Published in final edited form as:

AIDS Educ Prev. 2015 December ; 27(6): 505–521. doi:10.1521/aeap.2015.27.6.505.

The Development of a Counseling based HIV prevention intervention for African American men who have sex with men and women: The Bruthas Project

EA Arnold¹, D Operario², S Cornwell³, M Benjamin³, C Dillard Smith³, G Lockett³, and S Kegeles¹

¹University of California San Francisco

²Brown University

³CAL-PEP

Abstract

Background—African American men who have sex with both men and women (AAMSMW) are at high risk for acquiring and transmitting HIV, yet few interventions exist to address their unique prevention needs.

Methods—We conducted 3 focus groups, 21 in-depth interviews, and a pilot test of our intervention with N=61 AAMSMW which showed significant reductions in sexual risk behavior after 6 months. The intervention is currently being tested in a randomized controlled trial.

Results—We discuss the development of a culturally tailored, theoretically grounded counseling intervention for AAMSMW, presenting findings from our formative research, intervention development process, pilot study and the implementation of our RCT. We describe the content of each session, our protocol for merging Bruthas with HIV testing, and best practices for recruiting AAMSMW.

Conclusions—If Bruthas is found to be efficacious, the intervention will reach a vulnerable population to encourage uptake of regular HIV testing and reduced sexual risk taking.

Keywords

African American men; men who have sex with men; intervention development; bisexual; community collaborative research

Background

Reducing HIV infections among African Americans in the United States, and especially among African American men who have sex with men (AAMSM), ranks among the nation's top public health priorities and is part of the National HIV/AIDS Strategy (The White House Office of National AIDS Policy, 2010). From 2006 to 2009, a major driver of the increased

Corresponding Author: Emily A. Arnold, Ph.D., Center for AIDS Prevention Studies, University of California San Francisco, 550 16th Street, 3rd floor, San Francisco, CA 94158, Emily.Arnold@ucsf.edu, 415-476-6226.

Conflict of interest: None.

incidence of HIV in the United States was a 48% increase in the rate of infection specifically among young African American MSM (Centers for Disease Control and Prevention, 2011). Since the 1990s, the proportional increase in HIV has been highest for African American MSM compared with MSM of other racial/ethnic groups, and African American MSM also experienced the lowest decline in AIDS-related deaths and shortest survival times compared with other racial/ethnic groups (Bing, Bingham, & Millett, 2008). The burden of HIV in African American communities, and among African American MSM in particular, is commensurate to levels of HIV infection in some sub-Saharan African settings (G. A. Millett et al., 2012). Addressing race/ethnic disparities in HIV infection demands increased scientific and theoretical understandings of HIV risk among African American men to contribute to more innovative prevention and intervention strategies (Peterson & Jones, 2009).

Many African American men who have sex with men and women (MSMW) engage in high levels of risk behavior but challenge traditional HIV prevention approaches which are often tailored for and marketed to gay-identified men. African American MSMW, sometimes known as men on the “down low” (or DL men) to the extent that they remain secretive about their same-sex behaviors, tend to elude traditional public health approaches to HIV prevention, which typically target discrete risk group categories such as gay men/MSM or heterosexual men (Ford, Whetten, Hall, Kaufman, & Thrasher, 2007; Mays, Cochran, & Zamudio, 2004). DL men have previously been described as MSM who do not identify themselves as gay/homosexual or bisexual, have female partners (wives or girlfriends), and do not disclose their same-sex behaviors to their female partners (G. Millett, Malebranche, Mason, & Spikes, 2005). One of the few studies of this group surveyed 455 self-identified DL men which found, compared to non-DL MSM, higher levels of internalized homophobia, greater likelihood of having had unprotected vaginal sex, and lower likelihood of having had more than 7 male partners in the past 30 days (Wolitski, Jones, Wasserman, & Smith, 2006). Other studies have shown high levels of HIV-related risk behavior among AAMSMW, including unprotected insertive and receptive anal intercourse with men and transgender women, unprotected vaginal sex with women, multiple concurrent partners, and sex while under the influence of alcohol and drugs (Harawa et al., 2014; Operario, Smith, Arnold, & Kegeles, 2009; Wheeler, Lauby, Liu, Van Sluytman, & Murrill, 2008). While research has shown that MSMW, irrespective of race/ethnicity, engage in lower rates of unprotected anal intercourse (UAI) with male partners when compared to MSM (Montgomery, Mokotoff, Gentry, & Blair, 2003), other research indicates that MSMW tend to engage in higher levels of sexual risk behavior with female partners than with their male partners (Siegel, Schrimshaw, Lekas, & Parsons, 2008). Due to their sexual risk behavior with female, male, and transgender female partners, these men might operate as a bridge for HIV and other sexually transmitted infections across groups (Operario, Burton, Underhill, & Sevelius, 2008; Siegel, et al., 2008).

HIV prevention interventions developed for African American gay men may not be appropriate for AAMSMW. Existing HIV prevention interventions for African American men do not adequately address the psychological, interpersonal and social contextual factors for HIV risk among MSMW (Ford, et al., 2007; Malebranche, 2003; Mays, et al., 2004), nor are they delivered in a way that AAMSMW find acceptable. Intervention activities that

reinforce sexual minority identity and require open acknowledgement and discussion of same-sex experiences with other men are inappropriate for AAMSMW who are private about their sex lives, and do not identify as gay (Operario, Smith, & Kegeles, 2008). For these men, same-sex behavior might represent a source of internalized stigma, and thus explicit recognition and group discussions about same sex sexual activities could have adverse psychosocial consequences, such as increased internalized homophobia as well as potential “outing” of their sexual desires and same-sex activities to unwanted individuals. Thus, not only do interventions developed for African American gay men fail to address the critical issues facing AAMSMW, but the manner in which the interventions are delivered are unlikely to be acceptable by them. For example, interventions that involve small group activities are unlikely to reach AAMSMW because the men do not want to be seen by others attending such activities, nor do they wish to discuss their sexuality or sexual practices with gay-identified men. Culturally sensitive, theoretically grounded, interventions for AAMSMW require more sophisticated ways of addressing men’s sexual behaviors, their desires for secrecy, the impact of gender roles on their sexual identities, and the social and interpersonal determinants of their HIV risk behavior.

In this article, we discuss the development of an innovative, culturally tailored, theoretically grounded intervention for AAMSMW, entitled the “Bruthas Project.” Evaluation of the behavioral effects of Bruthas is currently underway. The aims of this article are four-fold. First, we outline the formative research, theoretical framework, and intervention development process. Second, we describe the content of each individualized counseling session, and our protocol for merging Bruthas sessions with standardized HIV counseling and testing. Third, we provide best practices for recruitment and engagement of AAMSMW in HIV prevention efforts, and last, we provide preliminary process evaluation findings from intervention participants in the randomized controlled trial (RCT) we are currently conducting.

Overview of the Bruthas Project Intervention Design Process

Given the problematic history of research in the African American community and resulting distrust of research participation, we felt it was important to use a community collaborative research framework in the implementation of this HIV prevention intervention program, as well as a formalized way to gather community input into the research. Community collaborative research is characterized by an engaged partnership between researchers and community members who work together to conceptualize, design, deliver, and evaluate programs to address health disparities (Sanstad, Stall, Goldstein, Everett, & Brousseau, 1999). The Bruthas Project Collaborative Research Team comprised university-based HIV prevention researchers working together with front-line HIV prevention counseling and education providers at a community-based organization (CBO) serving the African American community. This collaboration built on each partner’s unique strengths. The university-based partners brought the requisite scientific and methodological skills necessary to conduct a rigorous intervention trial while the CBO partners contributed in-depth knowledge and expertise about providing HIV testing in the African American community, and recruiting and building trust with AAMSMW men. The CBO partners were concerned about developing an intervention that could be taken “to scale” and implemented in other

community-based organizations across the US, which fit well with the desires of university-based partners who wanted to ensure that study results would have good external validity, so the intervention (if found to be effective) could be implemented in “real world” settings. To augment the collaboration, we developed a Community Advisory Board (CAB) consisting of community advocates, members of civic and social service organizations that work closely with African American male populations in the targeted geographic locations, and AAMSMW themselves. The CAB has been convened quarterly to provide advice and feedback on all matters related to Bruthas. In the formative stage of the project, the CAB gave input into the interpretation of preliminary research findings and in the application of these findings to developing the intervention, including its structure and content. In addition, we relied heavily on the CAB to provide feedback on session content and specific scripts that counselors would follow. They also provided input into recruitment, enrollment, and retention strategies.

We conducted extensive preliminary and pilot research to develop the content of Bruthas and identify an appropriate strategy for engaging AAMSMW in the program. We conducted two focus groups with 21 HIV-related CBO service providers who work with AAMSMW, and 21 in-depth interviews with AAMSMW themselves. The results of these activities have been published elsewhere (Operario, Smith, et al., 2008; Saleh, Operario, Smith, Arnold, & Kegeles, 2011). Using these findings as a basis for intervention development, we collaboratively designed the intervention content for Bruthas, as described more fully later in this paper.

Several decisions about the intervention and its delivery had to be made very early on in this project. The very first decision we made was for the intervention to be delivered as an individual-level intervention, via an interactive counseling approach. This decision was based on our recognition that MSMW would not want to attend an intervention group, and risk being seen by other members of the African American community, or discuss their sexual practices with others in a group format. The second decision we made was to provide the intervention in conjunction with another service being offered by CBOs, HIV counseling and testing (HIV-CT). In order to reach and engage the population, the intervention needed to be combined with HIV-CT which would give men in our population a way to access the intervention without being “outed.” The National HIV/AIDS Strategy emphasizes the need to get all at-risk groups to test for HIV regularly. Adding the Bruthas intervention to HIV testing makes sense since nearly all HIV-related CBOs are now providing HIV testing to clients, and seeking to increase the numbers of individuals being regularly tested. The third decision we made was to package the intervention as four distinct sessions, given the variety of issues that needed to be covered and recognizing that men would not want to attend a counseling session for longer than 60 minutes. Finally, we recognized that in order to retain men over a period of time to deliver the intervention, we would need to incentivize participation in each session. We conferred with our CAB and university-based IRB to develop appropriate incentive amounts that would not be coercive but that would allow us to retain our participants.

Insights from the Formative Research

Some of the insights gleaned from the formative research were relevant to the content of the intervention, whereas other insights related to the framing of the intervention and its delivery. There were several components to the formative research we conducted for use in intervention development. We sought insights from both AAMSMW as well as community-based service providers who would interact with our population in HIV prevention settings.

Six major findings emerged from our interviews with AAMSMW. *First*, we found a strong tendency for AAMSMW to compartmentalize their same sex behavior. Participants expressed anxiety about acknowledging their same sex desires and behaviors, and often described compartmentalizing their same sex experiences as discrete events (i.e., “things that I did”) rather than personal dispositional patterns related to identity, attraction, or orientation (i.e., “who I am”). Due to this internal conflict between engaging in same sex behavior versus being same-sex oriented, they did not feel ‘at risk’ for HIV, in part because they equated HIV risk with gay identity and did not perceive themselves as gay. *Second*, AAMSMW expressed a strong need for privacy about their sex and sexuality, and their need to avoid rumor or gossip, which they felt spreads quickly in their communities. The intervention therefore had to be conducted in such a way that individuals can be reached and also have complete privacy. *Third*, AAMSMW’s notions of masculinity and gender norms strongly impacted their behavior. Many participants had long-term girlfriends or wives, and presented themselves as more masculine. It was clear that the manner in which HIV prevention issues would be addressed in the intervention must be affirming of AAMSMW’s masculinity or male pride, and acknowledge the importance of children and female partners –wives or girlfriends - in AAMSMW’s lives. *Fourth*, AAMSMW described the occurrence of spontaneous sexual episodes with men, often in conjunction with substance use. Men often described that sex “just happened” with men, and was not planned ahead of time, sometimes occurring because sex was desired, and other times because sex was required in order to obtain access to a drug. Sex with men was often described as a way to fulfill a physical need or sexual urge, and participants rarely viewed their male sex partners as intimate or romantic lovers. Given the context that surrounded same-sex sexual encounters for our participants, we realized that an effective intervention must give participants non-judgmental space to talk about the social ecology of their occasions of spontaneous, often anonymous sex with other men, recognize its risks, and plan for safer sex actions given this context. *Fifth*, both AAMSMW and CBO service providers expressed the need to develop discreet yet affirming spaces located in the community, so they would be accessible, where AAMSMW could obtain sexual health services and be open about their attraction to men and sexual behaviors – yet not be considered to be or treated as though they are gay. Services should be provided in one-on-one sessions given the considerable concern about privacy, rather than group settings, thus confirming our initial decisions about the intervention. Finally, we learned that men would not be attracted to an intervention that was framed as an HIV prevention program. It was better to frame the program as broadly addressing “Black Men’s Health”, which would offer a more acceptable way for engaging AAMSMW in health education related to HIV prevention.

Findings from our focus groups with CBO service providers, most of whom were African American, complemented insights provided by the AAMSMW by revealing the barriers that AAMSMW might encounter when seeking HIV-related services in community settings (Saleh, et al., 2011). Service providers noted that AAMSMW challenged their assumptions about sexual behavior and sexual identity operating on a singular dimension; some service providers held negative personal beliefs about AAMSMW that reflected negative community depictions of these men as dishonest and untrustworthy. Focus group participants acknowledged difficulty in separating their personal beliefs about AAMSMW with their professional obligations to provide HIV prevention services in a non-judgmental fashion. Female service providers in particular referred to AAMSMW as “selfish” and “sneaky” while male service providers (most of whom were gay identified) were more balanced in their views, citing the cultural pressures to avoid being seen as “gay” stemming from church-based and family-based homophobic messages and norms. Further discussion revealed that these attitudes were exacerbated by media reports that portrayed AAMSMW in a negative light, which also undermined more open conversations within the community about sexuality, gender, and sexual behavior. These discussions helped the team realize that the staff and agencies that provided Bruthas to AAMSMW had to be trained to be sensitized to the needs of this population, particularly around the importance of respecting men’s privacy as well as withholding judgment regarding their decisions not to embrace an identity based on their same sex desire or activities.

To communicate a sense of connection and acceptance to our participants entering the community-based settings where Bruthas was to be delivered, we chose a name that would signal a feeling of belonging as men within the African American community. The term “brutha” is often deployed within community settings to signal a shared history and connection between men of African American descent. After a great deal of discussion with the Community PI, our lead counselor coined the name “Bruthas” for our project because it referred to the brotherhood that exists between African American men, and could help men overcome their concerns around privacy and judgment that might make them reluctant to participate in an HIV prevention intervention.

Theoretical Underpinnings of Intervention

The theoretical basis of Bruthas is the Information-Motivation-Behavior (IMB) model of health behavior change (Fisher & Fisher, 2000). The principles of IMB have been used widely in the development of behavioral interventions for at-risk groups (Fisher, Fisher, & Shuper, 2009). Fisher and Fisher suggest that to create a new HIV prevention intervention approach, open-ended formative research should be conducted in order to identify HIV prevention strengths and weaknesses within a target population. The IMB model proposes that HIV prevention *Information* and HIV prevention *Motivation* can have direct effects on HIV prevention *Behavioral* outcomes, and that these effects are mediated by improving individuals’ HIV *Behavioral skills*. The IMB theoretical framework for HIV prevention posits that (a) having HIV prevention information that is directly relevant to the personal practice of prevention is a prerequisite for engaging in HIV preventive behavior; (b) in addition to educating and building skills, HIV risk-reduction interventions must increase personal motivation to change risky behaviors, based on perceived social norms concerning

preventive acts, and perceived vulnerability to HIV infection; and (c) changing HIV-related risk behavior involves a series of steps that lead individuals to increase intentions to practice safer sex and test more regularly, by improving perceptions of self-efficacy for having safer sex and regular testing, and by building skills to practice safer sex and engage in regular HIV testing (Fisher & Fisher, 2000).

Content of the Bruthas Project Intervention

To determine the content of the intervention, we combined findings from our formative work and the IMB theory, specifically to define the content of the individual Bruthas counseling sessions. Table 1 summarizes the findings from our formative research, community input from AAMSMW and service providers, the IMB model, and the resulting HIV prevention messages that are incorporated into the intervention sessions. In order to decrease HIV-related sexual risk behavior with male and female sex partners, and increase regular HIV testing, the intervention addresses (1) gaps in knowledge about HIV transmission, testing, and treatment; (2) HIV prevention motivation (i.e., getting men to acknowledge their personal levels of risk behavior in order to become motivated to engage in preventive activities, and helping them to feel efficacious in their ability to reduce their sexual risk behavior with both male and female partners as well as increase the frequency of their HIV testing); and (3) enhancing HIV prevention behavioral skills (i.e., enhancing verbal and nonverbal sexual communication skills with both male and female partners, strengthening condom use skills, recognizing and strategizing for contextual triggers of unsafe sex, and engaging in HIV testing every 6 months). Using the findings of our formative research as a basis for intervention development, we collaboratively designed the intervention content for Bruthas. Our manual underwent multiple iterations of review and refinement, and we relied heavily on our Community Advisory Board (CAB) to provide us with feedback on session content and specific scripts that counselors could follow. Our CAB also helped us tailor the intervention to be most appropriate for African American men explicitly, incorporating perspectives on masculinity and the particular social roles of African American men in their families and communities into our intervention sessions and approach. The CAB members and members of the investigative team who were part of the target population also stressed that Bruthas must take a “whole man” approach and ensure that the intervention provided space and confirmation for the complex lives of our participants, who were much more than their sexual behavior.

Delivery of the Bruthas Project Intervention

As the issues were identified that needed to be targeted in the intervention, it became clear that multiple sessions would be needed in order to target all the issues for change, given the need to have short sessions. It was clear all sources of information that the men would only participate in relatively short sessions. We recognized that entire sessions were needed to focus on sex with men, separately from a session on sex with women. Yet the number of sessions had to be as limited as possible. The choice was made to have four sessions, delivered every 2–3 weeks over the course of no more than 3 months. Each session lasts for approximately one hour, and is facilitated by one member of our Bruthas team of African American male counselors, who were hired and supervised at the CBO.

The counseling sessions are designed to complement standardized HIV-CT, an approach that has been heavily emphasized for African Americans. Potential participants for Bruthas are identified through offering HIV-CT, which gives men a confidential way to begin to engage in HIV prevention conversations and disclose their same-sex activities. Once it is clear that participants fit the profile of a Bruthas participant, they can be referred for 4 additional in-depth counseling sessions, delivered over 3 months. All HIV-negative participants in the Bruthas Project intervention receive HIV-CT before going through the four intervention sessions, for HIV-positive men, there is no need for testing and they immediately begin sessions.

Bruthas Session 1: Individualized HIV-related risk assessment

The goals of the first session are to (a) assess HIV prevention knowledge and current sexual practices; (b) understand perceptions of personal vulnerability to HIV; (c) convey information about the prevalence of HIV locally and the importance of testing regularly; and (d) strengthen condom use skills. To orient participants to the nature of the local HIV epidemic, counselors begin the one-on-one session by providing participants with information about HIV and STI epidemics in the African American community in the Bay Area. Following a focus on increasing awareness of the high level of HIV prevalence among African American MSM in the local epidemic, counselors discuss basic awareness of the importance of regular HIV testing (at least every 6 months) and the availability of various treatment options if one tests positive. Counselors also assess men's behavioral risks for HIV and STI transmission. These discussions acknowledge how life experiences can affect HIV risk, and address participants' housing situation, employment status, educational background, history of incarceration and parole status, and substance use, as well as their attitudes towards regular HIV testing. Among HIV-positives, the facilitator discusses disclosure to sex partners and the risks of engaging in different safer sex practices with different types of sex partners. Some activities address building skills and comfort with sexual communication. The counselor also inquires whether HIV-positive participants are in treatment, and addresses the relationship of viral load and adherence with HIV transmission risk. This session includes two condom demonstrations (an initial demonstration using a penile model, conducted by the counselor, and a second demonstration conducted by the participant), and a review of effective safer sex negotiation strategies. Throughout, this first session emphasizes the development of rapport between the counselor and participant, in order to facilitate comfort and dialogue for subsequent sessions, and to improve retention in the program.

Bruthas Session 2: Safer sex and partner dynamics with women

The goals of the second session are to (a) identify partner dynamics, gender-related attitudes, and sexual practices that increase risk for HIV/STIs with female partners; (b) introduce specific behavioral strategies and skills to increase condom use, improve discussion about HIV/STIs, and encourage HIV/STI testing and screening with female partners; and (c) through role play exercises, provide opportunities to observe, practice, and obtain reinforcement on these behavioral skills. As in each subsequent session, this session opens with a brief review of the prior session and opportunities for discussion and reflection on

events of the previous weeks that are relevant to the intervention. The counselor then leads the participant into a discussion about his current or previous history of sexual relationships with a female, and facilitators and barriers to condom use, and safer sex and HIV/STI prevention with their female partners. Throughout the discussion, the counselor helps the participant to identify risk factors and vulnerabilities for unsafe sex, and consider behavioral strategies for reducing those specific vulnerabilities.

The session includes several role plays, in which various scenarios will be introduced for participants to practice how they would discuss or engage in safer sex behaviors or condom negotiations with female partners. Cultural attitudes regarding masculinity, particularly within heterosexual relationships, as well as male social and sexual roles and expectations are discussed. The counselor also asks the participant to reflect on his attitudes towards women, in the context of sexual communication and sexual risk behavior. For men who are HIV-positive, counselors also include discussion on disclosure practices with different types of female partners, and role play different scenarios regarding safer sex negotiation and HIV status disclosure. Participants receive feedback and encouragement following the role plays, and are given several opportunities to practice conversations with the counselor.

Bruthas Session 3: Safer sex and partner dynamics with men

The goals of the third session are to (a) identify male partner dynamics, sexuality-related attitudes, and sexual practices that increase risk for HIV/STI transmission; (b) provide specific behavioral strategies, including sero-positional strategies, and skills to increase condom use and improve conversations about HIV/STI prevention with male partners; and (c) through role play exercises, provide opportunities to observe, rehearse, and receive reinforcement for these behavioral skills. The session opens with a brief review of the previous session and opportunities for the participants to reflect on events of the prior weeks that were relevant to the previous session (e.g., sexual episodes or dating experiences with female partners; conversations about HIV with female partners). Following that, the counselor leads the participant into a discussion about his current or previous history of sexual relationships with males (including anonymous/spontaneous forms of casual sex, sex for pay, sex while incarcerated, sex under the influence, sex with an ongoing male partner), as well as condom use and discussion about safer sex and HIV/STI prevention with male partners (including barriers). Throughout the discussion, the counselor helps the participant to identify his triggers for unsafe sex with men, and consider the best behavioral strategies that may help the participant reduce his specific vulnerabilities.

The session also includes role plays, in which scenarios are introduced for participants to practice how they would discuss or engage in safer sex behaviors or condom negotiations with male partners. Cultural beliefs regarding masculinity, male social roles, and attitudes towards effeminate men will also be discussed. For men who are HIV-positive, counselors also include discussion on disclosure practices with different kinds of male partners, and role play a variety of different scenarios, which are designed for a variety of contexts, on safer sex negotiation and HIV status disclosure with men. Participants receive feedback and encouragement following the role plays, and are given several opportunities to rehearse risk reduction conversations with the counselor.

Bruthas Session 4: Overcoming contextual and environmental ‘triggers’ of unsafe sex

The goals of the fourth session are to (a) discuss factors—environmental, interpersonal and psychological—that might trigger participants’ desires for unsafe sex; (b) identify practical and concrete strategies for minimizing the effects of those triggers; (c) engage in role play or cognitive activities to practice how to manage high-risk contexts and minimize risky behaviors; (d) reinforce and encourage participants to consistently practice safer sex and maintain awareness of their HIV status. As in the previous sessions, this session opens with a brief review of the prior meeting and opportunities for discussion and reflection on events of the previous weeks that were relevant to the previous session (e.g., sexual episodes with men). Following that, the participant and client return to the condom demonstration exercise from Session 1; here, the participant practices his skills at putting a condom on the penile model, and the counselor provides feedback and positive reinforcement on the participant’s skills.

The counselor then leads the participant through two exercises to consider the factors that trigger unsafe sex, based on Personalized Cognitive Counseling (Dilley et al., 2002). First, the participant thinks about and then describes with complete detail a recent unprotected sex episode with a female partner; the counselor will listen and write down notes on reasons, justifications, and contextual or psychological triggers offered by the participant for that unsafe sexual episode. The counselor then leads a discussion to help the participant consider how to overcome contextual and psychological triggers for unsafe sex, and engages the participant in a discussion on common justifications for having unsafe sex with female partners. The second exercise follows the form of the first, with the participant describing with complete detail a recent unprotected sex episode with a male partner. As before, the counselor lists reasons, justifications, and contextual or psychological triggers for that unsafe sexual episode, and then leads a discussion to help the participant consider how to overcome those specific contexts, psychological triggers, and justifications for unsafe sex with male partners. Both exercises explore the role of substance use and its contribution as a ‘trigger’ of unsafe sex with male and/or female partners, the counselor also helps the participants develop strategies for situations that lead to sex under the influence. This session closes with affirming statements about the participant’s safer sex skills and his commitment to his health and protecting himself and partners from HIV. Men are provided with referrals to other health and social service agencies in the Bay Area, should they be necessary.

Implementation Characteristics of the Bruthas Project

Aside from the content of the manual itself, Bruthas requires particular forms of staffing, recruitment strategies, and spaces for actual delivery of the intervention. We discuss each of these implementation characteristics below.

Staffing

The characteristics of staff and counselors providing the services are a critical component of the Bruthas Project. Formative research provided insights into the desired qualities of effective Bruthas counselors: African American men who understand and are sensitive to the needs of AAMSMW, are trained in HIV test counseling, and are knowledgeable and empathic in delivering culturally appropriate HIV testing and referral services.

Recruitment in to Intervention

In order to provide an entry point for our participants, we use HIV testing as a way to recruit and reach men in the target population. Because testing is a central part of the HIV/AIDS National Strategy, and is emphasized for African Americans, it is an acceptable platform to use to engage men in conversations about HIV. Once men express interest in HIV testing, we can talk with them about their particular needs and then offer Bruthas to those who fit the target population profile. Also, our community partners have a mobile testing unit which Bruthas staff can take to areas where our target population congregates, giving men and our staff a private setting to discuss the realities of their sexual lives and experiences. Using the cover of offering HIV testing, we can engage with AAMSMW, provide testing services if appropriate, and then recruit them into Bruthas if they are eligible. We use three types of outreach and recruitment strategies to recruit members of this hard-to-reach population into the intervention, and provide incentives of \$35.00 for participants to complete each session.

In-person Recruitment

Bruthas staff approach men in known venues where the target population congregates, such as public parks, outside transit stations, or other known cruising areas. Recruitment staff approach individual men and speak to them first about the importance of HIV testing and maintaining good health. If men seem to fit the target population, recruiters then tell them about the study. They distribute small business card-sized or flyer-sized palm cards to interested individuals, and encourage them to contact the Bruthas Project if they are interested in participating. Enrollment into Bruthas is done through a two-step process. The first step is to screen all individuals who volunteer for the study by asking them brief questions about their recent sexual activity and sexual identity. If they qualify for the study, then they are asked to complete a longer survey assessment. During recruitment, interested men can set up an appointment to take the screener and assessment at one of our sites. If the team is working from a mobile testing clinic, screening and the initial assessment can take place at once in the privacy of the mobile testing unit.

Social Network-based Recruitment

Bruthas staff also rely on the social networks of our participants for recruiting others. Once the project staff has gained the trust of our participants, and built reputations as being open and non-judgmental as well as helpful, many of the AAMSMW enrolled in the study have been willing to refer other men to the project. Although we provide incentives for participants to engage in each intervention session, we do not incentivize referrals due to concerns that incentives could lead men to feel coerced by their friends to participate in the

study. However, we have found that some men feel so positive about Bruthas that they have wanted to get their friends and acquaintances involved.

Community-based Referrals

Bruthas recruitment staff also make presentations about the study at local CBOs, service agencies, and low income housing units around the Bay Area. They discuss the profile of the target population and provide an overview of the intervention. They leave recruitment materials, including palm cards, fliers, and resource sheets in public spaces at local community agencies, and also ask staff to refer potential participants to the study.

Safe Spaces for Delivery of the Intervention

In delivering the intervention, we realized that the intervention should be implemented in a space that is accessible and convenient for men to reach. Most importantly, the space had to be private, not located in a gay identified or AIDS identified organization, and have a generic waiting room that would provide “cover” for our participants if one of their associates found them there. We selected a clinical research site in San Francisco in the Tenderloin neighborhood and also used space at CAL-PEP, located in West Oakland. Both sites were private, located on major transit lines, in predominantly African American communities, and were not openly associated with HIV or with gay or bisexual men. For the counseling rooms themselves, we ensured that each one was set up to convey a sense of safety and acceptance, including white noise machines placed outside the room to assure participants that their conversations with our counselors were private. CAL-PEP also has mobile testing units that were useful for providing the intervention to participants in the field if they were unable or unwilling to report to one of our sites.

We also developed materials and used props to help participants absorb the intervention. We used clinical flip charts for the parts of the intervention sessions that referred to human anatomy and HIV, as well wooden dildos for condom demonstrations. Pamphlets containing all of our referrals were laid out for participants to look over and take if they so chose. Participants were given generic agency business cards with the contact information for their counselor, which had space for writing their next session appointment on the back. This allowed our participants to store the contact information for the Bruthas counselors in their wallets without risking their confidentiality should a female partner search their things. In all of our correspondence and voicemail messages, we referred to the study as the “Black Men’s Health Study.”

Retention in the Intervention

Attendance at all four of the counseling sessions is a vital aspect of the Bruthas Project intervention, since each session builds on the last one. Thus, retaining men through all of the sessions becomes a key dimension to consider when delivering the intervention. Our team used multiple strategies to retain participants over the 3 month period in which they attended the counseling sessions. At intake, Bruthas participants were asked to provide exhaustive contact information, including multiple phone numbers, email and home addresses, contact information for two friends or family members, and local hang-out spots. These were all stored in a database on a secure server and our participants were only identified by ID

numbers, ensuring their privacy. After the first session, all subsequent sessions were scheduled and written on a business card with the counselor's contact information on it. Counselors then called or sent text messages two days in advance of follow up sessions to remind participants to return. If participants failed to return, the counselors used all other tracking information, including sending emails and letters, as well as contacting family and friends to reconnect with the participant and invite him to return to the project. We also incentivized participation, which helped reduce attrition as well.

Pilot testing Bruthas

After we developed a draft of the Bruthas counseling manual, we conducted a preliminary pilot test of the Bruthas intervention. We recruited 61 AAMSMW in an uncontrolled pilot study that included a baseline HIV behavioral risk and psychosocial assessment survey, delivery of the four individual counseling sessions, and a 3-month follow up survey. The results of this pilot study have been published elsewhere (Operario, Smith, Arnold, & Kegeles, 2010). Of the N=36 participants who completed all 4 sessions and baseline and follow up surveys, we found significant reductions in unprotected receptive and insertive anal sex with male partners, fewer male and female unsafe sex partners, and decreased sex while under the influence of drugs. Participants also reported higher levels of social support and self-esteem, and lower levels of loneliness, at the 3-month follow-up. The Bruthas Project intervention was shown to be feasible to implement and is accepted by AAMSMW. It was clear from the pilot study that more attention needed to be paid to retaining participants in the intervention over time.

Bruthas is currently being tested in a large RCT. As part of this RCT, we recruit N=400 AAMSMW ages 18 and older who are randomly assigned to receive the Bruthas intervention (four individual counseling sessions) or to standard HIV counseling and testing only. All participants complete HIV behavioral and psychosocial risk surveys at baseline, 6-months and 9-months follow up. A subset of intervention participants are selected for qualitative exit interviews in order to gain more insights into the intervention process.

Preliminary Process Evaluation Findings from the RCT

To date, we have conducted N=21 qualitative interviews with intervention participants to gain insights into the intervention process itself. In general, our participants have reported positive experiences with the intervention, especially around feeling comfortable with our counselors, and having their privacy maintained. As one participant noted, *"I did not have to hide myself."* Another participant liked that the setting made him feel like his information was being carefully guarded: *"I feel like it was top secret, you know. I didn't worry about you guys doin' anything with the information because I didn't get that feeling. In other words, I trusted the Bruthas Project."* Indeed, several participants actually did not want sessions to end. One participant stated: *"Well, they probably could have extended it a little bit, get a little deeper into it, but I think I got a lot out of it, in the number of sessions, but I could have got a lot more if it was extended."* Another felt like he was learning a great deal. *"Instead of just stopping off at what, three or four sessions, just get more sessions, because I was getting to like it. Not just because of the money part, I was getting' something out of it"*

and I was learning stuff.” This positive feedback indicates that participants feel the intervention is acceptable and valuable.

We also found that the participants appreciated the emphasis on testing for HIV every 6 months. As one participant noted, *“Well, me, it’s [HIV testing] like a breath of fresh air, knowing you’re negative and don’t have it, and it lets you know what you’ve been doing, keep doing it and don’t deviate from your program ‘cause you might get it, it’s dangerous.”* Because the program is implemented in conjunction with testing, and gives participants four sessions to discuss their risk behavior to better understand their personal level of vulnerability to HIV, participants understand the need to practice safer sex and to test every six months to stay healthy.

Interestingly, participants also appreciate the use of visual materials as well as the models to help them practice and absorb the information since many learn information in different ways. *“Well, you know, some people, they have a hard time grasping the spoken information, and sometimes seeing things graphically helps them a little bit more. ‘Cause I used to be like that. I used to have an attention span where I forget about what you said in five minutes. But if you showed me flips... it’ll stick with me.”* In general, men were eager to absorb information, felt it was relevant and delivered in a manner and mode that they could grasp.

Men appreciated the help in identifying their triggers for unsafe sexual experiences, such as alcohol consumption, substance use, being with certain partners, and stated that awareness of these triggers allowed them to better prepare for these experiences and use condoms. One of our participants stated that Session 4 was actually the most helpful session for him in identifying the role of substance use and unsafe sex, an epiphany that eventually enabled him to quit using crack.

I learned that mostly it’s... the crack that drives the spontaneous [sex] — or it’s just that person’s drive for sex that stops a person from wanting to use a condom. So it’s best to not influence myself in that manner. Because I know it’s not just the men, it’s also the women... So – I figure, if I can trick a guy into putting on a condom and it’s two years later, what’s the difference with a girl? Like... [at the end of the program] I had the one session with T [a counselor]. And T. himself, he got me to say, if you can do it with a guy so easily, why wouldn’t you just stop smoking crack altogether and stop messing with the crack-head girls, also, right? And so – that’s where the thing – everything had changed. I was like, man, it makes more sense to just stay away from that type of environment. ‘Cause then, I was still thinking to myself, yeah, maybe I should... So, I was telling him that it would make sense for me to just let it go, you know? And he was just telling me, “Yeah, why don’t you just let it go?” So, I mean, that’s the most important thing, is to let go of the crack-head substance abuse thinking. And I could do it. So just to stay away from the crack block, I guess.

This participant managed to stay off of crack since having this conversation with one of our counselors, which had taken place 9 months before the interview. He reported that when he goes through the neighborhood now, which he refers to as the “crack block,” he just tells

dealers that he doesn't use anymore. Identifying the contextual factors that surround unsafe sex derived directly from our formative research, and for participants who are able to reflect on their triggers for unsafe behavior, it appears that some of them are able to make behavioral modifications that then make it less likely that they engage in unsafe sex.

Finally, we heard that it was essential for the team to have relevant up-to-date referrals in place, including for those who newly test HIV-positive. Here one of our participants, who tested preliminary positive following the baseline intake we do with all of our participants, talks about how the Bruthas staff took care of him and used their existing relationships with a nearby clinic to get him a confirmatory test and into treatment right away.

"After my HIV testing, I got the results read with the Bruthas Project, and being new to the city, no contacts, no – I was clueless. And the staff and counselors stepped up. You guys helped me out – just stepped up and walked me over to the one place out here, and – I don't know. It was good. It helped out a lot. And got me plugged in with one of the AIDS reps with [a local CBO], and he [the counselor] contacted me that same day, called me and was like, "Don't move! I'm coming to you!" I'm like, "Wow, okay!" 'Cause there was a lot of stuff starting to move pretty fast at that point. It was kind of overwhelming. So it was real good."

The participants all indicate an appreciation for the intervention, even stating that they wanted more sessions. A number of men told us that the Bruthas sessions were the first place where they have been able to reveal their sexual behavior and same sex desire without judgment. Key to the intervention's success was our ability to hire empathetic counselors who were African American men themselves, and who were able to protect the privacy and confidentiality of the participants in the project.

Limitations

There are two limitations that must be acknowledged. Although the intervention has been found to be promising, the results of our randomized controlled trial are still pending. Secondly, our team was multi-ethnic and multi-cultural, and while it included members of the target population it also included individuals from a variety of racial, ethnic, class, gender, and sexual identities. Thus, investigators came from a variety of cultural backgrounds, all of whom were influenced by their own unique implicit biases. Together the team collaborated to produce the Bruthas Project, working closely with a community advisory board and engaging in multiple reflective discussions with the CAB and with each other in order to develop a culturally tailored and appropriate intervention.

Conclusion: Bruthas is Promising, and tailored interventions are necessary for this population

In this paper, we outlined the formative research, theoretical framework, intervention development process, and the keys to successful implementation of an ongoing RCT to test the efficacy of the Bruthas Project. We also described the content of each individualized counseling session, our protocol for merging Bruthas sessions with standardized HIV counseling and testing, and provided best practices for recruitment and engagement of

AAMSMW in HIV prevention efforts. Because Bruthas is implemented in conjunction with HIV testing and counseling, it is congruent with the goals of the National HIV/AIDS Strategy, which emphasizes HIV testing every 6 months. Bruthas is also designed so that it could be replicated in other settings, where it could be paired with HIV testing in order to decrease HIV-related risk for a number of men. AAMSM are most heavily impacted by HIV, and little intervention work has been done to reach AAMSMW, a subset of AAMSM. If the Bruthas Project is found to be efficacious, the intervention will contribute to reaching a vulnerable population, encouraging regular testing and reduced sexual risk taking, ultimately reducing HIV incidence for a population that is disproportionately impacted by HIV.

Acknowledgements

We would like to acknowledge the rest of the members of the Bruthas Collaborative Research Team, including William Stewart, John Weeks, Shakema Snow, Raysean Ford, Michael Arnold, Elizabeth Bartmess and Desmon Pierceson for their invaluable contributions to the Bruthas Project. We also thank our participants and the members of our Community Advisory Board. Funding from the California HIV/AIDS Research Program (AL04-SF-818, and CHRP 00025475) supported the formative research and feasibility study, followed by a grant from NIH/NIMH (R01MH090890) to support the randomized controlled trial currently underway.

Sources of support: Dr. Arnold is funded by the National Institutes of Health and the California HIV/AIDS Research Program. Dr. Operario is supported by the National Institutes of Health. Ms. Cornwell, Ms. Dillard Smith, and Ms. Lockett are funded by the National Institutes of Health and the Centers for Disease Control. Dr. Kegeles is supported by the National Institutes of Health and the Centers for Disease Control.

References

- Bing EG, Bingham T, Millett GA. Research needed to more effectively combat HIV among African-American men who have sex with men. *J Natl Med Assoc.* 2008; 100(1):52–56. [PubMed: 18277808]
- Centers for Disease Control and Prevention. HIV among youth: National Center for HIV/AIDS VH, STD, and TB Prevention. 2011
- Dilley JW, Woods WJ, Sabatino J, Lihatsch T, Adler B, Casey S, McFarland W. Changing sexual behavior among gay male repeat testers for HIV: a randomized, controlled trial of a single-session intervention. *J Acquir Immune Defic Syndr.* 2002; 30(2):177–186. [PubMed: 12045680]
- Fisher, JD.; Fisher, WA. Theoretical Approaches to Individual-Level Change in HIV Risk behavior. In: Peterson, JL.; DiClemente, R., editors. *Handbook of HIV Prevention.* New York: Kluwer Academic; 2000. p. 3-56.
- Fisher, JD.; Fisher, WA.; Shuper, PA. The Information-Motivation-Behavioral Skills Model of HIV Preventive behavior. In: DiClemente, R.; Crosby, R.; Kegler, M., editors. *Emerging Theories in Health Promotion Practice and Research.* 2nd Edition. San Francisco: Jossey Bass Publishers; 2009. p. 22-63.
- Ford CL, Whetten KD, Hall SA, Kaufman JS, Thrasher AD. Black sexuality, social construction, and research targeting 'The Down Low' ('The DL'). *Ann Epidemiol.* 2007; 17(3):209–216. [PubMed: 17320787]
- Harawa N, Wilton L, Wang L, Mao C, Kuo I, Penniman T, Koblin B. Types of female partners reported by black men who have sex with men and women (MSMW) and associations with intercourse frequency, unprotected sex and HIV and STI prevalence. *AIDS and Behavior.* 2014; 18(8):1548–1559. [PubMed: 24523006]
- Malebranche DJ. Black men who have sex with men and the HIV epidemic: next steps for public health. *Am J Public Health.* 2003; 93(6):862–865. [PubMed: 12773340]
- Mays VM, Cochran SD, Zamudio A. HIV prevention research: Are we meeting the needs of African American men who have sex with men? *Journal of Black Psychology.* 2004; 30(1):78. [PubMed: 20041036]

- Millett G, Malebranche D, Mason B, Spikes P. Focusing "down low": bisexual black men, HIV risk and heterosexual transmission. *J Natl Med Assoc.* 2005; 97(7 Suppl):52S–59S. [PubMed: 16080458]
- Millett GA, Peterson JL, Flores SA, Hart TA, Jeffries WLt, Wilson PA, Remis RS. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK, and USA: a meta-analysis. *Lancet.* 2012; 380(9839):341–348. [PubMed: 22819656]
- 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-Psychological and Socio-Medical Aspects of Aids/Hiv.* 2003; 15(6):829–837.
- Operario D, Burton J, Underhill K, Sevelius J. Men who have sex with transgender women: challenges to category-based HIV prevention. *AIDS Behav.* 2008; 12(1):18–26. [PubMed: 17705095]
- Operario D, Smith CD, Arnold E, Kegeles S. Sexual Risk and Substance Use Behaviors Among African American Men Who Have Sex with Men and Women. *AIDS Behav.* 2009
- Operario D, Smith CD, Arnold E, Kegeles S. The Bruthas Project: evaluation of a community-based HIV prevention intervention for African American men who have sex with men and women. *AIDS education and prevention : official publication of the International Society for AIDS Education.* 2010; 22(1):37–48. [PubMed: 20166786]
- Operario D, Smith CD, Kegeles S. Social and psychological context for HIV risk in non-gay-identified African American men who have sex with men. *AIDS Educ Prev.* 2008; 20(4):347–359. [PubMed: 18673067]
- Peterson JL, Jones KT. HIV prevention for black men who have sex with men in the United States. *Am J Public Health.* 2009; 99(6):976–980. [PubMed: 19372510]
- Saleh LD, Operario D, Smith CD, Arnold E, Kegeles S. "We're going to have to cut loose some of our personal beliefs": barriers and opportunities in providing HIV prevention to African American men who have sex with men and women. *AIDS education and prevention : official publication of the International Society for AIDS Education.* 2011; 23(6):521–532. [PubMed: 22201236]
- Sanstad KH, Stall R, Goldstein E, Everett W, Brousseau R. Collaborative community research consortium: A model for HIV prevention. *Health Education & Behavior.* 1999; 26(2):171–184. [PubMed: 10097962]
- Siegel K, Schrimshaw EW, Lekas HM, Parsons JT. Sexual behaviors of non-gay identified non-disclosing men who have sex with men and women. *Archives of Sexual Behavior.* 2008; 37(5):720–735. [PubMed: 18506616]
- The White House Office of National AIDS Policy. *National HIV/AIDS Strategy for the United States.* Washington, DC: 2010.
- Wheeler DP, Lauby JL, Liu KL, Van Sluytman LG, Murrill C. A comparative analysis of sexual risk characteristics of Black men who have sex with men or with men and women. *Archives of Sexual Behavior.* 2008; 37(5):697–707. [PubMed: 18509753]
- Wolitski RJ, Jones KT, Wasserman JL, Smith JC. Self-identification as 'down low' among men who have sex with men (MSM) from 12 US cities. *AIDS Behav.* 2006; 10(5):519–529. [PubMed: 16691462]

Table 1

Using Formative Research, Community Input, and HIV Prevention Theory to Develop Bruthas

Formative Research Findings	Community Input	Prevention Theory (I-M-B)	Bruthas Project Intervention
Compartmentalization of Same Sex behavior and attraction	<i>Some men may not wish to acknowledge their same sex behavior and, due to this internal conflict, do not feel 'at risk' for HIV</i>	HIV Prevention Information, HIV Prevention Motivation and HIV Prevention Behavioral Skills	Reviewing HIV prevalence rates for MSM, learning how to communicate with male sex partners, use condoms with male partners and receiving support for same-sex behavior.
Need for Privacy around matters pertaining to sex and sexuality	<i>Men need to have HIV-related information specifically tailored for sex with both men and women, delivered in a culturally appropriate, non-judgmental way, in private settings.</i>	HIV Prevention Information	Delivering HIV-related information in a private, culturally appropriate manner, in one-on-one counseling sessions in a neutral space with African American male counselors.
Masculinity and Gender Dynamics	<i>HIV prevention skills need to be delivered in a way that does not undercut one's masculinity or male pride. Counselors have to acknowledge the importance of children and female partners in the lives of AAMSMW</i>	HIV Prevention Motivation and HIV Prevention Behavioral Skills	Discuss masculinity as a way to increase perceived control over sexual situations and practice of sexual communication skills and condom use. Discuss sexual negotiation and condom use in terms of long term goals (children and female relationships)
Spontaneous Sexual Episodes	<i>Spontaneous sex is never spoken about, important to give participants non-judgmental space to talk about social ecology of spontaneous, often anonymous sex, recognize its risks, and plan for safer sex actions.</i>	HIV Prevention Motivation and HIV Prevention Behavioral Skills	Behavioral skills around condom use, reviewing environmental triggers of unsafe sex and planning strategies to engage in safer sex within those contexts.