HHS Public Access

Author manuscript

J Sex Res. Author manuscript; available in PMC 2016 July 01.

Published in final edited form as:

J Sex Res. 2016 ; 53(6): 642–654. doi:10.1080/00224499.2015.1016139.

Contributions of Qualitative Research in Informing HIV/AIDS Interventions Targeting Black MSM in the United States

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Abstract

This article presents a systematic review of qualitative studies focusing on the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) among Black men who have sex with men (BMSM) in the United States. We reviewed studies that were published between 1980-2014. Qualitative methods employed in the studies reviewed include: in-depth interviews, focus groups, participant observation, and ethnography. We searched the following databases: PubMed, PsychINFO, JSTOR, ERIC, Sociological Abstracts, and Google Scholar for relevant articles using the following broad terms: “Black men” and/or “BMSM,” and “qualitative” and/or “ethnography.” Seventy studies were included in this review. The key themes observed across studies were: (1) heterogeneity, (2) layered stigma and intersectionality, (3) risk behaviors, (4) mental health, (5) resilience, and (6) community engagement. The review suggests that sexual behavior and HIV-status disclosure, sexual risk-taking, substance use, and psychological well-being were contextually situated. Interventions occurring at multiple levels and within multiple contexts are needed to reduce stigma within the Black community. Similarly, structural interventions targeting religious groups, schools, and health care systems are needed to improve the health outcomes among BMSM. Community engagement and using community-based participatory research methods may facilitate the development and implementation of culturally appropriate HIV/AIDS interventions targeting BMSM.

Keywords

Blacks/African-Americans; men who have sex with men; HIV/AIDS; qualitative research; prevention; interventions

Black men who have sex with men (BMSM) are disproportionately affected by Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in the United States, and men in this epidemiological group exhibit high risk for acquiring HIV relative to other groups. Recent studies of men who have sex with men (MSM) in the U.S.

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found not only that BMSM had the highest rates of HIV incidence as compared to other racial/ethnic groups, but that rates of HIV incidence were rising significantly among young BMSM (CDC, 2014; Prejean et al., 2011). However, the HIV crisis among BMSM is not a newly emerging one – for more than a decade HIV seroprevalence studies of MSM have consistently shown disproportionately high rates of infection among BMSM (CDC 2001, 2005, 2008; Valleroy et al., 2000).

The continuing HIV crisis among BMSM suggests that public health interventions are greatly needed in order to curb the epidemic in this group (Millet, Peterson, Wolitski, amp; Stall, 2006; Peterson amp; Jones, 2009; White House Office of National AIDS Policy, 2010). However, very few primary or secondary HIV prevention interventions have been developed or adapted for use with BMSM (Johnson et al., 2005). Of the 29 interventions used in the U.S. Centers for Disease Control and Prevention *Diffusion of Effective Behavioral Interventions* (DEBI) project—a primary source of HIV/AIDS interventions used by community-based organizations (CBOs) in the U.S. (Wilson amp; Moore, 2009)—only two, *Many Men, Many Voices* (*3MV*) (Wilton, Halkitis, English, amp; Roberson, 2005) and *d-up!: Defend Yourself* (Jones et al., 2008), are specifically focused on BMSM. There have also been more recent efforts to design group- and community-level interventions targeting BMSM, such as the HIV Prevention Trials Network [HPTN] Protocol 061, a large-scale, multi-city study exploring the feasibility and acceptability of a multifaceted HIV prevention and linkage to care intervention targeting BMSM. However, these efforts are still too few to respond to the diverse and unique prevention and treatment needs of BMSM and existing interventions do not focus on the multitude of factors at the individual, community, and structural levels that promote heightened risk in this population (Millett et al., 2011; Peterson amp; Jones, 2009; Wilson amp; Moore, 2009).

The Strengths and Limitations of Behavioral Research

The call for more HIV interventions designed specifically for BMSM comes with an increased need for empirical data on the HIV risk and protective factors that interventions targeting BMSM need to be focused on. Most available data comes from behavioral research, which has predominantly been quantitative and focused on individual-level behavioral and psychosocial factors related to HIV risk among BMSM. This research has provided important insights on the variety of risk factors that may place BMSM at heightened risk for HIV. For example, Millett and colleagues (2012) conducted a meta-analysis of empirical research identifying biologic, demographic, behavioral, psychological, interpersonal, socio-cultural, and structural factors associated with greater risk for HIV seropositivity and HIV risk and protective behaviors among BMSM in the United States. Factors that were shown to be related to HIV infection and/or risk behavior included STD infection, psychological distress, sexual identity, self-efficacy, peer norms regarding safer-sex, and social support. Other studies have highlighted additional risk factors, including older age of BMSM sexual partners and intra-ethnic group sexual partnering (Berry, Raymond, amp; McFarland, 2007; Bingham et al., 2003; Millett et al., 2012; Raymond amp; McFarland, 2009, Wilson amp; Moore, 2009).

Research has also suggested that HIV/AIDS interventions must address the different forms of stigma experienced by BMSM, and that greater attention must be paid to how different types of stigma (i.e., racism, heterosexism, homophobia, and classism) are layered and embedded in environments in which BMSM live, work, and socialize (Bowleg, Teti, Malebranche, amp; Tschann, 2013; Parker amp; Aggleton, 2003). The related concept of intersectionality, which suggests that social categories and identities are not independent but rather multidimensional and linked to structural inequalities (Bowleg et al., 2013), provides a useful reference in understanding how layered stigma works. However, while theory and research highlight the importance of understanding layered stigmas and intersectionality in relation to HIV vulnerability among BMSM, these factors have been largely overlooked in most quantitative research.

While HIV research focusing on BMSM has yielded important findings on risk and protective factors that operate on a population level, it has also at times promoted the conceptualization that HIV risk and protective factors (e.g., condom use, medication adherence, etc.) operate and can be intervened upon independent of social context and culture (Mays, Cochran, amp; Zamudio, 2004). Quantitative research is primarily concerned with isolating variables to estimate their effects independent of other potential variables that may confound, mask, or change their relationship to HIV risk. Quantitative studies provide critical information on the efficacy of interventions in controlled environments, and help researchers understand potential pathways through which interventions impact health outcomes. However, quantitative-focused research is limited in its ability to describe the dynamic context of HIV risk and resilience among BMSM—such as how layered stigmas, intersectionality, and other nuanced socio-contextual factors operate in the lives of BMSM and shape HIV risk in the population. Qualitative research, on the other hand, can examine the multitude of factors that work in concert to shape and construct social contexts and sexual cultures that structure HIV risk (Parker, 2001; Parker amp; Carballo, 1990; Parker amp; Ehrhardt, 2001; Parker, Herdt, amp; Carballo, 1991; Power, 1998).

The Potential of Qualitative Research in Informing HIV/AIDS Interventions

Much of the behavioral quantitative research focused on HIV among BMSM has failed to comprehensively describe the contexts in which risk and protective factors operate; these studies have been limited in their abilities to inform individual-, community- and structural-level interventions (Mays et al., 2004). By providing a contextualized perspective of HIV risk, qualitative research has great utility in informing the design, implementation, and dissemination of interventions at multiple levels (Campbell et al., 2000; Higgins et al., 1996). Qualitative HIV/AIDS research has the potential to enhance researchers' understandings of cultural meanings related to health, sexuality, resilience, and other factors related to HIV/AIDS (Herdt, 2001; Herdt amp; Boxer, 1991; Parker, 2001; Parker, Herdt amp; Carballo, 1991), can provide highly descriptive accounts of lived experiences that call attention to historical, socio-contextual, political, and structural factors (Bailey, 2009; Parker amp; Carballo, 1990; Parker amp; Erhardt, 2001; Silenzio, 2003), and allows for a more comprehensive understanding of the cultural and gendered aspects of language and communication in HIV prevention (Herdt amp; Boxer, 1991; Parker, 2001; Parker et al., 1991; Silenzio, 2003). Furthermore, with the rise of biomedical interventions such as pre-

exposure prophylaxis (PrEP) and treatment as prevention (TasP), clinical trials will continue to be conducted among the groups considered to be at greatest risk of infection. Qualitative research is a necessary step toward understanding the feasibility and acceptability of these biomedical interventions and their potential successes in being rolled out in real-work settings and with the groups that are most vulnerable and in need of novel HIV prevention and treatment strategies.

Though qualitative methodologies do not allow for outcome evaluations of intervention effects, and findings from studies employing qualitative methods may not be generalizable to populations or settings, qualitative research has great potential to aid in the formation and implementation of HIV/AIDS interventions (Campbell et al., 2000; Higgins et al., 1996). For this reason, researchers across disciplines have made numerous calls for more qualitative research on issues related to heightened HIV risk among BMSM (Koblin et al., 2006; Malebranche, 2003; Millet et al., 2011; Millet, Malebranche, amp; Peterson, 2007; Millett amp; Peterson, 2007; Normand, Lambert, amp; Ylahov, 2003; Torian, Makki, Menzies, Murrill, amp; Weisfuse, 2002). There is an enormous amount of information—much of which has been overlooked—that can be obtained from systematically reviewing qualitative research studies focusing on BMSM. It is critical that we use this information to inform the development of interventions targeting BMSM, which has been called for in the U.S. *National HIV/AIDS Strategy* (White House Office of National AIDS Policy, 2010).

The primary aims of this article were: (1) to systematically review findings from qualitative studies focusing on BMSM in the U.S., and (2) to use the findings obtained from these studies to identify priority areas for HIV prevention and treatment interventions targeting BMSM.

Method

We conducted a systematic review of the *PubMed*, *PsychINFO*, *JSTOR*, *ERIC*, and *Sociological Abstracts* databases, as well as the Internet-based academic article index *Google Scholar*, to obtain peer-reviewed articles published between 1980-2014. We searched the databases for articles using the following broad terms: “Black men” “Black gay/bisexual” and/or “Black men who have sex with men,” and “qualitative” and/or “ethnography.” No hand searches or direct communications were involved in the identification of published studies. The research team used Microsoft Excel to organize the themes and methods identified in the studies. In order to be included in the review, studies had to meet each of the following four inclusion criteria: (1) a description of the methods employed was provided; (2) qualitative methods (i.e., interviews, focus groups, participant observation, and/or other forms of ethnographic approaches, such as case studies) were used; (3) the study sample was comprised completely or by a majority (≥ 50%) of BMSM and/or the research focused on HIV, health, ethnicity, sexuality, gender and/or culture among BMSM; and (4) the study was published in a peer-reviewed journal within the disciplines of public health, social science, and/or medicine.

Initial counts of the articles identified varied according to the search engine used. For example, Google Scholar yielded 9,380 hits for the search term “Black men who have sex

with men" and "qualitative," whereas PubMed yielded 538 hits. For the purpose of this review, book chapters, qualitative research conducted outside of the U.S., White Papers, and other self-published reports were excluded from the review. Using our criteria, a total of 70 studies met inclusion criteria and were included for review. Studies that used the same sample (or a subset of) were included for review as separate if the goals of the research were distinct.

Key themes that emerged were identified and agreed upon by the co-authors in the course of reviewing studies. A subset of the research team read all 70 articles and compiled a list of themes by hand, with relevant text pulled from articles to highlight each theme. Themes were then reviewed and confirmed by the full team of authors. Six key themes that frequently emerged are focused on in this article. Finally, a subset of research team members worked to categorize each article along the six themes. Team members agreed in the categorization of studies more than 90% of the time; all disagreements were discussed until agreement was reached. Table 1 provides information on methods employed and major findings obtained for each study.

Results

The review yielded several important themes that point to priority areas for HIV/AIDS interventions targeting BMSM. These themes were broadly tied to: heterogeneity among BMSM; stigma tied to intersectional identities of race/ethnicity, sexual orientation, gender, social class, and HIV status; contextual factors influencing sexual risk behavior, substance use, and mental health among BMSM; and the associated factors of resilience and community engagement. Figure 1 depicts the occurrence of the six themes over time.

Heterogeneity among BMSM

A readily apparent theme that emerged was diversity within the population of BMSM. The different samples that were obtained in the studies and reported findings from the research suggest a high level of within-group heterogeneity among BMSM. Sexual behavior/orientation and masculinity represent key domains on which differences among BMSM were highlighted. Eleven of the 70 studies focused on non-gay identifying BMSM and/or men who have sex with men and women (MSMW). Likewise, many of the studies described masculinity—and more specifically masculine gender performance—as a critical factor used to distinguish and stereotype groups of BMSM (Arnold amp; Bailey, 2009; Beeker, Kraft, Peterson, amp; Stokes, 1998; Christian, 2005; Miller, Serner, amp; Wagner, 2005; Reback amp; Larkins, 2010; Strayhorn amp; Tillman-Kelly, 2013; Williams, Wyatt, Resell, Peterson, amp; Asuan-O'Brien, 2004), as well as a mechanism through which vulnerability to HIV among BMSM was enhanced (Beeker et al., 1998; Jerome amp; Halkitis, 2009; Reback amp; Larkins, 2010; Rhodes et al., 2011). Several studies highlighted the unique experiences and prevention needs of Black MSMW compared to other BMSM (Dodge, Jeffries amp; Sandfort, 2008; Jeffries, Dodge amp; Sandfort, 2008; Lapinski, Braz, amp; Maloney, 2010; Malebranche, Arriola, Jenkins, Dauria, amp; Patel, 2010; Mamary, McCright, amp; Roe, 2007; Reback amp; Larkins, 2010; Valera amp; Taylor, 2011; Washington amp; Brocato, 2011; Washington amp; Meyer-Adams, 2010; Wheeler, 2006; Williams et al., 2004). For

example, Williams and colleagues (2004), Mamary et al., (2007) and Reback and Larkins (2010) each described the negative impact of heteronormative gender roles and stereotypes about MSM on perceived risk and sexual risk behavior among Black MSMW. Studies also suggested that negative societal perceptions of bisexual behavior impeded outreach and prevention efforts targeting MSMW (Dodge et al., 2008; Jeffries et al., 2008; Lapinski et al., 2010).

Other dimensions of diversity pertinent to consider in the development of interventions targeted toward BMSM include HIV testing patterns and HIV status disclosure (Bird amp; Voisin, 2013; Harawa, Williams, Ramamurthi, amp; Bingham, 2006; Hussen et al., 2013; Lichtenstein, 2000; Miller, 2007; Wheeler, 2005; Williams et al., 2004), age (Eyre, Milbrath amp; Peacock, 2007; Haile, Padilla amp; Parker, 2011; VenDevanter et al., 2011), and drug use (Jerome amp; Halkitis, 2009; Washington amp; Brocato, 2011; Washington amp; Meyer-Adams, 2010; Wilton et al., 2005; Wu, El-Bassel, McVinney, Fontaine, amp; Hess, 2010). Several studies explicitly noted that interventions need to be cognizant that there is no one "type" of BMSM and therefore narrowly-focused interventions will be limited in their impacts (Arnold amp; Bailey, 2009; Fields et al., 2015; Hightow-Weidman et al., 2011; Hussen et al., 2013; Washington amp; Brocato, 2011).

Stigma tied to intersectional identities

Overwhelmingly, the qualitative studies reviewed highlight how stigmatized, intersectional identities among BMSM are tied to greater HIV risk. The studies suggest institutional and community-level stigma related to sexuality, femininity, and HIV/AIDS impact vulnerability to HIV and engagement in health behaviors among BMSM. The role of stigma tied to social class (i.e., socioeconomic status and race/ethnicity) in increasing risk for poor health outcomes among BMSM—largely via reduced access to comprehensive, culturally appropriate prevention- and care-based services (Haile et al., 2011; Miller et al., 2005; Tobin, Cutchin, Latkin, 2013; Wilson amp; Moore, 2009)—was also highlighted. For example, Tobin et al.'s (2013) in-depth interviews with 20 BMSM suggested that institutional stigma and society's stereotypes about Black men affected their ability to obtain employment and address substance use problems, which later shaped their HIV risk behaviors. In another study, Bird and Voisin (2013) found that HIV-related stigma was the primary barrier to sexual communication among HIV-positive Black MSM. These men received stigmatizing messages from family, the church and the gay community concerning their HIV status, which in turn influenced silence around HIV disclosure. Studies also highlighted how intersectionality and stigma are experienced by BMSM. For example, BMSM described being targets of not only homophobia, but also anti-femininity attitudes (Beeker et al., 1998; Christian, 2005; Graham, Braithwaite, Spikes, Stephens, amp; Edu, 2009; Malebranche et al, 2010; Malebranche, Fields, Bryant, amp; Harper, 2009; Miller et al., 2005; Williams et al., 2004). Several studies suggested that femininity among BMSM is considered generally undesirable and that taking the receptive role in sexual encounters with other men is considered to be less masculine compared to those who strictly take the insertive role. These studies suggest important connections between race and masculine identity among BMSM, and the potentially negative consequences of Black masculinity on the self-concepts and health behaviors of BMSM (Beeker et al. 1998; Malebranche et. al.,

2009; 1998; Stokes amp; Peterson, 1998; Strayhorn amp; Tillman-Kelly, 2013; Williams et al., 2004; Wilson amp; Moore, 2009).

Strongly tied to stigma around sexuality and femininity, AIDS stigma within BMSM's social networks and communities was observed in several studies reviewed (Arnold, Rebchook, amp; Kegeles, 2014; Bird amp; Voisin, 2013; Buseh et al., 2006; Fullilove amp; Fullilove, 1999; Harawa et al., 2006; Lichtenstein, 2000; Mamary et al., 2007; Miller et al., 2005; Williams et al., 2004; Wilson amp; Moore, 2009). For example, several studies highlighted the pervasiveness of the idea that HIV/AIDS is a disease of White gay men—which was a dominant view in the early years of the epidemic—and how it continues to have a devastating impact on the Black community's acceptance of AIDS as a disease of the community. This lack of acceptance has reduced the ability for the community to mobilize to address HIV/AIDS among BMSM (Fullilove amp; Fullilove, 1999; Harawa et al., 2006; Kraft, Beeker, Stokes, amp; Peterson, 2000; Williams et al., 2004; Wilson amp; Moore, 2009). Likewise, the studies showed that stigmatizing experiences occur within BMSM's families and peer groups (Beeker et al., 1998; Christian, 2005; Fields et al., 2015; Graham et al., 2009; Harawa et al., 2006; Kraft et al., 2000; Lichtenstein, 2000; Malebranche et al., 2009; Mamary et al., 2007; Stokes amp; Peterson, 1998; Voisin, Bird, Shiu, amp; Krieger, 2013), the religious communities to which they belong (Fullilove amp; Fullilove, 1999; Jefferies et al., 2008; Miller, 2007; Williams et al., 2004; Wilson amp; Miller, 2002; Woodyard, Peterson amp; Stokes, 2000), and the health care institutions they access (Buseh et al. 2006; Haile et al., 2011; Malebranche et al., 2010; Malebranche, Peterson, Fullilove, amp; Stackhouse, 2004; Miller et al., 2005; Wheeler, 2006).

Contextual influences on sexual risk behavior, substance use, and mental among BMSM

Studies reviewed showed that sexual risk behavior, substance use, and psychological well-being were contextually situated for BMSM and that health and risk among BMSM cannot be understood, or intervened upon, without examining the social contexts in which health-related behaviors occur. As described previously, stigma permeates the lives of many BMSM; studies suggested that stigma and daily experiences of discrimination were related to BMSM's increased likelihood of participating in situations that may increase the likelihood of sexual risk behaviors. For example, community-level homophobia may make BMSM more likely to seek sex in public parks or other venues in which there may be limited access to and use of condoms (Beeker et al., 1998; Lichtenstein, 2000). Similarly, stigma around sexuality and HIV/AIDS in the Black community may be related to men's reduced likelihood to talk openly about HIV/AIDS or condom use with sexual partners and increased risk behavior (Beeker et al., 1998; Hussen et al., 2014a; Stokes amp; Peterson, 1998; Voisin et al., 2013). For example, a participant in Stokes and Peterson's (1998) study noted, "I think the more comfortable an individual is…with their sexuality, the easier it may be for them to practice safe sex, or to reduce their risk for…unsafe sex practices" (p. 287).

Similarly, substance abuse and substance use-related HIV risk behavior among BMSM must be understood within the contexts of stigma, poverty, trauma, and internalized homophobia (Harawa et al., 2006; Lichtenstein, 2000; Nanin et al., 2009; Washington, Brocato, 2011; Washington amp; Meyer-Adams, 2010; Wheeler, 2006; Williams et al., 2004; Wilson amp;

Moore, 2009). For example, Lichtenstein (2000), in conducting an ethnographic work detailing the lives of BMSM in Alabama, observed that unprotected sex among BMSM remains covert and hard to intervene upon in part due to the high levels of drug abuse among poor men. The author noted, “the sex-for-drugs trade has a double purpose: addicted men seek to satisfy their craving for drugs, and non-addicted men seek to buy sex from other [drug-addicted] men” (p. 382). Lichtenstein’s work suggests a vicious cycle in which poverty, sex, and substance use are interconnected and work in concert to place BMSM and their partners at risk. In contrast, other research highlights how substance use serves as a way to facilitate and buffer same-sex sexual experiences among BMSM(Harawa et al., 2006; Williams et al., 2004; Wilton et al., 2005). These studies propose that with anti-gay stigma coming from their communities and families, and high levels of internalized homophobia, substance use becomes a necessary behavior for many BMSM in order to act upon homosexual desires and reduce negative feelings they have about having sex with other men. Collectively, the work reviewed here suggests that interventions that aim to simply reduce substance use behaviors among BMSM may not be effective in their reducing HIV risk, unless corresponding efforts are taken to reduce poverty, stigma and homophobia at the community level.

Much of the research examined also highlights the complex role of the Black church in understanding the health behaviors and mental health of BMSM. Some of the studies reviewed focused on the experiences of BMSM within the Black church (Fullilove amp; Fullilove, 1999; Jefferies et al., 2008; Woodyard et al., 2000), while others observed themes linked to the Black church as emerging out of their analysis (Hawkeswood amp; Costley, 1996; Stokes amp; Peterson, 1998; Wilson amp; Miller, 2002). What makes the role of the Black church so complex is that, though the studies suggested that it is perhaps the greatest stigmatizing force with regard to BMSM’s sexual behaviors and identities, there is also a strong presence of BMSM within the Black church, and the church serves as a great source of support for many of these men as they contend with external racism and work towards self-acceptance of their sexuality (Hawkeswood amp; Costley, 1996; Woodyard et al., 2000). For example, Wilson and Miller (2002) noted, “Faith was used by many of the men in the sample as a means to cope with heterosexism. Participants who kept the faith sought to cope with their sexual minority status by remaining close to God…Ironically, the church was also identified as among the most oppressive of non-gay friendly contexts, because numerous times respondents described heterosexist experiences within the church” (p. 382). Thus, the Black church appears to have both negative and positive effects on the health of BMSM.

Community engagement and resilience

One of the most pervasive themes observed in the review was that men perceived a lack of a cohesive BMSM community and that many did not identify with or participate in the mainstream (i.e., White) gay community. Men reported feeling marginal to both the Black and gay communities and indicated that there were few outlets for them to meet other BMSM and develop an organized community of men who feel connected to one another (Beeker et al., 1998; Kraft et al., 2000; Mamary et al., 2007; Stokes amp; Peterson, 1998; Wilson amp; Moore, 2009). Studies suggested that the lack of a BMSM community was related to the high levels of external and internalized anti-gay stigma, racism within the gay

community, and a lack of leadership and resources for community mobilizing. Without a cohesive community in which they could be engaged, BMSM are more likely to internalize negative views about same-sex behavior (Kraft et al., 2000; Stokes amp; Peterson, 1998), they may remain “hidden” and not disclose their homosexual behaviors and/or HIV status (Lichtenstein, 2008; Woodyard et al., 2000), and they may engage in unhealthy behaviors that can undermine HIV prevention (Mamary et al., 2007; Williams et al., 2004; Wilson amp; Moore, 2009). Given this, many of the studies reviewed here emphasized a focus on resilient aspects of BMSM’s social identities and lived experiences (Arnold amp; Bailey, 2009; Balaji et al., 2012; Hawkeswood, 1996; Hussen et al., 2014b; Jeffries et al., 2008) and the potential for creating communities that can foster resilience (Arnold amp; Bailey, 2009; Arrington-Sanders, Leonard, Brooks, Celentano amp; Ellen, 2013; LeGrand, Muessig, Pike, Baltierra, amp; Hightow-Weidman, 2014; Mamary et al., 2007).

Researchers’ understanding of the importance of community-level approaches to inform HIV/AIDS interventions targeting BMSM has increased substantially over the last decade. Several studies reviewed here called for community-level prevention strategies, including mobilizing the Black community to change stigmatizing views of homosexuality and HIV/AIDS (Andrasik et al., 2014; Beeker et al., 1998; Bird amp; Voisin, 2013; Christian, 2005; Kraft et al., 2000; Stokes amp; Peterson, 1998), promoting community education and advocacy (Beeker et al., 1998; Hawkeswood, 1993; Hawkeswood amp; Costley, 1996; LeGrande et al., 2014; Lichtenstein, 2000; Wilson amp; Moore, 2009), and enhancing cultural awareness among health care providers serving BMSM (Malebranche et al., 2004; Malebranche et al., 2010; Wheeler, 2006; Wilson amp; Moore, 2009). While there is a growing body of literature exploring alternative ways of approaching community-level prevention (Yoshikawa, Wilson, Shinn, amp; Peterson, 2005), the qualitative studies we reviewed here suggest that little work has been conducted on how to implement community-level HIV prevention approaches targeting BMSM.

Discussion

Qualitative data is essential to contextualizing, preventing, reducing and treating HIV among BMSM. It is through qualitative research that researchers and practitioners can begin to comprehensively describe, understand, and intervene upon the contexts of heightened HIV risk among BMSM. Our findings suggest that HIV/AIDS interventions that aim to appeal to all BMSM may be ineffective (Arnold amp; Bailey, 2009; Hawkeswood, 1993; Hawkeswood amp; Costley, 1996; Hussen et al., 2013; Miller et al., 2005; Strayhorn amp; Tillman-Kelly, 2013). Collectively, the 70 studies indicate that a two-pronged approach may be best: investing resources into designing and implementing broad-reaching community- and structural-level interventions targeted toward social institutions such as schools, healthcare delivery systems, and churches, as well as spurring the creation of behavioral interventions that are tailored to diverse sub-populations of BMSM, such as non-gender conforming BMSM, Black MSMW, young BMSM, and substance-using BMSM.

Additionally, findings suggest that interventions aimed at reducing interpersonal and institutional stigma are greatly needed. Stigma around HIV/AIDS and homosexuality, and more generally, sexuality, is deeply embedded in history, politics, and culture (Cohen, 1999;

Hill Collins, 2004). This review highlights the need for research that applies qualitative methodologies to contextualize and reduce stigma affecting BMSM. One potential opportunity for such interventions is through the Black church. Interventions must involve these institutions in order to succeed in minimizing the negative experiences BMSM often have within the church context, while maximizing the support and community-building experiences that are instrumental to men's spiritual growth and mental health (Pitt, 2010a; Pitt, 2010b). Other opportunities lie in addressing racism and stereotypes held within the gay and bisexual communities. For example, some BMSM experience eroticism and objectification due to their race/ethnicity, which sexualize efforts to engage with the predominantly White gay community Jamil, Harper amp; Fernandez, 2009; Wilson et al., 2009).

Findings from the studies reviewed draw attention to the importance of understanding *layered stigma*, or stigma stemming from a multitude of sources and attached to different personal characteristics and/or behaviors (Parker amp; Aggleton, 2003), within the lives of BMSM. BMSM contend with multiple stigmatized identities and/or behaviors, which may simultaneously intersect while also be perceived to be in conflict with each other (Bowleg et al., 2013; Wilson, 2008). The complexities of the stigma that BMSM experience must be understood within a framework that highlights how layered stigma operates. Given the intersectional nature of stigmatized identities, addressing one source of stigma that BMSM experience may serve to enhance the perception and/or internalization of stigma that comes from another source. For example, several studies we reviewed conceptualized BMSM's heightened risk for infection within a masculine socialization framework. This work suggests that BMSM's heightened risk is related to layered stigma and is due, in part, to the primacy that Black men place on hyper-masculine identities (Malebranche et al., 2009). These identities sharply contrast and conflict with homosexual behaviors and lifestyles, and notions of "being safe," as hyper-masculine performance, by definition, includes being a risk-taker (Kimmel, 1996; Wilson, 2008).

Findings from the 70 studies included in this review speak to the variety and complexities of issues related to the social and sexual experiences of BMSM, and provide direction with regard to the content of future interventions targeting BMSM. For example, interventions should focus on addressing internalized and external stigma, and reducing race-, sexual orientation-, gender-, and HIV status-based discrimination experienced by many BMSM. Additionally, individual level interventions to address psychosocial problems such as substance use and mental health should be tethered with structural level interventions to increase access to stable housing and employment in order to yield the most beneficial health outcomes among BMSM.

These studies also have great utility in informing future quantitative studies that desire to explain BMSM's heighted HIV risk. Specifically, our findings provide direction for potential mediators and moderators that connect the key variables identified in past behavioral research (e.g., psychological distress, sexual identity, self-efficacy, peer norms, and social support) and poor health outcomes among BMSM. Further quantitative investigation of the roles of stigma, poverty, trauma, and community engagement/mobilization in facilitating or hindering HIV risk is warranted. Quantitative research employing situation-, neighborhood-

and network-level analyses are needed to fully understand how contexts shape BMSM's heightened HIV risk. The work presented in this review also has the potential to inform future qualitative studies of BMSM and their communities. Similarly, findings from the review call for a mixed methods approach that works in concert to break down the contexts of HIV vulnerability among BMSM. Moreover, the studies we examined suggested that, in order to strengthen prevention efforts targeted toward BMSM, there must be a shift from the paradigm of scientist-driven behavioral research toward an approach to implementing research and interventions that focus on engaging BMSM and the social networks that surround them.

Limitations, Strengths, amp; Conclusions

This review of qualitative research informing HIV interventions for BMSM has certain limitations that should be considered. First, the breadth of themes that emerged from the qualitative studies could not all be adequately covered in our review. For example, themes related to romantic partnerships, types of sexual partners, and disclosure were excluded from this review but deserve further consideration. A second limitation of the qualitative studies reviewed can also inform future research. Notably, there were a limited number of theoretical and methodological approaches used by researchers. Data collection strategies were primary limited to in-depth interviews and focus groups, and researchers rarely indicated which qualitative methodologies, such as phenomenology, case studies, narrative analysis, and grounded theory, guided their studies. Employing qualitative approaches may produce naturalistic accounts of the lived experiences and social contexts of BMSM, which could further inform intervention efforts.

One strength of this review is that it provides clear direction for research on the implementation and dissemination of new interventions. With the increasing relevance of biomedical interventions to prevention and treatment efforts targeting BMSM, qualitative studies are needed to better understand how novel interventions, PrEP, will be accessed and taken up by BMSM. For example, although researchers envision PrEP as a preventative measure for "high risk" groups such as MSM and transgender women (Buchbinder et al., 2014; Buchbinder amp; Liu, 2011); it remains predominantly accessible only through health care providers and may be perceived as costly and burdensome among MSM (King et al., 2014). Not only do many of the highest risk groups also not have access to health insurance, preliminary evidence suggests that patient race may influence a provider's willingness to prescribe PrEP (Calabrese, Earnshaw, Underhill, Hansen, amp; Dovidio, 2014). Heterogeneity among BMSM, and the effects of intersectional identities and layered stigma on prevention and treatments, are themes we identified that have direct implications for understanding the effective rollout of new interventions and the feasibility that they will be taken up and efficiently disseminated to the most vulnerable BMSM. At the time of this review, no published qualitative research had addressed the feasibility and acceptability of PrEP specifically among BMSM.

Another strength of the review is that it builds upon, and its findings are validated by, past reviews focused on BMSM. For example, Dillon and Basu (2013) conducted a qualitative meta-synthesis of 12 qualitative studies with the specific goal of understanding the roles of

culture and structure in Black and Latino gay men's HIV/AIDS-related behaviors and practices. Similar to our review, these authors observed the ubiquitous role of stigma in impeding prevention and enhancing risk for MSM of color. However, their study was limited in its breadth and emergent themes were primarily discussed in individual-level frameworks.

In conclusion, the review suggests that qualitative studies have great potential in informing future interventions and research to address the crisis of HIV/AIDS among BMSM in the United States. Acknowledging the diversity that exists within the BMSM population is critical to intervention development and dissemination. Likewise, stigma, and related factors, including poverty and structural violence, must be addressed in order to see significant reductions in HIV among BMSM. Finally, efforts to engage BMSM in advocacy and prevention/treatment efforts, and to enhance resilience—at both personal and community levels—have strong potential as effective conduits to reducing the impact of the HIV epidemic affecting BMSM.

Acknowledgments

This research was supported by grant RO1-HD050118-03 S1 (awarded to Richard G. Parker, PhD by the Eunice Kennedy Shriver National Institute of Child Health and Human Development), a minority supplement to the parent grant RO1-HD050118, which supported a research study entitled Religious Responses to HIV/AIDS in Brazil. This article was also supported by a Eugene Kennedy Shiver U.S. National Institute of Child Health and Human Development administrative supplement to this parent grant (grant number RO1-HD050118-05 S1; Principal Investigator Richard G. Parker, PhD), issued under the American Recovery and Reinvestment Act of 2009.

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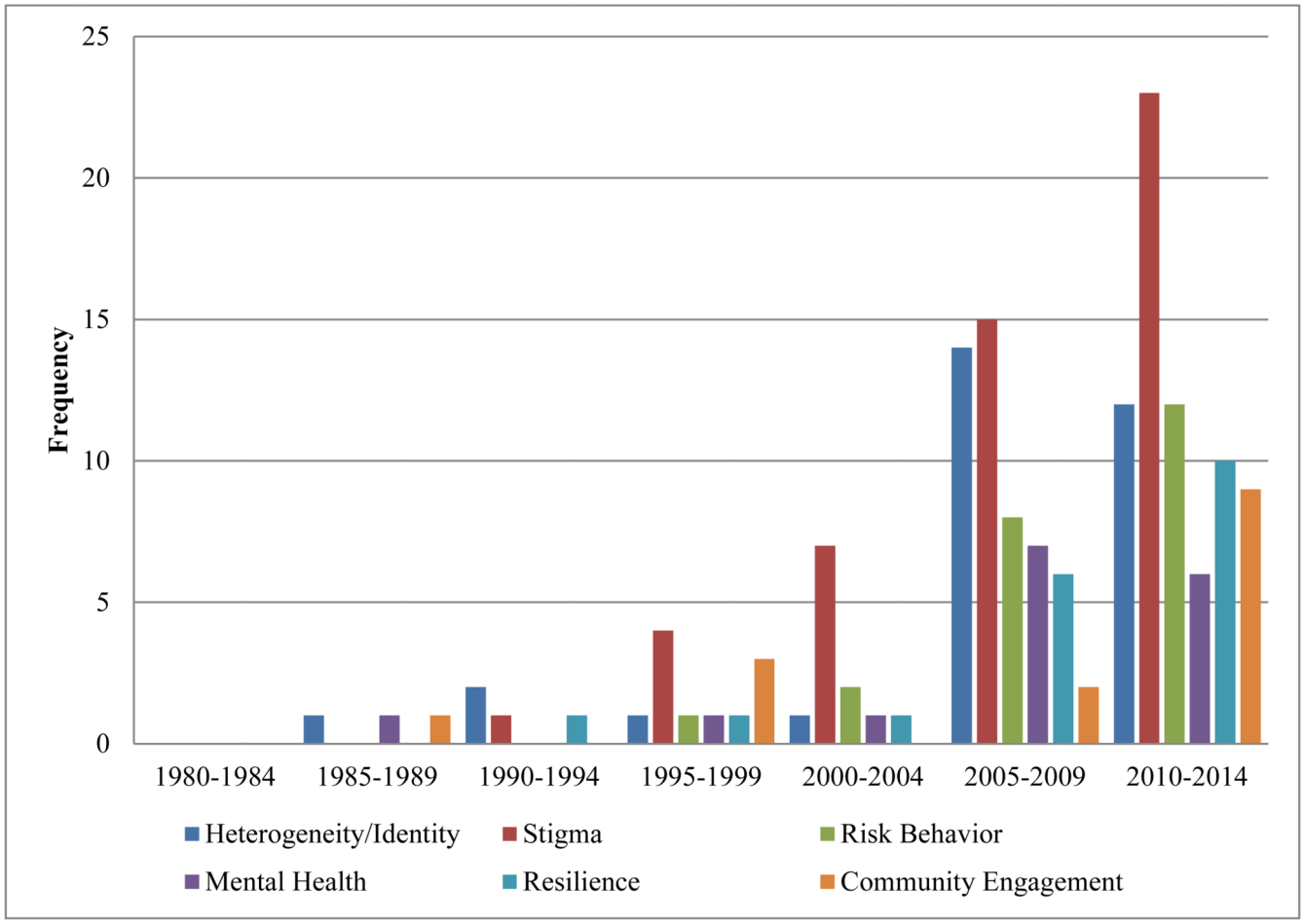

Figure 1. Frequency of six major themes identified in 70 qualitative studies focused on Black men who have sex with men (BMSM) by publication year (y-axis)

Table 1

Methods and major themes of findings from 70 qualitative research studies focused on Black men who have sex with men (BMSM) and HIV/AIDS. Asterisk denotes that the same sample is used in other cited studies. Only first authors listed.

#	Study	N	Methods				Major Themes					
			In-depth interviews	*Focus groups*	*Participant Observation*	*Other*	*Heterogeneity/ Identity*	*Stigma*	*Risk Behavior*	*Mental Health*	*Resilience*	*Community Engagement*
1	Loiacano 1989	6	■				■			■		
2	Mays 1992	110	■	■			■					
3	Hawkeswood 1993, 1996	156	■		■		■	■			■	
4	Beeker 1998	76*	■					■	■	■		
5	Stokes 1998	76*	■					■				
6	Fullilove 1999	N/A		■				■				
7	Myrick 1999	16	■			■						■
8	Kraft 2000	76*	■					■				
9	Lichtenstein 2000	158	■	■	■		■	■	■			
10	Woodyard 2000	76*	■					■		■		
11	Wilson 2002	37*	■					■			■	
12	Harris 2003	3	■			■	■	■				
13	Malebranche 2004	81		■				■				
14	Williams 2004	23		■				■	■			
15	Christian 2005	3	■		■		■					
16	Miller 2005	21	■	■			■	■				
17	Wheeler 2005	50	■	■			■	■				
18	Wilton 2005	24	■				■		■			

#	Study	N	Methods				Major Themes					
			In-depth interviews	*Focus groups*	*Participant Observation*	*Other*	*Heterogeneity/ Identity*	*Stigma*	*Risk Behavior*	*Mental Health*	*Resilience*	*Community Engagement*
19	Green 2005	30*	■		■		■					
20	Buseh 2006	20		■				■		■		
21	Harawa 2006	30		■				■	■	■		
22	Wheeler 2006	25		■			■		■			
23	Miller 2007	10	■					■				
24	Mamary 2007	25	■			■	■	■	■			
25	Morton 2007	3				■	■	■			■	
26	Eyre 2007	22	■				■				■	
27	Green 2007	30*	■					■		■		
28	Jeffries 2008	28	■				■	■			■	
29	Fields 2008	87	■							■		
30	Dodge 2008	30	■					■	■		■	
31	Malebranche 2009	29*	■				■		■			
32	Wilson 2009	71	■	■				■		■		
33	Graham 2009	22		■			■	■		■		
34	Jerome 2009	52	■	■				■	■	■	■	
35	Nanin 2009	29		■			■	■				
36	Arnold 2009	40	■		■		■				■	■
37	Jones 2009	4		■				■	■			■
38	Malebranche 2010	38	■					■	■			

#	Study	N	Methods				Major Themes					
			In-depth interviews	*Focus groups*	*Participant Observation*	*Other*	*Heterogeneity/ Identity*	*Stigma*	*Risk Behavior*	*Mental Health*	*Resilience*	*Community Engagement*
39	Pitt 2010a	34*	■						■		■	
40	Pitt 2010b	34*	■				■	■			■	
41	Reback 2010	21	■	■			■	■		■	■	
42	Han 2010	31		■			■	■				
43	Lapinski 2010	56	■	■			■	■	■			
44	Washington 2010	105*		■				■		■	■	■
45	Washington 2011	105*		■				■				
46	Wu 2010	34		■				■				
47	Haile 2011	10	■					■				■
48	Hightow-Weidman 2011	20	■	■				■			■	■
49	Valera 2011	9	■				■	■				
50	Rhodes 2011	88		■			■	■	■			
51	Van Devanter 2011	27						■	■			
52	Patton 2011	6	■				■	■		■		
53	Wilson 2011	81	■	■				■				■
54	Balaji 2012	16	■					■			■	
55	Voisin 2013	20		■				■				
56	Bird 2013	20	■					■	■			
57	Hussen 2013	29	■	■				■				

#	Study	N	Methods				Major Themes					
			In-depth interviews	*Focus groups*	*Participant Observation*	*Other*	*Heterogeneity/ Identity*	*Stigma*	*Risk Behavior*	*Mental Health*	*Resilience*	*Community Engagement*
58	Tobin 2013	20	■					■	■			
59	Frew 2013	54		■								■
60	Muessig 2013	22		■					■			■
61	Strayhorn 2013	29	■				■					
62	Arrington-Sanders 2013	17	■				■				■	
63	Bowleg 2013	12	■				■	■		■	■	
64	Hussen 2014a	20	■						■	■		
65	Fields[a] 2015	35				■	■	■	■			
66	Hussen 2014b	20	■						■		■	
67	Andrasik 2014	20		■								■
68	Arnold 2014	40	■				■	■	■		■	
69	LeGrand 2014	22		■						■		■
70	Magnus 2014	10	■			■						■

[a]Fields et al. (2015) was published online ahead of print in 2014, thus we included the article in this review.