Title: An Intersectional Approach to Gender and Preventive Healthcare Seeking: Engagement with Biomedical HIV Prevention among Black Men Who Have Sex With Men
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Short Abstract (150 words):
Black men who have sex with men (BMSM) have the highest HIV rates in the U.S. Pre-exposure prophylaxis (PrEP) offers a biomedical technology to prevent HIV – but requires adherence. However, whether and how ideological and structural dimensions of gender shape MSM's engagement with preventive healthcare remains underexplored. We conducted three interviews each with 31 BMSM, and 90-minute interviews with 17 key informants. Three institutions emerged as relevant to PrEP uptake: 1) relationships (feminine men were perceived as "having HIV/STIs," suggesting they might feel in need of PrEP); 2) the labor market (men felt excluded, stigmatized and unable to use employment to assert masculinity); and 3) healthcare systems (men avoided medical visits to appear a "man's man"; being "weak and worried" was associated with femininity). This context reflects the importance of an intersectional approach to increase PrEP uptake for BMSM and to conducting research on men, gender and preventive healthcare.

Extended Abstract:

Background: In the paper we examine the relationship between gender and preventive health care seeking, specifically how gender may prevent people from engaging in practices that might improve their health, either because they cannot or because they do not desire to. Speaking to questions in population health, we argue that the promise of biomedical HIV prevention technologies such as pre-exposure prophylaxis (PrEP) can only fully be realized if we understand how social institutions shape the way gender is enacted. Speaking to conceptual questions about theorizing gender in relation to health care seeking, we argue that it is vital to take an intersectional approach; in this case, that means attending to men's racial and economic position and the challenges they face in relation to the intense stigma attached to same-sex sexual practices. We used ethnographic methods to explore how institutions such as intimate or romantic relationships, the labor market and the health care system influence the ways Black men who have sex with men (MSM) in New York City engage with PrEP.

Black MSM have the highest rates of HIV incidence in the U.S. and represent the epicenter of the U.S. HIV/AIDS epidemic.[1] MSM, specifically young MSM, are the only group for whom rates of new HIV infections are rising.[1,2] Biomedical HIV prevention technologies, such as PrEP, present a strategy to stem the epidemic. In fact, many researchers, policy makers, and practitioners believe that MSM are the highest priority for receipt of PrEP. Researchers have argued that PrEP could allow MSM to circumvent some of the ways that gendered factors may otherwise inhibit their ability to engage in HIV prevention[3] (e.g., not wanting to abstain from sex or use condoms), though such statements rely on assumptions about MSM's relationship to societal institutions and how broader gendered structures are produced through communities and health systems.

Research on gender and health suggests that men may view healthcare seeking behaviors as a threat to their masculine identity, emphasizing how masculine stereotypes do not provide the space for men to perceive and admit a need for help or eventually seek care.[4] Choosing to seek care may imply a loss of status, control, independence and autonomy, as well damage to a man's identity.[4] At the same time, however, Black MSM in New York City confront multiple forms of social disadvantage, and to focus only on gender obscures the ways in which their experiences as men reflect their position of relative economic disadvantage, the legacies of racial discrimination, and the stigmatization of same-sex sexual behavior. In order to facilitate the uptake of PrEP among MSM it is important to consider the intersectional gendered social context for biomedical prevention, specifically how it may constrain or facilitate MSM's ability to engage with PrEP.

By questioning the health beliefs and behaviors men embrace, and their ascribed gendered meanings, and by examining how those meanings and practices can be understood in relation to other dimensions of inequality, we can better understand how gender may shape Black MSM's engagement with PrEP. Beyond that, however, in this paper we demonstrate the value of an intersectional approach to gender for understanding men's preventive health practices in general. There has been a great deal of research on how ideologies of masculinity shape vulnerability to HIV as well as health in general. The paper builds on this body of work by taking an intersectional approach to questions about gender and biomedical prevention, in ways that are conceptually relevant much more broadly to understanding men's engagement in preventive health care.

Methods: We draw on ethnographic research which explored how gender influences Black MSM's desire for, and potential capacity to access and be adherent to, PrEP. We recruited thirty-one Black MSM in New York City from July 2013-July 2014. Each individual participated in three 90-minute in-depth interviews, with the sample varying by age, income, sexual identity, and insurance coverage (see Figure 1). Inclusion criteria were identifying as Black, having had sex with another man in the last year, and residing in New York City. The interviews followed an ethnographic field guide which specified a set of topics to be addressed with each informant, while also allowing participants to raise themes and topics that were pertinent to

Figure 1: Respondent Sampling Frame for MSM		**Total**
Age	15-24	17
	25+	14
Health Insurance	Medicaid/Private	22
	No Insurance	9
Sexuality	Gay	19
	Bisexual	4
	Straight/Discreet	8

them. Topics included family, educational, social and sexual history, engagement with medical care, life goals and projects, and knowledge and acceptance of PrEP. We also interviewed seventeen key informants (e.g. non governmental organizational staff, community leaders and service providers).

Following consent, interviews were taped, transcribed, and uploaded into Atlas.ti. The interviews were first analyzed within cases to develop a narrative of each man's history of care seeking and engagement, gender and sexuality, relationship history and work history. A second round of analysis looked for within-respondent variation (for example prevention behaviors with different partners, or illnesses/injuries over time). Third, a cross case comparison assessed differences among men (and in particular among men of different age, social class, or sexual identity) in themes related to masculinity, HIV prevention, health care seeking and engagement, and PrEP**.**

Results: Participants both implicitly and explicitly articulated how the ways they approached HIV prevention practices, specifically the idea of using PrEP, were shaped by three socio-cultural domains, each of which had both institutional and cultural dimensions: 1) gender-appropriate roles and behaviors within the confines of relationships; 2) the labor market; and 3) the healthcare system. In each of those domains, however, the resources to which men have access as men, or the beliefs about what is necessary to successfully perform masculinity, can only be understood when gender is examined in combination with sexual stigma, limited economic opportunities and racial inequality.

Gender and Relationships

The ways MSM inhabit relationships and negotiate intimacy has significant implications for willingness to engage in HIV prevention. For example, behaviors that might be beneficial from a health perspective (such as taking PrEP) may carry significant social risk in terms of the potential to jeopardize vital social resources such as relationships. Many of the men reported that taking a medication associated in any way with HIV (even to prevent it) might generate stigma; this was a substantial concern since all the men felt that friends and family already associated their same-sex sexual practices with HIV risk. In addition to the stigmatization to which MSM are subjected in this social context, there was additional social scorn directed towards those who present as feminine or who engage in practices associated with femininity (particularly receptive anal intercourse) within a relationship; those men were described as "promiscuous," "sluts" and "having HIV/STIs." One self-described 'bottom' expressed frustration that a casual partner was upset upon seeing a piece of a condom wrapper on the floor: "'I was having sex, what's the big deal? [and the partner said] 'oh, you're a ho.' [To which he replied] "no, I may be a ho but a safe ho right now. What's wrong with you?"

Men who presented as feminine or bottoms were generally viewed as having higher HIV risk and thus being more in need of PrEP. Men asserted masculinity by being a 'top' during sex, which participants viewed as less risky. A 31-year old said, "In terms of just being top, I think that is one of a lot ways risks are a little lower with HIV and other things. People say that the risks are the same, but I know they're not." Therefore, men who demonstrated their masculinity by always being 'tops' felt less in need of PrEP, and men who wanted to demonstrate their masculinity by asserting that they were never bottoms said that they would avoid PrEP because they did not want others to think of them as feminine. Black MSM suggested that taking PrEP could subject individuals to the stigma of "failed" masculinity; conversely, the prestige of successful masculinity was particularly vital to these men as a means to mitigate the stigma they faced as MSM.

Gender and the Labor Market

The economic dislocations that have taken place in the United States in the late 20th and early 21st century have been particularly hard on Black men in urban areas with limited education.[5,6] These limited opportunities in the formal labor market were critical in shaping barriers to accessing preventive medical treatment as well as maintaining adherence to medication such as PrEP. The Black MSM we interviewed, few of whom had stable, well-paying, long-term employment, reported lacking the financial or social resources to demonstrate their masculinity. This limited access to employment limited Black MSM's opportunities to embody the traditional norms of successful masculinity such as providing financially for

their family. This limited access was particularly acute for Black MSM whose gender performance was more feminine. Black MSM described feeling stigmatized for transgressing what they felt were expected masculine/feminine binaries in public, even in places where their sexuality was accepted. These transgressions were particularly salient in the labor market where individuals already reported feeling stigmatized by their colleagues (or not hired at all) for being Black, poor, and appearing less masculine.

Not having a job, and thus having less access to traditional ways of appearing successful as men, may render MSM more in need to assert their masculinity. This included increased numbers of sexual partners or sexual aggression, a refusal to perform certain types of sex (e.g., being a 'bottom' or giving oral sex), and seeking preventive health care. One man, who worked in HIV outreach attempted to describe what happens when the intersection of race, class, sexuality and gender limits the ways men can assert their masculinity, "I think taking risk has a lot to do with issues of self-worth, self-esteem, perception and economic struggle."

Even as plans were being made in New York State to expand access to health insurance under the Affordable Care Act, very few of the men we interviewed had secured or could ever imagine securing the kind of job that would provide health insurance. The majority of men reported some level of economic struggle and a difficulty finding work, as one expressed, "I'm eager to work, my focus is work. Like, I need to find work. And then with a job, then I could look into the resources on how to get some type of health coverage." As a result of the difficulty obtaining and maintaining work, some men were only marginally associated with the formal labor force and instead engaged in odd jobs. As one man noted, "I've done some sex work just because I couldn't find other work," while another noted that he would do whatever is necessary "to get food on the table." Other hurdles to finding and keeping work included substance use, periods of depression, isolation, unstable housing, and incarceration. These intersectional factors challenged these men's ability to succeed in the formal labor market and thus be afforded the associated benefits of perceived masculinity; they also meant that men did not have health insurance, which made it more challenging to access preventive healthcare.

The constraints of the labor market affect access to jobs and unemployment or underemployment hinders men's abilities to engage in HIV prevention. Ironically, however, having a job can also constrain men's ability to engage in HIV prevention. Many of the individuals who the National HIV/AIDS Strategy described as needing increased access to HIV prevention measures (e.g. low income, young, minority males) are employed in part-time hourly positions that do not offer healthcare, paid sick leave, or much scheduling flexibility. Some men reported having to miss a doctor's appointment because the office was running late and they were afraid to miss work, while others did not feel they had the flexibility to even ask for time off. For example, "My doctor was running late that day, so I didn't see my primary doctor until it was time for my second appointment. Now I could have waited for my second one, but I did not want to risk anything with my job. So I had to make an appointment with him all over again."

The way men are positioned in the labor market, or within masculine peer groups, may impede engagement with HIV prevention or make the social risks of participation more pronounced. This may be particularly acute for PrEP because it is a tool for prevention, and therefore not seen as necessary for one's health. Though certain states in the U.S. are offering PrEP through Medicare (e.g. New York and California), and the pharmaceutical company that produces PrEP has agreed to provide it free of charge through a patient assistance program, the men we spoke with were wary of out of pocket costs and expending time addressing a disease they did not actually have.

The Healthcare System

Black MSM face an intersecting set of factors (e.g., race, gender, sexuality, class) that limit their opportunities to appear successful as men. Though pre-exposure prophylaxis (PrEP) offers a highly effective biomedical technology to reduce HIV risk, it is only effective if men seek it out, can access it, and are then highly adherent, actions which require engagement with the healthcare system. However, healthcare use and self-care behaviors are socially constructed as feminine among BMSM, and also among men more broadly,[4] which limits men's willingness to engage in preventive healthcare. As one man expressed, "I'm a man, I don't need to go to the doctor." As others have noted, the health care system is itself a gendered institution, with clearly delineated and institutionally-reinforced systems to

engage women in preventive care, and little in the way of equivalent systems for men.[7,8] Few of the men interviewed for this study described routine participation in any form of preventive care; beyond that, however, they largely perceived the very idea of care seeking as an indication of failed masculinity.

Men reported avoiding attending medical visits to appear as a "man's man". They associated being "weak and worried" and taking medication with femininity. Such assumptions influenced Black MSM's desire for PrEP, and their willingness to attend the medical visits necessary to maintain high levels of adherence. Some participants described not taking medication for existing conditions (e.g. diabetes, heart disease), and said they would not want to take medication (i.e. PrEP), particularly one with side effects, when they were not sick. Research demonstrates that men have shorter physician visits and receive fewer and briefer explanations than women; men also receive less information about how to change disease risk factors. The majority of men did not attend annual visits and, when they did, were not convinced of their utility. As one man told us, "They stick you, poke you, prod you, tell you the results, stress, diet, more tests, shit like that."

In addition to eschewing medical visits as a way of asserting masculinity, the majority of men reported avoiding medical care for additional reasons including a lack of finances, "motivation…just, I wanna sleep a little longer," and being "very terrified of the hospital, terrified of the dentist, so that stops me a lot from doing what I need to do to take care of my health." Even individuals who engaged with prevention services were often reluctant to present in a way that demonstrated their more feminine identity, or to tell the clinician about their sexual preferences because they felt it threatened their masculinity and might change how clinicians (or society more broadly) addressed them. As a 19-year old explained, "that changes everything because you really tell a doctor. Because then it's just like in a way you are kind of debt – like certain things you can't do no more. It feels like if you tell a doctor that, it feels like a lot of those things just start strings that being pulled from you… you are blacklisting yourself from certain things." Men reported going to the doctor for reasons such as concrete injuries (e.g., breaking an arm) or symptomatic STDs. As one man described, "I'm Johnny-on-the-spot with that shit [STDs]. I'm not trying to mess around with that. No sir, you want to get rid of that shit quick." Both of these reasons for attending care can be seen as a means of representing masculinity; breaking an arm could come from rough housing or sports, and some men described having STDs as a marker of sexual prowess and virility and thus masculinity. Our research suggests it was particularly important for MSM who had limited access to other dimensions of competent masculinity due to their race, class, gender and sexuality to use healthcare as a means of asserting their masculinity (i.e. by avoiding medical visits) as opposed to engaging in preventive care.

Conclusion: These contextual factors reflect the intersectional impact of the stigmatization of sex between men in Black communities and the social disadvantage many of these men face because of their race, class, education, and gender presentation; their experiences as men can only be fully understood by incorporating attention to the intertwined impact of multiple forms of social inequality. These intersectional factors were particularly relevant to limiting men's opportunities to appear as men within relationships, the labor market, and healthcare systems. Gender norms and hierarchies influenced perceptions of HIV risk, which subsequently affected Black MSM's openness to HIV prevention-related messaging and services. Increased attention to these intersecting factors, particularly gender—including norms and the negotiation of gendered performances—is vital for the development of meaningful and effective PrEP-related interventions among Black MSM. Incorporating an intersectional gendered lens into HIV prevention will help expand enabling environments that facilitate the scale-up and implementation of PrEP-related services throughout the United States. In addition, we argue that applying this intersectional gendered lens will provide critical insights into research on men, gender and preventive healthcare more generally.

References

1. Centers for Disease Control and Prevention. HIV among Gay and Bisexual Men: A fact sheet. Atlanta, GA: http://www.cdc.gov/hiv/risk/gender/msm/facts/index.html, 2014.
2. Centers for Disease Control and Prevention. HIV and Young Men who have sex with Men. Atlanta, GA: Center for Disease Control and Prevention, 2012.
3. Centers for Disease Control and Prevention: Department of Health and Human SErvices. Preexposure Prophylaxis for the Prevention of HIV Infection in the United States: Clinical Practice Guideline 2014.
4. Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social science & medicine* 2000; **50**(10): 1385-401.
5. Autor D. The polarization of job opportunities in the US labor market: Implications for employment and earnings. *Center for American Progress and The Hamilton Project* 2010.
6. Browne I, Misra J. The intersection of gender and race in the labor market. *Annual Review of Sociology* 2003: 487-513.
7. Lanier Y, Sutton MY. Reframing the context of preventive health care services and prevention of HIV and other sexually transmitted infections for young men: New opportunities to reduce racial/ethnic sexual health disparities. *American Journal of Public Health* 2013; **103**(2): 262-9.
8. Seymour-Smith S, Wetherell M, Phoenix A. 'My wife ordered me to come!': A discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. *Journal of Health Psychology* 2002; **7**(3): 253-67.