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Gay Identity and HIV Risk for Black and Latino Men Who Have Sex with Men

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Abstract

Strong gay identity among white men who have sex with men (MSM) has been associated with decreased HIV risk, but data for black and Latino MSM (BLMSM) are inconclusive. We examined gay identity and HIV risk among BLMSM to inform social and structural HIV intervention strategies. BLMSM were administered a computerized survey as part of an HIV research study during 2011–2012 conducted in New York City. We used a brief scale of Gay Identity Questionnaire. After data analysis, Stage I (not fully accepting) and Stage II (fully accepting) gay identity were determined based on participant responses. We used logistic regression to calculate adjusted odds ratios (aOR) and 95% confidence intervals (CI) for the association between gay identity with HIV risk and social determinant factors. Among 111 self-identified BLMSM (median age = 32 years, 68.4% with some college or higher education), 34.2 reported receptive anal sex without condoms in the previous three months. Gay Identity Questionnaire Scale assessment indicated that 22 (19.8%) were Stage I, and 85 (76.6%) were Stage II in this BLMSM sample. Stage II gay identity was more likely seen among BLMSM with high involvement in the gay community (aOR 3.2; CI 1.00, 10.26) and less likely among BLMSM who exchanged sex for food or shelter (aOR 0.15; CI 0.02, 0.98). Fully accepting gay identity may be protective for BLMSM as it relates to transactional sex; these factors warrant further research and consideration as part of HIV prevention strategies.

Keywords

Gay identity; HIV; Black/African American; Men who have sex with men

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Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Conflicts of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

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

Introduction

In the United States (U.S.), men who have sex with men (MSM), including persons who identify as gay and bisexual, account for 67% of all HIV diagnoses (Department of Health and Human Services 2015). Among MSM, black/African American (hereafter referred to as "black") and/or Hispanic/Latino (hereafter referred to as Latino) men who have sex with men (BLMSM) make up 64.1% (37.6% and 26.5%, respectively) of HIV diagnoses, compared with non-Hispanic white MSM who comprise 30.3% of HIV diagnoses (Department of Health and Human Services 2015). In New York City (NYC), MSM account for approximately 74% of all new HIV diagnoses (New York City Department of Health and Mental Hygiene 2015). HIV-related racial/ethnic disparities also persist; black and Latino MSM represent 72.5% (38.6% and 33.9%, respectively) of new HIV diagnoses in NYC compared with 21.3% of whites (New York City Department of Health and Mental Hygiene 2015). Increased HIV risk associated with condomless anal sex contributes to the disproportionate HIV diagnosis rate among MSM in general, including MSM of color (Centers for Disease Control and Prevention 2016).

Gay Identity Formation

Gay identity development can be an important element of psychological well-being for MSM (Garnets 2002). This process can significantly shape social interactions for MSM with other individuals from various communities (Howarth 2001). However, many communities do not accept or embrace same-sex relationships. As a result, gay-related stigma may occur in these communities leaving many MSM feeling socially ostracized (Herek 1984). Consequently, these negative experiences can contribute to psychological distress making gay identity formation challenging for many gay men (Brooks-Gunn and Garber 1999).

Gay identity formation can be particularly difficult for BLMSM because of the potentially challenging process of reconciling their sexual and ethnic identities (Garnets 2002; Vu et al. 2011). Similar to gay identity, ethnic identity is important for self-identification and sense of belonging for BLMSM (Parham and Helms 1985). Ethnic identity is salient particularly for blacks and Latinos living in the United States to help cope with negative social and structural circumstances related racial and ethnic discrimination (Gayles et al. 2016; Hatzenbuehler and Pachankis 2016). However, BLMSM also experience gay-related stigma and related sequelae (e.g., violence, micro aggression) from both within and outside their racial and ethnic group; such circumstances can potentially create personal distress for BLMSM during stages of identity formation (Glock 2001; Han 2008; Jeffries et al. 2013; Mizuno et al. 2015; Nadal et al. 2011; Quinn et al. 2015; Rosario et al. 2006). Therefore, gay identity formation for BLMSM in the United States can be significantly more challenging compared with their white MSM counterparts.

Gay Community Engagement

Engagement with established gay communities can also influence gay identity formation for BLMSM. However, the literature shows that gay community involvement, particularly with communities comprised of mostly white gay men, may be less prevalent for BLMSM (Lewis

et al. 2015). For example, studies show that black MSM are more likely to select sex partners within their own racial group compared to MSMs from other minority racial groups and ethnic groups (Lewis and Wilson 2017; Marks et al. 2009; Wei et al. 2011). In addition, Latino MSM, particularly foreign-born Latino MSM, may not engage with a developed gay scene even though engaging in condomless anal sex is prevalent (Lewis and Wilson 2017; Rhodes et al. 2012). Also, migration-related HIV risk syndemic factors play a role in community engagement, but these have been understudied among MSM of color (Lewis and Wilson 2017). In addition, little is known about the relationship of gay identity formation and gay community involvement among BLMSM.

Gay Identity and HIV Risk

For BLMSM, gay identity formation may have significant implications for HIV risk; but limited existing data are inconclusive. For example, gay-identified MSM were more likely to report higher rates of condom use and taking recent HIV tests compared to non-gay identified MSM (Pathela et al. 2006). However, Hampton et al. (2013) reported that non-gay identified black MSM engaged in more HIV risk behaviors compared with gay identified black MSM in NYC (Hampton et al. 2013). For Latino MSM, gay identity may serve as a protective factor for HIV by acting as a psychological buffer against gay-related social stressors, and thereby result in more condom use, less substance use and less general anxiety (Rosario et al. 2001, 2006; Waldo et al. 2000). In a study comprised of majority white MSM, gay-identified MSM were more likely to have had an HIV test compared to non-gay identified MSM (Rietmeijer et al. 1998).

Due to conflicting data regarding gay identity and HIV risk for BLMSM, we sought to fill a gap by examining gay identity, gay community involvement, HIV risk, and selected social determinants of health among BLMSM living in NYC. Our goal was to inform HIV prevention strategies that may reduce HIV racial and ethnic disparities.

Methods

Data were collected from spring 2011 through summer 2012 as part of a larger study (Project BROTHA) that explored the relationship between interpersonal communication about HIV prevention and HIV testing among MSM who identify themselves as black/African American and/or Latino/Hispanic; and their social networks (ages 18–64 years) in the NYC area (Aholou et al. 2017; Nanin et al. 2009). The study was 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 offered services for gay-identified/same-gender loving men of color in NYC.

A purposive sampling strategy was used to recruit BLMSM. The research team used structured outreach recruitment that combined active and passive strategies online and offline (e.g., banner ads on websites, such as Adam 4 Adam, Manhunt.com; distribution of palm cards with study contact information at community events; and large gay-focused events such as NYC Gay Pride Parade). In addition, the team used respondent-driven sampling (RDS), a network-based recruitment method (Heckathorn 1997). Eligible

participants were men who were: born male, ages 18–64 years, reported sex with a man at least once within the previous 3 months, had no HIV antibody test within the past year, were able to communicate in English, and were able to identify two other MSM from their social network. After signed consent, participants were enrolled and completed an Audio Computer-Assisted Self-Interview (ACASI) survey which obtained demographic information (e.g., age, sexual identity, educational background) and assessed psychosocial and behavioral issues.

We used the Gay Identity Questionnaire (GIQ) (Brady and Busse 1994) as part of the ACASI survey. The GIQ was derived from the Homosexual Identity Formation Model (HIF), which originally identified a six-stage process that an individual experiences during gay identity development (Cass 1979). Later, other studies reported data showing that the HIF six-stage process can be collapsed from six to two stages instead (Stages I and II) (Brady and Busse 1994). Therefore, for this study, data were collected from the men using six-stage Likert responses that were collapsed into two stages [Stage I (not fully accepting) and Stage II (fully accepting)] to describe gay identity for the purposes of data analysis. We examined the association between gay identity with several demographic (age, sexual orientation), social determinant factors (gay community involvement, employment, poverty, insurance, homelessness, incarceration), and HIV risk-related behavioral measures (condomless sex, injection drug use, sex exchange for food, drugs, shelter or money). We used logistic regression (adjusting for age) to calculate adjusted odds ratios (aOR) and 95% confidence intervals (CI) using SAS, version 9.3.

Results

A total of 111 BLMSM participated in the study; 58.6% self-identified as homosexual, gay or queer; 33.3% self-identified as bisexual or other; 46.0% were unemployed; 19.8% had graduated from high-school; 40.5% had some college; 27.9% had a bachelor's degree or higher. Eighty-two percent reported living above the poverty line, 12.6% reported being homeless in the past 3 months, and 72.1% report having health insurance coverage (Table 1). Additionally, the racial and ethnicity composition included 75.7% (n = 84) black/African American, 12.6% (n = 14) Hispanic/Latino, 9.9% (n = 11) identifying with both groups and 1.8% (n = 2) not reporting race or ethnicity (not shown in tables).

GIQ assessment indicated that 76.6% of BLMSM sample were "fully accepting" of their gay identity and 19.8% were "not fully accepting." About 67.6% of participants reported high involvement with the gay community; 46.8% reported having condomless anal insertive sex in the past 3 months; 34.2% had condomless anal receptive sex in the past 3 months; 88.3% reported being negative on most recent HIV test; 7.2% reported exchanging sex for drugs, money, food or shelter, and 2.7% reported injection drug use in the previous 3 months (Table 1).

The regression model is presented in Table 2. We excluded injection drug use and recent HIV test results from the analyses due to low cell sizes. Our bivariate analyses indicated that age, sexual orientation and homelessness during past 3 months were associated with Stage II gay identity, but statistically insignificant in the multivariate model. The multivariate logistic

regression models showed that Stage II gay identity was more likely seen among BLMSM with high involvement in the gay community (aOR 3.2; CI 1.00, 10.26) and less likely among BLMSM who exchanged sex for food or shelter (aOR 0.15; CI 0.02, 0.98).

Discussion

Most BLMSM in our study (80%) were fully accepting of their gay identity. Our analysis revealed a strong link between fully accepting of one's gay identity (Stage II) and high involvement in gay community. This finding is consistent with other studies indicating similar links between affirmative gay identity and having a strong social support system among black MSM (Crawford et al. 2002; Lapinski et al. 2010). Also, our findings are congruent with a study indicating high correlation between gay identity and community involvement among Latino MSM living in New York (Ramirez-Valles and Diaz 2005). Other studies identified social activism and socializing as factors related to gay community involvement among a sample of predominantly white MSM (LeBeau and Jellison 2009). Although social activism information was not part of data collection for this study, it may serve as a mediator between gay identity and gay community involvement and should be examined among BLMSM in future studies.

Our findings regarding gay identity and gay community involvement may be particularly salient for BLMSM due to racial/ethnic psychosocial challenges. Other studies indicate that disclosing sexual identity and engaging in HIV risk reduction behaviors are often inhibited by stigmatizing environments within some black and Latino communities, particularly in the context of homophobia and religiosity (Bogart et al. 2014; Jeffries et al. 2014). These anti-gay intra-group dynamics are further compounded by race- and ethnic-based discrimination that many MSM report encountering outside of their communities (Solorzano et al. 2000). Given the large and diverse black and Latino communities in New York City (United States Census Bureau 2016), our BLMSM participants likely engage with other BLMSM within their and other racially and ethnically diverse communities in NYC (Tieu et al. 2016). This notion is further supported by studies reporting discomfort of BLMSM toward involvement with predominantly white gay communities due to factors such as such sexual objectification (Lewis and Wilson 2017; Teunis 2007). Nevertheless, further exploration of how the dynamics of race and ethnicity influences the nature of BLMSM involvement in various gay and non-gay communities, particularly in the context of gay identity formation.

We also found that fully accepting gay identity was less likely among BLMSM if they exchanged sex for drugs, food, money or shelter. These findings are consistent with other data; an exploratory study revealed that Puerto Rican MSM involved with male sex work refused to be identified as gay or bisexual (Finlinson et al. 2006). In addition, a review of surveillance reports from Latin American countries indicated that MSM who engaged in sex exchange refused to identify themselves as gay or bisexual (Caceres 2002). Caceres (2002) reported that these men rationalized the paradox between their sexual identity and behavior by sexually engaging only in hegemonic male roles (e.g., practicing insertive oral or anal sex). Both of these studies included MSM who reported living in homophobic and stigmatizing environments, which contributed to ostracized gay subcultures and secretive sexual relationships and networks (Caceres 2002; Finlinson et al. 2006). Our study suggests

that some BLMSM living in NYC are perhaps living in more gay-affirming communities and are more likely to be fully accepting of their gay identity.

Limitations

This study has some limitations. First, participants were recruited in New York City, therefore our findings cannot be generalized to other geographic areas (i.e., rural settings). Second, possible recruitment biases may exist since some of the outreach efforts were focused in locations and events where BLMSM may be more accepting of their gay identity (e.g., Gay Pride events). Third, the measures used in our analyses had not previously been normed with BLMSM; additional psychometric studies are warranted to ensure optimally accurate measures for BLMSM. Lastly, this was a small, convenience sample; larger, adequately powered samples of BLMSM will allow for more rigorous analyses. It is possible that the small sample size did not permit sufficient statistical power to detect associations between gay identity and other risk factors and measures we studied.

Conclusions

This study suggests that fully accepting gay identity is associated with less risky behaviors and higher involvement in gay communities for BLMSM. Programs that strengthen and support gay identity should be evaluated for their effectiveness as an additional HIV prevention tool. Such programs could potentially help serve as a protective factor against social stigma and other factors that contribute to increased HIV risk behaviors and could be particularly useful for MSM of color due to compounded sexual and racial minority stigma (Nadal et al. 2011; Solorzano et al. 2000; Sue et al. 2007). Additional studies with larger sample of BLMSM are needed in both urban and rural areas to inform HIV prevention strategies for this disproportionately affected population. Also, more program development is essential to reduce potential HIV risks related to transactional sex for BLMSM. Researchers and service providers should consider that gay identity and related experiences can be very different for BLMSM compared with white MSM and other MSM. Violence, stigma, discrimination, and other negative experiences throughout one’s life can negatively affect sexual identity development and experiences, particularly for BLMSM. Creating avenues to help BLMSM develop better psychosocial and behavioral tools to live and love in healthier contexts is essential for HIV prevention.

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References

Aholou T, Nanin J, Drumhiller K, & Sutton M (2017). Missed opportunities for HIV prevention communications during sexual activity for Black men who have sex with men. AIDS Patient Care and STDs, 31, 33–40. [PubMed: 27893276]

Bogart L, Derose K, Kanouse D, Grifin B, Haas A, & Williams M (2014). Correlates of HIV testing among African American and Latino church congregants: The role of HIV stigmatizing attitudes and discussions about HIV. Journal of Urban Health: Bulletin of the New York Academy of Medicine, 92, 93–107.

Brady S, & Busse W (1994). The gay identity questionnaire: A brief measure of homosexual identity formation. Journal of Homosexuality, 26, 1–22. [PubMed: 8006415]

Brooks-Gunn J, & Garber J (1999). What's sex got to do with it? The development of sexual identities during adolescence Self, social identity and physical health (pp. 155–182). Oxford: Oxford University Press.

Caceres C (2002). HIV among gay and other men who have sex with men in Latin America and Caribbean: A hidden epidemic? AIDS, 16, S23–S33. [PubMed: 12685922]

Cass V (1979). Homosexual identity formation: A theoretical model. Journal of Homosexuality, 4, 219–235. [PubMed: 264126]

Centers for Disease Control and Prevention (Producer). (2016). HIV transmission. HIV/AIDS. Retrieved from http://www.cdc.gov/hiv/basics/transmission.html.

Crawford I, Allison K, Zamboni B, & Soto T (2002). The influence of dual-identity development on the psychosocial functioning of African-American gay and bisexual men. Journal of Sex Research, 39, 179–189. [PubMed: 12476265]

Department of Health and Human Services. (2015). HIV surveillance report 2014. Retrieved from Atlanta, GA.

Finlinson H, Colon H, Robles R, & Soto M (2006). Sexual identity formation and AIDS prevention: An exploratory study of non-gay identified Puerto Rican MSM from working class neighborhoods. AIDS and Behavior, 10, 531–539. [PubMed: 16736111]

Garnets L (2002). Sexual orientations in perspective. Cultural Diversity and Ethnic Minority Psychology, 8, 115–129. [PubMed: 11987589]

Gayles T, Kuhns L, Kwon S, Mustanski B, & Garofalo R (2016). Socioeconomic disconnection as a risk factor for increased HIV infection in young men who have sex with men. LGBT Health, 3, 219–224. [PubMed: 27002852]

Glock T (2001). Asian-Pacific Islander issues: Identity integration and pride. Berkeley, CA: Celestial Art.

Hampton M, Halkitis P, Storholm E, Kupprat S, Siconolfi D, Jones D, et al. (2013). Sexual risk taking in relation to sexual identification, age, and education in a diverse sample of African American men who have sex with men (MSM) in New York City. AIDS and Behavior, 17, 931–938. [PubMed: 22298339]

Han C (2008). A qualitative exploration of the relatinship between racism and unsafe sex among Asian Pacific Islander gay men. Archives of Sexual Behavior, 37, 827–837. [PubMed: 18286364]

Hatzenbuehler M, & Pachankis J (2016). Stigma and minority stress as social determinants of health among lesbian, gay, bisexual, and transgender youth: Research evidence and clinical implications. Pediatric Clinics of North America, 63, 985–997. [PubMed: 27865340]

Heckathorn D (1997). Respondent-driven sampling: A new approach to the study of hidden populations. Social Problems, 44, 174–199.

Herek G (1984). Beyond "homophobia": A social psycholigical perspective on attitudes toward lesbians and gay men. Journal of Homosexuality, 10, 1–21.

Howarth C (2001). Toward a social psychology of community: A social representations perspective. Journal for the Theory of Social Behaviour, 31, 223–238.

Jeffries W, Marks G, Lauby J, Murrill C, & Millett G (2013). Homophobia is associated with sexual behavior that increases risk of acquiring and transmitting HIV infection among Black men who have sex with men. AIDS and Behavior, 17, 1442–1453. [PubMed: 22569942]

Jeffries W, Okeke J, Gelaude D, Torrone E, Gasiorowicz M, Oster A, et al. (2014). An exploration of religion and spirituality among young, HIV-infected gay and bisexual men in the USA. Culture, Health and Sexuality, 16, 1070–1083.

Lapinski M, Braz M, & Maloney E (2010). The down low, social stigma, and risky sexual behaviors: Insights from African-American men who have sex with men. Journal of Homosexuality, 57, 610–633. [PubMed: 20455133]

LeBeau R, & Jellison W (2009). Why get involved? Exploring gay and bisexual men's experience of the gay community. Journal of Homosexuality, 56, 56–76. [PubMed: 19197643]

Lewis N, Bauer G, Coleman T, Blot S, Pugh D, Fraser M, et al. (2015). Community cleavages: Gay and bisexual men's perceptions of gay and mainstream community acceptance in the post-AIDS, post-rights era. Journal of Homosexuality, 62, 1201–1227. [PubMed: 26011048]

Lewis N, & Wilson K (2017). HIV risk behaviours among immigrant and ethinic minority gay and bisexual men in North Ameria and Europe: A systematic review. Social Science and Medicine, 179, 115–128. [PubMed: 28260636]

Marks G, Millett G, Bingham T, Bond L, Lauby J, Liau A, et al. (2009). Understanding differences in HIV sexual transmission among Latino and Black men who have sex with men: The Brothers y Hermanos study. AIDS and Behavior, 13, 682–690. [PubMed: 18752064]

Mizuno Y, Borkowf C, Ayala G, Carballo-Diéguez A, & Millet G (2015). Correlates of sexual risk for HIV among US-born and foreign-born Latino men who have sex with men (MSM): An analysis from the Brothers y Hermanos study. Journal of Immigrant Minority Health, 17, 47–55. [PubMed: 23949695]

Nadal K, Issa M, Leon J, Meterko V, Wideman M, & Wong Y (2011). Sexual orientation microaggressions: "Death by a thousand cuts" for lesbian, gay, and bisexual youth. Journal of LGBT Youth, 8, 234–259.

Nanin J, Osubu T, Walker J, Powell B, Powell D, & Parsons J (2009). "HIV is still real": Perceptions of HIV testing and HIV prevention among black men who have sex with men in New York City. American Journal of Men's Health, 3, 150–164.

New York City Department of Health and Mental Hygiene. (2015). HIV surveillance annual report, 2014. Retrieved from New York, NY.

Parham T, & Helms J (1985). The influence of black student's racial identity attitude's on preference for counselor's race. Journal of Counseling Psychology, 28, 250–257.

Pathela P, Hajat A, Schillinger J, Blank S, Sell R, & Mostashari F (2006). Discordance between sexual behavior and self-reported sexual identity: A population-based survey of New York City men. Annals of Internal Medicine, 145, 416–425. [PubMed: 16983129]

Quinn K, Dickson-Gomez J, DiFranceisco W, Kelly J, St. Lawrence J, Amirkhanian Y., et al. (2015). Correlates of internalized homonegativity among black men who have sex with men. AIDS Education and Prevention, 27, 212–226. [PubMed: 26010313]

Ramirez-Valles J, & Diaz R (2005). Public health, race, and the AIDS movement: The profile and consequences of Latino gay men's community involvement Processes of community change and social action (pp. 51–66). Mahwah, NJ: Lawrence Erlbaum Associates.

Rhodes S, McCoy T, Hergenrather K, Vissman A, Wolfson M, Alonzo J, et al. (2012). Prevelence estiamtes of health risk behaviors of immigrant Latino men who have sex with men. Journal of Rural Health, 28, 73–83. [PubMed: 22236317]

Rietmeijer C, Wolitski R, Fishbein M, Corby N, & Cohn D (1998). Sex hustling, injecton drug use, and non-gay identification by men who have sex with men. Sexually Transmitted Diseases, 25, 353–360. [PubMed: 9713915]

Rosario M, Hunter J, Maguen S, Gwadz M, & Smith R (2001). The coming-out process and its adaptational and health-related associations among gay, lesbian, and bisexual youths: Stipulation and exploration of a model. American Journal of Community Psychology, 29, 133–160. [PubMed: 11439825]

Rosario M, Schrimshaw E, & Hunter J (2006). A model of sexual risk behaviors among young gay and bisexual men: Longitudinal assoications of mental health, substance abuse, sexual abuse, and the coming-out process. AIDS Education and Prevention, 18, 444–460. [PubMed: 17067255]

Solorzano D, Ceja M, & Yosso T (2000). Critical race theroy, racial microaggressions, and campus racial climate: The experiences of African American college students. The Journal of Negro Education, 69, 60–73.

Sue D, Capodilupo C, Torino G, Bucceri J, Holder A, Nadal K, et al. (2007). Racial microaggressions in everyday life: Implications for clincial practice. American Psychologist, 62, 271–286. [PubMed: 17516773]

Teunis N (2007). Sexual objectification and the construction of whiteness in the gay male community. Culture, Health and Sexuality, 9, 263–275.

Tieu H, Nandi V, Hoover D, Lucy D, Stewart K, Frye V, et al. (2016). Do sexual networks of men who have sex with men in New York City differ by race/ethnicity? AIDS Patient Care and STDs, 30, 39–47. [PubMed: 26745143]

United States Census Bureau. (2016). Quick facts: New York City, New York. https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork/PST045216.

Vu L, Kyung-Hee C, & Do T (2011). Correlates of sexual, ethnic, and dual identity: A study of young Asian and Pacific Islander men who have sex with men. AIDS Education and Prevention, 23, 423–436. [PubMed: 22010806]

Waldo C, McFarland W, Katz M, MacDellar D, & Valleroy L (2000). Very young gay and bisexual men are at risk for HIV infection: The San Franciso young men's survey II. Journal of Acquired Immunodeficiency Syndrome, 24, 168–174.

Wei C, Raymond H, Guadamuz T, Stall R, Colfax G, Snowden J, et al. (2011). Racial/ethnic differences in seroadaptive and serodisclosure behaviors among men who have sex with men. AIDS and Behavior, 15, 22–29. [PubMed: 20217468]

Table 1

Demographic characteristics of Black and Latino MSM, NYC, Project BROTHA, 2011–2012 (n = 111)

Characteristic	N (%)
Age (years)	
18–29	43 (38.7)
30–40	28 (25.2)
≥ 41	34 (30.6)
Missing	6 (5.4)
Sexual orientation	
Homosexual, gay, or queer	70 (63.1)
Bisexual and everything else	39 (35.1)
Missing	2 (1.8)
Highest level of education completed	
< Grade 12	13 (11.7)
Grade 12 or GED	22 (19.8)
Some college, associate's/technical degree	45 (40.5)
≥ Bachelor's degree	31 (27.9)
Current employment status	
Employed full-time	18 (16.2)
Employed part-time	40 (36.0)
Unemployed	51 (46.0)
Missing	2 (1.8)
Living below poverty level	
Yes	20 (18.0)
No	91 (82.0)
Health insurance coverage	
Yes	80 (72.1)
No	29 (26.1)
Missing	2 (1.8)
Homeless in past 3 months	
Yes	14 (12.6)
No	95 (85.6)
Missing	2 (1.8)
Gay identity and involvement	
Homosexual identity	
Stage I	22 (19.8)
Stage II	85 (76.6)
Missing	4 (3.6)
Involve. w/gay community scale	
Low	32 (28.8)
High	75 (67.6)
Missing	4 (3.6)

Characteristic	N (%)
Condomless sex in the past 3 months	
Vaginal	
Yes	10 (9.0)
No	101 (91.0)
Anal insertive	
Yes	52 (46.8)
No	59 (53.2)
Anal receptive	
Yes	38 (34.2)
No	73 (65.8)
Exchange sex-food/drugs/shelter/money	
Yes	8 (7.2)
No	101 (91.0)
Missing	2 (1.8)
Inject drugs in past 3 months	
Yes	3 (2.7)
No	108 (97.3)
Result of most recent HIV test	
Negative	98 (88.3)
Did not get results/unk	3 (2.7)
Missing	10 (9.0)

GED general equivalency degree (or degree), *MSM* men who have sex with men, *NYC* New York City

Table 2

Regression model for fully accepting gay identity, Black and Latino MSM in New York City, Project BROTHA, 2011–2012 (n = 111)

Characteristic	Stage I (not fully accepting)	Stage II (fully accepting)	OR (95% CI)	*p* value	aOR	*p* value
Age (years)						
18–29	3	40	Referent		Referent	
30–40	8	20	0.19 (0.05, 0.79)	0.02	0.26 (0.05, 1.24)	0.30
≥ 41	9	23	0.19 (0.05, 0.78)	0.02	0.24 (0.06, 1.10)	0.22
Sexual orientation						
Gay/homosexual/queer	2	67	Referent			
Bisexual and others	20	18	0.03 (0.01, 0.13)	< 0.0001		
Highest education completed						
< Grade 12	4	9	Referent			
Grade 12 or GED	6	16	1.19 (0.26, 5.34)	0.83		
Assoc./some college	7	37	2.35 (0.56, 9.80)	0.24		
Bachelor's degree or more	5	23	2.04 (0.45, 9.39)	0.36		
Current employment status						
Employed fulltime	3	15	Referent			
Employed part-time	5	34	1.36 (0.29, 6.44)	0.70		
Unemployed	14	36	0.51 (0.13, 2.05)	0.35		
Living below poverty level						
Yes	17	71	Referent			
No	5	14	1.49 (0.47, 4.71)	0.50		
Health insurance coverage						
Yes	15	63	1.34 (0.48, 3.71)	0.58		
No	7	22	Referent			
Homeless in past 3 months						
Yes	7	7	0.19 (0.06, 0.63)	0.01	0.33 (0.07, 1.66)	0.18
No	15	78	Referent		Referent	
Involve. w/gay community scale						
Low	13	19	Referent		Referent	
High	9	66	5.02 (1.86, 13.52)	< 0.01	3.20 (1.00, 10.26)	0.05
Condomless sex (past 3 months)						
Vaginal						
Yes	5	5	0.21 (0.06, 0.82)	0.02		
No	17	80	Referent			
Anal insertive						
Yes	9	42	1.41 (0.55, 3.65)	0.48		
No	13	43	Referent			
Anal receptive						
Yes	6	32	1.61 (0.57, 4.53)	0.37		
No	16	53	Referent			

Characteristic	Stage I (not fully accepting)	Stage II (fully accepting)	OR (95% CI)	*p* value	aOR	*p* value
Exchange sex-food/drugs/shelter						
Yes	5	3	0.12 (0.03, 0.57)	0.01	0.15 (0.02, 0.98)	0.05
No	17	82	Referent		Referent	
Inject drugs in past 3 months						
Yes	1	2	NA			
No	21	83				
Result of most recent HIV test						
Negative	20	77	NA			
Did not get results/unk	1	2				

Subtotals exclude missing cases in outcome measure

GED general equivalency degree (or degree), *MSM* men who have sex with men, *NYC* New York City, *OR odds ratio, aOR* adjusted odds ratio, *NA* not applicable for analyses due to cell sizes ≤ 2