

# Conspiracy Beliefs and Trust in Information About HIV/AIDS Among Minority Men Who Have Sex With Men

## [Letters to the Editor]

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### *To The Editor:*

We read with interest previous reports published in this journal by Bogart and Thorburn<sup>1</sup> and Ross and colleagues<sup>2</sup> examining conspiracy beliefs about the origin of HIV in African Americans and other racial/ethnic groups. These and other studies have found conspiracy beliefs to be prevalent in the African-American population and have demonstrated associations between conspiracy beliefs and inconsistent condom use in African-American men.<sup>3</sup> Bogart and Thorburn<sup>1</sup> called for further studies investigating conspiracy beliefs among black men who have sex with men (MSM). In 2004, we surveyed participants in minority gay pride (MGP) events to assess barriers to implementation of rapid HIV testing programs, to determine if conspiracy beliefs existed among these minority MSM, and to identify trusted sources of information about HIV/AIDS.

Data were collected from a convenience sample of attendees at MGP events between June and October 2004 in Detroit, Michigan; Oakland, California (2 events); and Baltimore, Maryland as well as in the minority affinity sections of the Gay Pride event in San Francisco, California. Attendees  $\geq 18$  years of age were asked to complete the 2-page self-administered survey. Questions pertaining to conspiracy beliefs about HIV/AIDS (eg, how much do you agree with the following statements and trust (eg, how much would you say you trust information from ...)) were asked using a 5-point Likert scale ranging from 1 (not at all), to 3 (somewhat), to 5 (a lot). Three of the five conspiracy belief items were adapted from a published HIV/AIDS conspiracy beliefs scale that demonstrated good reliability.<sup>1</sup> Nonmonetary incentives worth  $\leq \$10$  in value (eg, gift cards, phone cards, compact disks) were offered to persons completing the questionnaire. Staff from health departments and community-based organizations (CBOs) conducted the recruitment and testing. A manual counter was used to count those approached for the purpose of calculating a response rate.

Data were analyzed using STATA, version 8 (Stata Corporation, College Station, TX). We used summary statistics to characterize conspiracy beliefs and trust and  $\chi^2$  tests and odds ratios (ORs) to describe the associations between holding such beliefs or trust in sources of HIV/AIDS information and the participants' race and self-reported HIV serostatus. We stratified our results by race/ethnicity. The project was reviewed at the Centers for Disease Control and Prevention (CDC) and determined to be part of evaluation of a public health program to implement HIV rapid testing; therefore, review by the CDC Institutional Review Board was not required.

A total of 1041 persons responded (49% response rate), of whom 696 were classified as MSM (defined as male respondents who identified as gay or bisexual and/or reported having sex with another man in the previous 5 years) and included in the analysis. Most of the respondents were racial or ethnic minorities: 35% were black, 22% Hispanic, 16% white, 15% Asian/Pacific Islander (API), and 11% other (eg, American Indian and mixed race/ethnicity); 11 (<1%) persons did not

provide information about race/ethnicity. A total of 18 respondents (9%) of the 190 persons who disclosed their status reported being HIV-positive.

Among all MSM participants, 86% agreed at least somewhat with 1 or more of the conspiracy beliefs. Black, Hispanic, and API MSM were more likely than white MSM to agree with conspiracy beliefs (Table 1). Compared with white MSM, black MSM were significantly more likely to hold all and API MSM were more likely to hold several of the conspiracy beliefs. For example, black (OR = 3.3 [1.9 to 5.7]), Hispanic (OR = 2.5 [1.4 to 4.6]), and API (OR = 2.9 [1.5 to 5.5]) MSM were more likely than white MSM to believe that HIV does not cause AIDS. In addition, 41% of self-reported HIV-positive MSM agreed, at least somewhat, that HIV does not cause AIDS. Small numbers of MSM reported being HIV-positive, however, and there were no significant differences by HIV serostatus in agreement with any of the conspiracy beliefs (data not shown).

TABLE 1. HIV/AIDS Conspiracy Beliefs and Trust of HIV/AIDS Information Sources Among Attendees at MGP Events, 2004

Among all MSM, the most trusted sources for information about HIV/AIDS (eg, percentage who trusted the information source a lot) were primary care providers (59%) and gay, lesbian, bisexual, and transgender organizations (GLBT) organizations (51%), followed by the CDC (49%) and health departments (46%). In contrast, only 15% of MSM trusted the government a lot, and 25% trusted the government not at all (data not shown). There were several differences by race/ethnicity. Compared with white MSM, black (OR = 0.5 [0.3 to 0.9]) and Hispanic (OR = 0.6 [0.3 to 1.0]) MSM were less likely to trust information from GLBT organizations and more likely to trust the Internet a lot (OR = 2.2 [1.1 to 4.7] and OR = 2.3 [1.1 to 5.0], respectively). Compared with white MSM, black MSM were more likely to trust the government a lot (OR = 2.3 [1.1 to 5.7]) and API MSM were less likely to trust primary care providers a lot (OR = 0.6 [0.3 to 1.0]).

We believe our report to be the first to assess HIV/AIDS conspiracy beliefs among minority MSM. Most respondents endorsed at least 1 conspiracy belief, and 4 of the 5 conspiracy beliefs were endorsed by 50% or more of black MSM. Although these beliefs were more commonly held by black MSM, they were also widely held by other minorities. In addition, we were able to identify primary care physicians and GLBT organizations as the most trusted sources of information about HIV/AIDS in this population.

Our study confirmed the findings of previous studies that found conspiracy beliefs regarding HIV in black and Hispanic populations.<sup>1-3</sup> Endorsement in the belief that HIV is a man-made virus was similar in our study for black MSM (50%) as found by Bogart and Thorburn<sup>1</sup> in their random sample of African Americans (48%).

Our data provide some insight into issues that could have an impact on the effectiveness of HIV prevention in minority MSM populations. The belief that HIV does not cause AIDS was more likely in all 3 minority groups (48% to 54%) than in whites (27%) and was common among HIV-positive persons. Considering recent data showing that black and Hispanic MSM are disproportionately more likely to be diagnosed with HIV, develop AIDS and less likely to survive 3 years after AIDS diagnosis,<sup>4</sup> explicit efforts need to be made to address this belief, which is potentially detrimental to efforts to diagnose and link HIV-infected persons into stable treatment and care.

Our finding that primary care providers were the most trusted source of information about HIV/AIDS may represent an opportunity to partner with primary care providers for HIV prevention; the CDC and its public health partners have developed guidelines for incorporating HIV prevention services into medical care.<sup>5</sup> There are competing demands on a physician's time during an office visit, however, and we did not measure how frequently these populations access

their primary care providers. Health care providers other than physicians (eg, nurses, physician assistants) may be better suited to provide HIV prevention information. The CDC and state and local health departments, traditional providers of HIV prevention information, were also trusted organizations. Our finding that black and Hispanic MSM were less likely than white MSM to trust GLBT organizations suggests that prevention messages designed for white MSM may have less impact on black MSM, especially if they are delivered by GLBT prevention providers. Even so, almost half of these men trusted GLBT organizations a lot. Our finding that black MSM were more likely to trust the government than white MSM was surprising, considering beliefs in the general African-American population that HIV/AIDS is a government conspiracy.<sup>3</sup> Alternatively, the finding could be attributable to the extraordinarily low prevalence of trust in the government about HIV/AIDS information among white MSM.

Our study is subject to several limitations. Respondents comprised a convenience sample of attendees of MGP events conducted in urban areas and are not representative of all minority MSM. A follow-up study in a representative sample of MSM is necessary to determine if these findings can be generalized to all minority MSM. Only 30% disclosed their HIV status; thus, our findings related to serostatus and conspiracy beliefs must be interpreted cautiously. The survey in San Francisco did not include the CDC and state and local health departments for the trust in information sources questions; thus, we do not report these data separately for API MSM because most API MSM were recruited in San Francisco. The survey was self-administered, and there may have been variation in the way respondents interpreted the questions or issues with literacy. Conversely, respondents may have provided more truthful responses to sensitive questions than if the survey was interviewer administered. Additionally, we had low numbers of American Indian MSM in our survey, limiting our ability to draw race/ethnicity-specific conclusions about these men.

Our findings that there are racial/ethnic differences in endorsement of conspiracy beliefs and trusted sources of information about HIV/AIDS provide further evidence that HIV prevention messages should be culturally tailored. Unfortunately, there is a paucity of efficacious HIV prevention interventions targeting minority MSM. In a systematic review of the US-based HIV behavioral intervention literature, there were no interventions targeting minority MSM that met the criteria for best evidence.<sup>6</sup> There is, however, evidence of the successful adaptation of an effective peer-based HIV prevention intervention adapted for black MSM.<sup>7</sup> Inclusion of minority researchers and use of community participatory research may increase transparency and representation of affected communities in the development of trusted interventions.

Research into conspiracy beliefs about HIV/AIDS must move beyond descriptive; HIV prevention interventions targeting black and other minority MSM should be developed with sensitivity to high levels of conspiracy beliefs and designed specifically to dispel those beliefs, particularly the belief that HIV does not cause AIDS. Primary care physicians and GLBT organizations seem to be trusted sources of HIV prevention information for these men. Additional research is needed to advance our understanding of trusted sources of information about HIV/AIDS for minority MSM and how best to deliver prevention services in light of these beliefs.

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<b>HIV/AIDS Conspiracy Belief</b>	<b>All MSM (N = 696)</b>	<b>(n)</b>
There is a cure for HIV/AIDS that pharmaceutical companies are hiding because of profits	52	
HIV/AIDS drugs can harm you more than help you	51	
HIV does not cause AIDS	45	
HIV is a man-made virus	42	
It is likely that I have been tested for HIV without my permission	37	

  

<b>Source of HIV/AIDS Information</b>	<b>Percent</b>
Primary care provider	59
GLBT organizations	51
CDC‡	49
Local or state health department‡	46
Black/Latino/Asian media	31
Public service announcements	27
Internet	21
Mainstream media	20
Government	15

Race-specific response rate to conspiracy belief questions: 73% to 96%.

Race-specific response rate to trust in information source questions: 84% to 98%, except for Black/L

\*Includes men who report multiple races.

† $P < 0.05$  versus white MSM.

‡Question not asked in San Francisco

§Not reported, because question not asked at site where API men were recruited.

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