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Social risk, stigma and space: key concepts for understanding HIV vulnerability among black men who have sex with men in New York City

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Abstract

Black men who have sex with men in the USA face disproportionate incidence rates of HIV. This paper presents findings from an ethnographic study conducted in New York City that explored the structural and socio-cultural factors shaping men's sexual relationships with the goal of furthering understandings of their HIV-related vulnerability. Methods included participant observation and in-depth interviews with 31 Black men who have sex with men (three times each) and 17 key informants. We found that HIV vulnerability is perceived as produced through structural inequalities including economic insecurity, housing instability, and stigma and discrimination. The theoretical concepts of social risk, intersectional stigma, and the social production of space are offered as lenses through which to analyse how structural inequalities shape HIV vulnerability. We found that social risk shaped HIV vulnerability by influencing men's decisions in four domains: 1) where to find sexual partners, 2) where to engage in sexual relationships, 3) what kinds of relationships to seek, and 4) whether to carry and to use condoms. Advancing conceptualisations of social risk, we show that intersectional stigma and the social production of space are key processes through which social risk generates HIV vulnerability among Black men who have sex with men.

Keywords

HIV; Black men who have sex with men; social risk; stigma; space; New York City

Black gay, bisexual and other men who have sex with men in the USA are disproportionately affected by HIV (Centers for Disease Control and Prevention 2014a). HIV prevalence among Black men who have sex with men is estimated to be 36% compared to 15% for

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white men who have sex with men and young Black men who have sex with men have incidence rates roughly double that of all other young men who have sex with men in the USA (Centers for Disease Control and Prevention 2014a). This reflects underlying structural inequalities that include economic insecurity, stigma and discrimination, and poor access to health care and treatment services (Maulsby et al. 2014; Millett et al. 2012; Radcliffe et al. 2010).

In this paper, we use the concept of social risk as a lens through which to analyse how structural inequalities generate HIV vulnerability among Black gay, bisexual and other men who have sex with men. Drawing on a long tradition in HIV research which documents the complex social drivers of HIV, including structural factors such as poverty, sexual oppression, and racism (Farmer 1992; Schoepf et al. 1988; Singer et al. 1990), researchers have proposed the concept of social vulnerability as an alternative to conceptions of risk that use individual-level behaviours to explain the social distribution of HIV (Mann and Tarantola 1996). While social vulnerability is useful for understanding how the way individuals are positioned within a social structure renders them vulnerable to illness, social risk is a also useful concept for analysing how social vulnerability can shape behaviour in health-relevant ways (Hirsch et al. 2009). Social risk is related to, but distinct from, social vulnerability.

Recent studies have identified a variety of reasons relating to trust and intimacy why men may engage in unprotected sex (Golub et al. 2012; Greene et al. 2014; Peterson et al. 2003). These studies have described how sexual relationships often entail navigating multiple and sometimes competing kinds of risks, but they have not explored this process in a theory-driven way. We hope that a clear theoretical articulation of social risk will advance understandings of such findings. The meaning of social risk is often taken as self-explanatory, but actually the concept has been used in several distinct ways. Social risk has been conceptualised as the stigma associated with an illness or behaviour (Burris 2000; Herek, Capitanio, and Widaman 2003), and defined as a health-related strategy that presents a threat to existing and possible future relationships (Castaneda et al. 2010; Eaves et al. 2014). Building on the work of Hirsch and colleagues (2009), we conceptualise social risk as the threat to culturally valued social resources that is associated with a decision or behaviour which also has health consequences; those health consequences may be immediate or in the distant future. As Hirsch and colleagues write (2009, 19):

> ‘The concept of social risk highlights how men and women who put themselves “at risk” of HIV infection are engaging in behaviours which generally make good sense in a particular social and cultural context. People are navigating opportunities and constraints that are often economically, socially and culturally more salient, significant and obviously consequential than the biomedical risk of HIV’.

Social risk is therefore helpful for understanding both why people refrain from engaging in health promoting behaviours and why they in engage in behaviours that involve health-related risks. To understand how social risk may drive HIV vulnerability among Black gay, bisexual and other men who have sex with men, we draw on two supplementary concepts: intersectional stigma (Collins 1991; Crenshaw 1989; Parker and Aggleton 2003) and the social production of space (Lefebvre 1991). Following Parker and Aggleton (2003) we see

stigma as a social process that is deployed to produce and reproduce relations of power and dominance along intersecting axes of social inequality. Previous ethnographic research has documented how Black men who have sex with men experience multiple intersecting forms of stigma along axes of sexuality, race, gender performance and class (Bowleg 2013; Garcia et al. 2015) and HIV status (Arnold, Rebchook, and Kegeles 2014). A consideration of social risk must account for the fact that Black men who have sex with men need to navigate various social and health risks in contexts in which their opportunities and priorities are circumscribed by their intersecting stigmatised identities. This paper extends existing work on social risk by considering how it is shaped by intersectional forms of stigma.

Our analysis of social risk is supplemented by a consideration of the social production of space (Lefebvre 1991). Spaces are not neutral backgrounds. They are imbued with particular meanings and generate certain behaviours. Through attending to space, scholars have revealed how structural inequalities spatially organise social life, excluding people from, or confining people to, particular settings (Garcia et al. 2014; Low 2011), in ways that influence health and sexual practices (Hirsch et al. 2009; Keene and Padilla 2014). For the present analysis, we approach the social production of space as a process that shapes social risk and generates HIV vulnerability by circumscribing where men do and do not engage in sexual relationships and by inciting or prohibiting certain behaviours within particular spaces.

Our analysis draws on a subset of findings from an ethnographic study conducted between June 2013 and May 2014 that examined the structural and sociocultural factors shaping Black gay, bisexual and other men who have sex with men's sexual relationships and health care engagement. Here we explore how structural inequalities including stigma and discrimination, economic insecurity and housing instability influenced this sample of men's sexual relationships. We present a schema for conceptualising the spatial organisation of these relationships, and use this to analyse how men navigated social and health risks within these spaces. We then explore the implications of our research for HIV prevention.

Methods

We conducted three 90-min in-person interviews with 31 Black gay, bisexual and other men who have sex with men who were recruited principally from Manhattan, New York City, through outreach and advertising in bars, clubs, community health centres, and also via the Internet. They were eligible to participate if they were aged 15 and older, were born as and identified as male, and reported having had anal or oral sex with a man in the past year. We created and administered interview guides based on the theoretical concepts of social risk, stigma, and sexual networks. We also conducted 60-min interviews with 17 community stakeholders (e.g. outreach workers, community advocates, healthcare professionals) involved in services and programme's related to Black men's health. Interviews were digitally recorded and transcribed. Over eleven months, the lead ethnographer (JG) conducted participant observation in places frequented by Black men, with a list of social spaces emerging from interviews to include public spaces (gay bars, nightclubs, parks, streets, churches and libraries) civil society organisations that work closely with Black MSM, and private spaces (participants' homes and house parties). Interview data and

fieldnotes were analysed using Atlas.ti 7.0 qualitative software, and the first and second authors coded the data with inter-coder agreement greater than 80%. For this analysis we employed a codebook based on our theoretical framework. The codebook was expanded over the course of the study to include open codes that emerged from the data. Here, we draw on several code families, including 'stigma/discrimination' and 'experience of structural factors' as well as from open codes that revealed the importance of the social context for health-related behaviours such as 'safe spaces' and 'trade-offs'.

Results

Sample characteristics

The men in our sample (N=31) had a mean age of 29 years. Ten had a history of incarceration. Eight had full-time employment, eight had part-time employment, and 15 were unemployed. In the last twelve months, 15 reported stable housing, 11 reported precarious housing (i.e., living with someone else and unsure about continuity of housing situation), and five had experienced homelessness. Based on self-report, 23 were HIV negative, five were HIV positive, and three chose not to answer that question. Five had private insurance, 17 had public insurance, and nine were uninsured.

Men described themselves using a range of sexual identity categories. Fifteen participants identified as gay, three identified as same-gender loving, four identified as bisexual, four identified as discreet, three identified as straight and two preferred no sexual identity. In the six months prior to being interviewed, men reported between one and 40 male sexual partners (mean = 6.06) and 5 men had sex with female partners (mean = 2.4). In the twelve months prior to being interviewed over half (N=17) of the men reported condomless sex.

Structural inequalities surrounding men's sexual relationships

Men's sexual relationships were largely shaped by economic insecurity, housing instability, and stigma and discrimination. These structural inequalities influenced the kinds of relationships men engaged in and where sexual behaviour happened. Almost half of participants were unemployed and over half had experienced homelessness or housing instability in the past year. Unstably housed and unemployed men sometimes used sex to satisfy material needs and several reported engaging in various kinds of sex work (the exchange of sex for money and/or material goods). This was generally not reported among the men of higher socio-economic status. Three unstably housed men were currently using sex work as their primary source of income, but many of the low-income men recounted recently having exchanged sex for resources such as food, alcohol, drugs, clothing, and the payment of phone bills and taxis. Economic insecurity and housing instability constrained these men's ability to negotiate condoms. Some recounted exchanging sex without condoms in order to have a bed for the night. As one participant (39, gay) explained, in a conversation about the exchange of condomless sex for housing:

> 'Okay. If you are eating and you have clothing, you have shelter, you're probably going to resist it and a very blatant resistance. But if you are hungry, that's a different ballgame. I can sit here and tell you I'm a very proud person but you let my stomach rumble for more than three days, okay, you can call me'

Men who lacked stable housing often said this was a barrier to sustaining a long-term relationship, and some men recounted having sexual relationships with multiple sexual partners in order to obtain temporary housing. As one said,

> 'It's a lot about being homeless and all that. It's not really conducive to having a relationship. So we have an understanding' (20, discreet)

For the unstably-housed and unemployed men, decisions about sexual relationships often also entailed economic and housing-related considerations. When they engaged in condomless sex, they were often navigating structural inequalities that were more immediately consequential than the medical risk of HIV infection. Among the men of higher socio-economic status, their goals and strategies regarding sexual relationships generally did not reflect these pressing economic considerations.

Stigma, discrimination and the spatial organisation of sexual relationships

We have documented elsewhere how these men experienced stigma across multiple institutions including the family, church, school and public spaces (Garcia et al. 2015, 2016). Here, our focus is specifically on how stigma and other structural inequalities shaped the spatial organisation of men's sexual relationships. On the basis of interviews and participant observation, we conceptualise the spatial organisation of sexual relationships as comprising four types of spaces: 1) the home, 2) public spaces and cruising spots, 3) virtual spaces including apps and websites, 4) predominantly Black and Latino gay bars and nightclubs. In this section, we analyse how men navigate social and health risks within these spaces.

The home

The social risks of engaging in sexual relationships at home were shaped by stigma and discrimination. Many men (N=21) recalled experiencing homophobic language and negative attitudes towards homosexuality from their families, and this was especially prominent among older men. One participant, (46, discreet), explained that:

> '[homophobic language comes] from your grandma, from your aunt, from your uncle's buddy, from your uncle – they could say everything about faggots and lesbians… It's not supported in the black community'.

Talking about sexuality with family members entailed social risks that ranged from losing family support to being thrown out. In the most extreme cases, four men were physically beaten by family members and familial homophobia directly contributed to housing instability among four participants. But much more commonly, men said that their family members found it difficult to accept their sexuality, although this changed over time. Some men felt supported by particular relatives, who also told them not to tell other family members. For instance, one college-educated participant (22, gay) who had a close relationship with his mother recounted: 'at the time, she [his mother] was kind of like, your grandmother will have a heart attack. It will kill her'. Another participant (26, gay) described the possible consequences of 'coming out' for young gay men in his community:

> 'You have to know what the consequences are gonna be. If you know your parents are gonna kick you out, then you don't come out, you just don't. If you know you're gonna get beat up every time you come home, you don't come out'.

Some participants connected their anxieties about discussing sexuality to their race and class position. One participant (27, same gender loving) emphasised that his family was not homophobic but rather they were worried about how his sexual orientation would affect his life chances.

> ‘She [his mother] told me that it wasn’t that she has a problem with me being gay; her problem is with how society looks at the lifestyle, and she said the last thing she wanted was for me to have something extra that puts me in danger for no reason’.

Negative constructions of homosexuality shaped how men conducted their sexual relationships. Many avoided introducing male sexual partners to family members. Several of the bisexual men said that while they felt comfortable bringing girlfriends homes, they would never bring a male partner home. Several of the younger men who lived with their families said they preferred to have sexual relationships at their sexual partners’ homes or in public spaces. One participant (29, gay) recounted leaving home to live in shelter because his mother, who allowed his brother to have girlfriends over, would not allow him to bring partners to the house.

> ‘I was a gay man and figuring out that my mum wasn’t too happy about it…. I couldn’t bring any company over or they couldn’t stay overnight or whatever, [but] he could bring girls over and there was discrimination towards me with my mum’

Even among men who lived independently, bringing sexual partners home sometimes entailed social risks. Some wished to keep their relationships with men secret from their landlords or neighbours. One participant (22, gay), who lived alone and was in a long-term relationship, avoided bringing his boyfriend to his apartment because his landlord had made homophobic comments and his boyfriend ‘doesn’t feel safe’ on the premises. He was concerned about neighbours hearing him and his boyfriend having sex, and at the time of the interview was searching for a ‘gay friendly’ apartment:

> ‘Regardless of how they feel about me having sex there, at least I would feel safe about the idea of bringing my partner over’.

The above examples illustrate how stigma and discrimination both in men’s family households and in other housing institutions (from landlords and neighbours) shape social risk. There were significant social risks to having sexual relationships at home (including losing family support, losing social status, feeling unsafe, losing housing) and this shaped the spatial organisation of sexual relationships and for HIV vulnerability, which we explore further in the following sections.

Public places and cruising spots

Many men reported meeting and having sexual relationships with men in public spaces including parks, streets, gyms and sports clubs, trains, supermarkets, and restaurants. Sexual relationships in these spaces were reported by men of various sexual identities, but were most common among men who were unstably housed or homeless. Some men who identified as straight or discreet said they preferred seeking sexual partners in cruising spots or via the internet because they did not want to be seen in gay bars or gay nightclubs, suggesting that stigma was a factor that drove men into these spaces. Most informants

emphasised that the people who seek sexual relationships in these places are trying to hide their sexual relationships with men. These interactions were often arranged in advance via apps such as Jack'd and Grindr, although some men arranged and initiated sexual relationships with men in public spaces themselves.

> 'Like in Queens, I found a spot because I was hitting somebody up from on Jack'd… He's like, "Hey, take a right. Take a left and then go up the block. Then go down and you're going to find a spot"…I didn't even know the guy, so it's crazy that I trusted him enough to actually follow his direction' (24, gay)

Consistent with prior studies (Lichtenstein 2000), observations at various New York City parks revealed that sex in these spaces was often rushed, taking place in the context of drug and alcohol consumption. At cruising spots in several parks, used condoms, bottles of sanitiser and lubricant littered the area, suggesting that men sometimes took steps to protect themselves from sexually transmitted diseases in these spaces. However, during interviews many men mentioned that condom-use was not always possible because sex was often rushed, and 'you don't have time to ask questions' (31, same gender loving). Some men said that they avoided asking about sexual partners' HIV status in these spaces, because this could make other men assume that they were HIV positive.

Fear of the police was also a significant social risk at public cruising spots. Several participants mentioned the possibility of arrest for sex in public spaces. One participant had been stopped at a cruising spot the year before, and several recounted instances of having to leave because police were around.

> 'They were just like, "You know you're not supposed to be here?" A lot of the areas where you can cruise at, you're really not supposed to be there. So who makes up the fucking rules to do all this shit? I'm like, "What?" ' (24, gay)

The social risk of being arrested generated HIV vulnerability by discouraging men from carrying condoms. A number of men thought that carrying condoms was dangerous because they could be used as evidence of sex work, 'cops believe if you have condoms on you, you're a sex worker' (29, gay). This reflects the legal practice - only recently suspended in New York City – whereby police used condom possession as evidence of sex work in criminal prosecutions (Huffington Post 2014). This led to confusion about the legal status of carrying condoms. A minority of participants thought it was illegal to carry condoms in public places. One asked, 'Are condoms legal to carry around?' (22, gay). Several avoided carrying condoms when cruising to avoid being racially profiled and arrested for sex work. Mistrust and fear of both the police and the criminal justice system was widespread among the men in our sample. Many men had been previously incarcerated (N=10) and most recounted being racially profiled in New York City. Thus, the social risks to engaging in sexual relationships within these spaces were shaped by men's intersecting stigmatised identities related to being both Black and a sexual minority. Those social risks influenced men's choices regarding their sexual behaviour.

In addition to fear of arrest, men were also concerned about being physically assaulted in these spaces. One participant had been chased from a cruising spot through the park by a group of men with bats, and several made reference to incidents in which other cruisers had

been physically assaulted. Fear of physical assault was another reason for rushed sex and potentially a factor that undermined condom use.

Together these findings illustrate how structural inequalities (economic insecurity, housing instability, and stigma and discrimination) circumscribe sexual behaviour to particular spaces by precluding sexual relationships at home and pushing it into public spaces. When sex occurred in public places such as the cruising spots, men's most immediate concerns were being arrested and being assaulted, and the social risk of being perceived as HIV positive put many men off asking about their sexual partners HIV status.

Virtual spaces: apps and websites

Virtual spaces emerged as a third dimension of socially produced space. Dating apps and websites are increasingly popular across the US (Smith and Duggan 2013), and most of the men we interviewed had used apps (Grindr, Jack'd), and websites (Black Gay Chat, Adam for Adam), at some point in their lives. Men who identified as discreet or straight (N=7) tended to seek sexual partners primarily through apps and websites. They perceived apps and websites as making the pursuit of sexual partners easier (facilitating the identification of other men interested in men) and socially safer (providing discretion and sometimes anonymity). Through apps and websites men coordinated important details in advance. As one participant (27, same gender loving) explained:

> 'So it's like kind of negotiating time, space, my place or your place, after your job or when you get off work? Do you have a girlfriend? Are you gay? Are you okay being with gay guys? Are you DL? Are you okay with someone who is not DL'

Men also arranged the buying and selling of sex via apps and websites. Some men who were in relationships with women restricted their sex with men to sex workers, and used apps as a discreet way to find them. Several of the men who engaged in sex work used the Internet to arrange exchanges. Although apps and websites were popular, many men perceived them as inherently 'risky' or 'dangerous', in part because of the chance of finding someone violent. One participant (18, gay), who had arranged to meet up for casual sex with someone he met on Twitter, recounted having unprotected receptive anal sex with a more masculine man against his will:

> 'He lied and said that he put one on and he didn't. I told him to get off of me and he wouldn't… And he was a lot bigger than I am, so it was just really bad'

The perception that Internet-initiated sex was dangerous was related to perceptions that Black and gay men were inherently 'risky', which some men attributed to public health messaging that Black men were at high risk of HIV. One participant (21, gay) explained that although it was dangerous to allow strangers into one's home, he did it because 'it's a whole different world for us… we live this lifestyle and take so many risks as gay men'. And another participant rationalised:

> 'We take so many risks as gay Black men. I would not encourage any young girl at my classes that I teach self-defence at to do. I tell them do not get in a car with strangers. Don't go with a stranger ever, ever, ever. I don't care if you're 16 or 20, don't do it. And here I am – ' (29, Gay).

There is some evidence that internet-initiated sex among MSM is more likely than non-Internet-initiated sex to be unprotected (Lewnard and Berrang-Ford 2014). These examples illustrate how stigma and discrimination shape men's subjective perceptions of risk: although men perceived these sexual relationships to entail certain physical dangers, they also felt that this risk was acceptable.

Black and Latino gay bars and nightclubs

Bars and nightclubs emerged as a fourth dimension of socially produced space. The men in our sample gravitated towards gay venues that were frequented by other Black men as well as Latinos. These spaces provided opportunities for men to socialise with other MSM and were often seen as affording relative social safety because same-sex desire was socially supported. Men who identified as gay or bisexual were more likely to seek sexual partners in gay venues than men who were straight or discreet, but several discreet men who refrained from being seen with partners on the streets said they were more comfortable socialising with their sexual partners in these spaces. As one participant (47, discreet) explained:

> 'Well, you'll never see me walk down the street holding another guy's hand or kissing out of the blue, another guy outside. Maybe inside the club, that's different, but not outside'

For those who engaged in sex work, bars offered some protection from police and were seen as preferable to the street for meeting clients, and unstably housed men sometimes went to clubs to find 'a generous friend' with a place to stay. However, many recounted being put off from attending these nights by 'drama', and many men described a hostile atmosphere in which verbal put-downs and violence were common. Discrimination in these spaces was most commonly directed at men of low socio-economic status and men with feminine gender performance. Visible characteristics that signified lack of economic resources (having the wrong clothes, not having cash for drinks) and feminine gender performance (styles of dressing, talking, walking) made men more likely to be targets of verbal insult and physical violence. In these spaces, stigma seemed to operate more along the axes of class and gender performance than of sexual identity. A number of the more feminine men said that they no longer attended gay nightclubs because they could not tolerate the insults. Several key informants made connections between forms of discrimination and social put-downs among Black men and HIV vulnerability. As one said:

> 'It's really bad at times. I see it all the time, the fighting, the arguments and the putdowns and – yeah, so if you feel like you're being put down all the time about your weight or about your financial situation or housing situation, sometimes you submit to someone who's waving $10 to $20 and have their own place' (HIV community advocate)

Two participants with relatively feminine gender presentation recounted being physically assaulted by more masculine-appearing Black men. One was assaulted outside a nightclub for being 'faggoty', and several participants expressed confusion as to why violence was being perpetrated among Black gay men. This highlights how intersectional stigma and the social production of space inter-relate in ways that shape HIV vulnerability. Although some men did prefer to find sexual partners in gay venues where the social risks of being seen

with a sexual partner were less because same-sex desire was socially recognised, failing to adhere to masculine norms of self presentation and revealing one's working class background could result in adverse consequences including verbal humiliation and physical violence.

Discussion

In summary, the concept of social risk sheds light on the processes through which structural inequalities generate HIV vulnerability. Among most of the men in this sample, the pursuit of same-sex relationships took place in a social context characterised by economic insecurity, housing instability, and widespread stigma and discrimination, all of which enhanced vulnerability to HIV. Such findings are supported by existing evidence that unemployment, incarceration, low income and education (Mayer et al. 2014; Millett et al. 2012), housing instability (Aidala et al. 2005) and stigma and discrimination (Eaton et al. 2015; Foster et al. 2011; Garcia et al. 2015) exacerbate HIV risk among Black gay, bisexual and other men who have sex with men. What we add to that literature is the idea that there is a shared process through which those different dimensions of social inequality produce HIV vulnerability. Building on prior applications of the social risk framework (Green and Sobo 2000; Hirsch et al. 2009) we draw attention to how men's position in a social structure (their social vulnerability) configures their opportunities, restrictions and priorities in sexual relationships and how these shape their choices and behaviours in health-relevant ways. We found the words of one of one of our key informants, a psychologist, particularly helpful for illustrating how social vulnerability, social risk, and health interrelate:

> 'It's tricky. It's juggling identities, juggling vulnerability, getting armour. I'm a firm believer in getting armor because it's a tough world out there, but not armour that's gonna strangle you and make you sick. Armour that keeps you safe, keeps you protected to a certain degree and that you can take off and leave at the door when you get home'.

In navigating these social risks, some men ended up with armour that was detrimental to their health (see Table 3). Sometimes social risk discouraged men from engaging in health promoting behaviours (e.g. carrying condoms) whereas other times it encouraged behaviours that involved health-related risks (e.g. not using a condom). Social risks influenced where men sought sexual partners and where they engaged in sexual relationships, whether they carried and used condoms, and also the kinds of relationships they engaged in.

Key forms of social risk among the men in this sample included losing family support, losing housing, being arrested, and being discriminated against because of sexuality. To advance understandings of how social risk operates, we have developed two supplementary concepts: intersectional stigma (Collins 1991; Crenshaw 1989; Parker and Aggleton 2003) and the social production of space (Lefebvre 1991). Intersectional stigma was a key process shaping social risk. Concerns such as feeling unsafe bringing your boyfriend home because it might get you kicked out, or worrying that carrying condoms might get you arrested, are not the personal qualms of individual men. Rather, these social risks are directly linked to men's intersecting identities as Black, sexual minority, and (mostly) of low socio-economic status, as evidenced in their disproportionate rates of homelessness, housing instability and

survival sex (Curtis et al. 2008; Dank 2015), in the high rates of hate crimes against young black sexual minority men (National Coalition of Anti-Violence Programs (NCAVP) 2012) and in Black men who have sex with men's high rates of incarceration (Brewer et al. 2014; Millett et al. 2012).

As well as men's stigmatised identities, we have posited the social production of space as a second process that shapes social risk and generates HIV vulnerability. Existing studies of space and HIV transmission have mostly focused upon how the characteristics of particular spaces influence risk behaviours (e.g. Rhodes et al. 2005). By treating space as socially produced (Lefebvre 1991), we emphasise the importance of research that goes beyond examining how particular spaces influence HIV transmission, to analyse how structural inequalities shape the spatial organisation of sexual behaviour and HIV vulnerability. While our focus is on the spatial organisation of sexual behaviour and HIV vulnerability, our approach engages with recent work that theorises the connections between space, stigma and health (Keene and Padilla 2014).

Although current HIV prevention efforts and research agendas emphasise individual-level behavioural and biomedical prevention approaches such as PrEP, PEP, and behaviour-change counselling (Centers for Disease Control and Prevention 2014b; Office of National AIDS Policy (ONAP) 2015), our research underlines the continued need to attend to the structural drivers of HIV among Black gay, bisexual and other men who have sex with men. Interventions that show promise for addressing stigma, discrimination and housing insecurity among Black men who have sex with men include: community-based participatory interventions that cultivate sociopolitical mobilisation among African American communities (Operario et al. 2010; Rhodes et al. 2011; Watts, Abdul-Adil, and Pratt 2002); community groups to support parents of LGBT youth and increase familial acceptance (CAMBA Project ALY (Accept LGBT Youth) 2015; P-FLAG 2015; Ryan et al. 2010); anti-stigma training workshops for key communities organisations such as churches (Paige et al. 2015); and housing assistance programmes for unstably housed people living with HIV (Kidder et al. 2007). Research and interventions that focus on the structural drivers of HIV should be a key priority for HIV prevention among Black gay, bisexual and other men who have sex with men.

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References

Aidala A, Jay EC, Stall R, Harre D, Sumartojo E. Housing Status and HIV Risk Behaviors: Implications for Prevention and Policy. AIDS & Behavior. 2005; 9(3):251–265. [PubMed: 16088369]

Arnold EA, Rebchook GM, Kegeles SM. 'Triply Cursed': Racism, Homophobia and HIV-Related Stigma are Barriers to Regular HIV Testing, Treatment Adherence and Disclosure among Young Black Gay Men. Culture, Health & Sexuality. 2014; 16(6):710–722.

Bowleg L. 'Once You've Blended the Cake, You Can't Take the Parts Back to the Main Ingredients': Black Gay and Bisexual Men's Descriptions and Experiences of Intersectionality. Sex Roles. 2013; 68(11–12):754–767.

Brewer RA, Magnus M, Kuo I, Wang L, Liu T, Mayer K. Exploring the Relationship between Incarceration and HIV among Black Men Who Have Sex with Men in the United States. JAIDS Journal of Acquired Immune Deficiency Syndromes. 2014; 65(2):218–225. [PubMed: 24091691]

Burris S. Surveillance, Social Risk, and Symbolism: Framing the Analysis for Research and Policy. Journal of Acquired Immune Deficiency Syndrome. 2000; 25(2):120–127.

CAMBA Project ALY (Accept LGBT Youth). [Accessed July 18, 2016] CAMBA Project ALY. 2015. http://www.camba.org/projectaly

Castaneda H, Nichter M, Nichter M, Muramoto M. Enabling and Sustaining the Activities of Lay Health Influencers: Lessons from a Community-Based Tobacco Cessation Intervention Study. Health Promotion Practice. 2010; 11(4):483–492. [PubMed: 18540006]

Centers for Disease Control and Prevention. HIV among African American Gay and Bisexual Men. 2014a. http://www.cdc.gov/hiv/group/msm/bmsm.html

Centers for Disease Control and Prevention. HIV Prevention Behavioral Interventions Selected for Support by the Division of HIV/AIDS Prevention. 2014b. https://effectiveinterventions.cdc.gov/docs/default-source/general-docs/HIV_Prevention_Behavioral_Interventions_Selected_for_Support_by_the_Division_of_HIV.pdf?sfvrsn=2

Collins, PH. Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment. London: Routledge; 1991.

Crenshaw K. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. The University of Chicago Legal Forum. 1989; 140:139–167.

Curtis, R., Terry, K., Dank, M., Dombrowski, K., Khan, B., Muslim, A., Labriola, M., Rempel, M. The Commercial Sexual Exploitation of Children in New York City. New York: Center for Court Innovation; 2008.

Dank, M. Surviving the Streets of New York: Experiences of LGBTQ Youth, YMSM, and YWSW Engaged in Survival Sex. Washington, DC: Urban Institute; 2015.

Eaton LA, Driffin D, Kegler C, Smith H, Conway-Washington C, White D, Cherry C. The Role of Stigma and Medical Mistrust in the Routine Health Care Engagement of Black Men Who Have Sex with Men. American Journal of Public Health. 2015; 105(2):e75–e82.

Eaves ER, Nichter M, Ritenbaugh C, Sutherland E, Dworkin S. Works of Illness and the Challenges of Social Risk and the Specter of Pain in the Lived Experience of TMD. Medical Anthropology Quarterly. 2014; 29(2):157–177. [PubMed: 25331799]

Farmer, P. AIDS and Accusation: Haiti and the Geography of Blame. Berkeley: University of California Press; 1992.

Foster ML, Arnold A, Rebchook G, Kegeles S. 'It's My Inner Strength': Spirituality, Religion and HIV in the Lives of Young African American Men Who Have Sex with Men. Culture, Health & Sexuality. 2011; 13(9):1103–1117.

Garcia J, Muñoz-Laboy M, Parker R, Wilson P. Sex Markets and Sexual Opportunity Structures of Behaviorally Bisexual Latino Men in the Urban Metropolis of New York City. Archives of Sexual Behavior. 2014; 43(3):597–606. [PubMed: 23479357]

Garcia J, Parker C, Parker R, Wilson P, Philbin M, Hirsch J. Psychosocial Implications of Homophobia and HIV Stigma in Social Support Networks Insights for High-Impact HIV Prevention among Black Men Who Have Sex with Men. Health Education & Behavior. 2015; 43(2):217–225. [PubMed: 27037286]

Garcia J, Parker R, Parker C, Wilson P, Philbin M, Hirsch J. Black MSM' as a Category: Why Gender, Sexuality, and Desire Still Matter for Social and Biomedical HIV Prevention Methods. Global Public Health. 2016; 28:1–23.

Golub SA, Starks T, Payton G, Parsons J. The Critical Role of Intimacy in the Sexual Risk Behaviors of Gay and Bisexual Men. AIDS & Behavior. 2012; 16(3):626–632. [PubMed: 21630012]

Green, G., Sobo, E. The Endangered Self: Managing the Social Risk of HIV. London: Routledge; 2000.

Greene GJ, Andrews R, Kuper L, Mustanski B. Intimacy, Monogamy, and Condom Problems Drive Unprotected Sex among Young Men in Serious Relationships with Other Men: A Mixed Methods Dyadic Study. Archives of Sexual Behavior. 2014; 43(1):73–87. [PubMed: 24202113]

Herek GM, Capitanio J, Widaman K. Stigma, Social Risk, and Health Policy: Public Attitudes toward HIV Surveillance Policies and the Social Construction of Illness. Health Psychology. 2003; 22(5): 533–540. [PubMed: 14570537]

Hirsch, J., Wardlow, H., Smith, D., Phinney, H., Parikh, S., Nathanson, C. The Secret: Love, Marriage, and HIV. Nashville, TN: Vanderbilt University Press; 2009.

Huffington Post. NYPD to Stop Seizing Condoms as Evidence of Prostitution. The Huffington Post. 2014. http://www.huffingtonpost.com/2014/05/12/nypd-condoms-_n_5310906.html

Keene DE, Padilla M. Spatial Stigma and Health Inequality. Critical Public Health. 2014; 24(4):392–404.

Kidder DP, Wolitski R, Royal S, Aidala A, Courtenay-Quirk C, Holtgrave D, Harre D, Sumartojo E, Stall R. and Housing and Health Study Team. Access to Housing as a Structural Intervention for Homeless and Unstably Housed People Living with HIV: Rationale, Methods, and Implementation of the Housing and Health Study. AIDS & Behavior. 2007; 11(S2):149–161. [PubMed: 17546496]

Lefebvre, H. The Production of Space. Vol. 142. Oxford: Oxford Blackwell; 1991.

Lewnard JA, Berrang-Ford L. Internet-based Partner Selection and Risk for Unprotected Anal Intercourse in Sexual Encounters among Men Who Have Sex with Men: A Meta-Analysis of Observational Studies. Sexually Transmitted Infections. 2014; 90(4):290–296. [PubMed: 24518249]

Lichtenstein B. Secret Encounters: Black Men, Bisexuality, and AIDS in Alabama. Medical Anthropology Quarterly. 2000; 14(3):374–393. [PubMed: 11036584]

Low SM. Claiming Space for an Engaged Anthropology: Spatial Inequality and Social Exclusion. American Anthropologist. 2011; 113(3):389–407. [PubMed: 22145154]

Mann, JM., Tarantola, DJ. From Vulnerability to Human Rights. In: Mann, J., Tarantola, D., editors. AIDS in the World II: Global Dimensions, Social Roots, and Responses. the Global AIDS Policy Coalition. New York: Oxford University Press; 1996. p. 463-476.

Maulsby C, Millett G, Lindsey K, Kelley R, Johnson K, Montoya D, Holtgrave D. HIV among Black Men Who Have Sex with Men (MSM) in the United States: A Review of the Literature. AIDS & Behavior. 2014; 18(1):10–25. [PubMed: 23620241]

Mayer KH, Wang L, Koblin B, Mannheimer S, Magnus M, Rio C, Buchbinder S. Concomitant Socioeconomic, Behavioral, and Biological Factors Associated with the Disproportionate HIV Infection Burden among Black Men Who Have Sex with Men in 6 U.S. Cities. Edited by Rongge Yang. PLoS ONE. 2014; 9(1):e87298. [PubMed: 24498067]

Millett GA, Peterson J, Flores S, Hart T, Wilson P, Rourke S, Heilig C, Elford J, Fenton K, Remis R. Comparisons of Disparities and Risks of HIV Infection in Black and Other Men Who Have Sex with Men in Canada, UK, and USA: A Meta-Analysis. The Lancet. 2012; 380(9839):341–348.

National Coalition of Anti-Violence Programs (NCAVP). Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Intimate Partner Violence. National Coalition of Anti-Violence Programs. 2012. http://avp.org/storage/documents/ncavp_2012_ipvreport.final.pdf

Office of National AIDS Policy (ONAP). National HIV/AIDS Strategy for the United States: Updated to 2020. 2015. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf

Operario D, Smith C, Arnold E, Kegeles S. The Bruthas Project: Evaluation of a Community-based HIV Prevention Intervention for African American Men Who have Sex with Men and Women. AIDS Education and Prevention. 2010; 22(1):37–48. [PubMed: 20166786]

Paige, M., Taylor-Akutagawa, V., Matthews, D., Gordon, S., Usher, D., Musgrave, G., Kornegay, M., Koblin, B., Frye, V. Project CHHANGE: Challenge HIV Stigma and Homophobia and Gain Empowerment: A Community-Level Anti-HIV Stigma and Homophobia Intervention in New York City. Poster presented at the United States Conference on AIDS; Washington, DC. September 10; 2015.

Parker R, Aggleton P. HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action. Social Science & Medicine (1982). 2003; 57(1):13–24. [PubMed: 12753813]

Peterson JL, Bakeman B, Blackshear J, Stokes J. Perceptions of Condom Use among African American Men Who have Sex with Men. Culture, Health & Sexuality. 2003; 5(5):409–424.

P-FLAG. [Accessed July 18, 2016] Support Groups for Parents, Families & LGBT People - PFLAG NYC. 2015. http://www.pflagnyc.org/support/meetings

Radcliffe J, Doty N, Hawkins L, Gaskins C, Beidas R, Rudy B. Stigma and Sexual Health Risk in HIV-Positive African American Young Men Who Have Sex with Men. AIDS Patient Care and STDs. 2010; 24(8):493–499. [PubMed: 20673080]

Rhodes T, Singer M, Bourgois P, Friedman S, Strathdee S. The Social Structural Production of HIV Risk among Injecting Drug Users. Social Science & Medicine. 2005; 61(5):1026–1044. [PubMed: 15955404]

Rhodes SD, Vissman A, Stowers J, Miller C, McCoy T, Hergenrather K, Wilkin A. A CBPR Partnership Increases HIV Testing among Men Who Have Sex with Men (MSM): Outcome Findings from a Pilot Test of the CyBER/Testing Internet Intervention. Health Education & Behavior. 2011; 38(3):311–320. [PubMed: 21393625]

Ryan C, Russell S, Huebner D, Diaz R, Sanchez J. Family Acceptance in Adolescence and the Health of LGBT Young Adults. Journal of Child and Adolescent Psychiatric Nursing. 2010; 23(4):205–213. [PubMed: 21073595]

Schoepf, B., Nkera, R., Ntsomo, P., Engundu, W., Schoepf, C. AIDS, Women, and Society in Central Africa. In: Kulstad, R., editor. AIDS. Washington, DC: American Society for the Advancement of Science; 1988. p. 176-181.

Singer M, Flores C, Davison L, Burke G, Castillo Z, Scanlon K, Rivera M. SIDA: The Economic, Social, and Cultural Context of AIDS among Latinos. Medical Anthropology Quarterly. 1990; 4(1):72–114.

Smith, A., Duggan, M. Online Dating & Relationships. Pew Research Center: Internet, Science & Tech; 2013. http://www.pewinternet.org/2013/10/21/online-dating-relationships/ [Accessed October 21 2013]

Watts RJ, Abdul-Adil J, Pratt T. Enhancing Critical Consciousness in Young African American Men: A Psychoeducational Approach. Psychology of Men & Masculinity. 2002; 3(1):41–50.

Table 1

Study methods.

Data collection method	Specific data elicited	Sample description
Participant Observation	Organisational behaviour, group composition, ways people discuss sexuality, race, gender, age, class; spoken rules of conduct and implicit cultural norms expressed, enforced, followed and navigated.	Over an 11-month period in: private spaces (homes, parties); public spaces (parks, streets, events); virtual spaces (chat rooms, blogs); and institutions (community organisations, health centres, religious institutions).
Key Informant Interviews	Organisational mission; role in organisation/community; knowledge and attitudes about Black men who have sex with men, HIV vulnerability, institutions and networks available to Black men who have sex with men; views about PrEP and other for HIV/STI prevention	17 informants, including 2 physicians; 3 mental health providers; 4 community organisation programme administrators; 5 outreach workers; 3 community mobilisers
In-depth Interviews	Session 1: History of family relations, coming of age, education, housing, making money, friends; community, recreation Session 2: Sexual history, including desire, casual and steady relations, sexual identity and racial identity Session 3: Perceptions of health and risk; practices and attitudes about medications and seeking health services; knowledge and attitudes about HIV prevention	31 participants

Table 2

Sample Characteristics.

Sample Characteristics	Total N=31
Age	29.0 (12.3) *
15–24	17
25+	14
Sexual Identity	
Gay	15
Same gender loving	3
Bisexual	4
Discreet	4
Straight	3
Other (e.g. ‘MSM’, None)	2
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

* Mean (Standard Deviation).

Table 3

Social Risk.

Decisions men made in their sexual relationships which may have health consequences	Strategies men employed to navigate social risk
Where to seek sexual partners and where to engage in sexual relationships	Seeking sexual behaviour in public places such as parks, trains, supermarkets because of lack of housing, lack of privacy at home or because of desire for discretion Using apps or website to find a sexual partner to avoid rejection or to maintain discretion Seeking clients inside gay bars and nightclubs where there is less risk of being arrested by police Not bringing sexual partners home to avoid family conflict Avoiding being seen with sexual partner in public spaces, and only hanging out with sexual partner in certain spaces such as gay bars and clubs where same-sex desire is normatively acceptable
Whether to carry and to use condoms	Not carrying condoms when cruising to avoid arrest Not prioritising condom use when engaging in survival sex to obtain temporary housing during period of housing instability or homelessness Not using a condom because sex is rushed in a public space
What kinds of relationships to seek	Engaging in sex work in exchange for money Having multiple sexual partners to gain access to temporary housing and other resources Only sleeping with sex workers to maintain public heterosexual identity Not asking a sexual partner about their HIV status to avoid people thinking you are HIV positive