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HIV-Related Communication and Safe Sex Practices among Heterosexual Black Men:

A Qualitative Report

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Abstract

HIV prevention efforts have given limited attention to the influence of social norms on the process of communicating about safer sex practices among heterosexual Black men. To address this and inform the development of an HIV prevention behavioral intervention for heterosexual African American men, we conducted computerized, structured interviews with 61 men living in high HIV prevalence neighborhoods in New York City to participate in either one of the five focus group interviews and/or an in-depth qualitative interview. Participants had a mean age of 33 years, 25% held less than a high school education, 66% earned an annual income of $10,000 or less, and 86% had a history of incarceration Qualitative analysis was used to identify emergent themes within the domains of condom use communication, HIV status disclosure with sexual partners, and general

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HIV knowledge among peers. Thematic analyses revealed that communication was hindered by (1) low perception of risk of sex partners (2) relationship insecurities and (3) HIV stigma within the community and between sex partners. Most communication related to condom use was based on their perception of their sex partner's HIV risk and fear of contracting HIV and/or a partner's reaction to proposing or using condoms. Discussions related to HIV status elicited concerns of being labeled as HIV-positive or leading to unprotected sex. Communication among peers was rare due in part to the stigma of HIV in the Black community. Effective HIV interventions for heterosexual should include communication strategies that address the cultural norms that influence safe sex practices.

Keywords

HIV; Black men; Heterosexual; Sex Communication

Introduction

TWENTY-FIVE PERCENT OF NEW HIV INFECTIONS IN THE UNITED States are attributed to heterosexual transmission, with Black Americans accounting for the majority of those diagnosed (Centers for Disease Control and Prevention [CDC], 2016). When compared to other races Black Americans are disproportionately affected by HIV in the United States (CDC, 2016). Overall, CDC estimates that African Americans represent more than one-third of all people living with HIV and almost half of all persons with newly diagnosed infection (CDC, 2017). While making up 13% of the population, they account for 45% of the estimated new HIV infections (CDC, 2016). Black Americans face a higher risk of being exposed to HIV infection with each sexual encounter than other racial/ethnic groups because of the high prevalence of HIV within their sexual networks (Laurencin, Christensen, & Taylor, 2008; CDC, 2017). If current rates persist, the CDC estimates that approximately one in 20 black men, one in 48 black women, and one in two black gay and bisexual men will receive a diagnosis of HIV during their lifetimes (CDC, 2017).

The disproportionate impact of HIV among Black Americans make understanding the nature of interpersonal communication about HIV/AIDS and safer sex practices among heterosexual Black Americans a vital component when addressing the barriers to HIV prevention among this population. Sexual health communication, which denotes to the ability to discuss sexual issues, including HIV, with another person, is associated with safer sex practices (Williams, Pinchon, Davey-Rothwell, & Latkin, 2016). Effective communication skills between partners, as well as characteristics of assertiveness and confidence, have been positively correlated with condom use and safer sexual practices (Orengo-Aguayo & Perez-Jimenez, 2009). Furthermore, social networks have a great influence on cultural norms and have been found to be a pervasive pathway for communicating about HIV prevention, such as frequency of HIV and STI testing, consistent condom use and relationship dynamics (Otto-Salaj et al., 2008; Peterson et al., 2009; Garcia et al., 2016). Black Americans descend from a collectivist culture and tend to make individual decisions within the context of communal and interpersonal concern (Kambon, 1998). Understanding how heterosexual Black men communicate about safer sex behaviors

and the social norms that influence them is essential to understanding their knowledge and attitudes about safer sex practices, their perceived risk of HIV infection, and their ability to protect themselves and their sex partners. The goal of this study is to gain information on relationship-level influences on sexual decision making and explore the natural social processes that occur between heterosexual Black men and their sex partners and peers when they communicate about HIV-related topics using a Social Cognitive Theory approach.

HIV-Related Communication with Sex Partners

HIV-related communication, including disclosure of HIV status, sexual histories, and condom negotiation between partners is an important behavioral target in interventions to decrease the risk of HIV transmission (El-Blassel et al., 2003; Sullivan, 2005; Noar Carlyle, & Cole, 2006; Davey-Rothwell & Latkin, 2007). Previous research has shown that discussions between sex partners about sexual histories, including HIV and STI status and testing have had a positive influence on sexual risk-taking (Quina, Harlow, Morokoff, Burkholder, & Dieter, 2000). Studies with Black men and women have described how discussions of condom use in the context of relationships that are perceived to be monogamous threaten the relationship; condoms have symbolic meanings and are indicators of infidelity and lack of trust for some individuals (Frye et al., 2013; Paxton et al., 2013). Condom use decreases quickly over time within these relationships, and individuals are less likely to use condoms with primary partners than with new or casual partners (Fortenberry et al., 2002). Thus, while condom use has not been found to explain racial disparities in STI prevalence (Hallfors, Iritani, Miller, Bauer, 2007; Hamilton & Morris, 2015), inconsistent condom use is still an important behavioral factor contributing to the heterosexual HIV epidemic among Black Americans and others. To date, studies have not adequately explored how sexual health communication within heterosexual Black American men's sexual relationships (whether primary or casual) may contribute to their decisions to get tested (Misovich, Fisher, & Fisher 1997) or use condoms (Bowleg, Valera, Teti, & Tschann, 2010).

HIV-Related Communication among Peers and Social Network

Motivation to engage in safer sex behavior is related to social norms, beliefs, and attitudes within the couple, rather than only at the individual level (Harman & Amico, 2009). HIV-related communication among peers has been positively linked to engaging in sexual health communication with sex partners (Powell & Segrin, 2004) and identified as one of the ways in which sexual scripts are used to construct and fortify sexual health norms (Mutchler & McDavitt, 2011). Peers are considered an important source of advice and information about sex, yet there are some differences in how individuals disclose private information with their friends by gender and sexual orientation (Gezahegn et al., 2016). Women and gay men usually find it easier to talk about private information with their peers than their heterosexual male counterparts who express embarrassment, lack of trust, and concern about not being taken seriously as a barrier to communicating (Gezahegn et al., 2016). Social networks offer an opportunity for individuals to not only communicate about HIV-related topics, which can influence the formation or alteration of social norms around testing and condom use, but also serve as a source of health information and resources. Communication about HIV prevention strategies among social network members may be a critical mechanism for

diffusing information and messages about testing for HIV, use of condoms, and other safer sex practices (Tobin, Yang, Sun, Spikes, Patterson, & Latkin, 2014).

To our knowledge, there are no studies that focus on how heterosexual Black men communicate about HIV-related topics or sexual health among their peers. The Black community holds values and norms surrounding communal perception and peer acceptance specific to sexuality that could have harmful, negative consequences on community members' sexual health (Darrow, Montanea, & Gladwin, 2009; Mutchler et al., 2015). In studies with young Black men who have sex with men (YB MSM), supportive peer sexual communication about safer sex norms is one way that they may influence each other to engage in safer sex behaviors (McDavitt & Mutchler, 2014). However, if peer norms were perceived to be unsupportive of safer sex or perceived to be judgmental or stigmatizing, they were more likely to engage in unprotected sex (McDavitt & Mutchler, 2014). Given that sexual communication among peer groups has the potential to create change in sexual behavior perception and actions, it is important to assess current conversations and perceptions among heterosexual Black men among their peers.

Methods

Study Sample

Men who met the following criteria were invited to participate: between age 18 to 45 who self-identified as heterosexual; African American, black, Caribbean black or multiethnic black; self-reported HIV-negative or unknown HIV status; resided in the South Bronx or Central Harlem; and reported either vaginal or anal sex with a woman in the past three months. We recruited men into two risk categories: higher and lower risk. Higher risk (HR) men self-reported unprotected vaginal or anal intercourse with two or more female partners; lower risk (LR) men self-reported unprotected vaginal or anal intercourse with only one female partner or 100% protected vaginal or anal sex with no more than two female partners. Men were ineligible if they reported oral or anal sex with a man in the past five years; injection drug user in the last three years; no sexual activity with a female partner in the past three months; or participated in any HIV or substance use prevention studies in the previous six months. We screened 348 men, of whom 158 (45%) were eligible as LR participants and 60 (17%) were eligible as HR participants. The final formative sample included 61 men who engaged in 30-minute ACASI interviews, 40 HR, and 21 LR. Of these 61 men, 30 men engaged as well in in-depth qualitative interviews and 35 men participated in one of five focus groups. Due to missing data, five participants were not included in the final analysis.

Procedure

Our data came from focus groups and individual in-depth interviews conducted as part of a larger CDC-funded study, designed to explore personal, behavioral, and socio-structural factors that affect HIV sexual risk behavior and designed an HIV prevention intervention among heterosexual Black American men in New York City. Men were recruited using street recruitment methods in two focal neighborhoods. Trained study recruiters intercepted men on heavy trafficked street areas and presented a brief (1–2 minutes) description of the study. Men were either given a card with a brief study description, including that they may

participate in a brief computer survey and either a group and/or an individual interview, and study site contact information or, if possible, recruiters collected limited contact information (i.e., first and last name, phone number) to contact and screen potential participants by telephone. Eligible men were invited to participate in a structured interview, the Brief Risk Assessment (BRA), and either a focus and/or an in-depth qualitative interview depending upon their risk category and/or what interview was being conducted that week.

All participants provided written informed consent before any data collection activities were conducted. Upon the completion of the consent process, participants were administered a 20-minute BRA using the Audio Computer Assisted Self Interview (ACASI) program. The BRA consisted of self-reported demographic factors, sexual risk behaviors, partnership characteristics, substance use, HIV testing history and other factors related to HIV risk behaviors. Staff were present to assist the participant with the ACASI and remained easily accessible during survey completion. After completing the BRA, each participant would engage in either the focus group or the in-depth interview, both of which lasted approximately between 90 and 120 minutes. Participants were reimbursed $15 for the BRA and $30 for the groups; they received a two-way Metrocard to cover transportation costs. Referrals for resources and services were made available after the interviews and groups by the study staff. All data collection activities were conducted at the research site located in South Bronx. The institutional review boards of the New York Academy of Medicine and the New York Blood Center approved the study protocol.

Theoretical Bases for the Formative Research

We used three data collection techniques guided by Social Cognitive Theory (SCT), to examine the HIV risk behaviors for heterosexual Black men that are affected by social cognitive factors, such as peer norms related to condom use and multiple sex partners, HIV risk perceptions, and sexual risk reduction self-efficacy (Frye, et al., 2013; Raj et al., 2014). The central construct of SCT is self-efficacy, the individual’s level of confidence or belief in their ability to implement a specific behavior, which can influence goals and aspirations, shape the outcomes people expect their efforts to produce, and determine how obstacles and impediments are viewed (Bandura, 1977). Basically, self-efficacy works in conjunction with outcome expectancy to moderate behaviors (Bandura, 1997). People with high efficacy have more positive beliefs about their performance outcome and shape their environments to support healthy behaviors (Bandura, 1997). Research built on SCT integrates information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy (Bandura, 1997). For the purposes of this study, we focus on the experiences that heterosexual Black men have with communicating with their partners and peers about sex, and how those conversations influence practicing condom use skills and strategies to modify perceived peer or partner normative beliefs about risk-taking.

Focus Groups and In-depth Interviews

The formative research was conducted in 3 stages: exploratory focus groups, qualitative in-depth interviews, and confirmatory focus groups. The first set of focus groups explored the men’s perceptions of normative sexual behaviors, intimate relationships, and sexual risk, including approaches to risk reduction and the personal, behavioral, and socio-structural

factors that influence risk and risk-reduction attitudes and behaviors. A written guide, with prompts, was used for each focus group to ensure that all topics of interest were addressed. Two trained, Black American male study team members, one acting as a moderator and the other as a note taker, facilitated all focus groups. During one focus group, the study project director, a female Black American, was present. The impact of her presence on the group was apparent, and thus only men were present in all subsequent groups. The goal of the in-depth interviews was to solicit detailed descriptions of the experiences of, perceptions of, feelings about and cognitions around the focal behavioral outcomes: condom use, concurrent partnerships, and HIV testing. Although the questions were based on the guide, we did not attempt to get detailed information on each domain from every participant but rather focused on domains that emerged as most salient to individual participants. The second set of focus groups were convened 4 months apart, with findings from the first set of groups and the intervening in-depth interviews informing subsequent groups. The purpose of the second set of focus groups was to discuss our findings from the qualitative interviews and to assess the validity of analyses of the interview data and elicit feedback on preliminary thinking regarding intervention characteristics for the target population (Table 1).

Data Analysis

All focus groups and individual interviews were audiotaped, transcribed, and reviewed for accuracy. Analysis of the focus groups was thematic, focusing on central themes that emerged and organized by the questions asked; attention was paid to the level of significance of a theme or discussion within the group. For each focus group, the analytic team reviewed the transcript and created summations of the group interview content. For the in-depth interviews, we used coding techniques borrowed from Strauss and Corbin's (1997) work on grounded theory. The coded transcripts were conducted in three steps and entered into NVivo 9 for Windows. First, the transcripts were summarized in an outline that identified the major themes of the interview. Based on the summaries and transcripts reviewed by the analytic team, a catalog of analytic areas represented in the data was compiled and given a code (a "closed code"). Second, the primary analyst reread the transcripts and identified text to be given a descriptive label (either a label from the closed code list or an original one, termed an "open code"). Next, the open-coded data were integrated into the closed code list. Third, the data under each behavioral outcome code (e.g., "condom use" "concurrent partnering" "HIV testing") were reviewed again and, if needed, recoded into sub-categories forming more concrete codes for analysis. They also confirmed a number of a priori codes by reading the first five interview transcripts in order to generate thematic categories, noting where coding inconsistencies occurred. The remaining interviews were coded by a single coder, who was also an in-depth interviewer, a co-author on for this manuscript, and member of the intervention development team. As the themes of the interviews emerged, we specifically paid attention to data that did not confirm emerging themes, noting these in subsequent analyses and application in the intervention development phase. Descriptive analyses were conducted on the BRA data to contextualize the qualitative approach using PASW Statistics 18, Release Version 18.0.0 (PASW/SPSS 18.0 Chicago, IL).

Results

Sample Characteristics

Table 2 describes demographic characteristics and sexual risk behaviors of the study participants, including condom use, HIV testing practices, and discussion about their HIV status with their sex partners.

Qualitative Analysis Results

Narratives about HIV-related communication centered around three key themes: (1) initiation of condom use, (2) discussions related to disclosure of HIV status and testing practices, and (3) communication among peers regarding sex and safer sex practices.

INITIATION OF CONDOM USE—When asked about the times that they talked to women about HIV, the participants expressed that the conversations were centered on the decision to use a condom during sex. Initiation of these conversations was either by the man or their sex partner at the early stages of their sexual relationship, usually before exclusivity was established if applicable to the relationship. Fear of contracting HIV was a significant motivator to start the discussion with sexual partners as one man explained:

> "I bring the conversation because I was really scared about, you know if she was using protection. I would be like, you know, 'When was the last time you had sex?' Or- and if- and 'In the last time you had sex did you use condoms' and 'When was the last time you took an HIV test? 'These are things that I would bring up to them."

The men often prompted the conversations if there was a perception of risk of contracting HIV from their sex partner. Having prior knowledge of their partner's sex history motivated them to use condoms with sex partners that disclosed having multiple partners. This highlighted that the men were aware of the risk associated with having sex with multiple partners.

Discussing condom use within an exclusive relationship was found to be difficult for participants. They were concerned that they would offend their sex partners by bringing up the topic. *"It's hard to talk to them about having safe sex because I'm afraid how they are going to feel about it … . I'm afraid that they might not feel the same way I feel and they might get offended."* Another participant reported that his sex partner became defensive after he spoke to her about the risk of not using condoms. *"Um, you know, [she] get defensive. Like, 'I don't want to hear that,' or just, like, not defensive, but just try to switch the topic or walk off or do some other kind of shit."* While some main sex partners are offended and would not want to discuss it; others were open to the conversation and assertive about the importance of initiating dialogue around condom use. One man discussed how he struggled with conversations with sex partners and experienced some resistance to condom use *I'll go, well, do you think we should use protection? Some of them will go, yeah, alright. Some of them will go … get checked, and no, we'll not use condoms. You got some of them that just blow off the handle just because I brought it up"*.

In some situations, there was no discussion about condom use. They did not use condoms at all or on a regular basis with all of their sex partners because they assessed their risk using subjective information based on the partner's appearance and/or personality. The men perceived their risk of HIV infection to be low at the time of sex. Despite admitting to the risk of contracting a treatable sexual transmitted disease, one participant discusses his decision to engage in unprotected sex with a high-risk casual partner:

> *"But based on my experience and my judgment of people, I feel I always make pretty good judgment as far as the women that I've dealt with. And that's kinda helped me make some of the decisions I made. At the end of it, I always knew there's a chance that it can happen because you wasn't protected. So it's never that it can't, but more so, you know, maybe she … or maybe she gave me crabs, but I never thought I would have AIDS because of it, you know".*

Overall the discussion regarding condom use was viewed as important regardless of the relationship status (exclusive vs. casual) to validate having unprotected sex so that individuals could be aware of their risk. As explained below:

> *"[If] both partners is not honest with each other and don't communicate, you are bound for destruction because you gonna have a secret, he's gonna have a secret. You know, and you're having unprotected sex. So, then when somebody gets burnt, you're blaming each other. If you all was talking and there was communicating from the beginning, they probably wouldn't have the situation going on".*

COMMUNICATION ABOUT HIV STATUS AND TESTING WITH SEXUAL PARTNERS—Communication regarding HIV status disclosure and testing varied among the men depending on their relationship status with their sexual partner. A few men said that the discussions about their HIV serostatus and testing came up at the start of the relationship. One man discussed how he and his partner (who he was considering to have a long-term relationship with) got tested together after dating for a couple of mouths and decided to engage in unprotected sex shortly afterward:

> "After three months we got tested again and that's when we started having unprotected. We had it once, we had a twice before then we just try; we know we're good, and then we just having unprotected sex after. That's how it happened."

It was a normative practice among the men to have unprotected sex after disclosing their HIV status and providing proof to their partner. One man describes how the conversation about HIV status with a new sex partner occurred after they had unprotected sex:

> "… We actually had sex first and then we talk about it afterwards which is kind of stupid. You know, she talked about it, and I said yeah, I told her, I got myself checked out all the time. I told her that my sister has HIV and she said all right and she said, she gets herself checked too. And I didn't ask for the results like I talked to somebody else about it, oh, you should have asked her for the results."

He did not acknowledge his risk until after discussing it with one of his peers. Low perception of HIV risk hindered his HIV status discussion with his sex partner as well as condom use.

There were some discussions that provided some possible understanding into what could hinder early HIV status conversations. Having a sex partner initiate conversation about HIV status was cause for concern and suspicions among the men in the sample. One man became suspicious if a new sex partner when she brought up the topic of HIV serostatus and testing prior to having sex:

> "It surprises me. I met a chick the other day, I didn't have sex with her but we was talking and we made out, you know what I am saying, a little foreplay going on and she asked me about it. And I was surprised too, she asked me like, have you ever got tested and all this other, she asked me and I asked her and it made me think that she had something you know, 'cause you never really get a girl ask you even though"

Others felt that if they brought up the conversation that their sex partner would think that they were HIV positive. *"I can't ask her because she might think I got it."* Others described conversations about HIV but did not feel the need to ask for test results to prove that their potential partner was negative, assessing their risk using subjective information based on the partner's word. *"… I don't ask a woman, like, are you HIV negative. I don't ask her for a blood test to get in a relationship and all that shit. I just go on their word; you know what I'm saying."*

HIV COMMUNICATION WITHIN SOCIAL NETWORK—Conversations about HIV within non-sexual social networks were rare among the sample. Some men indicated that if it came up, the conversation was short, either because there was no need to discuss it (because they were not going to be having sex with their male friends) or because the content of the conversation was brief and to the point ("You gotta strap up; it is critical out there."). One man indicated that in a conversation with peers, HIV was not considered a major concern because it mainly happened to females. Again, when longer and more in-depth conversations occurred it was typically because either a friend or family member acquired HIV, although at least one participant did HIV education and outreach himself. The men acknowledge that their peers were aware of HIV, but there was still some discomfort in talking about it and safer sex practices with non-sex partners. Consequently, one man noted that talking about safer sex practices between friends might warrant an adverse reaction. *"Everybody's entitled to your own opinion, but a lot of people is not going respect it or appreciate it. They might get aggressive, hostile. So, how you tell them about, like, you know, wearing condoms or go and getting tested. Like, they be getting an attitude".* One participant did not talk to his peers about HIV because he was unsure of the reaction that they might have to the topic being brought up in a discussion: *"… well, it's hard to talk to them about having safe sex because I'm afraid on how they going to feel about it. No. I'm afraid that they might not feel the same way I feel and they might get offended."* Even if the conversation came up if was often brief, as described below:

> "Well, you know what? I got a main friend, like a brother to me. We don't talk about HIV too much. Now I talk to this dude all the time and we have a lot of conversations, but it's never really focused on HIV. And I mean, this is somebody I talk to regularly, we talk about everything. And I think dudes don't talk about HIV that much, that if they do talk about, it's not for long."

Participants expressed a lack of communication not only among their friends but also within the family structure. *"Me and my family never talked about, um, practicing safe sex. Um, never talked about AIDS, any sexual transmitted diseases."* One participant attributed the general lack of HIV communication to the stigma associated with the disease in the Black American community. *"I think a lot of that just comes from society and the things that we learn. The way we hear about things and the way we do things in, I guess you would say the hood, it's different. Oh, he got an HIV test, oh, he got that. That's the first thing that somebody would say."* One man expressed that HIV-related stigma not only hindered communication within the community but it is also a barrier to HIV testing practices:

> "Growing up knowing that, it's like you sneak around and get HIV test, or sneak around and take a STD test because you know all your people is going to cry when you get back or if they see you coming out the free clinic-it's a stigma. It's what we go through. I think that's a number one reason when you grow up in neighborhoods that I have, that young African-American males or females don't do it as often as they should."

Discussion

This study expands existing literature by providing data on the HIV-related communication practices of heterosexual Black men with their sex partners and among their peers. Our analyses demonstrated that much of the conversation related to HIV centered on HIV testing results with sex partners and the desire not use condoms. The timing of this discussion varied from either prior to sexual intercourse or after an unprotected sexual encounter. For many of the participants, their capacity to discuss issues related to HIV not only depended on their comfort with the topic but also on their partner's openness to communicating about HIV. Our results are similar to previous studies that have looked at the sequencing of safer sex communication within sexual encounters which indicates that such communication usually takes place just before intercourse is about to begin, but relationship security often outweighed health concern (Noar, Black, & Pierce, 2009). The participants in the current study expressed that both parties in their sexual relationships were not always able to openly communicate their feelings to one another in a constructive manner. Thus, several participants avoided discussing safer sex topics until after a sexual relationship had been established due to their low perception of risk. Along with their low perception of risk, fear of rejection or accusations of infidelity from their sexual partners were major factors influencing participants' HIV-related communication. Tire men limited their sexual communication with their partners to avoid threats to the relationship either early in its initiation or later in its maintenance. These findings which attribute lack of communication to relationship insecurities are similar to traditional heterosexual sexual relationship scripts found among Black women (McLellan-Lemal et al., 2013). While many studies have placed responsibility and concern of safer sex negotiation on women, it is important to stress that male involvement in safer sex negotiation is imperative to diminish the cultural gender norms and imbalanced power dynamics that precedes increase risk behaviors in heterosexual relationships.

Talking about HIV testing at the start of a relationship does not ensure that sex partners will take the next, more difficult step of making sustained behavioral changes that protect the partnership against HIV and other STDs, such as practicing monogamy, consistently using condoms, and regular HIV testing (Noar, et al., 2009). Within this sample, we found that discussion of HIV test results was typically a prelude to discontinuing condom use and increased sexual risk behavior with co-current partnerships since these topics were not typically brought up until after the relationship had been established. Several men in the study expressed that after discussing their HIV status with their sex partners, they would not use condoms. A previous study of heterosexual couples found that steady dating couples who engaged in open sexual communication before the onset of first sexual intercourse had a lower likelihood of using condoms because they did not perceive themselves to be at risk for HIV/AIDS (Seal, Wagner-Raphael, & Ehrhardt, 2000). Given that concurrent partnering was also a common practice among the sample, the utility of HIV testing as an HIV risk reduction within a sexual partnership was compromised.

The discussion between partners about safe sexual practices and HIV testing could possibly cause anxiety and even conflict (Gillmore, et al., 2003; Bowleg et al., 2010). Bowleg and colleagues described how relationship power may have an influence on promoting effective HIV communication that leads to safer sex practices in heterosexual relationships (Bowleg et al., 2010). Negotiating safer sex when a partner does not have a favorable attitude towards using condoms, and when the suggestion of condom use introduces questions of infidelity, has been addressed with Black women in previous studies (Paxton, et al., 2013), yet it has not been examined among heterosexual Black men. The men in this study expressed that they found it difficult to discuss safer sex practices in established sexual relationships because they did not want to offend their sex partner or they did not want to be labeled as being HIV-positive. A previous study examining traditional masculine ideologies and social norms among Black men found that communication about safer sex practices was considered to be feminine and related to women’s emotions and feelings (Hall & Applewhite, 2013). These masculine norms have been found to lead to denial of health information, including self-care such as condom use, and services such as HIV testing among heterosexual men (Higgins, Higgins, Hoffman, & Dworkin, 2010; Hall & Applewhite, 2013). Attention to interpersonal relations and communication should become part of the overall design of HIV prevention programs to understand the cultural characteristics of Black Americans that influence sexual decision-making. Sexual decision making is influenced by information that is passed from generation to generation (Williams, Wyatt, & Wingood, 2010). Interventions that focus on developing culturally competent strategies for sex partners to communicate about sex, HIV risk, and HIV testing are essential to prevention strategies. These studies should focus on dyadic perspectives between couples to examine the relationship between receptivity and actual diffusion of sexual norms between individuals (McDavitt & Mutchler, 2014).

Participants reported that the discussions about HIV with their peers were generally rare or non-existent because Black Americans are already stigmatized as “at risk.” Despite research showing that individuals who communicated about sex with their parents were more likely to communicate with their dating partners and peers (Widman, Choukas-Bradley, Helms, Golin, & Prinstein, 2014), the men in study expressed that if the conversation came up it

discussions about sex, HIV was an “after thought.” Previous research has shown that the level or HIV communication in the Black community to does not always reflect its impact in the Black community (Bowleg, et al., 2010; Kaiser Family Foundation (KFF), 2012). According to the Kaiser Family Foundation, 56% of Black Americans reported that the subject of HIV/AIDS rarely or never come up in discussion with family and friends despite the fact that most Black Americans consider HIV to be the most urgent health problem for the United States (KFF, 2012). This may be due to the close proximity of HIV/AIDS within the Black community and social network. HIV has been a delicate topic in the Black community for many years due to the impact of the epidemic in the community and community-level stigma resulting from fear of transmission, homophobia, blame, and judgment regarding drug use and/or sexual behaviors (Herek, Capitanio & Widaman, 2002; Galvan et al., 2008; Mahajan et al., 2008; Darrow, Montanea, & Gladwin, 2009). In a study examining the impact of newspaper coverage of HIV/AIDS on HIV testing behaviors in the US population, Black Americans exhibited greater declines in HIV testing subsequent to increase news coverage compared to Whites (Stevens & Hornik, 2014). Stevens and Hornik (2014) explained that the increase news coverage of HIV led Black Americans to feel more susceptible to HIV, which activated fears and delayed HIV testing. This supports our findings that increasing communication about HIV and sexual health without considering the content of those communications may actually cause more harm by focusing solely on deficit models.

The men in the study expressed that HIV continues to be a sensitive topic among Black Americans, and they attributed the lack of HIV communication among their peers to the stigma associated with being HIV positive in the Black community. Within the Black community, HIV-related stigma is often linked to perceptions of sexual behavior and/or sexual identity, as well as to fears that the infection is easily transmitted (Galvan et al., 2008) and these multiple sources may interact in ways that influence HIV prevention-related behaviors among marginalized populations (Airhihenbuwa, Ford, & Iwelunmor, 2014). These beliefs have impeded treatment efforts among HIV-positive individuals because of their desire for secrecy or reluctance to disclose to partners (Earnshaw & Chaudoir, 2009). Among those with unknown status, fear of receiving a positive HIV test result remains a potent disincentive to seeking HIV testing (Valdiserri, Holtgrave, & West, 1999; Obermeyer & Osborn, 2007; Otto-Salaj et al., 2008; Washington et al., 2015). HIV stigma has the potential to impede the uptake of a novel and highly effective HIV biomedical prevention methods, specifically post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) (van der Straten et al., 2014; Calabrese & Underhill, 2015). Addressing how HIV stigma reduces HIV communication as part of PEP and PrEP dissemination efforts will be critical to ensuring that the new prevention methods do not exacerbate racial disparities in HIV infection.

It is important to point out that this study has limitations. First, this is a small sample of a selected group of heterosexual Black men living in high HIV prevalence urban neighborhoods in New York City and is not representative of all Black men. We cannot assume that all Black men are the same, it is important to recognize that the experiences of Black men may vary depending on socioeconomic status and environment. Second, this analysis address communication but the results only reflect the perspective of the

participants. We did not interview the participants' sex partners or peers in this study to future examine communication about HIV. These limitations notwithstanding, this study provides information on a population not often represented in the literature on HIV and advance knowledge about Black heterosexual men's HIV prevention needs, in ways that can inform future HIV prevention research, interventions, and policy. The data from this study may provide invaluable information concerning barriers to communicating about HIV with sex partners, and ways to address these barriers within a population that has limited exposure in published public health and behavioral research.

Our study shows the importance of adapting programs to address strong cultural norms and values among heterosexual Black Americans which includes beliefs regarding what is considered to be appropriate sexual behaviors and communication between partners. Knowledge about HIV prevention, transmission, and care can counterbalance the stigma that is caused by inaccurate information. Broader prevention strategies that measure the effects of stigma, sexual and gender norms, and the environmental conditions that communities disproportionately affected by HIV live in are necessary to improve educational efforts. Future research should explore how communication between sexual partners and peers' influences knowledge, attitudes, risk perceptions, and behaviors. Studies should examine relationship dynamics among Black Americans and the influence of cultural and community normative beliefs that may influence one's sexual behavior and communication. Effective interventions that increase understanding of HIV and improve sexual communication among heterosexual Black men are critical to slowing the spread of HIV in the Black community.

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Table 1.

Straight Talk Formative Phase: Focus group participants, New York City, 2009

No. of Participants	Risk Level	Focus Group Content
6	Low	Sexual behavior
9	High	Sexual behavior
5	High	Sexual behavior and intervention content and approaches
6	Mixed	Intervention content and approaches
8	High	Intervention content and approaches

Table 2.

Sociodemographic characteristics of participants by risk group, New York City, 2009

Variable	Total % (n=56)	Risk Group		p-value
		High Risk % (n=36)	Low Risk %	
	32.9	33.8	31.4	
Age, year (SD)	(7.90)	(6.90)	(9.81)	0.42
Heterosexual (self-described)	96	100	88	0.09
Born in the USA	98	97	100	1.00
Education (≤ HS/GED)	75	74	76	1.00
Income (≤ $10,000 annually)	66	69	59	0.54
Employment status	62	60	67	0.61
(unemployed)				
Public Assistance	6l	64	53	0.55
Incarceration (lifetime)	86	92	71	0.05
Incarceration (past year)	69	72	58	0.37
Have child(ren)	66	69	59	0.54
Primary Female Partner, p3m	71	67	81	0.34
	4.61	5.28	3.06	
Female Sex Partners, p3m	(6.0)	(6.87)	(2.86)	0.03
(mean, SD)	2.60	3.06	1.38	
Female Sex Partners, no	(2.82)	(3.17)	(0.65)	0.00
condom use (mean, SD)				
At least one episode of vaginal/anal sex, no condom use	87	90	80	0.40
HIV Test, ever	98	97	100	1.00
HIV Test, past year	82	82	82	1.00
Discussed his HIV status with some/all partners *	78	74	100	0.54
Discussed his partners' HIV status(es) with some/all partners **	69	64	81	0.34

* n=27 due to missing data;

** n=55 due to missing data