

# Public Health Responses to the HIV Epidemic Among Black Men Who Have Sex With Men: A Qualitative Study of US Health Departments and Communities

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In the United States, Black men who have sex with men (MSM) are disproportionately affected by HIV/AIDS. Thus, there is a need to understand the challenges facing health departments and community-based organizations responding to the HIV epidemic among this population. We interviewed 71 AIDS program directors, health department staff, and leaders of community-based organizations in 9 states and the District of Columbia. Participants identified psychosocial factors, a lack of capacity-building efforts, and stigma as barriers to HIV prevention responses targeting Black MSM. Participants identified culturally competent staff and culturally sensitive interventions as facilitating prevention responses. To ensure that HIV/AIDS interventions targeting Black MSM are effective, it is imperative to solicit the perceptions of frontline workers in health departments and community-based organizations. (*Am J Public Health*. 2009;99:1013–1022. doi:10.2105/AJPH.2008.140681)

Black men who have sex with men (MSM) exhibit an extremely high and disproportionate rate of HIV infection in the United States relative to other groups. Three epidemiologic studies conducted within the past 10 years highlight this point. First, the Young Men's Study employed a multisite, cross-sectional, venue-based survey methodology to collect behavioral and seroprevalence data from more than 3400 MSM between the ages of 15 and 22 years.<sup>1</sup> Findings from the study, released in 2000, showed that 14% of the Black MSM in the sample were HIV positive—the highest prevalence among the 5 ethnic groups represented by the sample. The study also showed that Black MSM were more than 6 times more likely than White MSM to be HIV positive.

Second, a study conducted by the North Carolina Department of Health involved a retrospective review of North Carolina men aged 18 to 30 years who were diagnosed with HIV between 2000 and 2003.<sup>2</sup> The study reported an increase in HIV cases among male college students from 2 in 2000 to 56 in 2003. Of the 56 cases in 2003, 88% were Black, and almost all were MSM.

Finally, the most disheartening seroprevalence data were published in 2005, from the

Centers for Disease Control and Prevention's 5-city study of MSM.<sup>3</sup> The study, which used a methodology similar to that of the Young Men's Study, showed an HIV prevalence of 46% among Black MSM, compared with 21% and 17% for White MSM and Latino MSM, respectively. Of the Black MSM who were HIV positive, 64% were unaware of their infection.

Given the high and increasing rates of HIV infection among Black MSM, researchers have begun to place a greater emphasis on understanding the psychological, behavioral, socio-cultural, and historical factors that may place these men at greater risk of becoming infected with HIV or transmitting the virus to sexual partners. For example, Millett et al.,<sup>4</sup> in a seminal literature review, noted that rates of HIV risk behavior (e.g., unprotected anal intercourse, injection drug use, and substance use during sex) were no higher among Black MSM than among White or Latino MSM. However, their research suggested that the higher HIV incidence observed among Black MSM might be explained by the higher rates of sexually transmitted infections among this population. Sexually transmitted infections cause decreased immune-system functioning, thus making men

more susceptible to the acquisition and transmission of HIV. The literature review also suggested that a lack of HIV testing and late HIV diagnosis among Black MSM could be linked to heightened risk for HIV among this group. Other work by Millett et al.<sup>5,6</sup> points toward characteristics of the sexual partners of Black MSM (e.g., older age, Black race, HIV-positive status) as important factors in explaining heightened HIV risk.

Likewise, Malebranche,<sup>7</sup> in pointing out steps for public health researchers and practitioners to take in thwarting the growth of the HIV/AIDS epidemic among Black MSM, suggested that a comprehensive understanding of HIV risk among Black MSM will require an examination of sexual networks, men's understandings of masculinity and sexuality, health care access, and increased susceptibility related to social and environmental stressors, among other issues. Other researchers have noted that homophobia and AIDS stigma within the families and communities of Black MSM may also explain heightened HIV/AIDS risk.<sup>8</sup> Homophobia and stigma may operate to reduce HIV testing and other protective behaviors among Black MSM and may impede HIV-status disclosure among HIV-positive Black MSM. These findings represent just a few of the myriad risk factors that may undergird the high rates of HIV infection and AIDS among Black MSM, highlighting the increased attention that needs to be focused on this public health crisis.

## HEALTH DEPARTMENTS AND THE HIV EPIDEMIC

Health departments represent a critical link between government funding dollars and frontline HIV/AIDS responses by community-based organizations (CBOs), health organizations, and other service providers. The Centers

for Disease Control and Prevention (CDC) gives state and local health departments significant HIV-prevention funding to support programs aimed at reducing HIV transmission risk behaviors.<sup>9</sup> This means that health departments, and the CBOs that rely on them for financial and programmatic support, play a crucial role in responding to local HIV epidemics in communities across the United States.

Since 2002, the CDC has supported health departments and CBOs in their HIV-prevention efforts through the Diffusion of Effective Behavioral Interventions (DEBI) project, a program aimed at translating HIV-prevention research into community-prevention practice.<sup>10</sup> To ensure that HIV-prevention interventions used in the field are grounded in empirical intervention-efficacy research, many CDC funding initiatives require health departments and CBOs that receive CDC funds to use DEBI project interventions. However, in linking prevention funding to DEBI implementation, policymakers may have overlooked important challenges that HIV-prevention practitioners face when using DEBI project interventions to address HIV in their communities. To reduce HIV infections among Black MSM, US health departments and the communities they serve must respond to the epidemic with individual-, community-, and policy-level interventions that are culturally grounded and that serve to increase health behaviors and reduce HIV risk factors among this population. Thus, it is important to allow staff at health departments and CBOs to have a say in translating research into practice and in turning funding dollars into reductions in HIV infections and increases in HIV testing.

Research has suggested that health department and CBO workers can be valuable sources of information in facilitating community-level improvements in HIV prevention,<sup>11,12</sup> but the literature provides little documentation of the overall impressions and experiences of these “frontline workers.” Moreover, none of the studies that do exist have specifically focused on prevention responses to the HIV epidemic among Black MSM. If social and behavioral research focusing on HIV among Black MSM is to have real-world applicability, researchers and policymakers need to understand how stakeholders in health departments and CBOs perceive the organization and implementation of

prevention responses within the organizational and cultural contexts that surround them. In other words, effective translation of research into practice requires a comprehensive understanding of the perceptions that health department and CBO staff have of practice, policy, and sociocultural factors that facilitate or impede the development, implementation, and effectiveness of HIV prevention strategies targeting Black MSM. Thus, there is a need to gain insight from health department and CBO staff who are implementing prevention responses to the HIV epidemic among Black MSM, to more comprehensively understand the best ways to mount consistent, organized, and effective responses to the crisis.

We conducted this study to assess the overall impressions of health department and CBO stakeholders with regard to their work in addressing heightened rates of HIV infection among Black MSM in their communities. We also assessed their perceptions of the barriers and facilitators they face in their responses to the crisis. The study was sponsored by the National Alliance of State and Territorial AIDS Directors (NASTAD), a nonprofit national association of health department HIV/AIDS program directors (i.e., AIDS directors) who administer HIV/AIDS prevention, care, and treatment programs funded by the states and the federal government.

## METHODS

A total of 71 AIDS directors, health department staff members, and CBO leaders participated in the study. Participants were sampled from 9 states and the District of Columbia (referred to as a “state” from this point forward). We selected states on the basis of their HIV/AIDS epidemiological profiles (i.e., disproportionate rates of HIV infection among Black MSM) and their location in the United States. We also strove to include localities that have been overlooked in much of the HIV research focusing on Black MSM but that were still representative of distinct US geographic regions where Black Americans live. The participating states included: California, Florida, Illinois, Maryland, Massachusetts, Michigan, North Carolina, New York, Texas, and Washington, DC. NASTAD worked with its members, including AIDS directors and their staffs,

to facilitate each state’s participation in the study. Participants were selected on the basis of their length of experience working in HIV/AIDS prevention or treatment programs, their experiences living in the cities and communities where they worked, and their familiarity with issues related to Black MSM and HIV/AIDS within the state.

Table 1 provides 2006 data for each of the 10 states in the following areas: interview participants, estimates for the Black population within in the state,<sup>13</sup> HIV/AIDS rates,<sup>14</sup> federal HIV/AIDS funding,<sup>14</sup> and the number of health department contracts with CBOs to provide HIV prevention programs targeting Black MSM.<sup>15</sup>

## Interview Protocol

We conducted semistructured 1-on-1 and small-group interviews between October 2006 and May 2007. The interviews were conducted within health departments and local CBOs in each of the states. Group interviews were conducted with no more than 3 participants, who were acquainted with one other and worked together. Interviews lasted 1 to 2 hours and were audio-recorded with the verbal consent of participants. The interviews were conducted by P.A.W. and T.E.M., who were experienced in working with health departments and CBOs and who had some understanding of the unique challenges these organizations faced.

Interviews covered a variety of topics. We asked questions that covered a broad variety of topics in order to facilitate discussion. Topics included general descriptions of rates of HIV infection and risk behaviors, impressions regarding risk factors related to HIV among Black MSM, experiences in organizing and implementing efforts to respond to the HIV/AIDS epidemic (here after *prevention responses*), and perceptions of practice, policy, and sociocultural factors that aid or hinder prevention responses. Specific questions included “How would you describe the HIV epidemic among Black persons, and particularly among Black MSM, in your jurisdiction? Are there problems or issues particular to Black MSM that promote risk behavior or hinder prevention efforts? What would you say your state/jurisdiction is doing to respond to HIV infection among Black MSM?” Broad

TABLE 1—Participants, by State, and Relevant State Characteristics: 2006

State	No. Participants and Role	Proportion of Population That Is Black <sup>a</sup>	Proportion of HIV/AIDS Cases Among Blacks <sup>b</sup>	Proportion of HIV/AIDS Cases Among MSM <sup>b</sup>	Total Federal HIV/AIDS Funding <sup>b</sup>	Health Department Contracts Directed Toward Black MSM, <sup>c</sup> Primarily (Partially)
California	7 health department staff 6 CBO staff/community leaders	6%	18%	67%	\$365 549 096	11 (167)
District of Columbia	5 health department staff 3 CBO staff/community leaders	55%	78%	44%	\$85 883 916	1 (18)
Florida	5 health department staff 2 CBO staff/community leaders	15%	49%	40%	\$281 846 999	2 (30)
Illinois	2 health department staff 4 CBO staff/community leaders	15%	49%	49%	\$102 599 329	6 (59)
Maryland	2 health department staff 1 CBO staff/community leader	29%	79%	26%	\$95 191 488	5 (135)
Massachusetts	2 health department staff 2 CBO staff/community leaders	6%	26%	36%	\$75 159 325	0 (20)
Michigan	3 health department staff 4 CBO staff/community leaders	14%	57%	49%	\$46 110 971	3 (15)
New York	3 health department staff 3 CBO staff/community leaders	16%	44%	28%	\$497 522 989	5 (100)
North Carolina	3 health department staff 3 CBO staff/community leaders	21%	67%	32%	\$44 649 272	5 (48)
Texas	5 health department staff 4 CBO staff/community leaders	12%	31%	55%	\$190 350 576	9 (19)

Note. MSM = men who have sex with men; CBO = community-based organization.

<sup>a</sup>Data from the US Census Bureau.<sup>13</sup>

<sup>b</sup>Data from the Kaiser Family Foundation.<sup>14</sup>

<sup>c</sup>Data from Randall et al.<sup>15</sup>

questions were followed up with more specific ones that were used to explore detailed issues and salient points that participants brought up.

### Analytic Approach

All interview recordings were transcribed, and personally identifying information was deleted from the transcripts. We employed a multistage, iterative process in analyzing transcripts from the interviews. The analysis was guided by the principles of grounded theory,<sup>16</sup> in which key themes and codes used to organize themes emerge out of the data and are not determined a priori. The qualitative analysis was conducted by a team consisting of P.A.W., T.E.M., and a colleague trained in qualitative data analysis.

In the first step of the analysis, a preliminary codebook was created based on the structure of the interview guide. The preliminary codebook consisted of the major level 1 codes

*barriers* and *facilitators*, representing perceived barriers to and perceived facilitators of prevention responses to the HIV epidemic among Black MSM. Second, the team reviewed transcripts from interviews in 3 randomly selected states, and each team member took notes on key themes in the interview. Third, level 2 and level 3 codes were created based on this initial transcript review. These codes represented the perceived sources of barriers and facilitators (level 2) and specific nuances and themes within each source (level 3). Fourth, the team engaged in the iterative process of coding subsets of interview transcripts, making updates and revisions to the codebook, and coding and recoding transcripts. Fifth, the team reviewed and discussed coding disagreements, and an assessment of intercoder reliability was obtained ( $\kappa=0.85$ ). We used NVivo version 2.0 (QSR International Pty Ltd, Doncaster, Victoria, Australia) to organize the data and

to assist in identification of key themes and intercoder reliability.

We amassed more than 80 level 2 and 3 codes that we used to document and organize the data within the level 1 codes. Each code provided information on the discrete instance when a topic or theme was discussed during the interviews. We examined the number of times codes were used within and across interviews in the 10 states to assist in identifying prominent themes. In an effort to understand how certain themes were related to one another, we conducted a coding analysis to examine how particular level 2 and 3 codes co-occurred. Code definitions and frequencies are provided in Tables 2 and 3.

### RESULTS

Results of the analysis consist of the themes captured in the level 1 codes *barriers* and

facilitators. Discussions of the main barrier and facilitator themes focus on topics captured by level 2 and 3 codes within each theme.

**Perceived Barriers to Prevention Responses**

As Table 2 shows, participants spoke with great frequency of barriers to efforts to prevent HIV among Black MSM. In 100% of the interviews we conducted, participants spoke of perceived barriers (with 414 individual references to perceived barriers). Participants most often spoke of health departments, CBOs, interventions, structural and psychosocial factors, social networks, and stigma in their discussions of perceived barriers to prevention responses. The greater the frequency with which participants mentioned specific barriers, the more prominent they likely considered those barriers to be. The coding analysis suggested that although participants said these barriers operated distinctly, many of them were also interconnected.

Participants' perceptions of barriers stemming from the practice realm (i.e., health departments and CBOs) were most often discussed in terms of capacity-building and the cultural competency of staff and available interventions. Participants noted a lack of health department-based capacity-building efforts targeting CBOs that served Black MSM. They suggested that the dearth of capacity-building negatively affected the performance of organizations serving Black MSM. One noted, "I don't think that we have invested enough in developing the capacity of some of our community organizations, particularly indigenous organizations" (CA participant). The theme of lack of capacity building frequently co-occurred with staffing concerns within health departments and CBOs. For example:

It's hard to maintain growing a generation of new workers who are African American, and gay, and Black. It has been an ongoing challenge. It's something that we have not been, and providers have not been, successful at. Something breaks down along the way. (MA participant)

Staffing concerns were tied to another key practice-based barrier: a lack of cultural competence among health department staff. Participants highlighted the importance of having health department staff at all levels of the department who look like the

**TABLE 2—Itemization, Examples, and Frequency of Mention of Perceived Barriers to Prevention Responses to the HIV Epidemic Among Black MSM**

	Specific Examples	Percentage of Interviews Coded	Number of References in Interviews
Health department-based (barriers originating from health departments)	Staffing, communication, capacity-building, outreach, data/surveillance	69%	96
CBO-based (barriers originating from community-based organizations)	Staffing, organizational stability, outreach	62%	75
Intervention-based (barriers related to interventions, or a lack thereof, targeting Black MSM)	DEBI, social marketing, adaptation	67%	52
Internet-based (barriers related to Internet-based outreach or Internet use among Black MSM)	Outreach, Web sites	26%	16
Structural factor-based (barriers related to transportation, geography, access to health care, or historical factors)		64%	60
Psychosocial factor-based (barriers related to low self-esteem, poor self-concept, or loneliness among Black MSM)		74%	90
Social network-based (barriers related to family, friendship, and sexual networks of Black MSM)	Family, friendship, sexual partners	74%	80
Stigma-based (barriers related to internalized and external stigma around homosexuality, sex, and HIV/AIDS)	Internal stigma, external stigma	67%	61
Racism-based (barriers related to personal, social, or institutional racism)		33%	18
Religion-based (barriers related to religion, spirituality, or religious groups)		31%	21

Note. MSM = men who have sex with men; CBO = community-based organization; DEBI = Diffusion of Effective Behavioral Interventions.

communities they serve. However, many noted that Blacks were underrepresented in their health departments and were typically in administrative roles rather than leadership roles.

Concerns about cultural competency and capacity-building efforts were not discussed solely within the context of health departments.

Participants also suggested that CBOs often lacked the capacity to truly understand the needs and concerns of the Black community and to implement interventions that are specifically appropriate for use with Black MSM. The following exchange from 2 Illinois participants highlights this theme:

**TABLE 3—Itemization, Examples, and Frequency of Mention of Perceived Facilitators of Prevention Responses to the HIV Epidemic Among Black MSM**

	Specific Examples	Percentage of Interviews Coded	Number of References in Interviews
Health department-based (facilitators originating from health departments)	Staffing, communication, capacity-building, community-planning groups, data/surveillance	54%	136
CBO-based (facilitators originating from community-based organization)	Cultural competency, outreach	77%	81
Intervention-based (facilitators originating from interventions targeting Black MSM)	Holistic, adaptation, social marketing	59%	57
Internet-based (facilitators related to Internet-based outreach or Internet use among Black MSM)	Outreach, Web sites	23%	13
Structural factor-based (facilitators related to transportation, geography, or access to health care)		15%	7
Psychosocial factor-based (facilitators related to high self-esteem and positive self-concept among Black MSM)		44%	23
Social network-based (facilitators related to the family and friendship networks of Black MSM)	Family, friendship	56%	38
Religion-based (facilitators related to religion/spirituality or religious groups)		18%	11

Note. MSM = men who have sex with men; CBO = community-based organization.

Participant 1: What happens is when the dollars . . . switch over to [the] African American community, the programs that have traditionally been working in the White communities, they take those same programs and . . . put kente cloth on it and call it Black. . . . And I've always had a problem with that. The cultural sensitivity is just not there.

Participant 2: It's not a one-size-fits-all [solution]. . . . I think the bottom line in this part of the conversation is that when you're doing cultural interventions and when you talk about addressing capacity [for intervening with] a specific culture, it has to be respectful of that culture. It has to be a "for us, by us" kind of intervention, as opposed to something that is a grant given to us to say, "I know what you need. I'm gonna fix it for you." The organization style

that's most effective is from the people to the people.

The insights of these participants reflect those of many who said that CBOs' lack of competency in delivering culturally appropriate approaches was hampering intervention and outreach efforts targeted toward Black MSM. For example, participants noted that venue-based outreach programs, which have been useful in reaching certain groups of gay men, were not always effective in reaching Black MSM because that group is less likely to socialize in traditional outreach venues, such as conventional gay bars and nightclubs.

Perceived barriers to prevention responses were directly tied to issues within intervention research and policy. Participants indicated frustration with the lack of culturally appropriate interventions available for Black MSM. Most health department and CBO participants noted that they were mandated to work with CDC-sponsored DEBI program interventions, despite the fact that there was only 1 DEBI intervention to date that focused specifically on Black MSM. In addition, participants said they found it difficult to implement interventions that had been designed under experimental conditions rather than in real-world settings. One participant, whose comments were echoed by many others, noted that "we focus a lot on the DEBI interventions, which are hugely important, but they're also expensive and labor intensive" (NC participant). Participants suggested that although evidence-based interventions were important to prevention efforts, some DEBI program interventions were difficult to implement in the field or were not specific to the unique concerns of Black MSM.

Many of the participants' concerns regarding barriers to prevention responses had to do with mental-health issues among Black MSM, notably psychosocial problems such as poor self-concept and low self-esteem. Psychosocial issues represented a thread that linked many of the other barriers of which participants spoke. Participants suggested that prevention responses would be facilitated by an increase in mental-health interventions targeting Black MSM. For example, a participant bluntly highlights where current interventions may be missing the mark and provides direction for future interventions:

So basically, in terms of HIV for Black gay men, it's not—and this is the punch line—it's not a question of them not knowing how to save their lives. It's a question of them knowing if their lives are worth saving. (DC participant)

Participants talked about how poor self-concept, low self-esteem, and loneliness were intertwined and were linked to self-hatred and internalized homophobia for many Black MSM. They noted that unprotected sex and risky behavior emerged out of personal and social factors that made it difficult for Black MSM to value themselves and their

experiences. Participants also noted that these personal and social factors were difficult to change.

Perceived barriers stemming from fractured, hard-to-reach social networks were also discussed in the interviews. In speaking of their outreach experiences, several participants noted that a lack of venues and of an organized community in which Black MSM can participate impeded intervention efforts. One noted: “a lot of Black gay men are ‘hidden,’ which means that they stay home. They do house parties. . . . They don’t go to gay bars, for example, they stay more hidden” (FL participant). The “hidden” nature of Black MSM communities bespoke the social and cultural factors that kept them from being gay in public, despite a personal desire for community-building and intimacy with other Black MSM. For example:

And engaging this population [is difficult]. . . . [We found] through our project [that] one of the emerging themes is a loneliness. People feel kind of just out there. . . . It’s still not okay to be out there about having sex, much less having sex with other men. [The message comes] from their communities, their families, as well as a larger culture. (NC participant)

Participants also discussed high-risk sexual networks as a major barrier to effective responses to the HIV epidemic. The risk of participating in these sexual networks was perceived to be related to a lack of disclosure about HIV status or knowledge of one’s status. One participant’s account highlights this issue:

In our case management, we’ll have 10 or 12 clients that got infected by the same person; they keep identifying that same person every time. They come in, that same name keeps popping up . . . but that person is not case-manageable, they’re on our caseload but they never come [in], they never comply, they never want to talk about things, they never want to be open and discuss these issues. (MI participant)

Stigma was a frequently discussed perceived barrier to prevention responses. The coding analysis we undertook suggested that stigma was related to several perceived barriers identified by participants. Specifically, participants suggested that stigma was directly tied to poor self-concept among Black MSM. Internalized stigma was characterized as a multidimensional phenomenon that affected

several different behaviors, from “coming out” to engaging in health-seeking behaviors such as HIV testing. One participant described stigma this way:

I think one of the core issues is self-value. That we are struggling with deep-seated internalizations of a whole range of oppressions that converge. It’s internalization of racism, internalization of homophobia, internalization of misogyny. All these things converge and you are then seeing how the epidemic, the stigmatization of it, and [of] the prevention and treatment [of HIV], then gets internalized, as well. (CA participant)

Stigma was described as something that Black MSM internalize and as something that these men encounter in their families, communities, and neighborhoods. Participants suggested that stigma makes it difficult for Black MSM to feel free to be who they are. One participant explained, “You still have the closet mentality, even if you’re out. You just feel like there’s certain places you can go and there’s certain things you can do and [it just] feels like you’re restricted, extremely restricted” (FL participant). Our participants’ experiences suggested that community-level stigma weighed very heavily on Black MSM, undermining practitioners’ intervention efforts. The participants felt that not enough was being done to combat individual- and community-level stigma and that antistigma interventions were desperately needed within the Black community. Other perceived barriers noted by participants included structural factors, the Internet, racism, and religion. Participants noted that a major structural barrier was a lack of affordable transportation options, which impeded access to intervention and outreach programs and community-building activities for many Black MSM. Participants also discussed how the physical distance between Black MSM living in rural areas or large states made it difficult for men to physically connect, which led to Black MSM using the Internet to meet other men. They suggested that the Internet was primarily used as a way to meet sexual partners and thus represented a potentially high-risk venue. Finally, level 2 codes identifying racism- and religion-based barriers frequently co-occurred with the theme of stigma, although these topics were mentioned less frequently than other barriers.

## Perceived Facilitators of Prevention Responses

Table 3 shows the specific facilitators of prevention responses that were mentioned in the interviews we conducted. In 100% of the interviews we conducted, participants referred to facilitators of prevention responses (with 311 individual references to perceived facilitators). Themes within facilitators were tied to mental health promotion and social support, among other areas. Our coding analysis suggested that, as with many of the barriers identified, several of the perceived facilitators were interrelated.

Participants said that communication between health departments and CBOs was crucial in facilitating prevention responses. Enhanced communication between health departments and the CBOs they partnered with increased the organizational capacity of CBOs and the cultural competency of health departments. Participants’ experiences suggested that when health departments took a genuine interest in the day-to-day affairs of the CBOs they worked with, those CBOs were better able to meet their performance expectations and deliver effective programming. Improved communication between health departments and CBOs meant that the health department was in a better position to assist with the identification of talented board members and skilled management staff, provide trainings on how to apply for state and federal grants, and assist with program evaluation activities. In this way, open communication allowed health departments to better identify CBOs’ technical assistance needs, putting both health departments and CBOs in stronger positions to organize prevention responses.

Communication between health departments and CBOs also proved to be important in winning the trust of CBOs that served Black MSM. Interview participants highlighted the need for transparency between health departments and the organizations they worked with. Transparency led to trust, they said, which provided immeasurable aid in facilitating collaborative efforts to prevent HIV among Black MSM. Our participants said that taking the time to listen to CBOs and community members—even when their message

was negative—was instrumental in fostering trust and facilitating prevention efforts. As a participant noted:

I hear all of the stuff, all of their great challenges, all of their successes, all the nightmares that they're having about their project. I get to hear all of it. . . . I just say, "Bring it on. Tell me. Communicate." I go out and I just get beat up and it's fine with me. . . . I'm so willing to get beat up because until people can feel like, "I can tell you anything," then they can't tell me anything. (MD participant)

Participants also perceived CBO competency—not only cultural competency, but also with regard to management and leadership—as a key facilitator of prevention responses. Participants said that when CBOs were headed by charismatic, capable individuals, they were more likely to be effective in delivering interventions and working with health departments to reach Black MSM. Likewise, participants felt that when CBO staff and providers looked like the Black MSM they served, they were more likely to be able to effect change in these men. For example:

It is very important to see someone in front of you who represents you. If I had HIV, I would want to see someone who is like me. Not someone with the virus, but someone who can relate to me. For the young people, the thing that they say [is] that there's no one at the table that looks like me, that can talk like me. (IL participant)

The experiences of the health department and CBO staff we interviewed highlighted the critical roles that interventions play in facilitating responses to the HIV epidemic among Black MSM. Participants said that innovative outreach programs that meet Black MSM "where they are" are extremely important to mounting prevention responses. One key example given was the use of holistic interventions that don't focus solely on HIV or on issues unique to gay men. Participants suggested that, given the internalized and social stigmas surrounding HIV and homosexuality, holistic interventions were more likely to get Black MSM involved. Many participants spoke of the use of "homegrown" holistic interventions as a way to reach Black MSM in their communities. For example:

I think we made some headway by [teaming up] with the Department of Health prostate,

colonoscopy, and heart association. When they're doing seminars, we team together, because I think when it comes to African Americans . . . holistic health approach[es] [are needed]. We start [by] saying, "Hey, let's talk about your colon. Let's talk about your prostate. Oh, by the way, [let's talk about] HIV/AIDS and other STDs." Make it all around, and then it wouldn't be so stigmatizing. (FL participant)

Many participants said interventions that promoted sexual skill-building and increased self-esteem and positive self-concept in Black MSM were important facilitators. Skill-building related to condom use and harm-reduction behaviors were cited as important psychosocial factors that needed to be incorporated into interventions targeting Black MSM. More importantly, participants suggested that interventions that focused on increasing Black MSM's positive sense of self were instrumental to facilitating engagement in healthy behaviors and relationships among Black MSM. For example:

I say . . . to this [young Black MSM], "You are worth something. I need you here next year, in 5 years. Protect yourself." You know? So I didn't say, "Here, wear a condom." [I said,] "I need you here, and if you test positive, I'm going to lose you." . . . Very often we don't do that kind of work. "You are worth something, because out there, the rest of the world is saying, 'No, you are not worthy of anything, you are not part of us.'" And I'm saying, "No, you need to be here. You owe me that much." You see what I'm saying? And he got it. He got it. And I bet you that any time he's doing whatever he's doing, he'll be thinking about it. I know that. (NY participant)

Participants said that prevention responses were facilitated by strengthening and utilizing existing networks of Black MSM. Notably, participants spoke of community-building efforts that connect Black MSM to each another as an important way to reduce social isolation and improve the visibility of Black MSM. Participants suggested that many health departments and CBOs should take advantage of existing social spaces in which Black MSM participate, such as Black gay pride celebrations and smaller-scale house parties, while also creating new social spaces. Also, participants referred to the house and ball community as an important, though undervalued, context for interventions and prevention activities. The house and ball community is an extensive network of "houses" made up of primarily Black and Latino lesbian,

gay, bisexual, and transgender people. The focal social event within the house and ball community is the "ball," in which houses and individuals engage in dance and performance competitions.<sup>17</sup> One participant highlighted the "enormity" of the house and ball community, which attracts many young Black MSM, in working to dismantle internalized stigma and promote self-worth:

But people our age also discount the enormity of [the house and ball community]. It's something that sissies do. It's something that little kids do. It brings the community down. And there are some things that are not so good that go on in ballrooms, right? But as everything, it has its good and bad. But I think as a . . . cultural practice . . . that can also be put to use to help reduce the impact of this epidemic on an entire community, it has to have some sort of recognition, which in some cases it's beginning to get that recognition, but clearly not as much as it should. So I think that [the house and ball community], in some ways, if we want to look at it as a model, offers a way to challenge that self-hatred or that internalization of those oppressions because it affirms femme people. It affirms femininity. It affirms a whole range of gender expressions and performances. (CA participant)

Participants said peer-led and social network-based prevention and messaging approaches were highly successful. They gave examples of working with university students, nightclub owners, sex-party promoters, and notable figures within the Black and Black MSM communities to disseminate HIV-prevention messages out and implement other interventions. For example:

We have gone to universities with primarily large African American student populations and do the ambassadorships as well as work with the Hellenic organizations, all the sororities and fraternities, to get them to have ambassadors so that they can do training statewide. . . . It's all peer-modeled. . . . We believe that peers are the best way of doing [HIV prevention work]. (IL participant)

Participants also understood religion and the Internet to be potentially useful in facilitating prevention responses and combating the psychological and network-based barriers previously mentioned. Religion was perceived to facilitate prevention efforts when Black MSM found gay-affirming churches that allowed them to grow spiritually and personally. Participants also suggested that the Internet could be a useful way to reach Black MSM and noted that it should be explored

as an outreach venue. Notably, several participants created interactive Web sites that promoted healthy sexual behavior, developed social networking Web sites with a focus on safer sex and harm reduction, and conducted outreach in Black MSM-themed chat rooms.

## DISCUSSION

The research presented in this article aimed to identify and describe the barriers and facilitators that frontline workers experienced in responding to the HIV epidemic among Black MSM. We focused on eliciting the perceptions, impressions, and experiences of staff within health departments and CBOs, who exercise tremendous influence on buy-in and implementation of HIV-prevention interventions. This is one of the first articles in the research literature on HIV prevention among Black MSM to give a voice to this often overlooked but extremely important group of stakeholders. Our findings highlight the importance of checking in with on-the-ground responders as they engage in prevention efforts. Moreover, the research presented here allows researchers and practitioners to have a better understanding of the issues that health department and CBO workers experience as they work to turn research into practice, which constitutes the primary component of the process of disseminating and implementing intervention research.

Several of our findings should be explored further. For instance, cultural competency was an important facilitator of prevention efforts when it was present, and its absence was an important barrier. Cultural competency, particularly on the part of health care providers, has been shown to affect the health-seeking behaviors of Black MSM.<sup>18,19</sup> However, very little work has sought to determine how cultural competency on the part of health departments and CBOs might affect HIV-prevention efforts targeting Black MSM. Our findings suggest that cultural competency facilitates prevention efforts, and a lack of it is a barrier.

Competency was also tied to effective communication between health departments and CBOs. Health departments and CBOs are inextricably bound in the implementation of

HIV-related outreach efforts, programming, and services oriented toward Black MSM. Our findings suggest that smooth working relationships, epitomized by transparency and open communication between health departments and CBOs, are crucial to successful responses to the HIV epidemic among Black MSM.

The quantity and quality of interventions targeted toward Black MSM should also be considered. Our findings confirmed research indicating that there are few rigorously evaluated interventions that specifically target Black MSM.<sup>20</sup> Our findings also confirmed research suggesting that available interventions may be lacking in their applicability to Black MSM in different regional and social contexts,<sup>4,8</sup> indicating that policymakers and practitioners need to remember that many interventions are not generalizable across all MSM. Our participants noted that interventions developed with input from members of the target population and targeted toward the unique needs of Black MSM in particular communities and regions are most likely to be effective. Thus, interventions that incorporate the principles of community-based participatory research are greatly needed. Likewise, our findings suggest that future interventions targeting Black MSM should take a holistic approach to health by focusing on HIV in conjunction with other important health and social concerns.

Stigma, psychosocial factors, and social networks were identified as important barriers to effective responses to the HIV epidemic among Black MSM. These 3 factors are interconnected, as the coding analysis suggested. The findings suggested that stigma represents a primary cause of the low sense of self-worth and low self-esteem that many Black MSM experience. Stigma, in the opinions of our interview participants, also prevented Black MSM from mobilizing and engaging in community-building activities. Although the mental health effects of stigma alone indicate the need for heightened intervention efforts, the connection between stigma and the reduced likelihood of Black MSM engaging in health-seeking behaviors (such as HIV testing) is cause for alarm.

Stigma, and its effects on the behaviors of Black MSM, must be understood in a historical context. Black Americans have a history of

denying and suppressing nonheteronormative sexuality, which in the present day has manifested as stigma toward homosexuality, male femininity, and HIV.<sup>21,22</sup> Our findings suggest that if health departments and CBOs are to change the course of the HIV epidemic among Black MSM, the Black community must address the issue of stigma. As participants noted, a way to do this may be to engage Black MSM in sexuality- and gender-affirming settings, such as the house and ball community, as a way to initiate conversations within the Black MSM community and the larger Black community.

## Limitations

This study had several limitations. First, the data represent the perceptions and experiences of a small, nonrepresentative population of health department and CBO staff. Scarcity of time and resources prevented us from speaking with stakeholders in many states with a high HIV seroprevalence among Black MSM, and it is likely that perceived barriers and facilitators unique to frontline staff in certain areas of the United States may not have been identified. Second, we did not explore differences in perceived barriers and facilitators by region. These differences are important to consider, but our goal was to provide an overarching view of public health responses to heightened rates of HIV infection among Black MSM, not to isolate regional variations. Third, we did not examine differences in perceptions and experiences on the basis of variations in organization type (i.e., health department vs CBO) or staff title (i.e., AIDS director vs CBO executive director). Titles and organizational affiliations were purposely omitted from quotes to protect participants' anonymity.

## Recommendations

Several recommendations for research, intervention, and policy can be gleaned from our findings:

*For researchers.* Conduct research to comprehensively describe the interrelationships among sociocultural factors (e.g., stigma, racism, and religion), psychological factors (e.g., low self-esteem and social isolation), and behavioral factors (e.g., low rates of HIV testing, reduced disclosure) affecting HIV risk among Black MSM, and demonstrate how



these factors may work individually and collectively.

Research and develop methods of determining intervention efficacy that are more congruent with real-world experiences and are feasible alternatives to the randomized controlled trial. Randomized controlled trials are important to the scientific evaluation of interventions, but they frequently disregard the realities of individual choice, group processes, and change occurring on multiple levels and within multiple endpoints.<sup>23</sup> Alternatives to the randomized controlled trial, such as dynamic trial designs, randomized encouragement designs, and other nonexperimental designs have been proposed,<sup>23,24</sup> and intervention researchers should study them.

*For practitioners.* Focus on increasing the number of DEBI program interventions targeting Black MSM. At the time of data collection, only 1 DEBI intervention was tailored for Black MSM. Recently, findings have been published suggesting the efficacy of an HIV prevention intervention adapted for use with Black MSM,<sup>25</sup> which is currently being added to the DEBI program. Nonetheless, more interventions targeting diverse groups of Black MSM are still needed.

Support the development, implementation, and evaluation of homegrown interventions targeting Black MSM. Focus on interventions that target not only HIV, but the myriad of health, psychological, and social factors that are directly or indirectly related to HIV risk among Black MSM.

CBOs' programmatic repertoires should include more than individual- and group-level behavioral interventions. To this end, community-based participatory research approaches should be used to develop and implement practical, field-tested community-level and structural-level interventions aimed at decreasing stigma and promoting access to culturally specific health programs and services for Black MSM. Likewise, innovative interventions that exploit the Internet and religious settings should be developed.

*For policymakers.* Promote efforts to increase the organizational capacity of CBOs that serve Black MSM, and foster open and respectful dialogues between health departments and CBOs. Policies that aim to enhance overall relationships between health departments and

CBOs will result in an increased ability to mount organized, collaborative prevention responses.

Implement hiring practices that aggressively aim to bring greater numbers of ethnic minorities, and specifically Black MSM, into health department and CBO staff. Increasing the number of people of color among health department and CBO staff may allow for greater cultural competency and improved communication and trust between health departments, CBOs, and the communities they serve.

Increase funding for prevention programs targeting Black MSM, to allow for the creation of new interventions tailored to the unique needs of Black MSM in different regions of the United States.

Our findings highlight the hard work being done by health departments and CBOs among Black MSM and emphasize the heightened attention that must be given to HIV among this population. It is vastly important to understand the challenges and successes of health department and CBO staff responding to the HIV/AIDS crisis. The perceptions of these individuals are highly useful in informing HIV prevention research and policy. When we provide a voice to those working on the front lines of our HIV/AIDS prevention efforts targeting Black MSM, we are better able to implement consistent, organized responses to the HIV/AIDS crisis among Black MSM in the United States. ■

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#### Contributors

P. A. Wilson designed the study, conducted interviews, directed analyses as a consultant to NASTAD, and wrote the article. T. E. Moore oversaw implementation of the study, conducted interviews and analyses, and assisted with writing the article.

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Institutional review board approval was not required for this study.

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