Perceptions Towards Condom Use, Sexual Activity, and HIV Disclosure among HIV-Positive African American Men Who Have Sex with Men: Implications for Heterosexual Transmission

Nina T. Harawa, John K. Williams, Hema Codathi Ramamurthi, and Trista A. Bingham

ABSTRACT *Disproportionately high HIV/AIDS rates and frequent non-gay identification (NGI) among African American men who have sex with men or with both men and women (MSM/W) highlight the importance of understanding how HIV-positive African American MSM/W perceive safer sex, experience living with HIV, and decide to disclose their HIV status. Thirty predominately seropositive and non-gay identifying African American MSM/W in Los Angeles participated in three semi-structured focus group interviews, and a constant comparison method was used to analyze responses regarding condom use, sexual activity after an HIV diagnosis, and HIV serostatus disclosure. Condom use themes included its protective role against disease and pregnancy, acceptability concerns pertaining to aesthetic factors and effectiveness, and situational influences such as exchange sex, substance use, and suspicions from female partners. Themes regarding the impact of HIV on sexual activity included rejection, decreased partner seeking, and isolation. Serostatus disclosure themes included disclosure to selective partners and personal responsibility. Comprehensive HIV risk-reduction strategies that build social support networks, condom self-efficacy, communication skills, and a sense of collective responsibility among NGI African American MSM/W while addressing HIV stigma in the African American community as a whole are suggested.*

KEYWORDS *African American MSM, Condom use, HIV disclosure, Non-gay identification.*

INTRODUCTION

African American men who have sex with men or with both men and women (MSM/W) have the highest incidence and prevalence of HIV/AIDS among any ethnic/behavioral risk group in the United States.^{1,2} Over one in three African American MSM/W are seropositive, and their overall HIV prevalence is two to three times that of White and Latino MSM/W.^{1,3} Although their HIV prevalence rates are much lower than African American MSM/W, African American women experience much

Harawa is with the Charles B. Drew University of Medicine and Sciences, University of California, Los Angeles, CA, USA. Williams is with the Semel Institute of Neuroscience & Human Behavior, Suite C8-871C, 760 Westwood Plaza, Los Angeles, CA 90024-1759, USA. Williams and Ramamurthi are with the Department of Psychiatry & Biobehavioral Sciences, University of California, Los Angeles, CA, USA; Bingham is with the Los Angeles Department of Health Services, HIV Epidemiology Program, Los Angeles, CA, USA.

Correspondence: John K. Williams, MD, Semel Institute of Neuroscience & Human Behavior, Suite C8-871C, 760 Westwood Plaza, Los Angeles, CA 90024-1759, USA. (E-mail: Keoniwmd@aol.com)

greater racial/ethnic disparities, with HIV/AIDS rates almost 19 times those of White women.⁴ Approximately half of all annually reported HIV/AIDS cases among non-injection drug-using African American women are attributed to heterosexual contact with an HIV-infected man who does not have an identified HIV risk.⁴ Various studies indicate that the male partners of many of these women likely had sex with another man.⁵⁻⁷

Unfortunately, many female partners of HIV-infected or high-risk African American men are unaware that their partners may be engaging in sex with men. In a large multi-site study of people with AIDS, just 6% of African American women reported having had a male partner who had engaged in sex with men.⁷ Since so few women are aware of their partner's high-risk status for HIV and could be specifically targeted for HIV-prevention efforts, targeting their male partners is a particularly critical prevention component for decreasing heterosexual HIV transmission among African Americans. Developing successful intervention approaches for non-gay identified (NGI) African American MSM/W requires understanding their motivators and barriers to sexual risk-reducing behaviors.

Although a growing body of qualitative work has begun to examine the psychosocial issues that NGI African American MSM/W face as both ethnic and sexual minorities,⁸⁻¹³ little of this work has focused directly on attitudes towards condom use or on other factors that influence potential HIV transmission to women. Such research is particularly needed given studies indicating that African American MSM are more likely than White MSM to have both male and female partners and to identify as heterosexual or bisexual.^{7,14-21} Much of the literature on African American MSM/W highlights their status as stigmatized and stereotyped minorities.^{8,10-13,22} An HIV-positive diagnosis increases their minority status, particularly given that HIV stigma is well documented among African Americans.^{23,24} Not identifying as gay, continuing to have sex with females, or not revealing an HIV diagnosis may be ways that HIV-positive African American MSM/W avoid triple-minority status; however, researchers have identified a range of complexities and competing rationales for non-gay-identification and bisexual behavior.^{8,12} Less well documented is the interplay between psychosocial factors and norms in African American communities and HIV-infected MSM/W's attitudes regarding condom use and HIV-status disclosure.

HIV prevention among NGI African American men is complicated by issues of secrecy, racism, and a lack of identification with gay communities and norms.^{8,10,13,22} Many African American MSM/W describe experiences of exclusion from both gay White and heterosexual African American communities,^{10,13} and approximately three-quarters of Black heterosexuals express negative attitudes toward same-sex behavior among men (similar to the prevalence found for white heterosexuals).^{23,25} Compared to White MSM/W, African American MSM/W are less likely to live in the gay enclaves commonly found in many urban centers.²⁶ Among some non-gay-identifying MSM, contact with other MSM/W may be limited to casual sexual encounters, sexual episodes that occur in anonymous settings, or situations in which drugs or money are exchanged for sex.^{9,10} These circumstances may not be conducive to effective and consistent condom use, discussions of HIV status or dissemination of prevention messages.^{9,27} Outside of this context, revealing one's HIV status may lead to unwanted questions or suspicions regarding how one became infected.⁸

The experience of exclusion is also evidenced in the social science literature on HIV, where research about African American men and their sexual behaviors has

been limited.²⁸ African American MSM/W frequently lack visibility and the political or economic power to express their issues with discrimination and isolation or to shape prevention policy or research. Given these circumstances, research is needed to examine how HIV prevention has been absorbed by African American MSM who also engage in sex with women. Numerous HIV studies have included African American MSM/W; however, few have examined issues specific to African American men who may also have female partners or who have been diagnosed HIV positive. In an effort to identify and to understand condom use attitudes and behaviors with male and female partners, influences of an HIV diagnosis on sexual behavior, and perceptions regarding HIV disclosure, we undertook an analysis of transcripts from three focus groups of predominately non-gay identifying and HIV-positive African American MSM/W. We focused on the salient factors that may act as barriers or motivators to protective behaviors.

MATERIALS AND METHODS

Design

Three 90-min focus groups were conducted with participants recruited through direct outreach, word of mouth, and fliers posted in three collaborating community-based organizations (CBOs) in Los Angeles County. The CBOs included a program serving the medical and health education needs of indigent men and women; a drug-treatment facility for HIV-positive, generally crack cocaine-addicted men; and an Afro-centric cultural center providing a variety of wellness services. Direct outreach was conducted by an African American recruiter familiar with the target community in settings such as nightclubs, coffee houses, HIV/AIDS clinics, and street/park locations. Recruitment fliers specifically targeted MSM/W who self-identified as straight, bisexual, *Down Low* (DL), or same gender loving. Participants were compensated \$40 cash and were provided light refreshments.

A focus group interview guide was developed through discussions with experts in the field of HIV/AIDS, CBO collaborators, and a community advisory board. Questions were specifically targeted for non-gay identified African American MSM/W and were framed to identify and explore 1) the influences and motivators on sexual and health-seeking behaviors, 2) condom use behaviors and attitudes, 3) nuances and techniques for describing same-sex behaviors and identities, 4) race and gender expectations of African American men, 5) the experience of living with HIV/AIDS, and 6) ideal strategies for engaging African American men in HIV risk-reduction programs.

Participants

Sixty potential participants responded to direct recruitment or contacted the study's voicemail to find out more about the study. Of these, 47 were screened, and 30 were enrolled after meeting the following eligibility criteria: male, African American, age 18 years or older, sexually active with at least one male partner in the prior 12 months, English-speaking, and non-gay-identifying. Non-gay identifying meant that the potential participant identified either with no label or with a term other than "gay" (i.e., "straight," "heterosexual," "bisexual," "*Down Low*," or "same gender loving") when asked, "What term best identifies your sexuality or sexual orientation?" We did not specifically recruit HIV-positive men; however, all but one of the eligible participants disclosed that he had HIV.

Procedures

The three focus groups were held in confidential settings at locations operated by the CBOs. Each focus group consisted of 9–11 participants, lasted 90-min, and was audio-recorded and transcribed. The facilitator asked 11 main questions and used probes where necessary to solicit additional or more detailed responses. After the sessions, participants were administered a brief closed-ended survey assessing their age, socioeconomic status, gender of recent sexual partners, and sexual orientation label. Sexual orientation label was assessed using a list of eight choices, including heterosexual (straight), bisexual, gay, same gender loving or SGL, down low or DL, homosexual, queer, and other/none of the above (specify).

Data Management

Audiotapes were transcribed verbatim and reviewed by the facilitator for accuracy and completeness. Transcripts were loaded into *Atlas.ti* 5.0 to maintain organization during the coding process.

Data Analysis

The constant-comparison method²⁹ was used in analyzing the transcript data. Three reviewers read the transcripts, coded phenomena, and applied the codes to other similar phenomena in the text. The line-by-line coding was based on the principles of grounded theory analysis, in which theory is developed inductively.²⁹ The aim of this analysis was to identify common patterns and themes related to safer sex and HIV infection based on responses to the following sets of questions and probes: 1) What are the general thoughts about condom use among African American MSM? Do condoms really protect people? Under what circumstances do African American MSM use condoms?; 2) Is lubricant used with condoms and if so, what kind?; 3) How does being infected with HIV/AIDS or other STDs affect the sex lives of African American MSM? Do they continue to have sex? Do they disclose? Do they use condoms?

RESULTS

Study Population

The 30 study participants ranged from 22 to 59 years but were generally in their mid-thirties to mid-forties (mean = 42 years). Just 20% had completed college, and only 40% were currently employed. Although all the participants were initially screened as NGI, post-survey identifications included gay, homosexual or queer (30%); bisexual (40%); heterosexual (14%); same gender loving or SGL (10%); *Down Low* or DL (3%) and no label (3%). One participant was transgender but self-identified as a heterosexual male during both the screening and the focus group. Although participants were initially screened as having had sex with at least one male in the previous 12 months, at post survey, two reported sex with just female partners, and one reported no sexual partners. Fifty-three percent reported sex with only male partners and 37% with both male and female partners.

Qualitative Findings

Condom Use A few participants indicated they used condoms *always* or *never* when having sex, but many reported inconsistent condom use and perceived both

advantages and disadvantages to using a condom. One of the main benefits reported was condoms' protective role against disease. For this sample of predominantly HIV-positive men, condoms were used to prevent transmission of HIV to others and to protect against HIV re-infection or infection with other sexually transmitted diseases (STDs). A significant minority of men expressed concerns about disease risk specifically from female partners. For example, one HIV-positive man discussed his fear of contracting "something" from his former wife because she had cancer, and another indicated that he likely contracted HIV from one of his female partners because he always engaged in anal sex with his female partners.

Some participants also considered preventing the financial burden of a pregnancy as a benefit of using condoms and stated that condoms were used with male and female partners for different reasons. With male partners, condoms were described as being important in the prevention of HIV and STDs, but with women, they were valued primarily in the prevention of pregnancy and child support expenses. This participant summarized the difference while touching on the larger issues of health as a personal priority.

... with MSM, more specifically with African American men, condoms is equated to health. So, you have to deal with the whole concept of being healthy. Making healthy choices, prevention. So, when you deal with those condoms, if you don't equate condoms to health or condoms to life, why am I using it? You know... but then with a woman, you know, if you're having sex with a woman, you equate a condom with maybe protection from STDs... and [having] no children. So, you equate condoms with money... So, with men [male partners]... its health. With women, condoms prevent us from having children... money [paying child support]...

Participants' responses to earlier questions about the personal health of African American MSM/W indicated that preventive health concerns were frequently ignored or devalued by the population.

Though many men acknowledged the availability of condoms, others complained of a lack of availability, particularly in homeless shelters and incarcerated settings. They also distrusted the effectiveness of condoms for disease prevention and had aesthetic concerns regarding condom use. That is, the experience of using condoms was often not considered safe or "pleasurable to the senses" as described by this participant.

My opinion is that men do not like to use condoms because the condoms take away from the feel of the pleasure of having the actual flesh... Condoms are not 100%... what's the word?... Safe. Because they can tear, they can break, they can get holes in them, and things like that depending on the type of lubricant you use with them... Some, if you use, like water-based, that's probably safe to use with condoms, but still, condoms... nobody really likes to use condoms. Me, personally, I don't like to use condoms because I just don't like the way they feel or taste, so I don't use them.

A few participants did, however, report aesthetic benefits to condom use such as condoms prolonging erections or being used to enhance foreplay. The experience of condom breakage was not surprising given that a number of participants indicated that NGI African American MSM/W commonly use oil-based lubricants during sex.

Various situations were described as influencing whether condoms were actually used. Exchange sex, where sex is traded for drugs, money, or basic needs, was a commonly reported situation. Some men described making more of an effort to use condoms when hustling while others noted that completing the transaction was the main priority, even if it meant having unprotected sex to avoid losing the partner and the payment. This was particularly true for indigent and drug-using men.

If you have someone that's homeless, for example, and you meet somebody and you're like, you can come and stay with me but I need some sexual favors and then that person is like, well, I don't want you to use a condom. . . Depending on who that person is and their situation, if they're coming off of drugs, been on the streets, or whatever, they're going to do whatever it is they need to do to get off the streets for that period of time. So, often they're not going to use a condom.

Loss of control and poor decision-making capacity, as when intoxicated, were also linked to not being able to make safer choices during sex.

I think that. . . the reason that most men don't use condoms is that they either are intoxicated or they are on some type of drug, and they are caught up in the heat of the moment, and they don't stop to think.

Furthermore, many participants linked substance use to male same-sex behavior itself. For example:

I think that drugs, alcohol, and sex and the MSM has been a major factor because what it has done for men that were on the *Down Low* that really had the feelings [of being gay] or had it inside of them. The drugs allowed them to have the excuse to experience what we've always wanted to experience anyway, you know. Once we got loaded, once we hit the pipe, once we're using speed, or once we had the alcohol, then, when I f-ked around with you, I can say I was f-ked up last night. . . So, what it has done, or what it did, it opened up the door to bring the *Down Low*, to expose it more. Because now we found something that. . . that lets us do what we want to do, be who we want to be. And we have an excuse to do it. . . it gives [us] an excuse for our feelings.

In other instances, substance use was described as leading non-gay-identified men into same-sex activity either in exchange for drugs or money for drugs or by lowering inhibition and heightening sexual desire.

A desire to practice safer sex was described as being complicated by the dilemma of sexual identity and expression that many Black MSM/W face in other circumstances as well. For example, this participant describes how trying to

introduce condom use with a regular female partner can lead to questioning about outside sexual activities:

...on the *Down Low* brother type thing... This man and his wife are having sex. He goes out and has sex with a man. And he comes home now and wants to put on a condom. The wife is like, well, why you going to put that on. We haven't been using it for such a long time. So now he has a fear of putting on a condom because the wife wants to know why you're putting on a condom... [she may also say]... uh, my tubes are tied, I can't get pregnant. What's going on? Are you doing something out there? So it creates a lot of questions.

Impact of HIV on Sexual Activity Dominant themes regarding the impact of HIV/AIDS on the sexual lives of African American men included isolation, rejection, and decreased partner seeking. Along with reports of experiencing significant HIV stigma from their families, participants reported experiencing rejection from sexual partners and reduced sex drive. Several participants described the psychological impact of their HIV-positive diagnoses and the emotional pain associated with this rejection. For example:

It's a hurting thing when you go back and you look at what your life could have been had you not made this mistake and you also have to say to yourself, well, how much time do I have left? You want to be with a person in an on-going platonic, well, whatever kind of relationship, and, once you disclose your status to them, sometimes they just back up altogether. They don't want to have nothing to do with you. So, it's really a lot of stuff that you're up against.

Some men indicated that the knowledge that their social networks have about their serostatus and sexual preferences worsened the rejection from potential sexual partners and lead to isolation.

If I meet somebody out in the streets, 9 times out of 10, it's somebody who knew me from my past. Or knew me from one of the places that I had been. And it's not always good, you know, so, now, you know, my days and nights are real boring, you know. So, lately... my sex life may be, you know, like once a year. And lately, it's been a lot of me and the TV...

Disclosure of HIV Status to Sexual Partners Many participants described selectively disclosing their HIV status to sexual partners and others. A few participants reported not having disclosed their status to anyone, and others strongly believed in the responsibility to always disclose to all sexual partners. A majority, however, described disclosure to sexual partners as a responsibility only within the context of a steady sexual relationship or when trying to establish a relationship.

It depends on the situation that you're in, too, cause maybe, it's like, you're just a one-night stand and you might never see this person again... And then again, it could be a relationship that you're building up that

you're trying to have. So, you might have to disclose. But 9 out of 10, nobody cares if they're [not] going to see the person again, tomorrow, or whenever. And, they just go and do what they got to do and keep on moving.

Interestingly, men did not discuss how attitudes regarding disclosure or the process of determining when to disclose differed with female versus male partners.

A sense of obligation to disclose combined with a fear of rejection from sex partners led some to avoid the situation of disclosure altogether by not seeking out sexual relationships.

...for me, being HIV positive it cuts it... my sex life is short, actually. Uh, I'm not in a relationship. I don't look for relationships and basically, if you meet someone new, we might hit it off and be compatible, have a lot of things in common. Then you have to disclose because you have to disclose. It's the only male thing to do. It's just right. But then once you disclose, then they could be negative, and if they are, they might not be educated on the virus. There goes the rejection... any STD, any sexually transmitted disease, uh, is a very big problem, uh, for me because it cuts back on my personal life.

DISCUSSION

Focus group participants identified a range of benefits and risks associated with condom use and HIV disclosure for NGI African American MSM/W. Their status as racial and sexual minorities who often experienced HIV stigma, drug addiction, low SES, and concerns about revealing their same-sex behaviors influenced attitudes, intentions, and behaviors related to the prevention of HIV transmission to male and female partners. If motivators and barriers regarding protected sex strongly favored effective and consistent condom use with male and/or female partners, HIV among African American MSM/W would contribute little to infection among heterosexual women. Either few behaviorally bisexual men would become infected or few would transmit their infection to female partners. However, this is not the case; although behaviorally bisexual men are less likely to be infected than behaviorally homosexual men, they still have high levels of HIV infection⁵⁻⁷ and appear to contribute to a significant proportion of HIV/AIDS cases among Black women.⁵⁻⁷

The attitudes and perceptions influencing condom use and disclosure that we observed were consistent with the *Theory of Reasoned Action and Planned Behavior*.³⁰ The theory states that behaviors are influenced by prior behaviors, control beliefs, and intentions that are influenced in turn by skills and situational control, peer norms, attitudes regarding perceived benefits and risks, and personal values. Perceived condom benefits included protection against disease and pregnancy and for some, enhanced sexual fulfillment or performance. Perceived risks included a loss of sexual pleasure and ineffective disease prevention. Both perceived benefits and perceived risks may be influenced by African American cultural attitudes that favor "natural" sex²⁸ and adhere to a range of conspiracy theories regarding the origins and transmission of HIV.³¹ These theories, which reveal a deep thread of distrust of government and medical institutions in the U.S.,

were mentioned by participants in other portions of the focus group transcripts. Situational influences affecting whether positive condom attitudes would translate into condom use intentions and actual condom use included exchange sex and substance use with generally male partners and anticipated suspicion from steady female partners. Furthermore, substance use, in the context of homophobia, secrecy, and poverty that many men experienced, influenced male-to-male sexual activity by allowing, justifying, or contributing to its occurrence. Benefits of HIV-status disclosure included fulfilling a perceived responsibility to disclose. Nevertheless, because of perceived community norms regarding disclosure or fears of rejection from potential sexual partners, disclosure was generally limited to sexual partners with whom participants anticipated or had an ongoing sexual relationship.

The literature on condom use among African American MSM/W is complicated. Despite their much higher HIV prevalence, two recent national studies indicated that African American MSM/W use condoms as much as, if not more than MSM/W of other races/ethnicities.^{3,32} Furthermore, Black and "other" race men who have both male and female partners tend to have less unprotected anal intercourse with males than those men who have only male partners. However, MSM/W who do not disclose their same-sex behaviors tend to have more unprotected intercourse with female partners than those who do disclose.¹⁴ These patterns likely reflect positive attitudes regarding disease prevention with male partners and fear of suspicion from female partners. In a study by Williams et al.,⁸ African American HIV seropositive MSM/W cited various reasons for not using condoms that were consistent with our findings. These included enjoying unprotected sex more than protected sex and substance use interfering with safer sex practices. They also implied that the acknowledgement of one's risky sexual behaviors was sometimes avoided because of secrecy surrounding same-sex behavior and HIV seropositivity in the African American community.

Quantitative findings from Peterson et al.,³³ that condom use among Black MSM/W was negatively associated with exchange sex and drug use and was predicted by self-efficacy and behavioral beliefs, were consistent with our data. African American and low SES men have been shown to report higher rates of condom failure than White and high SES men,^{34,35} possibly contributing to the distrust of condoms that we observed. That pregnancy prevention was the main motivator for condom use with females may indicate that condoms are rarely used for anal sex with females. To our knowledge, the frequency of anal sex with women among behaviorally bisexual men has not been documented, and our study did not ask this of participants. We note, however, the participant who mentioned having anal sex with all of his female partners. Data from our recent focus groups with women who had sex with behaviorally bisexual African American men indicate that many of these men preferred anal sex. MSM/W's intercourse preferences and condom-use patterns for anal and vaginal sex with women are areas of concern and further research.

HIV stigma has been documented in the Black community, particularly the distancing of people with HIV^{23,24}; however, the potential effect of stigma on sexual activity among people living with HIV is not well understood. A 16-site behavioral surveillance study of insertive anal intercourse among HIV-positive MSM/W, indicated that a large percentage were sexually abstinent, practiced safer sex by using a condom, or engaged in unprotected sex but only with HIV-positive partners. Black participants (54%) were less likely than White (67%) or Latino (65%) participants to be sexually active with a male partner.³⁶ While this study

assessed only for insertive anal intercourse, it is consistent with our findings that some HIV-positive African American MSM/W decreased their sexual activity after they were diagnosed with HIV. It may also suggest that experiences of rejection and isolation may be particularly intense for African American MSM/W, leading to a greater decrease in sexual activity than for other races/ethnicities. Nevertheless, our study and others indicate that a significant minority of African American MSM/W use condoms inconsistently or not at all following an HIV diagnosis^{5,8,9,36} and that knowledge alone regarding the possibility of re-infection or HIV transmission to their male and female partners does not deter unprotected sex for all individuals.^{8,9}

Disclosure poses many potential problems for HIV-positive NGI African American MSM/W. Along with HIV stigma in the general community and potential rejection from partners,³⁷ some men fear being questioned about how they were infected and being associated with a “gay disease.”⁸ Other documented complications with being identified as HIV-infected include potential rejection from family, friends, and religious communities and physical harm.^{8,38–40} The threat of losing the love and protection of family or religious standing within a cultural context where family and church are central and act as a buffer against racial and socioeconomic oppression, may be particularly untenable for NGI African American MSM/W.

These data provide insight into how NGI HIV-positive African American MSM/W perceive safer sex, experience living with HIV, and decide to whom to disclose their HIV status. Some of the important themes that emerged have been identified in other, predominately European or racially mixed samples. For example, the role of substance use in reducing the likelihood of protected sex among MSM^{41–43} and the sense of personal responsibility to disclose one’s HIV status within the context of a relationship, but not necessarily to casual partners,^{27,41,42} have been documented in numerous studies. However, our study does have a number of important limitations. The results were based on a relatively small convenience sample collected from one geographic area and thus, may not be generalizable. Participants for one of the three focus groups were recruited from a drug treatment facility for HIV-positive men, possibly over-representing drug-addicted men. The study focused on NGI MSM/W; however, 30% self-identified as gay, homosexual, or queer on the post-demographic survey, and just 43% of participants reported sex with women in the past 12 months. Nevertheless, a national probability study of urban centers indicates that 57% of African American MSM/W had sex with both men and women in the past 5 years.⁴⁴ We anticipate this percentage would be higher in our sample as participants were predominately non-gay identifying. In some cases, the change in participants’ self-identification between recruitment and the post-survey likely reflected the different manner in which the data were collected with potential participants being screened with an open-ended question and actual participants being asked to select the most appropriate sexual label from a list. In other cases, it is likely an indicator of the fluidity of sexual identity among African American MSM/W. Despite these limitations, most of the themes reported here were discussed across the three focus groups, and many were consistent with prior research.

CONCLUSIONS

Addressing the psychosocial concerns of and the sociocultural context in which African American MSM/W live is critical to effective HIV prevention. These concerns include homophobia, racism, and HIV stigma but also substance abuse,

socioeconomic pressures, and health as a low personal priority. Addressing these complex and interrelated challenges calls for comprehensive strategies that counteract the racial and economic marginalization of African American men in the U.S., address HIV stigma and homophobia in the African American community as a whole, and build social support networks, communication skills, and a sense of collective responsibility and esteem among NGI African American MSM/W. The former will make it more possible for African MSM/W to negotiate conflicting priorities while remaining uninfected or avoiding transmission to others, and the latter will help to reduce isolation and promote condom negotiation among HIV-positive men. Our findings further suggest that condom acceptability issues may interfere with a desire to practice safer sex. Directly addressing concerns about effectiveness, highlighting HIV and STD risks to and from female partners, promoting proper condom and lubricant use, and encouraging men to try different types of condoms to find those that maintain the greatest sensation may address this issue. Given that many HIV-positive and negative African American MSM/W have had or continue to have female partners and that much of the HIV/AIDS epidemic is concentrated among African Americans, the behaviors of these men will continue to impact the course of the heterosexual epidemic in the U.S.

ACKNOWLEDGEMENTS

This study was funded by Universitywide AIDS Research Program (AL04-CDREW-840) and the UCLA-Drew Project Export (NIH 1P20MD001148-01). The authors would like to thank the collaborating community-based organizations and their staff members for input into the study design, assistance with recruitment, and use of their facilities. These include The AmASSI Health and Cultural Center (Cleo Manago), JWCH Institute, Inc. (Sergio Avina), and Palms Residential Care Facility (Tony Wafford and Kevin Pickett). We also acknowledge William Cunningham, MD, MPH, of UCLA for his input into the development of the proposal and study design and Siri Sat Nam for facilitating the focus groups.

Institutional Review Board approval was received from the University of California, Los Angeles. Office for the Protection of Research Subjects.

REFERENCES

1. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 2004. (Vol.16). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2005.
2. Centers for Disease Control and Prevention. HIV prevalence, unrecognized infection, and HIV testing among men who have sex with men—Five U.S. Cities, June 2004–April 2005. *MMWR Morb Mort Wkly Rep*. 2005;54:597–601.
3. Bingham TA, Harawa NT, Johnson DF, Secura GM, MacKellar DA, Valleroy LA. The effect of partner characteristics on HIV infection among African American men who have sex with men in the Young Men's Survey, Los Angeles, 1999–2000. *AIDS Educ Prev*. 2003;15(1 Suppl A):39–52.
4. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 2003 (Vol.15). Atlanta: U.S. Department of Health and Human Services, Center for Disease Control and Prevention; 2004.
5. Wohl AR, Johnson DF, Lu S, et al. HIV risk behaviors among African American men in Los Angeles County who self-identify as heterosexual. *J Acquir Immune Defic Syndr*. 2002;31:354–360.

6. Chu SY, Peterman TA, Doll LS, Buehler JW, Curran JW. AIDS in bisexual men in the United States: epidemiology and transmission to women. *Am J Public Health.* 1992;82:220–224.
7. Montgomery JP, Mokotoff ED, Gentry AC, Blair JM. The extent of bisexual behaviour in HIV-infected men and implications for transmission to their female sex partners. *AIDS Care.* 2003;15:829–837.
8. Williams JK, Wyatt GE, Resell J, Peterson J, Asuan O'Brien A. Psychosocial influences on HIV risks among HIV positive African American and Latino MSM with a history of CSA. *Cultural Diversity & Ethnic Minority Psychology.* 2004;10:268–286.
9. Miller M, Serner M, Wagner M. Sexual diversity among Black men who have sex with men in an inner-city community. *J Urban Health.* 2005;82(1 Suppl 1):i26–i34.
10. Stokes JP, Peterson JL. Homophobia, self-esteem, and risk for HIV among African American men who have sex with men. *AIDS Educ Prev.* 1998;10:278–292.
11. Malebranche D. Black men who have sex with men and the HIV epidemic: next steps for public health. *Am J Public Health.* 2003;93:862–865.
12. Icard L. Black gay men and conflicting social identities: sexual orientation versus racial identity. In: Glipton J, Valentich M, eds. *Social Work Practice in Sexual Problems.* New York: Haworth; 1986:83–93.
13. Kraft JM, Beeker C, Stokes JP, Peterson JL. Finding the “community” in community-level HIV/AIDS interventions: formative research with young African American men who have sex with men. *Health Educ Behav.* 2000;27:430–441.
14. Centers for Disease Control and Prevention. HIV/STD risks in young men who have sex with men who do not disclose their sexual orientation, six U.S. cities, 1994–2000. *MMWR Morb Mort Wkly Rep.* 2003;52:81–85.
15. Doll LS, Petersen LR, White CR, Johnson ES, et al. Homosexually and nonhomosexually identified men who have sex with men: a behavioral comparison. *J Sex Res.* 1992;29:1–14.
16. Easterbrook PJ, Chmiel JS, Hoover DR, et al. Racial and ethnic differences in human immunodeficiency virus type 1 (HIV-1) seroprevalence among homosexual and bisexual men. The Multicenter AIDS Cohort Study. *Am J Epidemiol.* 1993;138:415–429.
17. Kramer MA, Aral SO, Curran JW. Self-reported behavior patterns of patients attending a sexually transmitted disease clinic. *Am J Public Health.* 1980;70:997–1000.
18. Torian LV, Makki HA, Menzies IB, Murrill CS, Weisfuse IB. HIV infection in men who have sex with men, New York City Department of Health sexually transmitted disease clinics, 1990–1999: a decade of serosurveillance finds that racial disparities and associations between HIV and gonorrhea persist. *Sex Transm Dis.* 2002;29:73–78.
19. Goldbaum G, Perdue T, Wolitski R, et al. Differences in risk behavior and sources of AIDS information among gay, bisexual, and straight-identified men who have sex with men. *AIDS Behav.* 1998;2:13–21.
20. Heckman TG, Kelly JA, Bogart LM. HIV risk differences between African American and white men who have sex with men. *J Nat Med Assn* 1999;91:92–100.
21. Millet G, Malebranche D, Mason B, Spikes P. Focusing “down low”: bisexual Black men, HIV risk and heterosexual transmission. *J Natl Med Assoc.* 2005;97:52S–59S.
22. Mays VM, Cochran SD, Zamudio A. HIV prevention research: are we meeting the needs of African American men who have sex with men? *J Black Psychol.* 2004;30:78–103.
23. Herek GM, Capitanio JP. Public reactions to AIDS in the United States: a second decade of stigma. *Am J Public Health.* 1993;83:574–577.
24. Clark HJ, Lindner G, Armistead L, Austin BJ. Stigma, disclosure, and psychological functioning among HIV-infected and non-infected African-American women. *Women Health.* 2003;38:57–71.
25. Herek GM, Capitanio JP. Black heterosexuals’ attitudes toward lesbians and gay men in the United States. *J Sex Res.* 1995;32:95–105.
26. Mills TC, Stall R, Pollack L, et al. Health-related characteristics of men who have sex with men: a comparison of those living in “gay ghettos” with those living elsewhere. *Am J Public Health.* 2001;91:980–983.

27. Gorbach PM, Galea JT, Amani B, et al. Don't ask, don't tell: patterns of HIV disclosure among HIV positive men who have sex with men with recent STI practicing high risk behaviour in Los Angeles and Seattle. *Sex Transm Infect.* 2004;80:512–517.
28. Bowleg L. Love, sex, and masculinity in sociocultural context. HIV concerns and condom use among African American men in heterosexual relationships. *Men Masc.* 2004;7(2):166–186.
29. Strauss A, Corbin J. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* 2nd ed. Thousand Oaks, California: Sage;1998.
30. Fishbein M, Middlestadt SE, Hitchcock PJ. Using information to change sexually transmitted diseases-related behaviors. In: DiClemente RJ, Peterson JL, eds. *Preventing AIDS: Theories and Methods of Behavioral Interventions.* New York: Plenum; 1994:61–78.
31. Bogart LM, Bird ST. Exploring the relationship of conspiracy beliefs about HIV/AIDS to sexual behaviors and attitudes among African-American Adults. *J Natl Med Assoc.* 2003;95(11):1057–1065.
32. Harawa NT, Greenland S, Bingham TA, et al. Associations of race/ethnicity with HIV prevalence and HIV-related behaviors among young men who have sex with men in 7 urban centers in the United States. *J Acquir Immune Defic Syndr Human Retrovirol.* 2004;35:526–536.
33. Peterson JL, Coates TJ, Catania JA, Middleton L, Hilliard B, Hearst N. High-risk sexual behavior and condom use among gay and bisexual African American men. *Am J Public Health.* 1192;82:1490–1494.
34. Grady WR, Tanfer K. Condom breakage and slippage among men in the United States. *Fam Plann Perspect.* 1994;26:107–112.
35. Stone E, Heagerty P, Vittinghoff E, et al. Correlates of condom failure in a sexually active cohort of men with have sex with men. *J Acquir Immune Defic Syndr Human Retrovirol.* 1999;20:495–501.
36. Centers for Disease Control and Prevention. High-risk sexual behavior by HIV-positive, men who have sex with men—16 sites, United States, 2000–2002. *MMWR Morb Mort Wkly Rep.* 2004;53:891–894.
37. Cline RJW, McKenzie NJ. Dilemmas of disclosure in the age of HIV/AIDS: balancing privacy and protection in the health care context. In: Petronio S, ed. *Balancing the Secrets of Private Disclosures.* Mahwah, New Jersey: Erlbaum; 2000:71–82.
38. Gielen AC, O'Campo P, Faden RR, Eke A. Women's disclosure of HIV status: experiences of mistreatment and violence in urban settings. *Women Health.* 1997;25:19–31.
39. Kalichman SC, Nachimson D. Self-efficacy and disclosure of HIV-positive serostatus to sex partners. *Health Psychol.* 1999;18:281–287.
40. Ostrow DG, Whitaker RED, Fraiser K. Racial differences in social support and mental health in men with HIV infection: a pilot study. *AIDS Care.* 1991;3:55–62.
41. Van Kesteren NMC, Hospers HJ, Kok G, Van Empelen P. Sexuality and sexual risk behavior in HIV-positive men who have sex with men. *Qual Health Res.* 2005;15(2):145–168.
42. Wolitski RJ, Parsons JT, Gomez CA. Prevention with HIV-seropositive men who have sex with men. Lessons from the Seropositive Urban Men's Study (SUMS) and the Seropositive Urban Men's Intervention Trials (SUMIT). *J Acquir Immune Defic Syndr.* 2004;37(2):S101–S109.
43. Sheon N, Crosby GM. Ambivalent tales of HIV Disclosure in San Francisco. *Soc Sci Med.* 2004;58(11):2105–2118.
44. Binson D, Michaels S, Stall R, Coates TJ, Gagnon JH, Catania JA. Prevalence and social distribution of men who have sex with me: United States and its Urban Centers. *J Sex Res.* 1995;32:245–254.