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Coming Out to Health Care Providers in Puerto Rico: Opportunities for Prevention and Engagement in Care

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ABSTRACT

Disclosure of same-sex attraction to healthcare providers (HCPs) by MSM is critical because it may promote appropriate health care. We describe factors influencing disclosure of same-sex attraction to HCPs by 302 MSM ages 18 to 73 years who participated in the Puerto Rico National HIV Behavioral Surveillance study. Over 50% had disclosed same-sex attraction to HCPs, and those who had disclosed were significantly older and more likely to be aware of their sexual partners' HIV status compared to MSM who had not disclosed. Non-disclosure of same-sex attraction to HCPs by MSM in Puerto Rico may be associated with missed opportunities for appropriate healthcare.

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Puerto Rico has the second highest overall prevalence of HIV infection (Miranda et al., 2009) and the third highest overall death rates from all causes for adults and adolescents living with HIV when compared to the U.S. mainland. Even when compared to similar ethnic minority populations residing in the United States, such as individuals of Mexican origin, HIV infection prevalence in Puerto Rico is nearly six times higher (Centers for Disease Control and Prevention [CDC], 2011, 2013; Clark et al., 2012). At the end of 2013, a total of 19,559 people were living with HIV/AIDS in Puerto Rico. Surpassing rates of new HIV infections among other populations at risk for HIV, MSM comprised 22.1% of the total number of persons living with HIV in Puerto Rico in 2013 (Puerto Rico Department of Health, HIV/AIDS Surveillance Program, 2012a, 2012b), with sex between men becoming the principal mode of transmission for that period (December 2014). Contributing to this relatively high burden of HIV infections among MSM are unprotected anal sex, early sexual initiation, and the greater prevalence of sex with injecting drug users (IDU) and persons who are HIV positive among MSM, compared with men who only have sex with women (Clatts et al., 2012; Colón-López et al.,

2011; Colón-López, Soto-Salgado, Rodríguez-Díaz, Suárez, & Pérez, 2013a; Lyons et al., 2012).

If healthcare providers (HCPs) are aware of such well-documented health risks for MSM, they could potentially improve disease prevention and general health outcomes for this population. However, there remain significant gaps in communication techniques and cultural competency among HCPs to elicit and appropriately address health concerns of MSM during clinical encounters (Epstein, 1998). HCPs may respond evasively, such as abruptly changing the topic when patients raise issues about sexual health, and may feel ill-equipped to address such concerns (Durso & Meyer, 2012). Patient-related factors that may impede disclosure of same-sex attraction include feeling stigmatized, fear of feeling judged, concerns about privacy and confidentiality, and the perception that disclosure is unimportant (Durso & Meyer, 2012; Fitzpatrick et al., 1994; Klitzman & Greenberg, 2002; Meckler, Elliott, Kanouse, Beals, & Schuster, 2006).

In Puerto Rico, the epidemiology of HIV among MSM, risk factors impacting general health, and issues related to health disparities and stigma have been studied in this group. However, disclosure of same-sex attraction to HCPs by MSM and the

potential impact on health-seeking behaviors and health outcomes for MSM have not been well studied (Clatts, 2012; Colón-López et al., 2011, 2013a, 2013c; Colón-López, Ortiz, Toro-Mejias, Clatts, & Palefsky, 2014; Guzmán, Ortiz, Torres, & Alfonso, 2007; Jimenez et al., 2012; Jovet-Toledo, Rodriguez-Diaz, Santiago-Rodriguez, Vargas-Molina, & Ortiz-Sanchez, 2014; Miranda, 2009; Ortiz-Sanchez & Rodriguez-Diaz, 2014; Oster et al., 2013; Varas-Diaz, Serrano-Garcia, & Toro-Alfonso, 2005). Therefore, this study sought to identify sociodemographic, behavioral, and health-related characteristics that are associated with disclosure of same-sex attraction by MSM to HCPs. This knowledge could raise awareness among HCPs about MSM health needs in Puerto Rico and inform targeted preventive care for MSM.

Method

Participants

Participants from our study were part of the Puerto Rico National HIV Behavioral Surveillance (NHBS) study. Our study included male participants who reported having had oral or anal sex with another man in the last 12 months, agreed to and completed the HIV rapid test, and answered the questions regarding disclosure of same-sex attraction or sexual practices to a HCP ($N = 302$). Thirty-three participants were excluded because they did not answer the question regarding disclosure of sexual attraction to a HCP.

Procedures

The national HIV behavioral surveillance system

Puerto Rico is among the jurisdictions participating in the NHBS conducted by the Centers for Disease Control and Prevention in collaboration with the HIV Surveillance System of the PR Department of Health. The methodology used in the NHBS study has been described elsewhere (MacKellar et al., 2007; Wejnert et al., 2013). We restricted our analyses to the data from the NHBS MSM Cycle Three from the San Juan Metropolitan Statistical Area (SJMSA). Recruitment was done through venue-based sampling, during which recruiters visited places frequented by MSM, such as bars, night clubs, and beaches; as well as various community and religious organizations. Eligibility criteria for inclusion in the study were born male, at

least 18 years of age, resident of the San Juan Metropolitan Statistical Area (SJMSA), able to understand English or Spanish, be a first time participant of the NHBS study, and reported ever having oral or anal sex with another man (Finlayson et al., 2011; MacKellar et al., 2007). Eligible individuals completed anonymous standardized face-to-face interviews that lasted for approximately 25 min with trained interviewers who noted responses using a handheld computer device with the Questionnaire Development System software. An HIV test was offered to those who completed the interview. The interview included questions related to demographics, sexual practices, drug use, HIV and other sexually transmitted infections (STI) testing and diagnosis. Ethics approval for this study was obtained through the University of Puerto Rico-Medical Science Campus Institutional Review Board.

Measures

Dependent variable

Similar to the NHBS-NYC data (Bernstein et al., 2008), disclosure was assessed using the question “Have you told any health care provider that you are attracted to or have sex with other men,” with the response options yes or no.

Independent variables

Sociodemographic variables included were age, education, household income, employment, sexual orientation, age of same-sex sexual debut, health insurance, and type of venue of recruitment. Age of same-sex sexual debut indicates the age at which the participant had his first sexual encounter (oral or anal) with another man. Age and age at same-sex sexual debut were used as continuous variables. Behavioral variables related to sexual practices included having a female sexual partner in the last 12 months (yes or no), having more than five male sexual partners in the last 12 months, and having unprotected anal sex in the last 12 months (yes or no). Health-related variables included whether the respondent had visited a HCP in the last 12 months, whether a HCP had recommended an HIV test in the last 12 months, having had an HIV test in the last 12 months, HIV status, awareness of current or recent sexual partner’s HIV status (awareness of partner’s HIV status referred to the most recent partner, regardless of whether the partner was a casual or main partner), having had a

syphilis test in the last 12 months, syphilis diagnosis in the last 12 months, and binge drinking in the last 12 months. The occurrence of an HIV testing recommendation by a HCP was assessed using the question “At any of those times you were seen by a HCP, were you offered an HIV test?” (yes or no). HIV status was determined by an HIV test performed at the time of the NHBS survey.

Statistical analyses

Bivariate analyses were used to examine differences in sociodemographic, behavioral, and health-related factors between participants who had disclosed their same-sex attraction or sexual practices to a HCP and those who had not. Logistic regression analyses were conducted to identify factors that were independently associated with disclosure of same-sex attraction or practices to a HCP. A p -value less than .05 was considered statistically significant. All analyses were performed using SAS statistical software version 9.3.

Results

The mean age of the participants was 31.5 years (range = 18–73 years). The majority of participants had attained at least a college education (73.8%), had health insurance (78.2%), and was employed (73.8%). Nearly all of the participants reported having a household income less than \$20,000 (94.3%). All participants self-identified as either homosexual (87.1%) or bisexual (12.9%), and none identified as heterosexual. Most of the participants (95.6%) were recruited in bars/clubs or sex venues. The mean age of same-sex sexual debut was 16.4 years ($SD = 5.4$).

Just over a half of participants (53.3%) reported that they had disclosed same-sex attraction or behavior to a HCP. Comparing men who had disclosed their same-sex attraction or behavior to a HCP to those who had not, there were no statistically significant differences in education, employment, household income, sexual orientation, health insurance, mean age at sexual debut, and venue at which recruitment for this study occurred (Table 1).

There were significant differences between men who had disclosed their same-sex attraction or behavior to a HCP and those who had not. Disclosure was associated with older age ($p = .015$), lower unawareness of sexual partner's HIV status (48.1% vs. 59.6%, $p = .047$), visiting a HCP in the last 12

Table 1. Demographic Characteristics of Men Who Have Sex With Men from the National HIV Behavioral Surveillance – Puerto Rico ($N = 302$).

	No.	%
Age (years) <i>M, SD</i>		31.5, 10.7
Age of sexual debut (years) <i>M, SD</i>		16.6, 5.4
Education		
High school or lower	79	26.2
Some college or higher	223	73.8
Health insurance		
No	66	21.8
Yes	236	78.2
Employment status		
Student	36	12.1
Employed full/part time	220	73.8
Unemployed	42	14.1
Annual household income		
\$0 to \$19,999	282	94.3
\geq \$20,000	17	5.7
Sexual orientation		
Homosexual	263	87.1
Bisexual	39	12.9
Disclosure to healthcare provider		
No	141	46.7
Yes	161	53.3
Venue type		
Bars/clubs or sex venues	238	95.6
Other venues ^a	11	4.4

Notes:

^aOther venues includes gyms, restaurants, parks and beaches, street locations, social organizations, and other places frequented by men who have sex with men.

months (78.9% vs. 68.8%, $p = .046$), and being prompted by a HCP to do an HIV test in the past 12 months (29.1% vs. 10.3%, $p = .001$).

Univariate logistic regression analyses (Table 2) showed that as age increased, men were 2.0% more likely to disclose same-sex attraction to a HCP ($OR = 1.02$, 95% CI [1.01, 1.06]). Likewise, men who were aware of their partner's HIV status were 58.0% more likely to disclose their same-sex attraction or practices to a HCP (odds ratio [OR] = 1.58, 95% confidence interval [CI]: 1.01, 2.51). Similarly, those who had visited a HCP in the last 12 months were 69.0% more likely to have disclosed their same-sex attraction compared to those who had not disclosed (OR = 1.69, 95% CI: 1.01, 2.85). Further, MSM who reported receiving a recommendation to test for HIV in the last 12 months were more than three times more likely to disclose to a HCP (OR = 3.58, 95% CI: 1.68, 7.63; Table 2).

Based on multivariate regression analyses, men who were older and men who were aware of their partners' HIV status were significantly more likely to have disclosed their same-sex attraction or behavior to a HCP (OR = 1.03, 95% CI: 1.00, 1.05; $p = .020$; Wald's test,

Table 2. Univariate Logistic Regression Analyses for Disclosure of Same-Sex Attraction or Behavior to Healthcare Providers by Men Who Have Sex With Men in the National HIV Behavioral Surveillance, Puerto Rico ($N = 302$).

Characteristics	Not disclosed same-sex attraction to health care provider		Disclosed same-sex attraction to health care provider		<i>p</i> value	OR (95% CI)
<i>Sociodemographics</i>						
Age (<i>M, SD</i>)		29.4, 9.5		32.5, 11.5	.015 ^a	1.02 (1.01, 1.06)
Age at sexual debut (<i>M, SD</i>)		16.6, 5.2		15.9, 5.2	.33	.97 (.93, 1.02)
Education	No.	%	No.	%		
High school or lower	41	29.1	38	23.6	.28	1.00 (Reference)
Some college or higher	100	70.9	123	76.4		1.33 (.79, 2.22)
Health insurance						
No	30	21.3	36	22.4	.82	1.00 (Reference)
Yes	111	78.7	125	77.6		.94 (.54, 1.62)
Employment						
Employed full/part time	96	68.57	124	78.48	.11	1.00 (Reference)
Student	22	15.71	14	8.86		.49 (.24, 1.00)
Unemployed	22	15.71	20	12.7		.69 (.36, 1.34)
Annual household income						
0-19,999	132	94.9	150	93.7	.65	1.00 (Reference)
≥20,000	7	5.1	10	6.3		1.25 (.46, 1.39)
Sexual orientation						
Homosexual	124	87.9	139	86.3	.68	1.00 (Reference)
Bisexual	17	12.1	22	13.7		1.15 (.58, 2.27)
Venue type						
Bars/clubs or sex venues	110	94.8	128	96.2	.59	1.00 (Reference)
Other venues ^b	6	5.2	5	3.8		.71 (.21, 2.40)
<i>Behavioral</i>						
Female partners in the last 12 months						
No	44	93.6	64	95.5	.29	1.00 (Reference)
Yes	3	6.4	3	4.5		.92 (.35, 2.40)
More than 5 male partners in the last 12 months						
No	111	78.7	124	77.0	.69	1.00 (Reference)
Yes	30	21.3	37	23.0		1.10 (.64, 1.90)
Unprotected anal sex in last 12 months						
No	57	40.4	61	37.9	.61	1.00 (Reference)
Yes	84	59.6	100	62.1		1.11 (.70, 1.77)
Aware of partner's serostatus						
No	84	59.6	77	48.1	.047 ^a	1.00 (Reference)
Yes	57	40.4	83	51.9		1.58 (1.01, 2.51)
<i>Health related</i>						
Visited healthcare provider in last 12 months						
No	44	31.2	34	21.1	.046 ^a	1.00 (Reference)
Yes	97	68.8	127	78.9		1.69 (1.01, 2.85)
Healthcare provider recommended HIV test						
No	87	89.7	90	70.9	.001 ^a	1.00 (Reference)
Yes	10	10.3	37	29.1		3.58 (1.68, 7.63)
Tested for HIV in last 12 months						
No	50	50.00	57	40.4		1.00 (Reference)
Yes	50	50.00	84	59.6		1.47 (.88, 2.47)
HIV prevalence						
No	131	92.9	147	91.3	.61	1.00 (Reference)
Yes	10	7.1	14	8.7		1.25 (.54, 2.90)
Syphilis tested in last 12 months						
No	3	8.6	7	11.5	.65	1.00 (Reference)
Yes	32	91.4	54	88.5		.72 (.17, 3.00)
Syphilis diagnosis in last 12 months						
No	139	98.6	156	96.9	.33	1.00 (Reference)
Yes	2	1.4	5	3.1		2.23 (.43, 11.7)
Binge drinking in the last 12 months						
No	90	73.8	115	83.3	.08	1.00 (Reference)
Yes	32	26.2	23	16.7		.56 (.31, 1.03)

Notes:

^aSignificant *p* value.^bOther venues includes gym, restaurants, parks and beaches, street organizations, and other places where men who have sex with men congregate.

and OR = 1.65, 95% CI: 1.04, 2.64, $p = .034$, Wald's test, respectively). Finally, there was a marginally significant association between disclosure and having visited a HCP in the last 12 months: Those who had visited a HCP in

the last 12 months were 65.0% more likely to have disclosed their same-sex attraction or behavior (OR = 1.65, 95% CI: 0.97, 2.81; $p = .066$; Wald's test) than those who had not.

Discussion

To our knowledge, this study is one of the first to examine factors associated with disclosure of same-sex attraction and sexual practices to HCPs by MSM in Puerto Rico. Just over a half (53.3%) of respondents reported that they had disclosed their same-sex attraction or behavior to a HCP. Disclosure, which was more likely with increasing age, was associated with knowing one's partner's HIV status.

Disclosure of same-sex attraction and sexual practices varies across societies. Reported prevalence of disclosure ranges from about 14% in one study conducted in the United Kingdom (Fannin, 2006), 35% in a Los Angeles study (Meckler, 2006), 61% in a New York study (Bernstein et al., 2008), and 71% in a study conducted across several cities in the midwestern United States (Petroll & Mosack, 2011). As suggested by Petroll and Mosack, differences in rates of disclosure by MSM to HCPs may be due to cultural and social differences across geographical areas. Social and cultural factors can contribute to creating a stigmatizing environment that is unfavorable for disclosure to take place, thereby contributing to missed opportunities for targeted healthcare, including HIV prevention, for MSM (Durso, 2012; Jovet-Toleda et al., 2014; Toro-Alfonso, Varas-Diaz, Andujar-Bello, & Nieves-Rosa, 2006; Varas-Diaz, 2005; Santiago-Rodriguez et al., 2014).

Disclosure was more likely with increasing age. This finding is similar to what was reported for MSM in the NHBS-NYC study, where men over the age of 28 years were twofold more likely to disclose to a HCP compared to younger MSM (Bernstein et al., 2008). Lack of disclosure of same-sex attraction and sexual practices by younger MSM is a concern given current data showing high risk sexual behaviors in this group. Data from the CDC have shown an increasing incidence in HIV infections among young MSM (CDC, 2012a, 2012b). Young MSM are often unaware of their HIV status, may underestimate their vulnerability to HIV infection (MacKellar et al., 2007), and are more likely to have high numbers of sexual partners and unprotected anal sex compared to men who only have sex with women (CDC, 2012c; Balaji, Bowles, Binh, Paz-Bailey, & Oster, 2013; Davidovich, deWit, & Stroebe, 2004; Davidovich et al., 2001; Lightfoot, Song, Rotheram-Borus, & Newman, 2005; Mustanski, Newcomb, & Clerkin, 2011; Sullivan, Salazar, Buchbinder, & Sanchez, 2009). Further, in addition to lower

likelihood of disclosure of same-sex attraction by younger MSM, men in this study who had not disclosed were less likely to be aware of the HIV status of their sexual partner. Therefore, behavioral studies and interventions targeting MSM should take into account important behavioral and psychosocial factors that may differ based on age.

We also examined whether there was any association between disclosure of same-sex attraction to a HCP and recent visit to a health facility. In the multivariate analyses, men who reported having visited a HCP within the past 12 months were more likely to have disclosed to a provider, although this was only marginally statistically significant. A similar association was reported for MSM in the NHBS-NYC study, with MSM who had visited a health facility within the past 12 months being 1.5 times more likely to have disclosed their same-sex attraction (Bernstein et al., 2008). Studies examining the patient–physician communication around topics such as HIV and sexual health issues reveal gaps in communication skills and techniques that are culturally appropriate for engaging MSM patients (Epstein, 1998; Neville & Henrickson, 2006; Mayer et al., 2012). For example, Epstein reported that HCPs may have difficulty in even initiating a conversation on sexual health and MSM health issues during the clinical encounter. With appropriate attitudes and skills, and a safe and supportive environment, MSM patients may feel more comfortable in disclosing same-sex attraction and sexual practices to HCPs. (Epstein, 1998; Mayer et al., 2012; Neville & Henrickson, 2006). HCP training may be an important strategy to equip providers with the appropriate skills to be able to elicit HIV risk behaviors and address the general health and well-being of MSM patients.

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