Gendered social institutions and preventive healthcare seeking for Black men who have sex with men: The promise of biomedical HIV prevention

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ABSTRACT:

Research on gender and health, including research conducted among Black men who have sex with men (BMSM), has primarily focused on how gender norms and roles shape health care engagement. Here we advance that work by demonstrating how a broader theorization of gender, particularly one that moves beyond gender norms and performance to incorporate structures such as the healthcare system and the labor market, can facilitate an understanding of how gender affects preventive healthcare seeking among BMSM, particularly the uptake of pre-exposure prophylaxis (PrEP), which is one promising approach to alleviate HIV disparities. This paper is based on a yearlong ethnographic study conducted in New York City with BMSM (n=31; three interviews each) and community stakeholders (n=17). Two primary findings emerged: 1) the labor market systematically excluded the men in our sample, which limited their ability to access employer-sponsored healthcare. Such discrimination may promote overt demonstrations of masculinity that increase their HIV vulnerability and decrease healthcare seeking and 2) Healthcare systems are not structured to promote preventive healthcare for men, particularly BMSM. In fact, they constrained men's access to primary providers and were usually tailored to women. Applying a structural, gendered lens to men's health—in addition to the more frequently researched individual- or interpersonal-levels—provides insight into factors that affect healthcare seeking and HIV prevention for BMSM. These findings have implications for the design of policies and institutional reforms that could enhance the impact of PrEP among BMSM. Findings are also relevant to the management of chronic disease among men more broadly.

KEY WORDS: Black men who have sex with men (MSM); healthcare seeking; sexual orientation; gender; qualitative research

INTRODUCTION

A large body of research examines how gender can influence men's health seeking behaviors and related outcomes (Dworkin, 2005, 2015; Sabo, 2005; Springer, Hankivsky, & Bates, 2012). Within HIV prevention work, scholars have explored the gendered organization of healthcare institutions and identified ways in which gendered institutional practices can differentially impact men and undermine their engagement with HIV prevention (Dovel, Yeatman, Watkins, & Poulin, 2015; Fleming & Dworkin, 2016). To date, however, the majority of research on gendered healthcare institutions and HIV prevention has focused on heterosexual men (Dovel et al., 2015; Fleming & Dworkin, 2016). At the same time, research conducted with Black men who have sex with men (BMSM) has focused primarily on how race, class, and sexuality influence BMSM's engagement with HIV prevention (Frye et al., 2015; Maulsby et al., 2014), with limited attention paid to the role of gender The limited research that has examined how gender may impact BMSM's engagement with HIV prevention has generally focused on gender performance and gender roles (Garcia et al., 2016; Malebranche, Gvetadze, Millett, & Sutton, 2012) rather than structural dimensions of gender. Here we argue that structural dimensions of gender have been overlooked as processes that shape preventive healthcare behaviors for BMSM. We draw on ethnographic data about pre-exposure prophylaxis (PrEP)-relevant practices among BMSM to demonstrate how a broader theorization of gender, and in particular one that moves beyond gender norms and performance to incorporate structures such as the healthcare system and the labor market, can facilitate an understanding of how gender affects preventive healthcare seeking among BMSM.

BMSM have some of the highest HIV incidence and prevalence rates in the US (Centers for Disease Control and Prevention, 2014) and researchers and activists have called for

additional interventions to address these health disparities (Grossman, Purcell, Rotheram-Borus, & Veniegas, 2013; Sullivan et al., 2015). In response, the Office of AIDS Research has placed a particular focus on biomedical HIV prevention (Office of National AIDS Policy, 2015).
A multi-national study among 3,000 MSM (Grant et al., 2010), iPrEx, found a 44% reduction in HIV infections among MSM on oral PrEP compared to those receiving a psychosocial prevention package; findings showed >90% efficacy among individuals with detectable drug levels (Anderson et al., 2012). Additional demonstration projects have supported these results (Schneider, Bouris, & Smith, 2015). As a result, the Food and Drug Administration approved Truvada as an oral PrEP prevention method for MSM in 2012 (Holmes, 2012).

Researchers argue that PrEP could allow BMSM to circumvent some of the barriers that might otherwise inhibit their ability to engage in HIV prevention (e.g., not wanting to abstain from sex or use condoms) (Bauermeister, Meanley, Pingel, Soler, & Harper, 2013; Maulsby et al., 2014). Such perspectives, however, overlook some of the critical community- and health-system-level challenges faced by BMSM in relation to biomedical HIV prevention as well as preventive care more generally. Indeed, the promise of biomedical HIV prevention technologies such PrEP will best be realized if they are provided in ways that account for the social factors that shape men's uptake and adherence. Here, we focus on how institutional dimensions of gender—specifically within the healthcare system and labor market—shape preventive healthcare for BMSM.

Healthcare systems

Researchers have described how men who are socially marginalized—e.g., due to their race, class, or sexuality—and who are thus unable to achieve culturally prestigious forms of masculinity—may assert their masculinity through other outlets such as a refusal to engage in

preventive healthcare (Connell, 2005; Courtenay, 2000; Courtenay, 1999). This concept has been explored in relation to both heteronormative masculinities and Black and queer masculinities (Bowleg et al., 2011; Courtenay, 2000; Fields et al., 2014). To date, the literature on how gender shapes men's preventive healthcare seeking has focused primarily on gender norms' impact on preventive behavior and healthcare engagement (e.g., 'men don't go to the doctor'; see e.g., Bowleg et al., 2011; Courtenay, 1999, 2000; Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010; Kalmuss & Austrian, 2010; Powell, Adams, Cole-Lewis, Agyemang, & Upton, 2016). These norms around healthcare seeking can also be racialized as well as gendered. Specific to BMSM, gendered norms that are both racialized and sexualized (e.g., 'black men on the 'down low' are responsible for transmitting HIV to innocent women') have also been suggested as barriers to health seeking behaviors (Dworkin, 2015; Saleh, Operario, Smith, Arnold, & Kegeles, 2011).

Gender's influence on care engagement encompasses both norms and institutional factors that shape men's opportunities to access health care. Indeed, men's opportunities to engage in healthcare are differentially allocated through opportunity structures (Blau, 1994), in this case health-care opportunity structures. Opportunities structures, for example, are pertinent to understanding why men are more likely than women to lack insurance and are nearly twice as likely to lack a primary provider (White, 2007). In addition, although various national-level guidelines have stressed the importance of women's gynecological visits, no parallel recommendations exist in the US for men (Lanier & Sutton, 2013). Furthermore, within health care institutions, visits for men are shorter than for women and men tend to receive fewer services and briefer advice about preventive care (e.g., breast versus testicular examinations) (Courtenay, 2000).

Even men with health insurance may not receive prevention-related information because insurance is more likely to cover acute medical intervention than information provision, counseling and prevention (Möller-Leimkühler, 2002). This means that people might have to pay out of pocket for HIV prevention services–services, with which they may already be reticent to engage (Möller-Leimkühler, 2002), –or be forced to seek those services at community clinics that feel unfamiliar or even uncomfortable. Thus, a norms-focused argument that "men don't go to the doctor" obscures the ways in which the very structure of healthcare limits men's opportunity to engage in preventive care.

The Labor Market

The lives of Black MSM are shaped by intersecting axes of inequality: the men in this study paid a social price for being Black, poor and sexual minority (Bowleg, 2013; Calabrese et al., 2018; Wilson, 2008). The impact of these overlapping inequalities is particularly stark in the labor market. Paid labor outside the home is a primary means through which men demonstrate masculinity (Cheatham, Barksdale, & Rodgers, 2008; Hammond et al., 2010). However, the restructuring of the US labor market in the 20th and 21st centuries has disadvantaged low-skilled and low-educated workers (Connell, 2012; Lewis, 2001). In 2016, the unemployment rate for people with less than a high school diploma was 7.4%, compared to 5.2% for those with a high school diploma and 2.7% for those with a Bachelor's degree (Bureau of Labor Statistics, 2018). Structural factors such as housing and zoning laws (Rugh & Massey, 2010), the unequal distribution of education funding (Frankenberg, Siegel-Hawley, & Wang, 2010), and the disproportionate incarceration of people of color (Pettit, 2012) have meant that low-skilled workers with limited education in the US are disproportionately Black men. In 2016, the unemployment rate for African Americans without a high school diploma was 14.1%, compared

to 6.5% for Whites and 5.9% for Hispanics; racial disparities also existed for those with high school and college degrees (Bureau of Labor Statistics, 2018).

Labor market engagement is also constrained for sexual minorities; gay men are less likely to be hired and, once hired, earn less than heterosexual men (Carpenter, 2005; Elmslie & Tebaldi, 2014). This discrimination is particularly salient for more effeminate gay men who often face social sanctions for their gender performance and for transgender men and women whose employment options continue to be extremely limited (Bradford, Reisner, Honnold, & Xavier, 2013; Tilcsik, 2011). This means that the men who are most at risk for HIV (i.e., BMSM who are often poor and have low education) are frequently relegated to part time work or odd jobs (Anderson, 2008; Holzer, 2009). Beyond the ways in which a reliance on part-time work may make men feel like failures as men, it also limits their ability to access employer-sponsored healthcare (Currie & Madrian, 1999). The life histories of many of the BMSM in our study, as described below, provided ample evidence of this labor market exclusion due to intersecting forms of inequality based on race, sexual orientation, and gender presentation.

Men, Gender and Health

In this paper we argue that BMSM's preventive healthcare practices are shaped by institutional as well as normative aspects of gender, such as gender roles and ideologies, an argument other have made about heterosexual men (Connell, 2005, 2012; Courtenay, 1999, 2000). We examine the healthcare system and the labor market as two gendered institutions that influence BMSM's preventive healthcare practices (Dovel et al., 2015; Fleming & Dworkin, 2016) and show how BMSM are negatively impacted by heteronormatively gendered institutional processes in health care and labor market settings. Assumptions about gender as a binary category mean that men often pay a penalty—in the form of social exclusion and

stigma—for being gender non-conforming (Frye et al., 2015; Lerner & Robles, 2017; Messner, 1997; Sabo, 2005; Sevelius, Deutsch, & Grant, 2016).

METHODS

Ethnographic data collection (July 2013-July 2014) included interviews with 31 BMSM in New York City who varied by age, income, sexual identity, and insurance coverage (See Table 1). Men participated in three 90-minute interviews. Topics included: family, childhood, education, work, sexual history, health care, life goals and projects, and knowledge and acceptance of PrEP. We also conducted semi-structured interviews with 17 community stakeholders (e.g., outreach workers, community mobilizers, healthcare professionals) involved in HIV prevention and/or BMSM health. We asked stakeholders about the institutions and support available to BMSM and assessed their knowledge and attitudes about BMSM and HIV prevention. All participants provided verbal informed consent. The Columbia University Medical Center Institutional Review Board approved all aspects of this study.

Interviews were digitally recorded, transcribed, and uploaded into Atlas.ti. We used theories of gender, health and sexuality to develop codes that were relevant to our research questions (Miles & Huberman, 1994); we also examined the interview guides to develop salient codes. Two researchers conducted line-by-line coding to allow salient themes to emerge. The study team developed a codebook that included overarching themes such as masculinity, gender and health, engagement in care, psychosocial factors, and PrEP-specific codes. To analyze the data we: 1) developed a narrative of each man's history of care seeking and engagement, gender and sexuality, and relationship and work; 2) looked for within-respondent variation (for example prevention behaviors with different partners, or illnesses/injuries over time); and 3) conducted a

cross-case comparison to assess key differences among men (in particular among men of different ages, social classes, or sexual identities). The analysis for this paper explored whether gendered social institutions enabled or constrained how BMSM engaged in preventive healthcare and thus came to know about PrEP and access PrEP.

RESULTS

Gendered Labor Market Structures

Connell and others argued that the economic and social processes that structure society created a gendered division of labor (Connell, 1987; Lewis, 2001; Scott, 1986), which impacts the type of individuals who can access jobs that provide services like employer-sponsored healthcare. The systematic exclusion of racial and sexual minorities from the labor market is not a historical accident but has been systematically (re)produced through the global economic order. Black urban men with limited education have been particularly disenfranchised by the economic dislocations that occurred in the US over the last 75 years (Autor, 2010; Browne & Misra, 2003). This disenfranchisement was reflected in the experiences of the men with whom we spoke, and their limited opportunities to engage in the formal labor market was a critical barrier to prevention-related behaviors and adherence to medications such as PrEP. These men, few of whom had stable, well-paying, long-term employment, reported a lack of financial or social resources. They also reported significant economic hardship and employment that was frequently limited to part-time work or odd jobs. Although many men strongly desired stable, long-term employment, this was rarely realized. As one man said,

> *"My goal on a daily basis is to become a productive member of society. One who has a job, maybe a credit card or two. Naturally, society is not making it easy for me to do that…Why? My skin color. My sexuality plays a major role. However, I keep pushing it and doing what it is I need to do."* (39, same-gender loving, Medicaid).

Despite New York State's expansion of health insurance under the Affordable Care Act (ACA) (Blavin, Blumberg, Buettgens, & Roth, 2012), which establishes minimum standards on the health insurance provided under employer-sponsored plans, very few of the men we interviewed had secured or could ever imagine securing the kind of job that would provide an employer-sponsored insurance or allow them to earn enough to purchase a plan on the open market. As a result of the difficulty of obtaining and maintaining work, most men were only marginally associated with the formal labor force and instead coped economically by "hustling," and doing odd jobs to "make ends meet." The men who relied on multiple gigs to survive often described themselves as being good at nothing. One described being a "jackass of all trades," a term he saw as reflecting his inability to find full time employment and a general sentiment that men lack the necessary skills to secure full-time work.

Many men went without healthcare not because they did not want to access it, but because they were unable to access the type of care they wanted as a result of their employment status. The structure of the labor market offered limited access to jobs, and the resulting unemployment or underemployment hindered men's abilities to engage in HIV prevention. Even men with jobs faced other, work-related barriers to engaging in preventive behaviors. Most of the individuals in our sample were low income, young, minority men – precisely those whom the Office of AIDS research identifies as in need of increased access to HIV prevention measures – employed in part-time hourly positions that did not offer healthcare, paid sick leave, or scheduling flexibility. One man shared how his co-pay changed as he shifted jobs, until he ended up in a position that did not offer any coverage:

"It would range, from when I was working at Starbucks making like nothing, and then

> *making a little bit more at NYU or Nissan, it was like $36.00 per visit. So I was just doing that and rolling with that. You know, but at the temp agency you can't really do Medicaid or health insurance* (26, gay, no insurance)."

The relevance of the labor market to men's access to healthcare access extended beyond HIV care. A man with diabetes described how he was unable to manage his illness due to lack of health insurance.

> *"I always feel like I have to get one thing first, and then it will lead to the next. So my focus is work. I need to find work. I need a job. And then with a job, then I could look into the resources on how to get some type of health coverage. I feel like I just need assistance* (27, same-gender loving, no insurance)."

This participant's experience with diabetes (a chronic illness) is particularly illuminating when considering the possible uptake of PrEP. It suggests that finding a job (in order to obtain health insurance) may take precedence over managing an illness, in this case an illness that he currently had (diabetes). Given that PrEP targets a potential future illness, rather than a current one, it may be an even lower priority among people who lack access to basic employment. It is also possible that employment might actually constrain a man's opportunities to get PrEP because the jobs men are most likely to find feature rigid work schedules, which can make it difficult to find time to see a doctor.

Enacting masculinity and the labor market

Researchers have applied the term 'compensatory masculinity' (Harrison, 1997; Whitehead, 1997) to describe how economically marginalized men respond to economic restructuring—and subsequent financial insecurity—by demonstrating their masculinity through other outlets. This concept is limited and yet useful: limited, because it implies a set of psychological processes that are invisible to the researcher and takes an economically determinist approach to culture, and yet useful because it calls attention to the possibility that risky behaviors

(e.g., violence, substance use, demonstrations of strength and increased number of sexual partners) (Calabrese, Rosenberger, Schick, & Novak, 2015; Goff, Di Leone, & Kahn, 2012; Kogan, Yu, Allen, Pocock, & Brody, 2015; Whitehead, 1997) may result from marginalization and discrimination.

Participants in this study were positioned within the labor market in ways that constrained their ability to achieve culturally-valued dimensions of successful masculinity, such as achieving financial independence (West & Zimmerman, 1987). Men in the study described how not having a job, and thus having limited access to traditional ways of appearing successful as men, caused them to assert their masculinity through other avenues. One of these included seeking out short-term, casual relationships that men perceived as requiring fewer economic or emotional obligations. For example, one participant (46, bisexual) described ending a long-term relationship with his girlfriend and pursuing more casual relationships with men because he "didn't feel man enough," because he was unable to "take care of business" or "be a provider." Another participant (18, gay) described avoiding relationships with men who were "too emotional," noting, "I ain't got time for that shit". Some men described enacting their masculinity through having increased numbers of sexual partners or sexual aggression or by refusing to perform certain types of sex (e.g., being a 'bottom' or giving oral sex). As one man noted:

> *"You have these Black men, who are just conditioned to be masculine and to not be weak. The gay Black men too, we bring that ideology into our sexual orientation as well…So if you're thinking that you should be masculine, then you don't want to put yourself into a position in terms of sex where you feel like that might make you appear weak. I need to stick to that label because that reaffirms my masculinity* (45, MSM, Medicaid)*."*

A participant who worked in HIV outreach made explicit connections between men's lack of employment, resulting economic instability, and their risk-taking behaviors: "I think taking risk

has a lot to do with issues of self-worth, self-esteem, perception and economic struggle" (31, gay, private insurance). Limited access to the labor market also impacted when and whether men developed stable, affective relationships. A peer educator described how men without jobs were seen as less desirable and thus more likely to be subordinated within relationships:

> *"Working can play a role in the dynamic of power. I work and I make my own money. So that sometimes that gives me an innate power over a guy who may not have those things because they see me as having accomplished these tasks that they haven't or society says that we, as Black men, should attain* (24, gay, Medicaid)."

Thus, men's precarious economic circumstances presented a threat to their masculinity and impacted the types of partners and sex in which men would engage.

Healthcare systems and preventive healthcare for men

Contrary to existing narratives about men, and specifically Black men (Fields et al., 2012; Fields et al., 2014; Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010), not wanting to seek care, many of the men in this study said they would engage in care if they could afford it, had insurance, and could see a provider with whom they felt comfortable. For example, one man explained that he wanted to get health insurance, but was currently unable to owing to his employment status. Though he had not been to a doctor in seven years, he expressed the desire to do so, though worried about the cost:

> *"I want to be a man's man but I want to be the better man so I'm going to check it out. That's what made me say, I know it's expensive and all, because I remember talking with some guys, who go "You get that insurance shit man? That's just taking away your $40 a week or $40 out your check a week." And I'm like, "Yeah but I'm gonna do it* (46, discreet, Medicaid)."

The juxtaposition of "man's man" with a "better man" demonstrates an acknowledgement that his actions challenged gendered expectations by prioritizing preventive

care. Similarly, a 31-year-old shared how being a father and wanting to provide for his children drove him to get a job and maintain access to health care. He described initiating conversations about sex with providers in order to ensure he received the appropriate tests (e.g., anal pap smears).

Despite men's desire to access clinical and preventive care, men experienced several barriers to healthcare engagement that are closely related to structural dimensions of gender. Many men described feeling uncomfortable entering clinical spaces tailored to women or to heterosexual men. The majority of men also noted that they were reluctant to discuss their sexual orientation with a healthcare provider. Several participants expressed that doctors did not know how to bring up same-sex sexual behavior – which was something most men felt uncomfortable raising on their own. One man described how conversations with his doctor were short and inadequate: "They ask me, "Are you sexually active?" I'll say yes, and then they'll say, "Are you using protection like contraception, condoms," that kind of stuff. I'll say yes. And that's really the extent of the conversation" (17, gay, private insurance). Not only were questions from clinicians highly general, suggesting they are ill-equipped to deal with sexual minority patients, but they were also framed in a way that heterosexuality was assumed unless the patient chose to broach the topic, which few men were willing to do.

In addition, men who engaged with prevention services described feeling stigmatized for transgressing what they felt were expected masculine/feminine binaries in healthcare settings. This was particularly acute for men with more feminine gender performances, who worried how clinicians addressed them. One adolescent felt that presenting as more effeminate "changes everything because certain things you can't do no more…you are blacklisting yourself from certain things" (19, bisexual, private insurance).

This issue of feeling comfortable with one's doctor was particularly salient for BMSM, as a result of their multiple stigmatized identities. Men emphasized that they felt more comfortable when they could develop a relationship with a particular provider and then see that person consistently, and that a key part of that comfort involved being able to choose a provider who was sensitive to their unique needs as men who were also racial and sexual minorities. However, it was predominantly the men who had employer-based care who had the power to choose and continue to see a specific provider. Government-sponsored healthcare, through which nearly all of the men we worked had coverage, included multiple administrative restrictions that limited men's choices. As one man told us:

> *"Do I have health insurance? Hell yeah, I got mother fucking Metro Plus*[1] *...But I don't like it because you can only go to certain doctors, you can't go to anywhere. Back in the days you can go in any fucking doctor as long as you had insurance coverage, now you got to go to your assigned doctor, that's not fucking cool"* (47, discreet, public insurance).

Even the few men who had a regular provider described frustration about how care was organized in public clinics and the limited number of providers from which they could choose with government-sponsored care. Specifically, men felt that this constrained their opportunities to develop a stable connection to a primary care provider. As one said,

> *"With Medicaid it's hard to get a primary care physician to look over you and continue to look over you. You'll get a doctor, you'll start liking your doctor, you'll discuss your whole entire life story with that doctor…and then for whatever reason that doctor is no longer there and you're pushed to another doctor and you have to start that relationship all over again"* (39, gay, Medicaid).

Having to build new relationships with healthcare providers may be especially challenging for BMSM who are already excluded and marginalized due to their intersecting stigmatized

[1] MetroPlus is administered by New York City and is offered to people with little or no income.

identities. One clinician summarized the various structural barriers that to be overcome in order for a patient to be in a position to begin to learn about HIV prevention measures:

> *"Predicated on someone actually showing up to the clinic, meaning they've crossed all the barriers of access and perceived homophobia and perceived racism and perceived cost issues or whatever goes into access. And then they've met a provider who they feel comfortable enough with to discuss these things and the provider is knowledgeable and willing to engage that person."*

This has several implications for BMSM's engagement with HIV prevention and PrEP. PrEP requires a doctor's visit every three months, meaning that otherwise healthy individuals must become adequately integrated into a medical system from which they normally feel excluded and frequently lack access. Men might therefore be less likely to continue taking PrEP even if they find a way to access it since the structure of the healthcare system means that they frequently lack a primary provider with whom they can discuss adherence challenges and from whom they can obtain medication refills. Such challenges remain salient, and may only become more difficult, given the uncertain future of the ACA.

DISCUSSION

We have examined how institutional dimensions of gender shape men's preventive healthcare behaviors, and specifically limit BMSM' opportunities and desire to engage with PrEP. Research on gender among BMSM has emphasized normative dimensions of masculinity, and may have even helped fuel stereotypes that men hate going to the doctor and do not access care even when they are sick and injured. Increased attention to the myriad ways that gendered institutions, including the labor market and healthcare institutions structure health-related decision-making is vital to better understand how this impacts men's preventive healthcare

seeking behavior. This is not necessarily a complete inventory of the gendered structural constraints on BMSM's opportunities to engage in biomedical prevention; other gendered social institutions such as schools and universities are also potentially important for shaping and constraining opportunities to secure preventive services.

The lives of the men in this study were influenced by multiple intersecting forms of inequality: their race, their non-heterosexuality, their socioeconomic status and, for many of them, their failure to conform to expectations regarding the performance of masculinity. Our analysis examined the interplay of BMSM's racial and economic position with intensely stigmatized same-sex sexual practices and, for some, feminine gender performances that marked them as failed men. These men, whose gender performances ranged from explicit demonstrations of hegemonic masculinity to hyper-feminine, described how the intersection of sexual orientation and gender presentation shaped their daily experiences, particularly when their gender performance rendered them unable to 'pass.' Men whose gender presentation was more masculine described hiding their sexuality in their daily lives (e.g., at school, work, or in certain neighborhoods) to avoid losing key forms of social capital—they were 'read' based on their gender as their sexuality was not readily apparent. For men with a more feminine gender performance, however, this was not an option: these men's gender performance was a signifier of their sexuality. Whereas race, for example, is externally signified, BMSM may pass as straight unless they are gender non-conforming, in which case their gender performance is publically understood to reveal their sexuality.

Consistent with previous studies conducted among BMSM (Bowleg, 2013) the men in this study reported intersecting identities and inequalities that placed them at multiple disadvantages within healthcare settings. For these men, the social price of being Black, poor,

sexual minority, and often having a feminized gender performance, off-set the privileges that the labor market and healthcare system might ordinarily confer on men (Dworkin, 2015). Indeed, many of the assumed benefits that men in the U.S. receive (e.g., financial, political, social success) are withheld for Black men when race, sexuality and gender intersect, particularly if they are characterized by a more feminized presentation (Calabrese et al., 2018; Dworkin, 2015; Harawa et al., 2008; Watkins-Hayes, 2014). These intersectional identities at the individual level therefore interact to produce inequalities at the social-structural level, in this instance around preventive healthcare seeking (Bowleg, 2013; Bowleg et al., 2011). Thought particularly severe for the BMSM we interviewed, it is important to note that the desire for continuity of care and a medical home is relevant for all men, regardless of race or sexuality (Coles et al., 2010). Future research should examine how the structural dimensions of gender interact in ways that impact men's health outcomes, including diseases such as diabetes, obesity or cancer. Work on cancer has, for example, examined how gender norms impact how men respond to a diagnosis of breast cancer or prostate cancer, but little work has explored how the structure of healthcare impacts care retention and health outcomes for men. In addition, future work should be attuned to the fact that structural dimensions of gender—which are often grounded in heteronormative ideologies—also have consequences for non-heterosexual populations.

Policy and research implications

In order to create a system that can help make preventive healthcare seeking the default behavior for men, a number of structural changes need to occur. First, it is important to eliminate the relationship between employment and access to affordable healthcare by creating a system where health insurance is available to all. While the ACA—and resulting Medicaid expansion—increased the availability of healthcare, it is often much more expensive than

employer-sponsored healthcare, making it out of reach for men like those in this study. Moreover, the future of the ACA remains uncertain, and there has been a great deal of variability across states in the extent to which governors and legislatures elected to expand access to Medicaid under the ACA (Garfield, 2017). A second line of policy intervention would be to regulate shift work in order to increase scheduling predictability for workers (Greenberg, 2016). Research among 'early career workers' (people aged 26-32) found that 41% did not know their schedule more than one week in advance and 74% did not know how many hours they would work each week (Lambert, Fugiel, & Henly, 2015). The unpredictability of 'just-in-time' schedules can lead to wide variations in salary, which impacts individuals' ability to afford health insurance. These variations also make it hard to attend doctors' appointments which are often scheduled months in advance. Third, men's comments about continuity of care underscore the importance of considering improvements in the quality of publicly-funded primary care to be a vital component of efforts to facilitate access to and engagement with biomedical prevention. Together, these three recommendations underline the ways in which a structurally-oriented analysis of gender can provide new tools to enhance combination prevention.

Fourth, work needs to be done to create clinical spaces that welcome all types of men, regardless of race or sexual behavior, so that once men are able to access preventive care they feel welcomed (Bell, Breland, & Ott, 2013; Same, Bell, Rosenthal, & Marcell, 2014). Currently, most gender-tailored healthcare institutions target women and, while clinics like Planned Parenthood will see and treat men, they are perceived to be a feminized and heterosexual space. While there are some notable examples of clinics that focus on men's health (Armstrong, 2003), these exceptions are primarily attached to large urban teaching hospitals. Additional work should be done to examine how to offer preventive healthcare services, including PrEP, in a non-

threatening and anonymous way (e.g., at a school clinic for younger men or at a community center that men might attend for other purposes).

Finally, while PrEP is now available through many insurance companies, Medicaid, and pharmaceutical companies' patient assistance programs, these rarely cover the infrastructure required to stay on PrEP (i.e., doctors' visits and lab tests). While New York State has recently created a program called PrEP-AP which reimburses providers for PrEP-related primary care services such as regular HIV testing, counseling, and supportive primary care services, most states still lack this structure (New York State Department of Health, 2018).

CONCLUSION

This research demonstrates the importance of attending to how gendered social institutions can shape the way that BMSM in the US engage with preventive healthcare seeking, specifically PrEP. Gendered social institutions, including (but obviously not limited to) the labor market and healthcare system—which are gendered according to heteronormative ideologies - structure the way sexual minority men, and men more generally, engage in healthcare. Men also suffer from gendered health disparities, and greater morbidity across a multitude of diseases including heart disease and cancer (Williams & Jackson, 2005). Incorporating an intersectional gendered lens (Bowleg, 2013; Crenshaw, 1989) into HIV prevention will identify structural factors that can then become targets for intervention. Addressing these systematic barriers will to help expand enabling environments that facilitate the scale-up of PrEP-related services throughout the U.S. Applying this structured gendered lens will therefore also provides critical insights into research on men, gender and preventive healthcare more broadly.

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.

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

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Table 1: Demographic Characteristics of Black MSM

Characteristic	**Total N=31**
Age	29 (avg)
15-24	17
25+	14
Sexual Identity	
Gay	15
Same gender loving	3
Bisexual	4
Discreet	4
Straight	3
Other (MSM, None)	2
HIV test last 6 months	

Yes	23
No	2
N/A (already positive)	6
Medical Exam last 12 months	
Yes	22
No	9
Prior Knowledge of PrEP	
Yes	15
No	15
HIV Status (self-report)	
Negative	23
Positive	5
Undisclosed	3
Housing	
Stable	15
Precarious	11
Homeless	5
Employment	
Full time	8
Part time	8
Unemployed	15
Insurance Status	
Private	5
Public	17
Uninsured	9