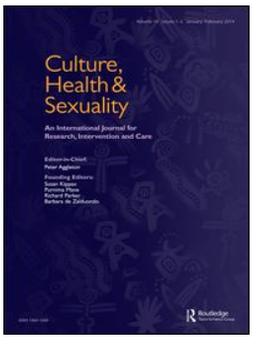

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The role of patient–provider sexual health communication in understanding the uptake of HIV prevention services among Black men who have sex with men

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ABSTRACT

We examined factors that may be associated with whether Black men who have sex with men a) disclose their sexual orientation to healthcare providers, and b) discuss their sexual health with healthcare providers to inform interventions to improve HIV prevention efforts and reduce HIV incidence rates among Black men who have sex with men. During 2011–2012, we conducted semi-structured individual in-depth interviews with Black men who have sex with men in New York City. Interviews were audio recorded. We examined transcribed responses for main themes using a qualitative exploratory approach followed by computer-assisted thematic analyses. Twenty-nine men participated. The median age was 25.3 years; 41% ($n = 12$) earned an annual income of < US$10,000; 72% ($n = 21$) had a college degree; 86% ($n = 25$) reported being single; 69% ($n = 20$) self-identified as gay or homosexual. We identified three main themes affecting whether the men discussed their sexual orientation and sexual health with healthcare providers: 1) comfort discussing sexual health needs; 2) health literacy; and 3) trust. Identifying strategies for improved comfort, health literacy and trust between Black men who have sex with men and healthcare providers may be an important strategy for increasing sexual health patient–provider communications, increasing opportunities for HIV prevention including testing and reducing HIV-related health disparities.

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HIV; Black men who have sex with men; health provider; communication; healthcare; USA

Introduction

Despite representing an estimated 2% of the US population (Purcell et al. 2012), men who have sex with men accounted for 67% of estimated new HIV infections in 2014 (Centers for Disease Control and Prevention 2015). Black/African-American men who have sex with men (hereafter Black men who have sex with men) are at particularly high risk for HIV compared with other men who have sex with men. In 2014, Black men who have sex with men accounted for the highest number and percentage of diagnoses of HIV infection among men who have

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sex with men with 11,201 (38%) cases compared with 9008 (31%) for white men who have sex with men and 7552 (26%) for Hispanic/Latino men who have sex with men (Centers for Disease Control and Prevention 2015). Moreover, Black men who have sex with men are more likely to be unaware of their HIV status than their white counterparts, further exacerbating these racial disparities (MacKellar et al. 2005; Millett et al. 2006).

Persons who are unaware of their HIV serostatus are more likely to unknowingly transmit HIV to others (Marks, Crepaz, and Janssen 2006). In 2012, approximately 15% of men living with HIV had undiagnosed infection and analyses show that young men (ages 15–39 years) received an HIV test at only 1% of 66,905,523 healthcare visits during 2009–2012 (Ham et al. 2016). Increasing rates of HIV testing in men who have sex with men for early detection, treatment and decreased ongoing transmission is vital. However, HIV testing rates remain suboptimal among men who have sex with men (Centers for Disease Control and Prevention 2016), and improvements in testing are needed to reach national HIV prevention goals (2015) of increasing the percentage of people living with HIV who know their serostatus to at least 90% by the year 2020.

Current US Centers for Disease Control and Prevention and US Preventive Task Force guidance recommends HIV screening for all adults and young people, age ranges 13–65 years, at least once during healthcare visits (Branson et al. 2006; US Preventive Task Force 2013). In addition, data suggest that sexually active men who have sex with men may benefit from more frequent (every three to six months) HIV and sexually transmitted infection screenings (Workowski and Bolan 2015). Data show that persons who discuss sexual health with their healthcare providers are more likely to test for HIV during a clinical visit (Smith et al. 2010). One potential approach for increasing HIV testing in Black men who have sex with men is to improve men's communication about sexual health with their healthcare providers.

Improving men's communication with healthcare providers about sexual health may not only facilitate increased rates of HIV testing, but can also be used as an entry point for HIV prevention care among this population. If men are able to discuss sexual health with their providers, they may receive more comprehensive care which may include sexual health counselling, and routine sexually transmitted infection testing and treatment. Furthermore, for those at risk for acquiring HIV, clear and honest communication about sexual identity and practices would allow a healthcare provider to prescribe pre-exposure prophylaxis for their patients. Lastly, sexual health communication is vital for those who are living with HIV but unaware of their status in order for them to receive testing and subsequent linkage to care.

Previous studies on sexual health communication, including sexual orientation and sexual behaviours, among Black men who have sex with men and their healthcare providers have noted that barriers to such disclosure include perceived stigma and discrimination, lack of trust and inadequate access to culturally competent services and providers (Levy et al. 2014; Malebranche et al. 2004). Providers' perceived acceptance of their patients' sexual identity has been cited as a facilitator of sexual health communication (Mimiaga et al. 2007). While both quantitative and qualitative studies have attempted to elucidate how to improve sexual health communication among Black men who have sex with men and their healthcare providers (Levy et al. 2014; Malebranche et al. 2004; Mimiaga et al. 2007), the aim of the current study was to gain further insight into the factors that may be associated with whether Black men who have sex with men a) disclose their sexual orientation to healthcare providers, and b) discuss their sexual health with healthcare providers. This information may inform future efforts to improve HIV prevention and reduce HIV incidence among Black men who have sex with men.

Methods

This study reported here is part of a larger investigation, the Brothers Connect Study, which used both quantitative and qualitative data to examine the contextual risk and protective factors linked to HIV risk for Black men who have sex with men in the New York City area (Boone, Cook, and Wilson 2016). Data collection included a self-administered cross-sectional survey, which included validated scales on internalised homophobia, HIV-related stigma and psychological distress, an 8-week longitudinal sex-diary survey, and an in-depth interview (Boone, Cook, and Wilson 2016).

During 2011–2012, researchers recruited Black men who have sex with men, ages 18–30 years, from the New York City area. Men were recruited using various resources, including the local media, websites, flyers posted at community-based organisations and snowball sampling. We also targeted youth-oriented venues (including gay-friendly social spaces, coffee shops and lounges/bars) and websites for recruitment. To be eligible for the study, participants had to be of male sex at birth; identify as a man; identify as Black, African-American, Black Latino, Black Caribbean/West Indian or mixed-race Black/African-American; have a confirmed age of between 18 and 30 years; have engaged in oral or anal sex with another man in the last two months; and have access to a private, regularly checked email account. After providing signed informed consent, participants completed a cross-sectional survey, using a computer-assisted self-interviewing method in a private area at the study site location (Boone, Cook, and Wilson 2016). A sub-sample of those completing the survey participated in an 8-week structured sex diary. Finally, a sub-sample of those who completed the survey and all eight weeks of the sex diary was invited to participate in an individual in-depth interview. We enrolled those who accepted the invitation until we reached our target goal of 30 participants for in-depth interviews. We anticipated that data saturation would be reached by interviewing 30 participants (Guest, Bunce, and Johnson 2006; Marshall et al. 2013). Due to scheduling conflicts, one participant was unable to complete his interview. Although 30 participants were not able to be interviewed, we did reach data saturation. In this paper, we report on the data from the in-depth interviews.

Participants were administered 60–90-minute semi-structured in-depth interviews by trained, Masters-level research staff members. Interviews were audio recorded. Table 1 contains a sample of questions asked during the in-depth interviews. Participants were compensated US$40 for their time at the end of the interviews. The Columbia University and the US Centers for Disease Control and Prevention Institutional Review Boards approved the study.

All interviews were professionally transcribed. The research team then reviewed the transcriptions for accuracy and made edits as necessary. The first author and principal investigator

Table 1. Sample in-depth interview questions (Barriers and Facilitators to HIV Prevention, Testing and Treatment), Brothers Connect Study, New York, 2011–2012.

1.What are your perceptions of doctors and healthcare providers?
• What are your barriers/facilitators of trying to find a doctor? (For example, health insurance, location, having a provider that you feel you can talk to.)
• What types of support would you consider important for you to go to the doctor?
• Are you currently receiving any medical treatment or medication?
• Is it stressful to go to the doctor? Do you find it easier to just ignore some things and hope they go away on their own?
• Do you talk to your medical provider about sex?• How easy was that conversation?

read each transcript and conducted the coding independently. The analysts then compared their code lists, discussed discrepancies and created a preliminary content codebook. Several read throughs of the transcripts and extensive reviews and revisions of codes were undertaken through monthly meetings until a mutually agreed upon codebook was developed (Lincoln and Guba 1985; Shenton 2004). Final codes were then entered into NVivo (version 10) for analysis. To ensure coding consistency, analysts independently coded three transcripts and met to discuss any discrepancies until a consensus was reached. Text segments were recoded as necessary. Each analyst (AR and PW) then coded 13 of the remaining 26 transcripts. Salient and co-occurring concepts were identified and organised into thematic categories. Audit trails with memos to record the interpretation of the codes and data were kept by study team members engaged in the analysis (Shenton 2004).

Results

Twenty-nine individual in-depth interviews were conducted: median age = 25.3 years; 41% (n = 12) of men earned a yearly income of <US$10,000; 72% ($n$ = 21) of men had a college degree, including a graduate degree; 86% (n = 25) of men reported being single; and 69% (n = 20) self-identified as gay or homosexual. In addition, 79% (n = 23) self-reported being HIV-negative; and 75% (n = 21) reported having had an HIV test within the previous six months. Detailed demographic data can be found in Table 2.

Three themes emerged based on responses of participants' perceptions to healthcare providers and are discussed in detail below: 1) comfort discussing sexual health needs; 2) health literacy; and 3) trust in provider competence and confidentiality. Themes did not differ based on the HIV status of participants.

Names reported with quotes are pseudonyms to protect confidentiality.

Comfort discussing sexual health needs

Participants with healthcare providers who made sexual health a regular part of care reported talking to their providers about sexual health needs and were more comfortable doing so. One participant said:

> I feel comfortable with [my physician]. We have established a rapport where I do feel comfortable talking to him about pretty much everything. If I have an issue, there's something new on my body, or something I need to talk to him about, something's going wrong, I can tell him. We have that kind of relationship. He's earned that trust from me and I don't feel judged by him, which I like. (Mason, age 29)

Participants also stated that physicians may sometimes proactively ask questions about sexual health, rather than wait for patients to bring these discussions up themselves. One interview participant revealed how this technique helped him feel more at ease discussing sexual behaviour with his physician:

> I think the initial time I went to him, I was kind of like hesitant. I was just, 'Ah, okay.' 'Cause he asked me all the questions, and I was just like, 'Ah, yeah, okay,' and I felt kind of weird saying that I was gay, but after that it was good, so we talk about everything. Like we joke around too, like 'Yeah, wrap it up.' (James, age 25)

Another participant commented:

Table 2. Demographic characteristics of interview participants, Brothers Connect Study, New York, 2011–2012 ($n = 29$).

	N (%)
Median age (years)	25.3 [IQR: 6.34]
Race	
African-American/Black	18 (62.1)
Black Hispanic/Latino	6 (20.7)
Afro-Caribbean/West Indian	2 (6.9)
Mixed race	3 (10.3)
Education	
High School Diploma/GED	1 (3.5)
Some college	7 (24.1)
College degree	14 (48.3)
Graduate degree	7 (24.1)
Income	
US$0–10,000	12 (41.4)
US$11–20,000	4 (13.8)
US$21–30,000	7 (24.1)
US$31–40,000	2 (6.9)
≥ US$41,000	4 (13.8)
Employment ($n = 27$)	
Working	11 (40.7)
Student	5 (18.5)
Unemployed	9 (33.3)
Disability	2 (7.4)
Health insurance	
Private	5 (17.2)
Medicaid	11 (37.9)
Other insurance	2 (6.9)
Don't have health insurance	9 (31.0)
Don't know if have health insurance	2 (6.9)
Relationship status	
Married	1 (3.5)
Have a boyfriend/girlfriend	3 (10.3)
Single	25 (86.2)
Sexual orientation	
Gay/Homosexual	20 (69.0)
Bisexual	9 (31.0)
Ever tested for HIV	
Yes	28 (96.6)
No	1 (3.5)
Last HIV test ($n = 28$)	
In the last 6 months	21 (75.0)
In the last year	4 (14.3)
1–3 years ago	1 (3.6)
More than 3 years ago	2 (7.1)
HIV status – self reported	
HIV-negative	23 (79.3)
HIV-positive	6 (20.7)
Incarcerated (ever)	
Yes	7 (24.1)
No	22 (75.9)

Definitions: GED = graduate equivalency diploma; IQR = interquartile range.

> Well, [my last provider] didn't ask, one [question]. [My current provider] always asks, 'So how's the sex life?' And I'm like, 'It's boring.' And we laugh about it. I'm like, 'No, really. It's fine.' And so, it's like give or take. It depends on the provider, for sure. (Mike, age 22)

Finally, men felt it was important for healthcare providers to avoid making assumptions about the sexuality of their patients. Providers should use neutral questions and language (e.g. 'Do you have a male or female partner?') rather than assuming homosexuality. One

interview participant contrasted the ways in which two different providers asked him about his sexual orientation and the implication of these differences:

> Interviewee: [One woman] was like 'Oh, you have sex with men, right?' The [other provider] was like, 'Oh, I don't want to be rude, but I just want to know, do you have sex with men, sex with women, sex with both? Sex with transgender?' And, I was like, 'I have sex with men.'
>
> Interviewer: Okay, but, how easy or difficult was that conversation [with the second provider]?
>
> Interviewee: I mean, it was fine. It was better than the [first] doctor. (Aiden, age 25)

Health literacy

Health literacy played a dual role in influencing the discussion of sexual health between Black men who have sex with men and their providers. For this analysis, we defined health literacy as 'the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make an appropriate health decision' (Ratzan et al. 2000, vi). For some study participants, perceived health literacy increased comfort discussing sexual health. When asked how easy it was to talk to his doctor about sex, Tristan (age 27) said:

> It's pretty easy. I guess 'cause I work in the field, I'm kind of open about everything and then I just talk.

Conversely, for a few participants, high perceived sexual health literacy appeared to serve as a barrier to discussing sexual identity and practices with their providers. When asked whether he discussed sexual health with his healthcare provider, Evan (age 30) said 'No, I know very much about sex'. Another participant specifically described why he chose to use technology to answer his sexual health questions rather than talking to his doctor:

> Interviewee: I don't really [talk to my doctor]. I guess I read online and – but I don't really – there are people that I could have conversations with about that, but, for the most part, I just do my own reading.
>
> Interviewer: Why?
>
> Interviewee: 'Cause I guess the only time it comes up is if I have a specific question about something, like if I wanna know how to do something better, or if something is gonna be risky for my health, then I'll look it up. (Elijah, age 27)

Similarly, a participant discussed STI testing options during sexual health conversations as follows:

> Usually, I go with everything I want done. It's kind of weird 'cause I'm a medical student. Like I know what I need to get. One time he did offer me – it wasn't sexual health – it was like an oral glucose test or something, 'cause I told him my mom and dad became diabetic recently. He's like, 'We need to get you tested.' So he's very good about being proactive with that stuff. Sexual health-wise, I think I'm usually on top of my stuff and I know what I want. (Mike, age 22)

Trust

Finally, trust played a dual role in sexual health communication between study participants and their providers. Trust in the confidentiality of visits and in provider competence

influenced participants' willingness to discuss sexual health. Participants who trusted that their provider would keep their conversations private were more likely to discuss sexual health concerns. One participant described a case where going to an indiscreet provider caused him to restrict what he shared with her:

> I really do not talk to [my doctor] about [sexual health] because she's not accepting. She would yap off at the mouth. I've been in the hospital before 'cause me and my roommate goes to that same one and when he would tell her something, she would go tell everybody in the office. And I just got embarrassed, so I would never talk to her about it. (Josh, age 20)

Additionally, participants who trusted in the professional competence of their provider were more likely to discuss their sexual health. When asked if it was difficult to talk to his provider about sex, one interview participant described why trust in his doctor's abilities made him more willing to talk about sexual health:

> No, because that's your doctor. Doctors know about everything about sex and this and that. So, the doctor is the one person you should not be ashamed to talk to because he or she is the one to help you out. They know about everything about diseases, and this and this. You can't fool your doctor. You're fooling yourself. You wanna go out there get yourself some help. (Tariq, age 34)

Discussion

Overall, our findings suggest that healthcare providers can promote discussion of sexual orientation and behaviour with their Black men who have sex with men patients by creating an environment which makes the men feel comfortable discussing their sexual health needs, which improves their overall knowledge of sexual health, and which makes them feel that the information they share will be kept confidential.

This article based on recent in-depth interviews with Black men who have sex with men provides new context in the era of more effective HIV treatments (previous similar data with Black men who have sex with men were collected more than 10 years ago) (Malebranche et al. 2004; Mimiaga et al. 2007). For Black gay men and other men who have sex with men, those at risk for HIV and those who are HIV-positive, understanding factors which can facilitate engagement and conversations with healthcare providers is vital. Study findings also add to the literature on communication by informing future interventions to encourage sexual health communication in clinical settings.

By proactively asking questions about sexuality in a non-judgemental way, healthcare providers are able to ease their Black men who have sex with men patients' anxiety about disclosing their sexual identity and behaviour. This finding is consistent with other studies (Coker, Austin, and Schuster 2010; Malebranche et al. 2004; Mimiaga et al. 2007). Research suggests that Black men who have sex with men are more likely to discuss their sexual health with providers who approach it in a 'matter of fact' fashion and show no judgement in their speech or body language (Mimiaga et al. 2007). Perceived acceptance of men who have sex with men has also been shown to be an important provider factor, as men who have sex with men are more likely to have discussions with providers who demonstrate acceptance of their sexual behaviours (Mimiaga et al. 2007). The literature also reveals that it is critical for providers not to assume all their patients are heterosexual and use language that is inclusive of lesbian, gay, bisexual and transgender patients (Coker, Austin, and Schuster 2010; Mimiaga et al. 2007).

Participants' perceived health literacy was found to both facilitate and hinder discussion about sexual health with providers. One possible explanation is that current technology (e.g. Google, WebMD®, etc.) gives people access to instant answers to personal health-related questions. By utilising these resources instead of talking directly with healthcare providers, patients can avoid what they perceive to be potentially embarrassing conversations while receiving faster responses to their questions (Hou and Shim 2010; Tustin 2010). It may be critical for future research to provide a clearer picture of the health effects of relying on technology, like WebMD® and Google, for self-diagnosis, rather than seeking care from healthcare providers. A combination of information from these websites and provider advice may better allow patients to take an active role in their healthcare (Wald, Dube, and Anthony 2007). By finding the right combination of sources of health information and increasing the ability of patients to receive tailored prevention and treatment in their own homes, providers and public health professionals may be able to increase access to appropriate care recommendations for individuals and communities with significant barriers to accessing healthcare.

It is also worth noting that the facilitating aspect of health literacy coincided with the comfort level of discussing sexual health among our participants. Participants felt more comfortable discussing their sexual health when they perceived themselves as 'knowing what they needed', or being more health literate. This is consistent with the wider literature which has noted that patients are more satisfied and feel engaged in the decision-making process with their providers when they have higher levels of health literacy (DeWalt, Boone, and Pignone 2007; Phillips and Arya 2016).

Finally, fear of healthcare providers disclosing personal information to others was a salient topic among participants. This finding is consistent with those of Ravenell, Whitaker and Johnson (2008), who found that Black men who have sex with men who were uncertain about the confidentiality of their visits with their provider were more likely to avoid going to, disclosing their sexual orientation to and discussing their sexual health with healthcare providers. It is important for providers to regularly assure patients of their discretion and of privacy laws regarding clinical visits and discussion. This may be stated verbally or included as a note on patient intake forms (Coker, Austin, and Schuster 2010).

There were however some limitations to this study. First, we used a convenience sample of Black men who have sex with men in the New York City area. Given that a substantial proportion (over 40%) of participants came from community-based recruitment venues and were very cooperative (i.e. agreeing to complete sex diaries), individuals in this study may differ from other men who frequent non-urban venues and other venues outside of their communities and are not willing to participate in research studies. Second, our sample was small; future studies should enrol larger numbers of Black men who have sex with men to gain more opinions and perspectives regarding this important topic. Third, our study did not gather the perspectives of service providers themselves; understanding both sides of the sexual health communication dialogue is important for ensuring buy-in and support for HIV prevention interventions. Finally, there are a variety of healthcare settings and types of visits in which Black men who have sex with men may interact with healthcare providers, including primary care providers, research staff, urgent care staff, etc. Future studies should include questions that encourage participants to describe their sexual health discussions based on the type of provider and healthcare setting.

Our findings illustrate there are several factors that affect whether Black men who have sex with men disclose their sexual identity and/or discuss sexual behaviours and sexual health with their providers. This is particularly relevant as interventions such as pre-exposure prophylaxis, which require honest communication between patient and provider, are made available for those at risk of acquiring HIV, including Black men who have sex with men. Currently, pre-exposure prophylaxis uptake among Black men who have sex with men and provider awareness and prescription of pre-exposure prophylaxis is sub-optimal (Eaton et al. 2015; Smith et al. 2016). Black men who have sex with men who regularly speak to their healthcare providers about sexual health are more likely to be tested for HIV and other sexually transmitted infections (Smith et al. 2010), and may be more likely to be prescribed pre-exposure prophylaxis, if needed.

As healthcare providers and public health professionals work towards national HIV and AIDS prevention goals and the increased availability of biomedical prevention options (National HIV/AIDS Strategy for the United States 2015; Raifman, Flynn, and German 2017), strengthening patient–provider communication, including how providers are trained to interact with and care for Black men who have sex with men, is vital (Raifman, Flynn, and German 2017). It is important too to tackle stigmatising treatment and Black men who have sex with men's perceptions of being marginalised in healthcare settings, in an effort to ensure that Black men who have sex with men do feel valued and more likely to engage in HIV care (Haile, Padilla, and Parker 2011). Research on a recent risk-reduction intervention with persons living with HIV (participants were mostly Black men) indicated that training HIV providers to identify risk and provide a prevention message resulted in increased prevention conversations and significantly reduced the average number of sexual partners reported by the patients (Rose et al. 2010). Increased provider training and improved communications allows for trust as a foundation for clinical interactions that expands beyond that of HIV prevention to improve overall patient care. Future research and interventions could target increasing sexual health awareness, provider training and leveraging HIV testing and sustained engagement in care to reduce HIV-related health disparities and improve care for Black men who have sex with men.

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. The use of Trademark names does not mean endorsement by the Centers for Disease Control and Prevention.

Disclosure statement

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