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Experiences and Perceptions of Black Men Who Have Sex with Men About Acquiring HIV: A Qualitative Narrative Perspective

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In the United States, Black men who have sex with men (MSM), between the ages of 18 and 34 years, have the highest rates of new HIV infections. The prevalence of HIV in this population is three to four times higher than their White MSM counterparts. Twelve Black MSM from the Bay Area, nine with HIV and three without HIV, were interviewed regarding their experiences and perceived risks of acquiring HIV. Narrative analysis revealed these themes: (a) tested regularly for HIV, (b) HIV knowledge varied before arriving in San Francisco, (c) condom use typically nonexistent when under the influence of alcohol and other drugs, (d) inability to negotiate sex and condom usage, and (e) sense of anticipation, resignation, and acceptance about acquiring HIV. Implications of this study highlight the need for Black MSM to have earlier HIV prevention education, including condom negotiation skills, particularly when under the influence of drugs and/or alcohol.

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Thirty-five years into the HIV epidemic, the Black population continues to bear the greatest burden of HIV in the United States (Centers for Disease Control and Prevention [CDC], 2017). Blacks represent 13% of the U.S. population (U.S. Census Bureau, 2017); however, they account for 46% of new HIV infections (National Institute on Drug Abuse, 2018). When comparing racial groups impacted by HIV in the United States, Blacks have higher rates of infection when compared to both Hispanic and White populations (CDC, 2015a). In fact, 1 in 16 Black men and 1 in 32 Black women will acquire HIV (National Institute on Drug Abuse, 2018).

The primary transmission of HIV for 72% of Black men is sexual contact with other men; men who have sex with men (MSM) account for 45% of new HIV infections in the United States (CDC, 2015b). It is estimated that one in two Black MSM will acquire HIV in their lifetime (Murray, Gaul, Sutton, & Nanin, 2018), and these numbers rival those found in the general populations of developing countries (Voisin, Hotton, & Schneider, 2016). According to the CDC (2017), young Black MSM, defined as ages 18 to 34 years, have been most seriously affected by HIV and face

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the most severe burden of HIV. Among young Black MSM, HIV prevalence is three to four times higher than in their non-Hispanic White counterparts. This population continues to have disproportionally high rates of new HIV infections (Matthews, Smith, Brown & Malebranche, 2016b), despite national strategies, interventions, and programs.

The Office of National AIDS Policy (2015), stated that the

> … overall goal of the National HIV/AIDS Strategy is to prevent HIV among Black Americans, especially Black MSM. To lower risks for all Americans, prevention efforts should acknowledge the heavy burden of HIV among Black Americans and target resources appropriately. (p. 4)

We believe that the full devastation from this disease is yet to be seen in the Black community, particularly because we already know that Black MSM tend to be unaware of their HIV status (Matthews, Smith, et al., 2016b), test late in the disease process, have higher morbidity, and subsequently have higher mortality rates.

The purpose of our study was to describe the experiences and perceived risks of acquiring HIV in young Black MSM between the ages of 18 and 34 years. This understanding can help design HIV prevention and education programs with specificity to this vulnerable and at-risk population.

Methods

To capture the stories of Black MSM and their experiences with HIV, we conducted a study using narrative analysis methods. Narratives allow the researcher to hear participant stories and to better understand how participants see their roles in the stories and describe personal experiences in detail (Holloway & Wheeler, 2010; Riessman, 1993).

Recruitment and Data Collection

As part of the process for receiving ethical approval from the University of California, San Francisco's Human Research Protection Program, the primary author/researcher explained the purpose of the study and obtained letters of support from organizations providing services to young Black MSM in the Bay Area. These agencies were chosen because they had a number of clients who might have met the inclusion criteria and agreed to assist with the study.

Using purposive sampling, participants were recruited between March 2013 and December 2015, with most interviews occurring during the last 12 months, after taking time to build relationships with the community. Study inclusion criteria included: (a) self-identified Black male, (b) between the ages of 18 and 34 years, (c) living in the local area, (d) had had sex with men, and (e) could speak, read, and comprehend English. Exclusion criteria were Black males born outside of the United States because their experiences, cultures, and histories were different than those experienced by Americans.

After providing informed consent, participants were interviewed either at the community partner organization where they were recruited or at other outside locations chosen by the participant in collaboration with the researcher. Our interview guide (Table 1) was pilot tested and reworked with a small analytic group of qualitative researchers. Spaces chosen were private, safe, and quiet so that interviews could be recorded and notes taken by the researcher. At all times, care was taken to maintain privacy and confidentiality of participants during the interview process, including offering participants the option of using a pseudonym, but most chose to use their real first names.

Narratives were obtained through interviews. One-on-one interviews were used to obtain in-depth descriptions of participant experiences related to the research problem (Creswell, 2007). In-person interviews are better for collecting personal and sensitive data, particularly in a population with substance use issues. The interviewer created a safe, private space for participants to share openly about their experiences while also respecting their confidentiality and preserving anonymity. All interviews were audiotaped, with notes made during and after the interview. Most interviews lasted 90 minutes. The interviews were transcribed verbatim by a transcription service and transcription was verified against the audio recordings by the first author in order to ensure that gaps and content were adhered to in the transcription process.

Most participants chose to answer all of the questions, with the exception of a couple of instances

Table 1. Interview Questions

1) Tell me about what it is like to be a young man who has sex with men.
2) Tell me the story of how you came to learn your HIV status.
   - What lead you to take the HIV test?
3) What ideas do you have about how you might have managed maintaining this HIV status?
4) Tell me about the role past substance use played in your life prior to testing for HIV.
5) What role, if any, did substance use play in you acquiring HIV or any other STD?
6) Is there someone, someplace, or a way that would have been best to communicate prevention messages to you?
7) Who is a part of your "family" and other social networks?
8) Have you experienced problems in your life because of socioeconomics, stigma, racism, etc.?
9) Do you have mental health or other health issues?
10) What are your words of wisdom or other things that would have helped you or other people your age to help them avoid becoming HIV-infected? (suggestions of peer prevention messages)
    - To avoid risky sexual behavior?

Note. STD = sexually transmitted disease.

where the researcher saw that the participants looked too emotional or took too long of a hesitation. In those cases, participants were reminded that they had the option to not answer the question, which they accepted; they were also asked if they wanted to stop the interview, and both times the participants declined and wanted to continue telling their stories.

Participants were offered a $20 USD gift card for their participation and to offset travel expenses. They were given an additional $10 USD for each qualifying person they referred and who completed the study; this is called chain referral or snowball sampling (Holloway & Wheeler, 2010). Only one participant was recruited through snowball sampling.

Data Analysis

Analysis focused on better understanding the experiences and perceptions regarding acquiring HIV in the stories and lives of Black MSM. An important aspect of the analysis was sharing the exact words and complete stories of the participants in our study. Representing the voices of the participants was central to the analysis. Few studies that portray the experiences of Black MSM exist, and for that reason, our analysis focused on the words of the participants. For this reason, the data include the complete context of the story and are represented in their entirety as told by the participants.

Coding. Transcripts were reviewed by the primary researcher. Following a careful review, each transcript was coded by the research team, which included the first and senior authors. Initial coding focused on capturing the main ideas from the stories of the participants. Transcripts were then coded by another researcher in the same manner to ensure reliability of the coding approach. Codes were compared and discussed by the team. The team compared and contrasted codes until agreement was reached. Following initial coding, we worked to combine similar codes to ensure that our analysis was linked to our study aims and questions. From the combined coding analyses our team formulated, defined, and named the primary narrative themes (Riessman, 1993). Application of themes to the transcripts were reviewed by the research team and consensus was reached on each transcript.

During data collection and data coding, we created analytic memos and field notes; memos and field notes were also coded by the research team. The primary researcher shared initial codes and emerging findings with two of the participants in order to validate findings and to diminish bias in our analysis and interpretation (Strauss & Corbin, 1998).

Results

Sample

The majority of participants ($n = 8$) were between the ages of 22 and 29; the mean age was 26 years. Nine of the men identified as gay and nine of them were also infected with HIV. Marijuana was the most frequently identified drug used; however, the majority of participants ($n = 7$) also reported using methamphetamines. Fifteen years old was the median age for both first sex and drug use (information about age of drug initiation was not obtained on the first four interviews). Most of the participants ($n = 7$) identified as single. Equal numbers of participants completed some high school ($n = 6$) and some college ($n = 6$). In terms of employment status, most were either employed part time

Table 2. Summary of Research Findings

Purpose of the Study	Overarching Themes	Sub-themes
Describe the experiences and perceived risks of acquiring HIV in Black MSM between the ages of 18 and 35 years.	HIV awareness	Tested regularly for HIV
		HIV knowledge varied before relocating to San Francisco
	HIV risk-reduction apathy influenced by substance use	Condom use typically nonexistent when under the influence of alcohol and other drugs
		Inability to negotiate sex and condom usage
		Sense of anticipation, resignation, and acceptance about acquiring HIV

Note. MSM = men who have sex with men.

($n = 4$) or unemployed ($n = 4$). Half of the participants ($n = 6$) were raised in the East Bay and the others were born outside of the Bay Area.

Findings

The narratives of 12 young Black MSM, nine infected with HIV and three without HIV infection, revealed two overarching themes and five subthemes (Table 2). The results provide perspective and insight to understanding the experiences and perceived risks of acquiring HIV by young Black MSM. The themes represented stories with exemplars in each participant's own words and acknowledged the multitude of factors that contributed to HIV infection in this vulnerable, high-risk population, who bear the greatest burden of HIV disparity in the United States.

HIV Awareness

Almost all participants had some awareness about HIV prior to relocating to San Francisco, including an understanding about the disease and how the virus is transmitted.

The majority of participants said that they received regular HIV testing: "Every 3 to 6 months … I was going to get tested, but that don't mean I was using protection" (P6, with HIV).

> I went in for STDs [sexually transmitted diseases] just kind of regularly because 3 months before it was all negative … Yeah, it was just like my 3 months' checkup because right before the summer started it [HIV test] was negative. So, yeah this was like the one time that I wasn't scared. I just felt like it was kind of routine for me. (P8, with HIV)

Testing incentives appeared to be the driving factor for routine HIV testing, as evident in these statements: "I do [HIV] testing whenever they want me to test. Like somebody said … If it's for incentive–I test now … I test any time–any time they have incentive for money, I usually go test" (P9, without HIV infection).

> Yes, and so there were always incentives for taking an HIV test. If you take an HIV test, you get a $10 Safeway card. Like, cool, yeah. So, I was always doing that. So, I always knew my status and stuff like that … I was always up on it because I was always looking for an incentive like getting a gift card or something. (P5, with HIV)

Despite being incentivized, there was value for participants to receive regular HIV testing and to know their HIV status:

> I test regularly. Even though I only have sex with my boyfriend, we get tested regularly just to make sure our status stays. We're always on top of our health to make sure we stay negative and all the stuff … You've got to make sure that if you say you love somebody, you're in love with them, you protect them, and you protect yourself. That's how I feel. (P10, without HIV infection)

One participant described being immune to acquiring HIV and then later testing positive:

> And as I think about it now, it was real sad like the way I went about it [having sex with partner

> with HIV]. But, like I said, I thought I was immune to the disease really because like 6 months it went on. I mean like, and I was still testing negative, you know? And I finally got that positive test and they told me. (P5, with HIV)

This participant described his confusion with understanding what it meant to be told that his roommate had an undetectable viral load:

My roommate, he said he was undetectable and we didn't know we weren't supposed to have sex. We had sex and I just took the risk. I saw his medication there too, so I'm like he's probably undetectable. That's the only person I've had sex with … At the time I thought I knew about the risk factors I was taking, but I don't think I knew as much. I thought undetectable meant like you can't detect it at all, and that's not true. (P8, with HIV)

Another participant noted that he was given sexual health information from a local gay youth center:

> SMAAC is a gay youth center. It's the LGBT youth center, Downtown Oakland. It used to be. Ain't there no more. They talk about everything: sex, condoms, everything … I stay HIV-negative because of SMAAC and because of – SMAAC taught me. (P9, without HIV infection)

And finally, this participant talked about not getting much information in his home state (in the Southern United States, which is impacted by incredibly high rates of HIV in Black communities), but he has gotten much more information as a result of being connected to an organization in San Francisco and receiving free education materials and resources.

> The virus isn't new, but there wasn't a promoting of it [in U.S. South]. And here [in San Francisco] there's promoting for getting tested … And then also just the fact that at the AIDS Foundation they will leave stuff out like condoms and lubes for the taking for free. And it's like those little, little resources right there can start a little seed in my mind for like, "Okay. Well, look at that. Safe sex is a possible outcome for you if you choose to." It's all about the choice again, but the education was lacking pretty much. (P12, without HIV infection)

HIV Risk Reduction Apathy Influenced by Substance Use

The drug of choice for a majority of participants was marijuana, although most participants identified methamphetamine as causing them more challenges with HIV risk-reduction behaviors. This finding was surprising because methamphetamine use has been found to be more common among White MSM (Buttram & Kurtz, 2015). When Black MSM in our study were under the influence of alcohol and other drugs, they reported they had a sense of anticipation, resignation, and acceptance about acquiring HIV. Substance use appeared to be linked to HIV risk-reduction apathy.

For most participants, condom use was typically nonexistent when under the influence of alcohol and other drugs. This theme was prevalent for participants with and without HIV infection.

> And I wasn't taking HIV seriously. I knew that people I was sleeping with were positive. I didn't care. I mean like they would tell me. They would say, "I'm HIV-positive. I want you to know that." And I was like, "Fine. Okay, whatever." … now, usually when there's drugs involved you can forget trying to put on a condom because nobody is going to go for that. I mean because it's like oil in water. It doesn't mix. (P5, with HIV)

Moving to San Francisco and engaging in drug use also brought a heightened awareness of people living with HIV. With substance use, however, HIV awareness and protection were less of a concern, as this participant said:

> … when I moved to San Francisco and started to hear about people with HIV and I knew that in the gay community there was popular and stuff, but that didn't – by me getting high all that went in the back – out the window (P1, with HIV)

The participants in our study talked about the effects of crystal methamphetamine and how it impacted condom use:

> My friends – you do crystal – crystal is a sex drug. That's where a lot of people get infected, with doing crystal. They are really getting infected. Crystal is a sex drug. It makes you go,

> go, go. You get so horny you just be going for like 6 hours getting fucked. So, that's just ridiculous. And then the condom is gone and you out of condoms. "Fuck this condom," and you just keep going. Keep going. Keep going. Keep going. (P9, without HIV infection)

This participant shared some additional insights about his condom use when under the influence of drugs:

> Well, see, because when you're in the heat of the moment and you're on a drug, if you ain't got no condoms you just might decide to have sex raw or you might with somebody and they tell you they ain't got nothing and because you're on a drug you just bypass the question altogether. "Don't even tell me nothing about your STD status. I don't want to know." There's people and I've been in situations myself like that where I just didn't care. (P6, with HIV)

Another participant shared his perceived connection between HIV and crystal methamphetamine, as well as how that impacted HIV sexual risk behaviors, including an idea called "poz-ing" (attempting to infect someone who is living without HIV infection).

> But a lot of people who have HIV in the city use crystal and it's been hard for me to find people who aren't really dependent on it. Yeah, I think the crystal scene in San Francisco is really – that's another thing I'd also say. If someone uses crystal in San Francisco, they're practically HIV positive. Yeah, and it also coincides yeah, PNP [party and play] and BB, bareback [sex without a condom]. So, usually smoking crystal meth and you're not using condoms, and now, I understand that basically means that you're having sex with positive guys. Super risky sex, super risky sex, and super risky sex. I did some research on it and I found out a lot of guys in the city participate in "poz-ing" … getting like an uninfected guy positive and it's almost fetish. (P4, with HIV)

Another participant shared his experiences with older MSM who provided him with alcohol, marijuana, and pills. Once the sexual experience is underway, this participant was less interested in stopping and putting on a condom because he felt it would ruin the mood.

> I remember the stuff these older dudes were telling me, or they fed me this liquor and passed me the blunts [marijuana] and stuff, it would make me like really horny and then you don't be thinking about condoms. You're really not … Because you're high, you're drunk, you're feeling good. They're probably rubbing on you in the right way, touching on you and saying the right stuff in your ear and stuff. And then you're not thinking about no condom, especially if you're hammered, you know? … Yeah, weed and the alcohol and the pills play a big role because I'm not really horny all the time, but they make me horny and 9 times out of 10 I'm not thinking about putting on no condom … If a condom is not readily available and ya'll are already in the heat of the moment, they're not fixing to stop in the heat of the moment to get no condom for you if it's not readily available. If it's not right in your pocket, why would you stop touching on me and doing that to go look for a condom? That's going to take 3 minutes. Now I done lost my woody. Now I'm irritated. Now I need more drink. Now I need another blunt to get back in the mood. I'm irritated. I'm going home. And that's how it be in the gay community. Gay people want it fast, now, and in a hurry. When it comes to drug-induced sex, it needs to happen fast. (P10, without HIV infection)

This narrative speaks to the participant's sense of obligation to the person providing the drugs to them and then going along with having sex without a condom because of peer pressure.

> But nowadays since everything is so connected through the phone, a lot of people hook up through the phone … So, usually those attachments come with, "Use drugs with me." And it's kind of – it sucks for me because it's like I should be able to be strong enough to say, "Well, I don't want to do any drugs, but we could still kick it." But even that's a challenge because being around it you'll still be tempted, especially if they're like asking you to do it. So,

> that's where that peer pressure kicks in like, "Oh, it's okay. It's okay. We're fine. Let's just do it." And that's how I've ended being in situations as far as sex-wise where it's like doing activities without a condom. You know, "Oh, it's okay. It's fine. Let's just do it without a condom." And it's like, okay, you know, thinking that I have to say yes just because someone might be sharing their stuff with me. So, it's kind of like I feel – is entitled the right word? I feel like I have to because they're doing something for me in a sense … I have to learn that it's not the top's responsibility to supply the condom. (P12, without HIV infection)

Participants have an inability to negotiate sex and condom use. There is a power differential in these narratives, particularly with older male sex partners. This narrative describes the situation in attempting to negotiate sex with older men:

> But it's when I'm with somebody older that pulls the reins and be like, "No, little nigga, you fixing do like this." And I'll be like, "Woo! Okay, yeah this is what we fixing to do." It'll be a shift in power and it's like, I don't know. The freaky side in me like that … But if it's an older dude and they know what they're talking about and I feel it up in here, yeah then. They be like, "Nigga, we ain't using no condom, nigga. We fixing to do this right now." It'll be like – it was like that for hella years when I was younger. Praise God I'm so glad I've like never ever caught nothing or whatever, caught no STDs or anything because I was with maybe five, maybe four older dudes that I was in serious relationships where I was having sex without condoms … we wouldn't use condoms, but they would tell me all this like. "If you're feeling wild you need to use condoms because not all motherfuckers ain't going to tell you like I'm going to tell you, because you know I care about you" … I was young and dumb, stupid, dumb, sexy, stupid, full of cum, just high, drunk. (P10, without HIV infection)

Attempting condom negotiation, in the following case, meant the participant would lose his place to stay.

> I've tried it a couple of time [condom negotiation]. Trying to just stick to and say that, "Yeah, I'm going to need a condom. I'm going to need you to use a condom." But it didn't work out because they ended up usually telling me that, "Well, you can leave then because I don't do that." (P5, with HIV)

Another participant shared about needing to be prepared for a sexual encounter, including having condoms readily available, and how difficult this could be. He wrestled with whose responsibility it is to provide the condom, the top guy or the bottom guy?

> So, it was about 1:00 a.m. in the morning. I would have never thought that I was going to run into a boy, so I didn't have protection on me and stuff. I didn't have lube on me … Then I met a boy and the next thing you know he is trying to penetrate me. And it's like by then it's too late to be like, "No, no, no," because it's feeling good. But then at the same time that it's feeling good, it's like in the back of mind it's like I know I should have been more prepared because if I am going to be willing to just engage in some random sex outside that I need to be alert … because in my mind it's like if you're the top and you're going to do it, then since you want to put your thing here that you would want to wrap it up. But no, it's totally up to me to speak up because every situation where I haven't it's always been raw sex. (P12, without HIV infection)

Finally, participants spoke about a sense of anticipation, resignation, and acceptance about acquiring HIV, where participants were not going to great lengths to avoid becoming HIV-infected anymore. There does not seem to be a heightened concern about avoiding becoming infected with HIV, but instead almost a sense of complacency and expectancy in terms of acquiring the disease. It's almost an acceptance of the inevitable, for a number of different reasons, based on the comments in these narratives:

> When I think about it I did want it [HIV]. I was trying to get positive. Yeah, I was trying to get it. Yeah, that's what it was because when I got here I couldn't get any services because all of

the services you have to be HIV-positive. (P5, with HIV)

I've worked in the field with HIV so long that I practically know everything there is to know about HIV except when they come out with a new medication. So, me knowing that and understanding how it works, I just never really let myself go under because I knew that one day this day would come. So, I'd just rather embrace it than push it away. (P11, with HIV)

And just through listening to different [HIV-infected] people's stories and tell their truths so freely, it empowers me to, you know, if I am going to use [substances] not to be really shamed for it … It's like you're still here, so like regardless of if it became addictive or if it's just something that's light use that you pretty much – they're still here, so it's not a death sentence kind of. And that's how I'm starting to look at HIV and AIDS as well because I have participated in risky behavior … I was very afraid before, but now due to education I'm not as nervous as I was before because I see that there will be help for me if that does happen. (P12, without HIV infection)

When I went to go get tested, my results came back positive. Was I shocked? Not really, because I had worked at a bathhouse [sex club] previous. I was making pretty bad decisions, I guess, when I was working at the bathhouse, because I was a dancer there. I was a stripper, and then, that kind of led to drugs and alcohol and clubbing and just pretty much partying. Like I prepare myself for it by telling myself, "Oh, it's possible, it's bound to happen." (P3, with HIV)

So, the next day, I went to [take HIV test] and, what do you know, it says that I was positive and she asked me if I was all right and I said I was all right, but I kind of knew that I was positive. (P4, with HIV)

Discussion

Excerpts from the narratives revealed some of the factors contributing to the high rates of new HIV infections among Black MSM between the ages of 18 and 34 years. While substance use has been a common driver of both HIV acquisition and treatment outcomes in all populations, in general, Black MSM, when compared to White MSM, have lower rates of substance use (Fields et al., 2011; VanDevanter et al., 2011); our study focused on Black MSM who did use substances. It was clear that the issues were complex and multifaceted.

From the narratives, almost all of our participants were aware of HIV and were tested regularly. It was surprising to see that many of the participants were testing regularly for HIV, especially because there has been little outreach and effort targeted to this age group and demographic. Even with varying degrees of knowledge about HIV, most of the participants were aware that they were engaging in risky behaviors, particularly when they were under the influence of drugs or alcohol. Buttram and Kurtz (2015) noted that "Black MSM experience greater incidence and prevalence of HIV and a host of other syndemic health and social disparities, including substance use" (p. 2), compared to other MSM. In addition, other researchers (VanDevanter et al., 2011) have noted that it is fairly common that once Black MSM are under the influence of drugs or alcohol, they lose the interest and ability to negotiate condom use or to avoid engaging in unprotected receptive anal intercourse (Harawa et al., 2008).

There has been a sense of acceptance and resignation about eventually becoming HIV infected in this population. Those who eventually became infected described the diagnosis as a sense of relief and something they were not surprised about because of the behaviors they were engaging in at the time, namely unprotected anal intercourse, often under the influence of drugs or alcohol. Because of substance use, our participants were apathetic about acquiring HIV and it was almost as if they wanted to get infected. Or, did this speak to the powerful influence of methamphetamine and the ability of the drug to bypass reasonable concerns for self-protection, including

condom negotiation, by Black MSM? There does not seem to be a historical context or significance among Black MSM about the death and devastation caused by HIV in the earlier years of the epidemic. This highlighted the need to have new and innovative HIV prevention programs that would focus on "introducing concepts of self-efficacy, sexual communication, and risk negotiation [to] help manage risk related to sexual positioning" (Dangerfield, Ober, Smith, Shoptaw, & Bluthenthal, 2018, p. 9).

The solution would be to offer young Black MSM the educational tools and resources needed to begin navigating condom negotiation and use successfully, similar to that used by Javier, Abrams, Moore, and Belgrave (2018), who suggested incorporating experiential skill-building activities into a culturally tailored condom-protective program. The programs should be available in low-income neighborhoods and should also incorporate drug-use reduction approaches (Voisin et al., 2016). It is imperative that education materials be racially and ethnically appropriate for this age group and accessible in locations that would be safe for them.

Quinn and Dickson-Gomez (2016) noted the connection between increased HIV risk and increased sexual and drug-related risk behaviors by some Black MSM because of limited social support. LeGrand, Muessig, Pike, Baltierrra, and Hightow-Weidman (2014) reported that Black MSM "overwhelmingly reported a lack of sense of community" and "places to socialize" (p. 4). Social isolation limits one's ability to openly discuss and explore sexuality and learn from informal role models, including social networks with older MSM (Arrington-Sanders et al., 2016). The Black MSM in our study noted a desire to have relationships with other MSM and the difficulty they had finding this without HIV risk being involved. This speaks to the need of providing more social-based community resources and services for at-risk Black MSM, which would allow them to build community, reduce sexual risk behaviors (LeGrand et al., 2014), and connect with other MSM in safe spaces. Garcia and colleagues (2015) offered the following as a working definition of safe spaces: (a) safe spaces promoted supportive social norms and peer networks through a range of leisurely activities that were culturally relevant, (b) safe spaces enabled human development by providing skill-building opportunities to those who experienced marginalization from education and work environments, and (c) safe spaces promoted empowerment and community mobilization against stigma, discrimination, and violence.

Finally, we must keep in mind that stigma associated with HIV will continue to make Black MSM practices stay hidden and continue to fuel the epidemic in this population. The National HIV/AIDS Strategy (Office of National AIDS Policy, 2015) suggested that more effort was needed to focus on minimizing stigma related to HIV and normalizing HIV testing for all people, particularly to decrease the burden of HIV in Black MSM. Arnold, Rebchook, and Kegeles (2014),

> found that HIV-related stigma and homophobia, within the larger societal context of racism, were related to sexual risk behavior, reluctance to obtain HIV testing or care, lower adherence to treatment medication, and disclosure of a positive HIV status to sexual partners. (p.1)

The authors suggested the development of community-level mobilization to counter homosexual stigma and HIV in the Black community. The HIV epidemic certainly is not over and Black MSM will continue to be disproportionately impacted unless appropriate steps are taken.

Limitations

The limitations of our study include the sample size and the age range of the participants. Recruitment of this small sample took place over a 3-year period. Reaching a vulnerable group of MSM took time and trust development to collect the sensitive data presented in this paper. Several participants did not show up at agreed-upon study visit times and numerous efforts had to be made to reschedule appointments. It was also important to reassure participants that their confidentiality would be maintained and that the researcher would not report any of their behaviors to law enforcement authorities or community agency staff. Another limitation of the study was that participants were drawn from community agencies only. This sample was not reflective of the broad range of living conditions among Black MSM, including those who were independent and

not connected to any community agencies. Finally, the study was completed with Black MSM in the Bay Area and, therefore, cannot be transferred to other geographic areas across the United States or to other racial or ethnic groups. Similar studies need to focus on Black MSM in cities with larger Black MSM communities.

Conclusion

If we are to have an impact on reducing HIV in young Black MSM, we must have efforts guided by the Black MSM we want to reach. We are not going to reach them using interventions that have been used with mainstream White MSM communities. Efforts must be racially and ethnically appropriate for Black MSM, with graphics and messaging that reflect their unique circumstances. Their voices and experiences must be heard and taken into consideration when developing programs to address their specific needs.

Black MSM also need to understand the relationship between substance use and how it influences the ability to make decisions about using protections against HIV infection and other STDs. Expected long-term health outcomes would be decreased substance use, decreased HIV and STD transmission risk, improved health of Black MSM, and decreased HIV disparity. More research is needed to fully understand the experiences of this population and the range of factors contributing to the disproportionate numbers of new HIV infections. The vision of the National HIV/AIDS Strategy is that,

> [O]ne day the United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination. (Office of National AIDS Policy, 2015, p. 3)

The findings of our research will help contextualize actions that need to be taken by nurses, clinicians, and community-based organizations in response to the National HIV/AIDS Strategy, primarily in education and skills-building approaches that sustain and reinforce education that is needed to effectively encourage people across the age span, particularly younger Black MSM, to take steps to reduce their risks for HIV infection. Nurses, clinicians, and community-based organizations will play a critical role in helping to get new HIV infections to zero. We dream of that day and hope to see it happen in our lifetimes, but much work still needs to be done, particularly with Black MSM. As Matthews, Herrick, and colleagues (2016a) noted, "we will not end the HIV epidemic in this country without a powerful and effective response to the HIV epidemic among Black MSM" (p. 6).

Key Considerations

- HIV prevention efforts have not effectively reached Black MSM, and thus, efforts to eradicate this disease in the United States are hindered. More outreach and innovative approaches are going to be required.
- Understanding HIV experiences and perceptions can give nurses, clinicians, and community-based organizations the insight and guidance they need to develop culturally relevant interventions to meet the complex needs of this population.
  - Nurses and clinicians should perform thorough sexual histories, including information about prior STD and HIV screenings, as well as substance use behaviors.
  - Black MSM should be provided with information about preexposure prophylaxis.
  - Black MSM need to have earlier HIV prevention education, including condom negotiation skills, particularly to provide protection when they are under the influence of drugs or alcohol.
- Black MSM would benefit from spaces and places where they can build community with one another, empowering them to work toward decreasing stigma and homophobia within the Black community.

Disclosures

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

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References

Arnold E., Rebchook G., Kegeles S. (2014). "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*, *16*(6), 710-722. https://doi.org/10.1080/13691058.2014.905706

Arrington-Sanders R., Morgan A., Oidtman J., Dao A., Moon M., Fortenberry J., Ott M. (2016). Sexual health research with young Black men who have sex with men: Experiences of benefits and harms. *Archives of Sexual Behavior*, *46*(4), 937-946. https://doi.org/10.001/s10508-016-0715-5

Buttram M., Kurtz S. (2015). A mixed methods study of health and social disparities among substance-using African American/Black men who have sex with men. *Journal of Racial and Ethnic Health Disparities*, *2*(1), 1-10. https://doi.org/10.1007/s40615-014-0042-2

Centers for Disease Control and Prevention. (2015a). *Health disparities in HIV/AIDS, viral hepatitis, STDs, and TB: African Americans/Blacks HIV/AIDS*. Retrieved from http://www.cdc.gov/nchhstp/healthdisparities/africanamericans.html

Centers for Disease Control and Prevention. (2015b). *HIV among African Americans*. Retrieved from http://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html

Centers for Disease Control and Prevention. (2017). *HIV among African American gay and bisexual men*. Retrieved from https://www.cdc.gov/hiv/group/msm/bmsm.html

Creswell J. W. (2007). *Qualitative inquiry and research design* (2nd ed.). Thousand Oaks, CA: Sage.

Dangerfield D. II, Ober A., Smith L., Shoptaw S., Bluthenthal R. (2018). Exploring and adapting a conceptual model of sexual positioning practices and sexual risk among HIV-negative Black men who have sex with men. *Journal of Sex Research* 1-11. https://doi.org/10.1080/00224499.2018.1433287

Fields E., Bogart L., Smith K., Malebranche D., Ellen J., Schuster M. (2011). HIV risk and perceptions of masculinity among young Black men who have sex with men. *Journal of Adolescent Health*, *50*(3), 296-303. https://doi.org/10.1016/jadohealth.2011.07.007

Garcia J., Parker C., Parker R. G., Wilson P. A., Philbin M. M., Hirsch J. S. (2015). "You're really gonna kick us all out?" Sustaining safe spaces for community-based HIV prevention and control among Black men who have sex with men. *PLoS One*, *10*(10), e0141326. https://doi.org/10.1371/journal.pone.0141326

Harawa N., Williams J., Ramamurthi H., Manago M., Avinia S., Jones M. (2008). Sexual behavior, sexual identity, and substance abuse among low-income bisexual and non-gay identifying African American men who have sex with men. *Archives of Sexual Behavior*, *37*, 748-762. https://doi.org/10.1007/s1058-008-9361-x

Holloway I., Wheeler S. (2010). *Qualitative research in nursing and healthcare*. London, UK: Wiley-Blackwell.

Javier S., Abrams J., Moore M., Belgrave F. (2018). Condom use efficacy and sexual communication skills among African American college women. *Health Promotion Practice*, *19*(2), 287-294. https://doi.org/10.1177/1524839916676253

LeGrand S., Muessig K. I., Pike E., Baltierra N., Hightow-Weidman L. (2014). If you build it will they come? Addressing social isolation within a technology-based HIV intervention for young Black men who have sex with men. *AIDS Care*, *25*(9), 1194-1200. https://doi.org/10.1080/09540121102014.894608

Matthews D., Herrick A., Coulter R., Friedman M., Mills T., Eaton L., … Stall R. (2016a). Running backwards: Consequences of current HIV incidence rates for the next generation of Black MSM in the United States. *AIDS and Behavior*, *20*(1), 7-16. https://doi.org/10.1007/s10461-015-1158-z

Matthews D., Smith J., Brown A., Malebranche D. (2016b). Reconciling epidemiology and social justice in the public health discourse around the sexual networks of Black men who have sex with men. *American Journal of Public Health*, *105*(5), 808-814. https://doi.org/10.2105/AJPH.2015.303031

Murray A., Gaul Z., Sutton M., Nanin J. (2018). "We hide …": Perceptions of HIV risk among Black and Latino MSM in New York City. *American Journal of Men's Health*, *12*(2), 180-188. https://doi.org/10.1177/1557988317742231

National Institute on Drug Abuse. (2018). *Research report series: Which populations are most affected?*. Retrieved from https://www.drugabuse.gov/publications/research-reports/hivaids/who-risk-hiv-infection-which-populations-are-most-affected

Office of National AIDS Policy. (2015). *National HIV/AIDS Strategy*. Retrieved from https://www.whitehouse.gov/administration/eop/onap/nhas

Quinn K., Dickson-Gomez J. (2016). Homonegativity, religiosity, and the intersecting identities of young Black men who have sex with men. *AIDS and Behavior*, *20*(1), 51-64. https://doi.org/10.1007/s10461-015-1200-1

Riessman C. (1993). *Narrative analysis*. Thousand Oaks, CA: Sage.

Strauss A., Corbin J. (1998). *Basics of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

U.S. Census Bureau. (2017). *QuickFacts – United States*. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045217

VanDevanter N., Duncan A., Burrell-Piggott T., Bleakley A., Birnbaum J., Siegal K., … Ramjohn D. (2011). The influence of substance use, social sexual environment, psychosocial factors, and partner characteristics on high-risk behavior among young Black and Latino men who have sex with men living with HIV: A qualitative study. *AIDS Patient Care and STDs*, *25*(2), 113-121. https://doi.org/10.1089/apc.2010.0100

Voisin D. R., Hotton A. L., Schneider J. A. (2016). The relationship between life stressors and drug and sexual behaviors among a population-based sample of young Black men who have sex with men in Chicago. *AIDS Care*, *29*(5), 545-551. https://doi.org/10.1080/09540121.2016.1224303