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"The Skill Is Using Your Big Head Over Your Little Head": What Black Heterosexual Men Say They Know, Want, and Need to Prevent HIV

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Abstract

Although the disproportionate toll of HIV/AIDS among Black heterosexuals, particularly in low-income U.S. urban areas is well documented, Black heterosexual men are rarely the explicit focus of HIV prevention messages, research, and interventions. We conducted 4 focus groups with 28 Black men, aged 19 to 51 years, who were enrolled in the workforce and fatherhood development program of a local community-based organization to examine (a) the priority and role of HIV/AIDS in their lives and (b) their HIV prevention needs. Although none articulated HIV as a top life priority, respondents nonetheless prioritized educating their children about HIV prevention and protecting their main partners from HIV if they had other sexual partners. Analyses demonstrated that participants said they wanted and needed: to learn how to talk to partners about HIV testing and use condoms when tempted not to do so, and more discussion-oriented educational opportunities to learn and exchange prevention strategies.

Keywords

Black heterosexual men; HIV prevention; incarceration; HIV risk; condom use

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On November 7, 1991, Los Angeles Lakers basketball star Earvin (Magic) Johnson announced that he was HIV positive, becoming arguably the first and most famous Black man to publicly disclose that he had contracted HIV via heterosexual sex (Casey et al., 2003). Johnson's announcement was a media showstopper, one made all the more riveting by the fact that Johnson was a heterosexual man, not a member of one of the groups perceived to be most at risk for HIV: heterosexual women (Centers for Disease Control and Prevention [CDC], 1990a), men who had sex with men (MSM), or injection drug users (CDC, 1990b). Although Johnson's disclosure dispelled the notion that Black heterosexual men were free from HIV risk, HIV prevention messages and interventions for Black heterosexual men did not follow suit (Exner, Gardos, Seal, & Ehrhardt, 1999). In 1993, 2

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years after Johnson's announcement, among men who contracted HIV due to heterosexual exposure, 8% were Black (CDC, 1993). In 2009, 16 years later, 69% were Black (CDC, 2011). Although the number of HIV interventions for Black heterosexual men has increased (see Henny et al., 2012) since heterosexual men received the mantle "the forgotten group" to describe their invisibility in HIV interventions (Exner et al., 1999), HIV prevention theory, research and interventions for this population still lag (Bowleg & Raj, 2012). Thus, the more than two decades old anniversary of Johnson's announcement provides a fitting historical backdrop against which to examine the rank and role of HIV/AIDS in Black heterosexual men's lives and what they perceive their HIV prevention needs to be.

HIV epidemiology belies Black heterosexual men's relative invisibility in HIV prevention theory, research, and interventions. The Black AIDS Institute has chided U.S. public health officials for deemphasizing evidence of a generalized epidemic (i.e., >1%) in U.S. Black communities (Wilson, Wright, & Isbell, 2008). Indeed, the prevalence of HIV in Black heterosexuals in 24 U.S. cities between 2006 and 2007 (Denning, DiNenno, & Wiegand, 2011) was higher than that of any other ethnic group. A key limitation of this study, however, was the absence of data intersected by race and gender. An inadvertent consequence of such an omission is that it obscures knowledge about HIV prevalence among Black heterosexual men. In Philadelphia, the site of this study, public health officials have documented that although MSM still account for the majority of HIV incidence, the number of Black men reporting heterosexual transmission as their primary mode of HIV exposure is growing rapidly (Philadelphia Department of Public Health & AIDS Activities Coordinating Office, 2011). In 2009, heterosexual exposure accounted for 21% of new HIV cases among Black men in Philadelphia. The urgency is heightened further by the fact that the virus is more efficiently transmitted from men to women (Nicolosi et al., 1994) and that men wear and primarily control condom use (Amaro, 1995).

These disturbing statistics and facts underscore a dire need for more research with Black heterosexual men to inform effective HIV interventions for this population. Several quantitative studies document that diverse Black populations (e.g., college students, STD clinic patients) are fairly knowledgeable about HIV/AIDS (e.g., Sutton et al., 2011; Williams & Sallar, 2010) in general (e.g., modes of transmission) but sometimes show mixed knowledge about more specific aspects of HIV prevention (e.g., the importance of correct and consistent condom use; Bazargan, Kelly, Stein, Husaini, & Bazargan, 2000). Findings from a handful of qualitative studies document that Black heterosexual men perceive themselves to be at HIV risk (Essien, Meshack, Peters, Ogungbade, & Osemene, 2005), consider HIV and STIs (sexually transmitted infections) to be top health priorities in Black communities (Baker et al., 2012b), and have average or poor knowledge about HIV transmission (Baker et al., 2012a; Heeren & Jemmott, 2011).

Public health officials have long acknowledged the pivotal role that local communities and community-based organizations (CBOs) can play in reducing HIV risk in Black communities (Center on AIDS & Community Health, 2005). Most recently, the National HIV/AIDS Strategy (White House Office of National AIDS Policy, 2010) affirmed this view with recommendations for community-level approaches to reduce HIV. Pursuant to advocacy for more community-based approaches to reduce HIV risk in Black communities,

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we designed this study as the preliminary step in a plan to develop an intervention for Black heterosexual men and integrate it within a local CBO that provided workforce and fatherhood development services to a primarily Black male clientele. Specifically, we designed the study to gain an in-depth and culturally specific understanding of Black heterosexual men's HIV prevention needs and experiences with HIV/AIDS to inform the development of the aforementioned intervention. The study examined four research questions: (a) Where and how does HIV prevention rank as a priority in participants' lives? (b) What role, if any, does HIV/AIDS play in participants' lives? (c) What do participants know about HIV prevention? (d) What do they say they want and need to know about HIV prevention to protect themselves from HIV?

Method

Participants

Participants were 28 self-identified Black men who ranged in age from 19 to 51 years (M = 34.79 years). Most of the sample was unemployed (n = 25; 88.75%) and had been incarcerated (n = 26; 91.7%); 12 of the 28 (43%) were currently on parole. The majority of the sample (n = 27; 96%) self-identified as heterosexual; one respondent self-identified as bisexual. To protect the confidentiality of participants, we did not link data from the study's demographic questionnaire to individual participants. Consequently, we were unable to identify the participant who self-identified as bisexual to exclude his data from the analyses. We nonetheless use the term Black *heterosexual* men to describe the entire sample. Our decision to do this is predicated on arguments that we have asserted in detail elsewhere (see Bowleg & Raj, 2012) about how the use of terms such as men who have sex with women (MSW) often obscure the experiences and perspectives of Black heterosexual men in HIV prevention initiatives. Demographic characteristics of the total sample and by focus group are shown in Table 1.

Measures

We used the interview guide approach to systematically elicit detailed responses to specific questions across the study's four focus groups (Patton, 2002). The interview guide approach provides for researchers to outline topics and issues in advance and gives facilitators the flexibility to decide how they sequence and phrase questions (Patton, 2002). We chose this approach because we wanted to systematically collect comprehensive responses to specific questions across the study's focus groups (Patton, 2002). Sample focus group questions included, "What are the top three priorities in your life?"; "What are some of the ways to prevent the transmission of HIV?"; "What do Black men need to know about HIV prevention?"; "What do Black heterosexual men need to protect themselves from HIV?"

Procedures

We recruited a convenience sample of participants enrolled in a local CBO that provided workforce, personal, and fatherhood development services to a predominantly Black male clientele. The third author introduced the study to prospective participants during an in-person visit to the CBO and invited prospective participants to voluntarily sign up for one of 28 slots (i.e., 4 groups of 7 men per group) on a first come, first serve basis. Once all slots

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had been filled, participants were randomly assigned to one of four focus groups. Prospective participants were screened by phone to determine whether or not they met the study's eligibility criteria of identifying as Black/African American, being at least 18 years old, having been born and raised in the United States, and reporting heterosexual intercourse during the last 6 months. We conducted two focus groups a day on two separate days. We scheduled the focus groups between classroom breaks on two of the days of the CBO's regularly scheduled seminars. Participants had no prior knowledge of the exact day or time of the focus group to which they would be assigned. All the participants ($n = 28$) who signed up for one of the slots met the study's eligibility criteria and all these participants showed up for their assigned focus group.

Dr. David Malebranche, an experienced HIV prevention researcher, physician, and qualitative expert and Black man, conducted all the focus groups and took detailed field notes after each group. The groups, which were digitally recorded, ranged in length from 67 to 101 minutes and included 7 men each. After completing the focus groups, participants completed an anonymous demographic questionnaire. Participants received a $25 cash incentive. The institutional review board at Drexel University approved all study procedures.

Data Analysis

Focus group discussions were professionally transcribed, edited for clarity and to remove personal identifiers, and then imported into NVivo 9.0, a qualitative data analysis software package. All the study's authors read the transcripts multiple times to familiarize themselves with the data. Thereafter, the second and third authors used Nvivo 9.0 to create topic and analytical codes. Topic coding refers to the assignation of labels to specific pieces of text; analytical coding focuses on meaning and interpretation (Richards, 2009). Sample codes included "knows someone with HIV/AIDS" and "need to protect self from HIV." To code analytically, analysts recorded their interpretations of the topic codes and the relation of these codes to the study's research questions. We assessed the trustworthiness of our analysis as previously described (see Bowleg, Lucas, & Tschann, 2004) and determined that our analyses demonstrated credibility, transferability, and confirmability (Lincoln & Guba, 1985). We used NVivo's coding comparison feature to compare coding consistency and obtained a Kappa coefficient of 72.28, indicating good agreement (QSR International, 2011). Demographic data were analyzed using SPSS.

With the exception of minor edits to improve clarity or the deletion of extraneous phrases (e.g., expressions such as "You know what I'm sayin'?"), all quotes are provided verbatim. To protect the confidentiality of participants, we have provided pseudonyms. Most of the men announced their names prior to speaking to facilitate tracking of each speaker during analyses. Because focus groups typically feature multiple people speaking simultaneously, it is not always possible to keep a record of names, however. Thus, pseudonyms are reported in the results only when there was a recorded name of a speaker on the transcript.

Results

All of the study's focus groups were characterized by lively discussions in which participants provided candid responses to the facilitator's questions, engaged each other with

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commentary and questions, and shared their experiences and perspectives. We present below our findings relevant to the study's four research questions.

Where HIV/AIDS Ranks as a Priority

To gauge where HIV prevention ranked among the top priorities in participants' lives, a focus group guide question asked respondents to list their top three life priorities. No participant cited HIV/AIDS or HIV prevention as a priority. Instead, participants listed things, such as self, family, or religion/spirituality as priorities most frequently. Lamont's mention of money as a priority evoked unanimous nods of agreement:

> Cause you can't provide for your family, yourself and do things that you need to do without them dead presidents [money]. You know, money plays a big part in getting ourselves together. We can get ourselves together as far as personal wise, but as far as like stability, you need funds.

Kyle was the only respondent to list health as a priority, noting, "In order for me to achieve what I got to do, I gotta be healthy, both physically and mentally." When specifically asked by the facilitator, "Where does HIV fit into the mix of your list of priorities?," most respondents were effusive about the importance of HIV. Citing the importance of his family, Lloyd summed up why he considered HIV to be important despite not having mentioned it earlier when the facilitator asked him to state his top priorities:

> … [With] HIV-AIDS, now you're speaking on not only yourself but your family and your children and maybe even your children's children, so it's important. It's highly important to be responsible and [when you] take chances that we take [in terms of having other sexual partners or not using condoms], you know, you gamblin' with your life … you gamblin' with your children's lives or your … or, like say for me, I'm married [and thus, my pregnant wife's life]. I hate to even think about it, but that's heavy.

HIV prevention was not a stated priority for all of the respondents, however. According to Kyle, "As far as what's important to me? OK, [HIV prevention] doesn't really register on the radar because I know what I know [about how to prevent HIV]." Like Lloyd, however, Kyle noted that teaching his teenage children how to protect themselves from HIV was a priority.

The Role of HIV/AIDS in Participants' Lives

Because Black heterosexual men are rarely the focus of HIV prevention messages, we wanted to gain a deeper understanding of what role, if any, HIV/AIDS played in participants' lives. Analyses of the narratives highlighted four key themes: (a) most of the participants recalled learning that a close acquaintance, such as a friend, family member, or former sex partner was living with or had died from HIV/AIDS-related complications or becoming aware of inmates with HIV/AIDS during incarceration; (b) having this knowledge serve as a "wake-up call" or "reality check" that heightened participants' perception that their drug or sexual risk behaviors might have exposed them to HIV; (c) fearing an HIV-positive test result after HIV testing; and (d) the immense challenge of consistent condom use or monogamy.

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Knowing a Close Acquaintance With HIV/AIDS or Having Observed Inmates With HIV/AIDS.—Focus group narratives were replete with accounts of participants personally knowing someone with HIV/AIDS. Kendrick provided a typical recollection: "Well I have a personal experience with a friend of mine since school, she died of AIDS, and I watched her, basically wither away." Similarly, Byron recounted his experience of witnessing his uncle's struggle with HIV/AIDS:

> Even though I was in jail when my uncle died, I remember when the symptoms first started to arise. And I would be upstairs and it started with a simple cough that escalated [and] escalated the next thing I know he was diagnosed [with AIDS], getting SSI (Supplemental Security Income) benefits [for disability], you know, goin' and getting medication, and then [he] pass away.

After close acquaintances, participants recounted that observing fellow inmates with HIV/AIDS was the other way that they had become conscious about HIV/AIDS and their risk for HIV.

Wake-Up Calls and Reality Checks.—A recurrent theme in many of the discussions about knowing someone with HIV/AIDS or having observed people with HIV/AIDS while incarcerated was that these experiences had frightened many of the respondents and heightened their perceptions about how their own drug or sexual risk behaviors may have exposed them to HIV. Reflecting on his past experiences as a self-described drug and sex addict, Lamont recalled that he had never taken his previous bouts with STIs such as syphilis and gonorrhea "seriously. … So I was still out there doin' my thing." Everything changed when he was incarcerated however, and "I started to finally wake up." His real wake-up call, however, happened after a fight-related injury:

> So that sent me to the hospital ward and I was in there gettin' my [injury] treated and I had to walk past the AIDS ward, where they kept all the inmates that had AIDS and all that. And I walked past there and the way that those people looked, I knew that I didn't want no parts of that. And so I was like this thing is real for real. Then a few people in my family died from it. And slowly but surely it started to hit me and I started, you know, seein' it on TV … And plus I was scared because when I first came to jail I was thinkin,' man, all the women I done been with and we all gettin' high … I probably got the shit. … So I took an AIDS test while I was in jail. It came back I didn't have it, but before it came back I was so scared.

Similarly, Jonathan attributed his reported consistent condom use to fear:

> What makes me use condoms is the AIDS thing. When you hear stories about people that got burned [got a STI] or … they might have died of AIDS or somethin' and that's how they caught it [sexually]. That alone make you … start using condoms.

Fear of an HIV-Positive Test Result.—Echoing Lamont's experience with HIV testing, others recounted how their immense relief at a negative HIV test result had motivated them to reduce their HIV risk behaviors. Typical was Jonathan, who after years of having been tested for various STIs had recently had his first HIV test. This, he explained, was because

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he did not know until someone told him otherwise that HIV testing had to be requested; it is not included in the usual battery of STI tests. Reflecting on his realization, Jonathan recalled,

> So now I'm like, "Oh man all this time [the people testing me] was tellin' me I was cool [didn't have HIV], I never got AIDS tested. … When I got the [HIV test] results my heart was like racin' because I did a lot of dirt in my day (laughs). … It made me really take a step back a little bit, you know what I mean, cause I definitely played Russian roulette many nights (laughs).

But whereas fear had motivated several of the respondents to "stay away from that [risky stuff]," others acknowledged that adopting sexual risk–reduction strategies, such as consistently using condoms or reducing the number of concurrent sexual partners was a formidable challenge.

Challenges to Risk Reduction Behaviors.—Despite feeling motivated to reduce their risk behaviors in the wake of observing a close acquaintance and/or fellow inmate with HIV/AIDS or a negative HIV test, respondents were especially vocal about the challenges of reducing their sexual-risk behaviors. Discussions about these challenges centered around two themes: (a) using condoms consistently and (b) being monogamous and/or reducing the number of concurrent sexual partners. Focus group participants offered numerous reasons (e.g., lust, passion, lack of sensation, not having condoms, not being accustomed to using condoms, or not caring about one's health) why Black men might continue to engage in sexual risk behaviors despite personal knowledge of someone with HIV/AIDS or having observed people with HIV/AIDS while incarcerated. But whereas most of these discussions focused on individual-level barriers to condom use, Shareef, who was living at a halfway house after his release from prison shared an example of an institutional barrier to men's condom use.

> … I'm at a halfway house right now and my man [the supervisor] came in the door —you know how much a box of Magnums [brand of condoms] cost? And they took the condoms. They took the condoms from me. Now, my whole thing is, we are men just coming home from prison so one of the most important things on our mind is going out and having sex …

Perturbed by the halfway house's policy that residents not be allowed to have condoms, Shareef further reflected on how this policy inadvertently facilitated sexual risk:

> But you're supposed to be protecting the community so, number one, knowing that we're just coming home from prison, not having no jobs, why would you want us to go out and make babies anyway and bring lives? Like that's not bettering the community. And then two, like all we want to do is pop it [have sex]. We probably see somebody walking down the street that's a hooker, we gonna slide up in it so why would you take condoms from men? That's just, that's the most likely [men] that need condoms.

Monogamy and/or reducing the number of concurrent sexual partners were the other challenges to HIV risk reduction that many participants perceived to be daunting.

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Perspectives varied with some men espousing that they were monogamous because of their spiritual or religious values, their own personal values or moral codes, their desire to reduce their risks for HIV or other STIs, their emotional commitment to their partners, or most frequently, as a consequence of their emotional or chronological maturity. Indeed, maturity was the most recurrent theme across the focus groups with many men reporting that they had simply tired of what Jalen called "free-balling" or another termed it, "the thrill of the chase" of having many different sexual partners. Kevin reflected that:

> Or sometimes it happens after too many partners and you be like, man I'm tired of this, like every day I got to go here or go there and then I'd be so tired when I get in the house, I can't even treat her [my main partner] right.

Echoing this perspective, Kwame articulated the energy needed to juggle multiple relationships:

> … You get tired of hopping around with different relationships. And [if] you have three-four women, man you have to know what this person like, know what this person like, know what this person like, know what this person like.

> … It's costly anyway you look at it, because this woman might like to go out and eat, this woman might like to go out of town, this woman might like to gamble, you know. In certain situations, you have to keep your mindset. I mean, that's too much to remember.

As for the role of getting older, Jeff opined,

> I think … you'd be more settled down as you get older. Like as time go on because when you in your prime, you 20 to 30 [years old], you like, man this is the time I got, to do this and do that. But then as you get older you like, well hold on now … Now it's time to settle down.

For other participants however, the excitement and lure of having sex with multiple women overwhelmed their exhaustion or desires to be monogamous. This was the case with Bruce who despite being in a relationship with a "good girl," described the attraction this way:

> I'm tired [of having lots of women] but it's hard. It's like, to me, I don't know about anybody else, to me, it's an addiction. I love women; like big girls, small girls, pretty girls. You know what I'm sayin? That's me. But it's like I love women and it's hard, it's like real hard. … I'm tryin' [to be monogamous], but I can't. You know I can't go to [to my main partner] and be like [I want to have sex with other women]. I can't. … And a lot of dudes do it cause they might [and do] not want to lose their woman.

It was also not difficult to find women with whom to have sex, participants offered. Without explicitly using the term *sex ratios*, several implied that unequal sex ratios (the notion that Black women outnumber Black men) played a role in why it was so difficult for many Black men to be monogamous. [There are just] so many girls out there," was the way one participant described it. He continued: "Oh man, there's too many out there that's willing to give it up … even when you got somebody that you can get [sex] from on a consistent basis." Frank added the sex ratios and incarceration context angle:

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> It's the temptation of just, it's like 10 [women] to one [man] really. You got so many males locked up and gone and it's like, it's really probably 15 [women] to one [man] now. And then it's the way they dressing and I mean, it's like a man gotta really try to stay focused just to get down the street sometimes.

What Participants Say They Know About HIV Prevention

In general, participants demonstrated moderate to excellent knowledge about how to prevent HIV, including but not limited to modes of transmission, the role of abstinence, the distinction between HIV and AIDS, and the importance of consistent condom use, and HIV testing. There were several discussions about whether one could tell that a woman was HIV-negative or "clean" by looking at or smelling her, but such discussions were rare. Many participants cited prisons and jails as one of the most important sources of their education about HIV/ AIDS. For example, Kirk revealed how when he was incarcerated in prison he observed that:

> A lot of people that was fainting and they had pneumonia. That's a sign of AIDS, I mean, and that made me want to get deeper into it and so I went to the school building and took up the class. I mean I even gave lectures on it. I still have the certificate at home for HIV Prepared Awareness.

In another focus group, Keenan reflected on how a chart of different STIs that he had seen while imprisoned in the county jail had inspired him to use a similar chart to teach his children how to prevent HIV when he was released from jail. Keenan's mention of the STI chart jogged Ray's memory to recall how Ray's time in prison had also provided him with what he perceived to be one of the most important lessons about HIV prevention:

> I remember when I was upstate [in prison], they used to have this thing in the nurses office, this chart for the HIV, and it was like, every partner that somebody slept with that you slept with, and it say 10 people that they slept with in the last five years and shit. I used to read that chart every time I used to go in there and look at that chart and look at that chart and boy it made me think, "My God, man I ain't playin no game [in terms of contracting HIV]."

What Participants Say They Want and Need to Prevent HIV

Although focus group respondents articulated fairly good to excellent knowledge about how to prevent HIV transmission, analyses of what they said they want and need to prevent HIV highlighted important gaps and opportunities for HIV prevention for Black heterosexual men. Respondents' answers about what they wanted and needed to prevent HIV coalesced around three key themes: (a) how to ask a partner to be tested for HIV, (b) how to use condoms when tempted not to do so, and (c) more opportunities to be educated about HIV/ AIDS in interactive classes.

How to Ask a Partner to be Tested for HIV.—The issue with which many focus group members said they most struggled was how to suggest that a sexual partner be tested for HIV. Quentin aptly summed up the issue this way:

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> I need to know the best way to bring it about with certain females without bein' ignorant. You know, not be, like say, "Let's get tested." … Yeah, like without being ignorant and sayin' they got something [such as a STI] and bein' rude about it. I'm just tryin' to find a polite way to go about it.

In response, Jonathan, another member of the group, shared some advice based on his own experiences of convincing a partner to be HIV-tested. Rather than implying that the woman's sexual history was the cause of the testing, Jonathan advised keeping the focus on the man's motivation for seeking HIV testing.

> I've done it before, so I'm gonna help you out. Me personally, I told her I was about to go get a test, I took her completely out of it. I said, "I'm about to go get a [HIV] test." … Once she heard it come out of my mouth, like I'm goin,' like it wasn't like I was askin' her or nothing … that was like the open door right there, and I walked through it; like, "Want to come?" And she's like, "Yeah," and we went down there … and everything was good [we both tested HIV negative].

How to Use Condoms When Tempted Not to.—The other issue with which focus group members said they grappled and needed skills to resolve was how to be disciplined in terms of using condoms in the face of challenges, such as being overcome by lust, passion, encountering sex partners who were casual about or did not want to use condoms, being inebriated, or not having condoms. Learning how to overcome temptation in the face of sexually attractive women could be especially daunting as this respondent summed up:

> … I don't know too many [men who could resist the temptation]. He may say he ain't gonna do it [have sex without a condom] with Halle Berry [but] … it's kind of hard. They're sitting right there. I'm telling you, it's hard. Beyonce sitting right there with nothing on? I'm poppin' [sexually aroused].

One participant summed up the challenge this way, prompting peals of group laughter and nods of agreement: "The skill is using your big head [brain] over your little head [penis]." Disciplined, was what another speaker said men needed to be to "not to fall into lust [of not using condoms]". Across the focus groups, participants recounted instances of when they knew that they should have used a condom with a sexual partner, but chose not to do so. For example, Lloyd described how what he called the "lustful moment" could be a barrier to condom use either because it occluded rationale thinking about the need to use a condom or because of perceptions that condoms might disrupt the moment. He described the experience this way:

> Sometimes you could be caught up in that moment and when you're in that moment, even though you're protected and all that, you might even have protection but when you're in that lustful moment and dealing in emotions, sometimes you're not thinking like, well maybe this or maybe that [that I could contract a STI]. 'Cause I remember a few times when I was young like, "Man, you got a condom?" … Once she say, "All right [it is okay not to use a condom]," [then] all right, like I don't feel like running to the store and getting a condom. Like even though I would of put a condom on … but the moment is there. … Like the moment might not be there when I get back. The moment is now.

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Echoing the view that condoms were incompatible with "the heat of passion," Corey described how the logistics involved in accessing the condom (e.g., opening the wrapper) were a primary obstacle to his condom use.

> Like the heat of passion … You know, you're getting into it, you don't feel like fumbling around with the wrapper and it's like, the only reason I never use them is 'cause it's too much work man; especially if the girl isn't really encouraging you [to use a condom], like if she ain't saying nothing [about condom use].

Both Lloyd's and Corey's narratives about how the "heat of passion" could interfere with condom use highlight another dimension about why some men choose not to use condoms when they feel tempted not to do so. That is, if their female partners do not request condoms, the woman's silence about condoms further reinforces the male partners' disinclination to use condoms.

Views about participants not using condoms when they perceived that they should have were not unanimous, however. Whereas many men said they needed more information about how to use condoms consistently, others cited certain heuristics that governed condom use, such as when a prospective partner looked "… promiscuous … you like I'm gonna hit that. I got the tool [the condom], when she out there like that."

More HIV/AIDS Education via Interactive Classes.—Despite their fairly excellent knowledge about how to prevent HIV, most participants were adamant that they wanted more education about HIV/AIDS. In particular, respondents said that they wanted to learn more about HIV prevention in settings that facilitated dialogue about HIV risk and prevention. Illustrative of this view, Sean advocated for "Good classes … like open forums [where you can discuss and exchange information]. Shareef chimed in:

> I feel as though the best way to learn about AIDS is through the schools. That's where I learned, I believe the most information I know about AIDS is coming up through school. I think it was in middle school, you know, I was in middle school around, right after the Magic [Johnson announcement], the Eazy E, [rapper who died from HIV/AIDS] that '92 era. So I was in middle school and that's when I was given [the information that] most stuck with me.

Respondents agreed that fliers or pamphlets about HIV prevention would likely be futile because as Kirk noted, "Like you said, classes cause if you … It's like you hand me a flier and you might be like … aight [all right] … and sit that jawn [thing] down." He added, "You gonna get a better outlook of it if you're around a group of dudes … that you're comfortable around." This was an inadvertent outcome of the focus groups as in each group, some member educated another about how HIV test results were delivered or how to ensure that condoms were available for the heat of the moment. For example, in response to a participant's disclosure about how he feared that searching for a condom might disrupt the flow of sexual activities, Quentin first acknowledged and empathized with Kirk's quandary: " It's like hypnotizing, it's like sometimes you get put under the spell and like in the heat of the moment, and you just like, I'm gonna get this [sex] right now." Then he shared his strategy for ensuring consistent condom us, "But now I have condoms on standby, like everywhere. I make sure condoms are everywhere. Therefore, you don't have to kill the

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mood by doin' that. Make sure they are everywhere so I always can grab them." In another focus group, respondents shared ideas about where to obtain free condoms in Philadelphia.

Discussion

Magic Johnson's HIV-positive announcement remains a watershed moment relevant to Black heterosexual men and HIV/AIDS. With the exception of the recent media blitz devoted to the 20th anniversary of Johnson's announcement, however (Moughty, 2011), media and public health awareness of Black heterosexual men's HIV risk has dwindled markedly since the 1991 announcement. This attrition may reflect that much of the media's HIV/AIDS coverage has historically spotlighted Magic Johnson, a celebrity who is Black, rather than ordinary Black heterosexual men and communities disproportionately affected by HIV/AIDS (Cohen, 1999). Meanwhile, the incidence and prevalence of HIV/AIDS for Black heterosexual men has steadily increased. In light of this, this study aimed to examine the rank and role of HIV/AIDS in the lives of a sample of Black men who were clients of a local CBO. And, with an eye toward developing a future HIV-prevention intervention, the study also aimed to gain a culturally grounded understanding of Black heterosexual men's stated HIV prevention needs.

Grounded in the voices and reported experiences of the Black men who participated in the study, our research advances knowledge about Black heterosexual men's HIV prevention needs, in ways that can inform future HIV prevention research, interventions, and policy. The study has several noteworthy findings. The study empirically documents that although Black heterosexual men may be relatively invisible in HIV prevention messages and research and interventions compared with Black heterosexual women and Black MSM, HIV/AIDS is far from invisible to them. With poignant detail and candor, participants shared their fears that they might be HIV positive as a result of their former drug and sexual risk behaviors. Moreover, the majority of the participants recounted knowing a family member or friend who was living with or had died of HIV/AIDS-related complications and/or having observed fellow inmates suffer with HIV/AIDS.

Consistent with the findings of a previous HIV-prevention focus group study with Black heterosexual men (Essien et al., 2005), many of the participants in the current study reported that knowing someone with HIV/ AIDS and observing the effects of the disease firsthand had served as the catalyst for them to reduce their own risk behaviors. Motivations to protect their children and other family members from HIV also figured prominently in many of the focus group narratives. Intimate relationships and the dynamics within them (e.g., relationship power, condom communication and negotiation, sexual violence) figure prominently in much of the HIV-prevention theory, research, and interventions focused on Black heterosexual women (e.g., Amaro, 1995; Wingood & DiClemente, 1998), not so Black heterosexual men, however. This presumably is a relic of traditional gender ideologies and stereotypes that posit that men are not as relationally oriented as women. Our study's findings counter this view, however. Our findings are consistent with previous qualitative research that has highlighted the importance of relationally oriented norms, such as feeling connected to and responsible for the family as core gender ideologies for Black men (Hunter & Davis, 1992, 1994).

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In recent years, with increasing frequency and urgency, HIV prevention researchers have emphasized the importance of social–structural context for understanding and addressing the disproportionate toll of HIV/AIDS in U.S. Black communities (Adimora & Auerbach, 2010; Blankenship, Friedman, Dworkin, & Mantell, 2006). Our study's findings further bolster this perspective. With 22 of the 28 participants reporting histories of incarceration, our analyses highlight how Black heterosexual men's HIV risk and that of their sexual partners may be yoked to the social-structural context of incarceration. Indeed, incarceration serves as a screen onto which many of the study's narratives were projected. For example, jails and prisons were the sources to which several men attributed their "wake-up calls" that they were at risk for HIV, the sites where many were tested for HIV, and the places where the sight of other inmates living with HIV/AIDS motivated many respondents to reduce or eliminate risky behaviors.

One of the study's most disturbing narratives relative to incarceration and risk was Shareef's description of having the halfway home to which he was released post-incarceration confiscate the condoms he had purchased because condoms were prohibited. Eradicating institutional obstacles to condom use such as this are obviously essential to reduce HIV risk in Black communities. There is also a clear need to intervene in the direction of human behavior. Men who as a result of their incarceration have not had sex for a while are, participants in our study inform, highly motivated to seek out sex. Thus, there is a need for education and advocacy to change policies that impose barriers to condom use in facilities such as the halfway home that Shareef described. Collaborative partnerships between academic researchers, community-based organizations, and staff and peer educators in prison and jails provide a model for such education, advocacy, and policy change (Grinstead, Zack, & Faigeles, 1999). There is also a need to facilitate HIV-protective behaviors for newly released men by building on the lessons of efficacious interventions that bridge sexual-risk reduction during incarceration with community reentry (Wolitski, 2006). Research further bolsters the efficacy of HIV interventions that are specifically tailored to men, such as those with histories of incarceration (Henny et al., 2012).

As for what Black heterosexual men say they want and need to protect themselves and their partners from HIV, results show that they want to know how to encourage their partners to be tested for HIV in nonstigmatizing ways. Recognizing the importance of consistent condom use, they need strategies to stay disciplined about condom-use when tempted not to use condoms. And they want more education tailored to them in ways that foster dialogue. Our study suggests that opportunities for peer education and group-level interaction might be especially effective ways to educate Black heterosexual men about HIV prevention, and more importantly provide them with opportunities to learn effective strategies for HIV prevention from other Black heterosexual men. The focus groups demonstrated numerous examples of this, with participants exchanging knowledge about HIV/AIDS and prevention and successful strategies about condom use and HIV testing.

There are several limitations to our research. The first is that the sample consisted of a group of men who were enrolled in a community-based program designed to boost men's workforce, personal, and fatherhood development skills. As such, this sample may be more relationally oriented than men not enrolled in such a program. This may also explain the

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multiple references to the importance of protecting children and partners from HIV. Participants were also older, a theme recounted often in their narratives about tiring of chasing women and how they behaved when they were younger. Moreover, most of these participants had histories of incarceration. Thus, study findings may be more reflective of these demographics. That is, a similarly focused study with other groups of Black men (e.g., younger men, men without histories of incarceration, MSM, higher socioeconomic status men) may have yielded different narratives about the rank and role of HIV/AIDS or men's HIV-prevention needs. Social desirability is another limitation. Despite several participants' acknowledgements that they had concurrent partners, or had previously engaged in drug and sexual-risk behaviors, in general men reported behaviors that were more protective (e.g., HIV testing, using condoms, being monogamous) than risky. The fact that focus group participants were classmates at the CBO and thus knew each other implies that men may have been less likely to share stigmatizing experiences, such as having had same-sex sexual experiences. It is also possible that participants' responses to the focus group facilitator's questions about how HIV factored as a priority in their lives may have reflected social desirability bias toward the facilitator and/or other group members.

These limitations notwithstanding, our study highlights at least four noteworthy implications for HIV prevention interventions for Black heterosexual men. The first implication pertains to how to prioritize HIV prevention within the list of low-income Black heterosexual men's competing life priorities. One of the study's most interesting findings was that when asked to list their top three life priorities, none of the participants mentioned HIV/AIDS. However, when the focus group facilitator prompted them to reflect on where HIV prevention factored into their list of priorities, many participants were emphatic about the importance of reducing HIV transmission to their partners and protecting their children from HIV risk. Echoing the results of a recent meta-analysis of HIV interventions for Black heterosexual men (Henny et al., 2012), our study suggests that HIV prevention messages and interventions that highlight Black men's role as family protectors may be used effectively to engage Black heterosexual men in HIV prevention efforts.

Second, the study has implications for how HIV prevention education can be infused within existing programs and services for Black men. Our study shows that just because men do not spontaneously articulate HIV as a priority does not mean that it is not a priority for them. Nor is HIV/AIDS just abstract or theoretical. HIV/AIDS was salient in the lives of many of the study's respondents either because they knew a close acquaintance with HIV/ AIDS, had observed men with HIV/AIDS while incarcerated, or they had received "reality checks" about their own risk behaviors. This suggests that effective HIV interventions for Black heterosexual men are likely to be those that infuse HIV prevention messages and skills within existing community-based programs and services (e.g., workforce development, community reentry postincarceration, violence prevention, fatherhood development) that are priorities for Black men (Bowleg & Raj, 2012). Helping to ensure that Black heterosexual men, their partners, and communities are free from HIV aligns naturally with the goals of many traditional non-HIV/ AIDS-related programs designed to improve Black men's overall health and well-being.

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The third implication of the study is that information and education alone are not likely to be sufficient to reduce Black heterosexual men's HIV risk behaviors. The information–motivation–behavioral skills model (IMB), which posits that HIV prevention information, motivation, *and* behavioral skills determine sexual-risk reduction behaviors (Fisher & Fisher, 1992), provides empirical insight into why this is the case. Numerous IMB studies, including those with exclusively or majority samples of Black heterosexual men (R. A. Crosby et al., 2008; R. Crosby, DiClemente, Charnigo, Snow, & Troutman, 2009; Kalichman, Cherry, & Browne-Sperling, 1999), have documented the efficacy of the IMB for sexual-risk reduction. Our study demonstrated that many of the participants were knowledgeable about HIV/AIDS and HIV prevention, but several narratives about not using a condom when one was warranted may reflect low motivations for condom use. Similarly, narratives about fumbling with condom wrappers, not wanting to disrupt the heat of the moment to get condoms, and questions about how to talk to partners about HIV testing also highlight a lack of behavioral skills relevant to sexual-risk reduction. These findings suggest that IMB-influenced interventions may be effective for bridging HIV knowledge, motivation and behavioral skills to increase Black heterosexual men's protective behaviors.

Finally, our study has implications for the format and kinds of innovation that may be needed to successfully engage Black heterosexual men in HIV prevention initiatives. For example, participants in our study were emphatic about their desire to learn more about HIV prevention in settings that facilitated dialogue and the sharing and receiving of HIV prevention information in groups of men with whom they felt comfortable. Although none of the study's respondents mentioned barbershops, community-based HIV prevention barbershop programs such as those of Project Brotherhood in Chicago (Project Brotherhood, 2011) and Project StraighTalk's Barber and Beautician STD/HIV Peer Education Program in Durham, North Carolina (The U.S. Conference of Mayors Best Practices Center, 2001) demonstrate that barbershops are innovative and culturally appropriate sites for the kinds of interactive HIV prevention education that men in this study said they wanted. Indeed, recent research highlights that not only did Black heterosexual men consider barbershops to be reliable and trustworthy sources of HIV prevention information, most were enthusiastic about barbershop-focused HIV prevention programs (Baker et al., 2012a).

Family, self, spirituality/religion, and money—these, not HIV prevention, were the top priorities that participants articulated when first asked to state their top life priorities. Our study spotlights that the omission of HIV/ AIDS from the list of Black heterosexual men's top priorities is not at all indicative of the rank and role of HIV/ AIDS in their lives. Rather, it suggests that unemployed Black heterosexual men with histories of incarceration have other personal and social-structural realities that trump concerns about HIV. It is also likely that this reflects how rarely Black heterosexual men are the focus of HIV-prevention messages and HIV-prevention research and interventions. A case in point: although African Americans are the primary focus of the CDC's (2012) 5-year $45 million *Act Against AIDS* communication campaign, none of the agency's three targeted campaigns specifically mention Black heterosexual men. Our study signals that despite their invisibility in HIV prevention efforts, Black heterosexual men are not oblivious to their HIV risks and want and need more HIV prevention education and skills to protect themselves, their children, and their partners from HIV. The continued omission of Black heterosexual men from most HIV

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prevention initiatives inadvertently risks ensuring that too many Black heterosexual men will continue to rely on their "little heads over their big heads" in the absence of HIV prevention efforts designed specifically and explicitly for Black heterosexual men.

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Table 1.

Demographic Characteristics of Focus Group (FG) Participants ($N = 28$).

Characteristic	Total sample (N = 28); n (%)	FG 1 (n = 7); n (%)	FG 2 (n = 7); n (%)	FG 3 (n = 7); n (%)	FG 4 (n = 7); n (%)
Age in years; mean (*SD*)	34.7 (9.29)	37 (8.71)	33.14 (8.49)	35.57 (11.23)	33.43 (10.11)
Age range (in years)	19–51	27–50	21–45	21–51	19–46
Annual income range ($)					
0–4,999	7 (25)	1 (14)	3 (43)	1 (14)	2 (29)
5,000–9,999	1 (4)	0 (0)	0 (0)	1 (14)	0 (0)
10,000–14,999	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
15,000–19,999	3 (11)	1 (14)	0 (0)	1 (14)	1 (13)
20,000–24,999	1 (4)	1 (14)	0 (0)	0 (0)	1 (14)
25,000–29,999	1 (4)	0 (0)	0 (0)	0 (0)	0 (0)
Employment status					
Employed	3 (11)	0 (0)	0 (0)	1 (14)	2 (29)
Unemployed	23 (82)	6 (86)	6 (86)	6 (86)	5 (71)
Relationship status					
Single	21 (75)	4 (57)	6 (86)	5 (71)	6 (86)
Married	1 (4)	1 (14)	0 (0)	0 (0)	0 (0)
Living with partner	4 (14)	2 (29)	0 (0)	2 (29)	0 (0)
Highest level of education					
Some high school	4 (14)	1 (14)	2 (29)	1 (14)	0 (0)
High school graduate/GED	17 (61)	5 (71)	4 (57)	3 (43)	5 (71)
Some college/vocational school	4 (14)	0 (0)	1 (14)	2 (29)	1 (14)
Incarceration history					
Yes	22 (79)	6 (86)	6 (86)	5 (71)	5 (71)
No	2 (7)	0 (0)	1 (14)	0 (0)	1 (14)