Factors Foster Resilience to HIV/AIDS

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Since the beginning of the HIV/AIDS epidemic, gay, bisexual, and other men who have sex with men (gbMSM) have been disproportionately impacted by HIV/AIDS health disparities. Research showed that resilience to HIV/AIDS is associated with increased use of relevant health services, lower sexual health risks, and improved mental health outcomes among racially and ethnically diverse gbMSM. As the subpopulation that has historically been impacted by HIV/AIDS the longest, older gbMSM living with HIV/AIDS have inarguably exhibited resilience to HIV/AIDS the most. The qualitative study described in this paper sought to identify and examine protective factors that fostered resilience to HIV/AIDS based on the insights and lived experiences of racially and ethnically diverse, older gbMSM. Applying a community-based participatory research approach that included the meaningful involvement of older gbMSM living with HIV/AIDS in different roles (i.e., advisory committee member, collaborator, peer researcher, and participant), the study recruited and included forty-one older gbMSM living with HIV/AIDS from Ontario, Canada, in confidential, semi-structured interviews. Utilizing thematic analysis, we identified three major themes from the participant interviews as factors that fostered the resilience of older gbMSM to HIV/AIDS and helped to address HIV/AIDS health disparities: (1) established protective factors, (2) behavioral protective factors, and (3) controversial protective factors. This paper argues for the importance of valuing and capitalizing on these protective factors in the conceptualization and development of interventions, services, and programs that are dedicated to fostering resilience to HIV/AIDS.

protective factors interventions resilience to HIV/AIDS gay bisexual
other men who have sex with men

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1. Introduction

Since the beginning of the HIV/AIDS epidemic over forty years ago, gay, bisexual, and other men who have sex with men (gbMSM) have been disproportionately affected by HIV/AIDS health disparities, especially in Canada and the United States [1][2][3][4][5][6][7]. Moreover, research has shown that over the years, the HIV/AIDS epidemic has become inextricably linked to other forms of health disparities and social problems (i.e., psychological comorbidities, problematic substance use, sexual victimization, stigmatization, and different forms of discrimination) that have also disproportionately affected gbMSM [6][8]. In recent years, despite continuing to account for only a small fraction of the male population of North America [7][9], gbMSM have remained the subpopulation that is most adversely affected by the clinical and social impacts of HIV/AIDS, representing approximately 52% of new HIV cases in Canada [3][7] and nearly 69% of new HIV cases in the United States [4] by the end of 2018. According to recent statistical reports, the vast majority of newly diagnosed cases of HIV/AIDS have involved racial and ethnic minority gbMSM [3][4][6], who appear to experience persistent access barriers to HIV-related healthcare and services, and have lower levels of awareness and knowledge of biomedical interventions to mitigate the risks of HIV transmission [8][10][11].

For the purpose of guiding our study, we defined and conceptualized resilience to HIV/AIDS as the capacity of gbMSM to: (1) survive the clinical and social impacts of HIV/AIDS; (2) live full lives despite a chronic illness; (3) thrive despite the challenges brought about by HIV stigma and discrimination; and/or (4) meaningfully contribute to the goal of ending the HIV/AIDS epidemic.

2. Analysis on Results

We were able to identify three major themes from the analysis of our interview data: (1) established protective factors, (2) behavioral protective factors, and (3) controversial protective factors, all of which our participants believed fostered their resilience to HIV/AIDS. Each major theme included sub-themes (i.e., specific protective factors) that were described by participants in the interviews.

2.1. Established Protective Factors

During the interviews, participants discussed factors that were fairly established in prior academic literature as factors that afford a certain level of protection to gbMSM from the clinical and social impacts of HIV/AIDS. These factors included sub-themes such as *education*, *religion and spirituality*, and *social support from family and friends*.

According to participants (n = 10; 24%), HIV *education* (i.e., acquiring information or knowledge on HIV from training or study) was a significant influence on how they made important decisions regarding their physical and mental health, as well as the kind of care they accessed and received from community-based health and social services. They felt that the more information they gathered and understood, the better decisions they made when it came to accessing HIV care and attaining desirable health outcomes. In particular, education on how to prevent HIV transmission, how to remain healthy in terms of suppressing their viral load and maintaining their CD4 counts, and the latest information on HIV/AIDS were the most salient to participants. Peter, who had been residing in Toronto and living with HIV/AIDS for over a decade, explained, “Well, knowledge is power. If people are able to get the information and knowledge they need from HIV education, they would be able to manage their health more easily and have more peace of mind.” Participants claimed that they gained education about matters that were most relevant to them from different sources, including information shared by their healthcare and service providers, information pamphlets from clinics, community reports from community-engaged researchers, lunch and learns, and other HIV education events sponsored by ASOs and highly recommended and reliable online resources.

Participants also discussed the importance of *religion and spirituality* in fostering their resilience to HIV/AIDS. Although many participants revealed that religion, its tenets, and practices had made their lives difficult growing up, they also shared how much they valued the spirituality they had that was rooted in their religious upbringing and background. They felt that their spirituality was a crucial factor that protected them from the clinical, and more so, the social impacts of living with HIV/AIDS, such as stigma and discrimination. Several participants turned to their religion later in life, receiving comfort from knowing that they could believe in a higher power and a community that will accept them unconditionally. Gerry, who was born in the Greater Toronto Area and raised Catholic, expressed, “I am still a Christian and a person of faith. I go to church and pray regularly. This keeps me grounded and strong, especially during really tough times.” Mandy, who was diagnosed with HIV shortly after immigrating from China to Canada, shared, “I don’t attend church because people there eventually ask what I do. I do sex work to survive. But I keep my faith. I know God loves me and that He understands.” While some participants were still strongly tied to their religion, others felt they stayed just as resilient by remaining spiritual without organized religion.

A large majority of participants (*n* = 24; 59%) attributed their resilience to HIV/AIDS to their *social support from family and friends*. Most of these participants (*n* = 18; 75%) were eager to admit that not everyone in their family and close circle of friends were able to provide the unconditional support they needed, especially during their most challenging times. However, many participants explained that often, even if only one or two family members or friends stuck by them after they disclosed their HIV diagnosis, the support and loyalty they received was enough to help them through their difficult days. A devoted mother, a reliable brother, or an old and dear childhood friend, was all they needed to muster the fortitude to keep going during their prolonged hospitalizations and recovery. Joey, who lived in the Greater Toronto Area and identified as bisexual, recounted how difficult it was for his sister after he was diagnosed with HIV, “My sister was okay about it after a while. She could not wrap her head around it at first but it was never an issue with her children. She eventually came around with her kids’ help and became very supportive.” Other participants were not as fortunate to have supportive family members but had numerous gbMSM friends who provided a strong support system. Chris, who grew up in Downtown Toronto, narrated, “Four of us lived in one house in the 90′s. It was rough, but what happened in that house, stayed in that house…we supported each other no matter what. We were chosen family and remain friends to this day.”

2.2. Behavioral Protective Factors

Participants described how they implemented particular behavioral strategies that afforded them some layer of protection from the clinical and social impacts of HIV/AIDS over the years. These behavioral strategies were described in prior academic literature, but as far as we could determine, were minimally discussed in the context of fostering resilience to HIV/AIDS among racially and ethnically diverse, HIV-positive, older gbMSM. These behavioral protective factors represented sub-themes, such as *compartmentalizing*, *serosorting*, and *volunteering*.

Many participants (*n* = 31; 76%) revealed the enormous challenges they experienced having to deal with sexual minority discrimination and HIV stigma in several aspects of their lives. In order to avoid embarrassment, judgment, or rejection, participants realized early on during their struggles that *compartmentalizing* certain aspects of their lives, particularly by keeping their sexuality and HIV status separate or concealed from their work and families, just made their lives easier, at least until their circumstances would get better or they were able to find more suitable solutions to their challenges. For the most part, participants who chose to compartmentalize decided that they would only be open about their sexuality and their HIV status to other gbMSM, especially those whom were either their friends or sexual partners. Mpenda, who was already HIV-positive before migrating to Canada as a refugee, expounded on his conscious strategy to avoid more difficulties and foster his resilience, “They still have their biases. If you meet me in my [local] Kenyan community, I am very careful with others even if they are refugees themselves. I don’t share my HIV status…and I tread with a lot of caution.” Benny echoed similar sentiments as he described how he survived and adjusted in the Greater Toronto Area during the early years after his HIV diagnosis, “As an Asian man who is gay and HIV-positive, I kept three things separate. Work, home, and my gay life…they were compartmentalized for nearly seven years. Back then, that’s how I coped. I regularly avoided the Asian community.” Although they recognized that compartmentalizing did not necessarily directly contribute to fostering their resilience, participants believed that this behavioral strategy provided them reprieve that allowed them to foster their resilience in other more direct ways.

Another behavioral strategy that our participants implemented in order to mitigate the clinical and social impacts of HIV/AIDS was *serosorting*. By choosing to engage in sexual activity only with other HIV-positive gbMSM, participants believed they were not only able to increase the convenience of selecting prospective sexual partners, but they were also able to decrease significant sources of stressors, such as navigating status disclosure issues, embarrassment, and most importantly, rejection. According to participants, serosorting was not difficult to do because of the availability of online and mobile phone app dating options that either gave them the opportunity to identify themselves upfront as HIV-positive on their profile or allowed them to meet others in a space that was exclusively for HIV-positive individuals. These options saved them time and from the trouble of having to sort through hundreds of dating profiles, as well as navigating through the challenges of disclosing their HIV status and responding to unfavorable reactions to their disclosure. Robert, who sought out other gbMSM in Downtown Toronto solely through mobile phone dating apps, related, “I always looked to hook up with people who were HIV-positive. I didn’t want to deal with having to disclose later on…or the possible rejection. Things were better this way. Both parties are already aware of each other’s status beforehand.” Victor felt almost the same way, especially about having to face rejection, “I am extremely shy and I want to avoid any possible confrontation. I don’t know if my self-esteem is too low, but the idea of having to repeatedly experience rejection…it’s just too much for me.” Similar to compartmentalizing, serosorting did not seem to directly foster the resilience of gbMSM to HIV/AIDS, but it also offered a level of protection to our participants from the distressing social impacts of HIV/AIDS. As a protective factor, serosorting prevented the erosion of the resilience to HIV/AIDS our participants had already amassed, thereby indirectly allowing their resilience to foster and continue to grow.

Finally, our participants also relied on *volunteering* as a behavioral protective factor that they believed helped to foster their HIV resilience. Unlike compartmentalizing and serosorting, volunteering was a behavioral strategy that clearly had protective effects that indirectly and directly fostered resilience to HIV/AIDS based on the lived experiences of our participants. The vast majority of the racially and ethnically diverse, older gbMSM living with HIV/AIDS who joined our study had purposely volunteered their time and efforts to work at LGBTQ+ not-for-profit agencies and/or ASOs at some point since their HIV diagnosis. Participants asserted that volunteering provided them with several advantages that they had no doubt afforded them both protection from the adverse effects of HIV/AIDS and increased their capacity to foster their resilience. By volunteering, they were able to gain abundant opportunities to mentor others whom they felt could benefit from their knowledge and lived experiences, a feeling of being able to give back or pay it forward to their community, and a greater sense of productivity. Volunteering also provided them with many occasions to socialize and build their networks, learn new information about HIV science and treatments, and gain easier access to services and programs at community-based organizations that were relevant to them. When we asked him why it was important for him to volunteer, Mike, who had been living and availing of HIV services in rural Southwestern Ontario for over five years, replied, “It feels good to be able to help people. Sometimes it’s difficult not to judge other people’s choices when you meet them. But when you’re volunteering, you don’t do that. You’re there to help, and knowing that feels good.” Other participants had related responses to the same query. David from Downtown Toronto answered, “I get opportunities to participate in advocacy work, even activism. It’s more than just stuffing condoms. It makes me fulfilled because I believe the work is important. It also gives me easier access to programs I like [at ASOs].” Bill, on the other hand, had a distinctive story, “Volunteering was absolutely helpful to me! It was part of my overall recovery. It allowed me to build confidence and learn how to survive.” He then added, “Soon after my diagnosis, my entire life revolved around volunteering those three hours. It gave me purpose. If I could get out of bed, hold it together for three hours, it was a good week.”

2.3. Controversial Protective Factors

There were some factors (i.e., sub-themes) that kept reoccurring in the conversations we had during our interviews. Although these factors were the topics of previous empirical studies that focused on the mental health and wellbeing of HIV-positive gbMSM, they were not gleaned and examined directly from the insights and lived experiences of racially and ethnically diverse, older gbMSM living with HIV/AIDS in the aforementioned prior research, specifically for the purposes of discussing factors that foster resilience to HIV/AIDS. Apart from having been discussed repeatedly by many of our participants, the main commonality of these factors rested on the understanding that, although some scholars may find them controversial because they inspire much debate in extant research discourse, our participants believed that these factors not only afforded them protective effects against the clinical and social impacts of HIV/AIDS over the years, but these factors also fostered their resilience to HIV/AIDS based on their lived experiences. These factors include *abstinence*, *trauma from the loss of many lives to HIV/AIDS at the start of the epidemic*, “*managed*” *substance use*, and *meaningful sexual relationships*.

Several of our participants (n = 11; 27%) revealed that as younger adults, they were once married to women, had traditional nuclear families with biological children, and tried to customarily lead their lives as heterosexual men. Most of these participants were raised in religious and conservative families, felt they grew up with sheltered lives, and lived in places that provided them with very little opportunities to learn about same-sex attraction, explore their sexual orientation and non-heterosexual urges, and engage in sexual activities as men who desired to have sex with other men. In other words, their circumstances in the earliest decades or so of their lives practically compelled them to exist in a world of enforced heteronormativity and they hardly made any efforts to live to the contrary. Even as they became fully aware of their own sexual urges that were different from most other men’s, and even after having had chances to experience occasional dalliances with other men, they still chose (for the most part) to voluntarily deny themselves the opportunity to embrace their true sexuality, and instead, practiced *abstinence* from same-sex activities. In their interviews, these participants also revealed that they believed these prolonged periods of abstinence, particularly at the beginning and at the peak of the epidemic, afforded them protection from the risks and clinical and social impacts of HIV/AIDS. Ethan, who identified as bisexual and lived in the Greater Toronto Area, narrated, “I was already in my third year in college when I first went to a gay bar. I met somebody and it wasn’t a great experience. I felt guilty about it. I ended up getting married and had two kids.” Ethan further explained, “I didn’t have a lot of experience. My repertoire wasn’t large as far as gay activities. In fact, I didn’t become HIV-positive till 2013, and I know it was because I was doing things so infrequently before then.” For certain scholars, abstinence remains controversial as a strategy to be included in the development of interventions for HIV care. However, from the insights of several participants of our study, it was a factor that afforded them protective effects, in terms of both HIV acquisition, as well as transmission after being diagnosed with HIV.

Participants knew that practicing abstinence would help protect them from acquiring various antibiotic-resistant sexually transmitted infections, which are more challenging to manage medically among gbMSM living with HIV/AIDS, who may or may not be immunocompromised. For some of our participants who had been living with HIV/AIDS for many years, fostering their HIV resilience not only meant making the effort to protect themselves from the clinical and social impacts of HIV/AIDS but also trying to make a difference in terms of their advocacy and activism, particularly by doing their part in contributing to the goal of ending the HIV/AIDS epidemic. From the lessons they learned on how their own abstinence could potentially prevent the transmission of HIV to other gbMSM, practicing more self-restraint, or at least being more judicious about their choices regarding the frequency of their sexual activities, was something they believed was worth considering in order to foster their wellbeing and their resilience to HIV/AIDS.

One of the more polemical factors that participants discussed as they recalled their lived experiences of struggling through many challenges due to HIV/AIDS was what they considered *“managed” substance use*. At least a quarter of our participants claimed that their use of illicit drugs was a coping mechanism that definitely helped them get through harrowing experiences, such as family rejection, job loss, isolation, depression, housing and income insecurity, stigma, discrimination, and condemnation. For many, they felt they were able to “manage” their substance use because they only used marijuana, mushrooms, and ecstasy to cope, but no cocaine, methamphetamines, or heroin. Others believed that their substance use was “managed” because they never did intravenous drugs. Still others believed that as long as their substance use was with other people they knew and trusted, and only on occasions when their environment and setting were within their own control and choice, they considered their substance use to be “managed.” For a few though, many years of using stronger, more dangerous substances was necessary to get them through the darkest, most difficult days of their lives. Several participants reported that there were many years of their lives lost to substance use. Dan, who lived in Downtown Toronto and was very familiar with its street-based drug scene, shared, “Sounds odd but without drugs all those years, I may not have lasted this long. I was messed up, but doing drugs was all I could do to make it through the day.” At the time of their interviews, several (n = 8; 20%) participants were already sober or had been substance-free for years. While these participants acknowledged that they now recognize that there could have been other ways to cope with their difficult experiences living with HIV/AIDS in the earlier years after their diagnosis, they insisted that at that point in their lives, using drugs was their best or only available recourse to cope.

At the time of their interviews, almost half of our participants revealed that some of the most *meaningful relationships* they previously or currently had that helped them foster their resilience to the impacts of HIV/AIDS started out as *sexual* relationships. Some of these relationships remained sexual and monogamous in the traditional sense, some remained sexual and monogamous with a modified definition of “monogamy” (i.e., a commitment to each other in all respects except for their sexual activities), and some remained very emotionally close, platonic, and/or pragmatic, but were no longer sexual. The aspects of all these relationships that remained consistent across the board included friendship, understanding, companionship, communication, emotional connection, trust, loyalty, consistency regarding taking care of one another, sharing resources, and/or sharing a life together. In whichever way our participants defined the boundaries of their meaningful relationships (in terms of bonding, commitment, or monogamy), one thing for certain was that these relationships were not only protective in terms of withstanding the impacts of HIV/AIDS but were also bases of strong foundations for them when it came to fostering their HIV resilience. Mario, who had been in a long-term relationship with his partner for nearly 30 years, expressed, “Being in a healthy relationship is good for my sexual, mental, and overall health. If my relationship is healthy, I stay healthy.” Steven described the features of his relationship that made it a dependable source of protection and resilience: “We take care of each other. We may not be [sexually] exclusive, but our companionship, loyalty, trust, and dedication to caring for each other all go a very long way.”

3. Current Insights

Three major themes that helped to foster our participants’ resilience to HIV/AIDS were identified: (1) established protective factors; (2) behavioral protective factors; and (3) controversial factors that our participants believed provided them protective effects against, and fostered their resilience to, HIV/AIDS. It was the aim of our study to examine protective factors that fostered resilience to HIV/AIDS based distinctly on the unique insights and lived experiences of racially and ethnically diverse, older gbMSM living with HIV/AIDS, particularly factors that may prove edifying and useful in the conceptualization and development of interventions to be implemented by ASOs and other community-based agencies that are dedicated to fostering the resilience of gbMSM to HIV/AIDS and addressing HIV/AIDS health disparities. In the sections that follow, we discuss the merits of considering, valuing, and possibly capitalizing on these protective factors in the conceptualization and development of interventions fostering resilience to HIV/AIDS, especially because they were harnessed from the insights and personal experiences of gbMSM who have in all greatest likelihood exhibited the most HIV resilience since the start of the epidemic in North America.

Recognizing the Different Ways That Protective Factors Foster Resilience to HIV/AIDS

It is important to note that the protective factors we identified during our study helped our participants foster their resilience to HIV/AIDS in different ways, particularly when considering them as factors in the development of interventions for addressing HIV/AIDS health disparities. For example, factors such as *education*, *social support from family and friends*, *volunteering*, and *meaningful sexual relationships* were all associated with the improved use of important health services in the community and positive personal clinical health outcomes among our participants. Factors such as *religion and spirituality*, *compartmentalizing*, and *“managed” substance use*, on the other hand, were factors that helped our participants to cope with the social impacts of HIV/AIDS by buffering the adverse effects that stigma and discrimination brought to their lives. Finally, inasmuch as factors such as *serosorting*, *abstinence,* and recognizing *the traumatic loss of many lives to HIV/AIDS at the start of the epidemic* are known to be factors that are linked with efforts for preventing HIV transmission between gbMSM, these factors also consequently helped to foster the HIV resilience of our participants because they gave our participants the gratifying sense of having the capacity, options, and opportunities to support HIV prevention interventions and concurrently contribute to the goal of ending the HIV/AIDS epidemic (a goal that is very meaningful to them as gbMSM living with HIV/AIDS), and thus, foster their resilience to HIV/AIDS.

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