, Gaul Z, Sutton MY, Nanin J. “We hide...”: perceptions of HIV risk among black and latino MSM in New York City. *Am J Mens Health*. 2018;12(2):180–8. 10.1177/1557988317742231. [PubMed: 29161954]
14. Solorio R, Forehand M, Simoni J. Attitudes towards and beliefs about HIV testing among Latino immigrant MSM: a comparison of testers and nontesters. *AIDS Res Treat*. 2013;2013:563537. 10.1155/2013/563537. [PubMed: 24455221]
15. Barrow FH, Armstrong MI, Vargo A, Boothroyd RA. Understanding the findings of resilience-related research for fostering the development of African American adolescents. *Child Adolesc Psychiatr Clin N Am*. 2007 Apr 1;16(2):393–413. [PubMed: 17349515]
16. Fergus S, Zimmerman MA. Adolescent resilience: a framework for understanding healthy development in the face of risk. *Annu Rev Public Health*. 2005 Apr;21(26):399–419.
17. Luthar SS, Zigler E. Vulnerability and competence: a review of research on resilience in childhood. *Am J Orthopsychiatry*. 1991Jan;61(1):6–22.
18. Masten AS, Hubbard JJ, Gest SD, Tellegen A, Garmezy N, Ramirez M. Competence in the context of adversity: pathways to resilience and maladaptation from childhood to late adolescence. *Dev Psychopathol*. 1999 Mar;11(1):143–69. [PubMed: 10208360]

19. Herrick AL, Stall R, Goldhammer H, Egan JE, Mayer KH. Resilience as a research framework and as a cornerstone of prevention research for gay and bisexual men: theory and evidence. *AIDS Behav.* 2014;18:1–9. 10.1007/s10461-012-0384-x. [PubMed: 23321946]
20. McNair OS, Gipson JA, Denson D, Thompson DV, Sutton MY, Hickson DA. The associations of resilience and HIV risk behaviors among black gay, bisexual, other men who have sex with men (MSM) in the Deep South: the MARI study. *AIDS Behav.* 2018May;22:1679–87.
21. Meyer IH. Identity, stress, and resilience in lesbians, gay men, and bisexuals of color. *Couns Psychol.* 2010Apr;38(3):442–54.
22. Fauci AS, Redfield RR, Sigounas G, Weahkee MD, Giroir BP. Ending the HIV epidemic: a plan for the United States. *JAMA.* 2019;321(9):844–5. 10.1001/jama.2019.1343. [PubMed: 30730529]
23. Guilamo-Ramos V, Thimm-Kaiser M, Benzekri A, Chacón G, López OR, Scaccabarozzi L, Rios E. The invisible US Hispanic/Latino HIV crisis: addressing gaps in the national response. *Am J Public Health.* 2020;110(1):27–31. 10.2105/AJPH.2019.305309. [PubMed: 31725313]
24. Levison JH, Levinson JK, Alegría M. A critical review and commentary on the challenges in engaging HIV-infected Latinos in the continuum of HIV care. *AIDS Behav.* 2018;22:2500–12. 10.1007/s10461-018-2187-1. [PubMed: 29948334]
25. McCree DH, Walker T, DiNenno E, Hoots B, Valverde E, Ocfemia MC, Heitgerd J, Stallworth J, Ferro B, Santana A, German EJ. A programmatic approach to address increasing HIV diagnoses among hispanic/latino MSM, 2010–2014. *Prev Med.* 2018;114:64–71. 10.1016/j.ypmed.2018.06.007. [PubMed: 29908762]
26. De Santis JP, Gonzalez-Guarda R, Provencio-Vasquez E, Deleon DA. The tangled branches (Las Ramas Enredadas) sexual risk, substance abuse, and intimate partner violence among hispanic men who have sex with men. *J Transcult Nurs.* 2014;25(1):23–32. 10.1177/1043659613504110. [PubMed: 24084703]
27. Denson DJ, Gelaude D, Saul H, Schoua-Glusberg A, Randall LA, Kenward K, Gall E, Hickson D, Schamel J, Frew PM. “To me, everybody is infected”: understanding narratives about HIV risk among HIV-negative Black men who have sex with men in the Deep South. *J Homosex.* 2021;68(6):973–92. 10.1080/00918369.2019.1694338. [PubMed: 31794351]
28. Hickson DA, Truong NL, Smith-Bankhead N, Sturdevant N, Duncan DT, Schnorr J, Gipson JA, Mena LA. Rationale, design and methods of the ecological study of sexual behaviors and HIV/STI among african american men who have sex with men in the Southeastern United States (The MARI Study). *PLoS ONE.* 2015;10(12): e0143823. 10.1371/journal.pone.0143823. [PubMed: 26700018]
29. Bernard RH. *Social research methods: qualitative and quantitative approaches.* 2nd ed. Los Angeles, CA: Sage Publications; 2013.
30. Schreier M *Qualitative content analysis in practice.* Los Angeles, CA: Sage Publications; 2012.
31. Hruschka DJ, Schwartz D, St. John DC, Picone-Decaro E, Jenkins RA, Carey JW. Reliability in coding open-ended data: lessons learned from HIV behavioral research. *Field Methods.* 2004;16(3):307–31. 10.1177/1525822X04266540.
32. Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics.* 1977;33(1):159–74. 10.2307/2529310. [PubMed: 843571]
33. Gwet KL. *Handbook of inter-rater reliability: the definitive guide to measuring the extent of agreement among raters.* LLC: Advanced Analytics; 2014.
34. Bazeley P *Qualitative data analysis: practical strategies.* Los Angeles, CA: Sage; 2013.
35. Bernard HR, Wutich A, Ryan GW. *Analyzing qualitative data: systematic approaches.* Thousand Oaks: SAGE Publications; 2016.
36. Babel RA, Wang P, Alessi EJ, Raymond HF, Chongyi W. Stigma, HIV risk, and access to HIV prevention and treatment services among men who have sex with men (MSM) in the United States: a scoping review. *AIDS Behav.* 2021;25(11):3574–604. 10.1007/s10461-021-03262-4. [PubMed: 33866444]
37. del Rio C *Latinos and HIV care in the southeastern United States: new challenges complicating longstanding problems.* *Clin Infect Dis.* 2011;53(5):488–9. 10.1093/cid/cir440. [PubMed: 21844032]

38. García M, Ramos SR, Aponte-Soto L, Ritchwood TD, Drabble LA. “Family before anyone else”: a qualitative study on family, marginalization, and HIV among Hispanic or Latino/a/x Mexican sexual minority males. *Int J Environ Res Public Health*. 2022;19(15):8899. 10.3390/ijerph19158899. [PubMed: 35897270]
39. Gonzales S, Sommers BD. Intra-ethnic coverage disparities among Latinos and the effects of health reform. *Health Serv Res*. 2018;53(3):1373–86. 10.1111/1475-6773.12733. [PubMed: 28660697]
40. Kimball D, Rivera D, Gonzales M, Blashill AJ. Medical mistrust and the PrEP cascade among Latino sexual minority men. *AIDS Behav*. 2020;24:3456–61. 10.1007/s10461-020-02916-z. [PubMed: 32405726]
41. Martinez O HIV-related stigma as a determinant of health among sexual and gender minority Latinxs. *HIV specialist*. 2019;11(2):14–7. [PubMed: 31396600]
42. Mizuno Y, Borkowf C, Millett GA, Bingham T, Ayala G, Stueve A. Homophobia and racism experienced by Latino men who have sex with men in the United States: correlates of exposure and associations with HIV risk behaviors. *AIDS Behav*. 2012;16:724–35. 10.1007/s10461-011-9967-1. [PubMed: 21630014]
43. Page KR, Martinez O, Nieves-Lugo K, Zea MC, Grieb SD, Yamanis TJ, Spear K, Davis WW. Promoting pre-exposure prophylaxis to prevent HIV infections among sexual and gender minority Hispanics/Latinxs. *AIDS Educ Prev*. 2017;29(5):389–400. 10.1521/aeap.2017.29.5.389. [PubMed: 29068715]
44. Poppen PJ, Reisen CA, Zea MC, Bianchi FT, Echeverry JJ. Predictors of unprotected anal intercourse among HIV-positive Latino gay and bisexual men. *AIDS Behav*. 2004;8:379–89. 10.1007/s10461-004-7322-5. [PubMed: 15690111]
45. Rivera DB, Brady JP, Blashill AJ. Traditional Machismo, Caballerismo, and the pre-exposure prophylaxis (PrEP) cascade among a sample of Latino sexual minority men. *J Sex Res*. 2021;58(1):21–8. 10.1080/00224499.2020.1743961. [PubMed: 32243199]
46. Alonzo J, Mann L, Tanner AE, Sun CJ, Painter TM, Freeman A, et al. Reducing HIV risk among hispanic/latino men who have sex with men: qualitative analysis of behavior change intentions by participants in a small-group intervention. *J AIDS Clin Res*. 2016;7(5). 10.4172/2155-6113.1000572.
47. Gelaude D, Denson D. “Why you putting this drug in your body to fight off something that you don’t have?” Perceptions about PrEP use among Black and Latino men who have sex with men in the US South. *J Homosex*. 2023;70(5):900–16. 10.1080/00918369.2021.2005998. [PubMed: 34851803]
48. Lauby JL, Marks G, Bingham T, Liu KL, Liao A, Stueve A, Millett GA. Having supportive social relationships is associated with reduced risk of unrecognized HIV infection among black and Latino men who have sex with men. *AIDS Behav*. 2012;16:508–15. 10.1007/s10461-011-0002-3. [PubMed: 21805191]
49. Muñoz-Laboy MA. Familism and sexual regulation among bisexual Latino men. *Arch Sex Behav*. 2008;37:773–82. 10.1007/s10508-008-9360-y. [PubMed: 18521735]
50. Pérez A, Santamaria EK, Operario D. A systematic review of behavioral interventions to reduce condomless sex and increase HIV testing for Latino MSM. *J Immigr Minor Health*. 2018;20:1261–76. 10.1007/s10903-017-0682-5. [PubMed: 29247266]
51. Bauermeister JA. It’s all about “connecting” reasons for drug use among Latino gay men living in the San Francisco Bay Area. *J Ethn Subst Abuse*. 2007;6(1):109–29. 10.1300/J233v06n01_07. [PubMed: 17430819]
52. Chard AN, Metheny NS, Sullivan PS, Stephenson R. Social stressors and intoxicated sex among an online sample of men who have sex with men (MSM) drawn from seven countries. *Subst Use Misuse*. 2018;53(1):42–50. 10.1080/10826084.2017.1322985. [PubMed: 28792280]
53. Fernández MI, Jacobs RJ, Warren JC, Sanchez J, Bowen GS. Drug use and Hispanic men who have sex with men in South Florida: implications for intervention development. *AIDS Educ Prev*. 2009;21(Supplement B):45–60. 10.1521/aeap.2009.21.5_supp.45. [PubMed: 19824834]
54. Sarno EL, Swann G, Xavier Hall CD, Newcomb ME, Mustanski B. Minority stress, identity conflict, and HIV-related outcomes among men who have sex with men, transgender women,

and gender nonbinary people of color. *LGBT health*. 2022;9(6):411–7. 10.1089/lgbt.2021.0401. [PubMed: 35594255]

55. Colpitts E, Gahagan J. The utility of resilience as a conceptual framework for understanding and measuring LGBTQ health. *Int J Equity Health*. 2016 Dec;15:1–8. 10.1186/s12939-016-0349-1. [PubMed: 26728322]
56. Peinado S, Treiman K, Uhrig JD, Taylor JC, Stryker JE. Effectively communicating about HIV and other health disparities: findings from a literature review and future directions. *Front Commun*. 2020;5: 539174. 10.3389/fcomm.2020.539174.
57. Dacus JD, Sandfort TG. Perceived HIV risk among Black MSM who maintain HIV-negativity in New York City. *AIDS Behav*. 2020;24(11):3044–55. 10.1007/s10461-020-02852-y. [PubMed: 32240429]

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Table 1
Demographic characteristics of HIV-negative Hispanic/Latino men who have sex with men (HLMsM) in the U.S. South, 2016 (*n* = 51)

Sociodemographic variables	Percent* (<i>n</i>)
Interview conducted in Spanish	31% (16)
Sexual identity	
Gay	69% (35)
Bisexual	24% (12)
Pansexual	2% (1)
Queer	2% (1)
Questioning	2% (1)
Undefined	2% (1)
Interview location	
Atlanta, GA	18% (9)
Baton Rouge, LA	2% (1)
New Orleans, LA	6% (3)
Jackson, MS	2% (1)
Miami, FL	73% (37)
Place of birth	
United States	53% (27)
Cuba	27% (14)
Columbia	6% (3)
Venezuela	6% (3)
Honduras	2% (1)
Puerto Rico	6% (3)
Age (Mean = 33, SD = 15, range = 15–63)	
15–17 years	20% (10)
18–23 years	14% (7)
24–29 years	22% (11)
30–45 years	14% (7)
46 + years	31% (16)
Currently employed	51% (26)
Currently receiving public assistance	33% (17)

Sociodemographic variables	Percent [*] (n)
Stayed on the street, in a shelter, or temporarily in someone's home in the past 12 months	26% (13)
Currently homeless	14% (7)
Educational achievement	
High School/GED or less	47% (24)
Some college/bachelor's degree	45% (23)
Any post-graduate study	8% (4)
Current health insurance status	
Uninsured	35% (18)
Insured	62% (31)
Don't Know	4% (2)
PrEP use	
Yes	6% (3)
No, unaware of PrEP	37% (19)
No, don't need it	24% (12)
No, concerned about side effects	33% (17)
HIV testing frequency ^{**}	
Never been tested	10% (5)
Every 3–6 months	61% (31)
> 12 months	29% (15)
Saw a doctor or nurse in past 12 months	84% (43)
Currently in a relationship	59% (30)
Number of new sex partners in the past 6 months	
0	14% (7)
1–3	4% (2)
4–6	4% (2)
7–10	20% (10)
11 +	59% (30)
Feels there is a community of men like him in the city	88% (45)
Connection to a community of men with sexual attraction to other men of your race in your city?	
Not connected	22% (11)
Somewhat connected	51% (26)

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Sociodemographic variables	Percent [*] (n)
Very connected	16% (8)
Sex-related use of internet in past 6 months	
To get information related to sex, sexuality or health?	59% (30)
To chat with other men with sexual attraction to men?	69% (35)
To find a boyfriend or long-term romantic partner?	33% (17)
To meet guys for casual sex?	43% (22)
To access pornography	73% (37)
For online sex/cybersex?	6% (3)

^{*} Percentage rounded

^{**} Question is "How often have you been tested for HIV?" and may include recent test for eligibility