

**Behavioral Risk and HIV Service Needs
of At-Risk African Americans
in Five California Regions**

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**One Love: African American HIV Prevention
Capacity Building Project**

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Executive Summary

From June through August 2007, focus groups were conducted with African American men who have sex with men (MSM), and high risk women, in five regions in the state of California. One hundred and twenty-six participants attended seventeen groups for young men who have sex with men (between the ages of 18-24), men who have sex with men (ages 25 and up), and “high-risk” women (with sexual and injection risk). Participants discussed social, economic, and psychosocial issues that impact their ability to engage in healthful behaviors, and provided feedback on their experiences with HIV services and suggestions for improvement.

Participants in every population discussed struggling with: basic survival issues (housing, employment, access to health care), multiple stressors and health issues, difficulty prioritizing self-care, fluctuating self-esteem, and challenges protecting themselves from HIV despite education about transmission. All populations cited economic issues, depression, substance abuse, and unequal relationships as factors that contribute to their engagement in sexual risk-taking behavior. MSM populations stated that issues that impact health and well-being for themselves and members of their community included acceptance from family, community, and church. Women stated that issues surrounding maintaining relationships with men, including men on the down low (men who engage in undisclosed sex with men), made it difficult for them to engage in healthful behaviors and contributed to their risk picture.

Participants expressed concern about the lack of African American staff and programming at HIV service organizations; experiences of mistreatment from HIV service providers; incompetent providers; and funding issues, including misappropriation of funds intended for African American populations. Participants emphasized the need for culturally competent services for their communities, including: wrap-around services (multiple supportive services), assistance with basic survival issues, African American-specific HIV prevention programs, education about HIV transmission, health management resources, social support and empowerment opportunities, mobile testing, and online information resources.

I. Background

In California, African Americans represent over eighteen percent of all AIDS cases, yet African Americans are less than seven percent of the state's population.¹ One Love is a statewide African American HIV Prevention Technical Assistance and Capacity Building Project funded by the California Department of Public Health Office of AIDS. The purpose of the project is to reduce the incidence of HIV/AIDS among California's African American communities through a collaborative, interdisciplinary approach including augmentation and development of regional coalitions, invigorating a statewide movement, community-based research, policy advocacy, web-based informational resources, training, and technical assistance. The project focuses on the following five California regions: Sacramento/Central Valley, Bay Area (Alameda/San Francisco), Los Angeles, Inland Empire (San Bernardino/Riverside), and San Diego.

As part of our efforts to organize African American communities affected by HIV/AIDS and solicit community input on the direction and delivery of technical assistance services, we sought qualitative data on issues of concern amongst consumers and community members. The California State Office of AIDS directed the parameters of the One Love Project, as well as this focus group project, to specifically target men who have sex with men, and "high risk" women. This statewide focus group project was conducted in five California regions, with the goal of gaining a better understanding about psychosocial and life issues that contribute to behavioral risk, experiences with HIV prevention services, suggestions for improvement of services, and how to direct technical assistance efforts.

Past Research

This qualitative research project examines behavioral risk and HIV service needs of at-risk African Americans. It prioritizes the voices of the community by bringing their spirit and expertise to life through numerous quotes throughout this report. The following is a selection of other research that furthers understanding of African American populations at risk for or living with HIV/AIDS.

The "Systematic Review of HIV Behavioral Prevention Research in African Americans" is an overview of African American HIV prevention intervention research, with a focus on the following populations: MSMs, injection drug users, heterosexuals, and youth. <http://hivinsite.ucsf.edu/InSite.jsp?page=kb-07-04-09>. For a good overview article on African American issues, see "HIV/AIDS case profile of African Americans: guidelines for ethnic-specific health promotion, education, and risk reduction activities for African Americans," Williams PB, *Family and Community Health*. December 2003; 26(4):289-306. In addition, the Center for AIDS Prevention Studies, University of California, San Francisco has conducted numerous California-based research projects on African American populations, <http://www.caps.ucsf.edu>.

¹ California Department of Public Health, Office of AIDS. "HIV among African Americans," Fact Sheet, 2/07

“A National Black Gay Research Agenda” provides an excellent directive for further research on the African American MSM population.

http://www.naesmonline.org/aesm_pdf/BGMRA.pdf. Some of the earlier research on the African American MSM population includes the African American Men’s Health Study, <http://www.caps.ucsf.edu/projects/AAMHS/>. For an overview fact sheet, see “Black Men’s HIV Prevention Needs,” <http://www.caps.ucsf.edu/pubs/FS/blackmen.php>. An excellent San Francisco-based project is “Impoverished African American men who have sex with men lack basic sexual risk information and have high levels of sexual risk for HIV/AIDS.” Crosby GM, Williams AM, Bein E, Durazzo R, Headlee J, Bey J. *Int Conf AIDS*. 2000 Jul 9-14; 13: abstract no. WePeD4773.

<http://gateway.nlm.nih.gov/MeetingAbstracts/102241144.html>. For information on Project START, a study of young men being released from prison, go to: <http://www.caps.ucsf.edu/pubs/reports/pdf/STARTS2C.pdf>

Though the following article is not African American-specific, it provides an excellent overview of issues affecting African American women. “Pathways of Risk: Race, Social Class, Stress, and Coping as Factors Predicting Heterosexual Risk Behaviors for HIV Among Women,” Ickovics JR et al, *AIDS and Behavior*. December 2002; 6(4):339-350. An important California-based study and intervention is the HOME (Health Options Mean Empowerment) Project. The purpose of the HOME project was to design and test an intervention for women whose male partners were being released from San Quentin State Prison. The women were primarily low-income women of color. Prior to designing the intervention, qualitative and quantitative formative research was conducted.

<http://www.caps.ucsf.edu/projects/Centerforce/HOME.php>.

Sisters Informing Sisters on Topics about AIDS (SISTA) is a group-level, gender- and culturally-relevant intervention designed to increase condom use among African American women. For information on the SISTA Project: A Peer-Led Program to Prevent HIV Infection Among African American Women, go to <http://www.effectiveinterventions.org/go/interventions/sista>. A related article is DiClemente RJ and Wingood GM. (1995). “A randomized controlled trial of an HIV sexual risk-reduction intervention for young African American women.” *Journal of the American Medical Association*, 274 (16), 1271-1276.

<http://jama.ama-assn.org/cgi/content/abstract/274/16/1271>

Eligibility Criteria

For the purposes of this project, there are three populations:

- Young African American men who have sex with men between the ages of 18 and 24 (YMSM);
- African American men who have sex with men, ages 25 and up (MSM); and

- High risk African American women, defined as follows:
 - Women who are injection drug users (IDUs) and/or whose partners are IDUs
 - Women whose male sexual partners have recently been incarcerated
 - Women who have multiple sexual partners
 - Women who have sex with men who have sex with men (WSMSM)

Methods

This project was a collaborative effort among all of the One Love staff and consultants. Research Consultant Willy Wilkinson worked with Executive Director Madalynn Rucker, Regional Coordinator Clarmundo Sullivan, Project Manager Jamal Bey, and Evaluation Consultant Keith Baker to design the project, including identifying the populations to be surveyed, establishing eligibility criteria, developing the focus group questions, and planning for implementation. Administrative Coordinator Patricia Wells screened potential participants and arranged for recording devices and transcription services. Regional coordinators Clarmundo Sullivan, Gloria Crowell, Michael Torrance, Nosente Uhuti, and Verna Gant worked with local HIV prevention organizations to identify and recruit potential participants and secure meeting locations. In addition, they distributed flyers through local outreach efforts, including street-based and venue-based outreach.

Participants were screened by phone at a central location, on a toll-free number available during normal business hours. In order to establish rapport and comfort level, all focus groups were population-specific. Each of the regional coordinators, as well as an additional facilitator, Terry Evans, facilitated the groups. An incentive of a \$25 gift card was provided to each participant upon completion of the group.

Seventeen groups were conducted statewide from June through August 2007. A total of 126 participants attended. Twenty-nine participants attended four groups for YMSMs, 41 participants attended six groups for MSMs, and 56 participants attended seven groups for women.

The focus groups were electronically taped and uploaded. The data were then transcribed verbatim by multiple transcribers at a San Francisco transcription service. Wilkinson conducted the data analysis by coding them into categories that emerged from the data, and documenting topics in order of priority as indicated by participant comments. Wilkinson wrote the report and developed summary Powerpoint presentations for the aggregate data, as well as separate presentations highlighting region-specific data. In these reports and presentations, categories and subcategories are displayed in the order of this documented priority.

Limitations

Though this focus group project is large-scale, it was not intended as a scientifically rigorous endeavor; rather the project was a community-driven effort to identify the current issues, concerns, and needs of African Americans at risk for and living with HIV/AIDS, in each of the five regions. A primary goal was to identify gaps in services from the consumer perspective in order to inform how to direct and deliver technical

assistance and capacity building services to entities providing HIV/AIDS services to African American communities. A secondary goal was to use the focus groups as an opportunity for regional coordinators to establish and enhance relationships with local providers and organizations as part of their community organizing and coalition building efforts.

Thus, there were a number of limitations, particularly with regards to the data collection process. Rather than adhere to a strict research protocol, potentially involving outside researchers with few or no ties to local communities, primary importance was given to having facilitators that were One Love regional coordinators, and members of each local community, who could recruit and establish a rapport with participants. Although efforts were made to maintain consistency in the facilitation of the focus groups, there were multiple facilitators with different styles and approaches to time management.

As we planned for the implementation phase, we were aware that the focus group instruments had too many questions; but since we were eager to obtain a great deal of information, we decided to keep the high number of questions and request that facilitators not spend too much time on each question. If facilitators were not able to move the discussion forward relatively quickly, the group was unable to respond to all the questions. One group scheduled a second meeting in order to complete the group.

In addition, there were some technical difficulties and transcription issues. Facilitators used electronic recording devices that were not fully charged; in four groups the recording device stopped working halfway through and abruptly ended documentation of the group. Like other recorded data collection efforts, there was some loss of data in the transcription process when the transcribers were unable to determine what was being said. Transcribers did not attend the groups and thus did not enumerate the participants, so they were not able to distinguish one from the other during the transcription process. Still, this approach was effective in that it allowed for a more intimate comfort level within the group, since there were no outside researchers in the room.

Because of the compelling nature of the discussion, time management issues, and technical difficulties, there was ultimately more focus on behavioral risk and less focus on gaps in services. Nonetheless, participants were very forthcoming and did provide useful feedback on their experiences with local service providers, in addition to deeply honest self-assessments of difficult behavioral risk issues.

The scale of the project was broad in that we sought information from participants from diverse regions throughout the state. Because of the considerable differences among and between the state's five regions, the populations exhibited great differences not only from other populations, but also amongst members of the same population. This breadth sometimes made it difficult to generalize on the outlooks, concerns, and struggles of each population. Finally, despite considerable efforts on the part of regional coordinators, not every population was accessed in every region.

II. Resiliency in the African American Community

Many needs assessments focus on behavioral risk, unmet needs, and gaps in services, with little or no focus on strength and resiliency. Indeed we sought data so we could gain a better understanding about not just “what is working,” but primarily “what’s not working.” The result is that research on marginalized communities often depicts a gloomy picture of challenges and struggles, without much attention to community successes. This report is no exception.

While many of us are inspired and motivated to action by the harsh realities of our lives, we are also inspired by stories of our survival and resiliency. With that in mind, we want to begin by first highlighting the profound resiliency in the African American community. Participants of every population and region demonstrated tremendous strength of spirit, intention to care for their health and well-being, and willingness to be vulnerable to discuss difficult issues in their lives. They exhibited profound loyalty, commitment, and care for their community.

Women: “I try to just do the best I can and be there for my family, regardless if they’re young, old, or whatever. Just be there for them. And what I’ve been learning to do is love myself, because in order to love others, I have to be able to love myself first.”

MSM: “Being clean now, people look at me in a different way. I had a hard time accepting the fact that I do have boundaries now, and I do have opinions that are valid, and people take my ideas and use them. It’s still tough for me to believe that, but it’s happening. But my life done did a 360.”

YMSM: “Success. I mean just being happy with who I am, as far as myself. I mean, there are some other things, but as far as being gay, I’d rather be happy as a gay person instead of being someone who is confused and all the time worrying about what other people are going to think. I ain’t got time to worry about everybody.”

III. Overview of Issues

Overview of Life Issues that Contribute to Behavioral Risk

Participants stated that they are dealing with multiple issues that impact their ability to prioritize self-care, such as access to stable employment, housing, and health care, the essential triad that directly affects community health and well-being. In order to assist consumers and facilitate healthful behaviors, service approaches need to first recognize and address these life issues. All populations described, to varying degrees, struggling with basic survival issues:

- Financial Stability
- Education
- Housing/Homelessness
- Employment: getting a job; establishing and developing a career
- Access to health care
- Relationships with family, community, and church
- Drug addiction
- Prostitution
- Recidivism
- Concern about younger generation

Most Important Health Issues

Participants were asked to describe the most important health issues in their lives. Most participants simply called out these topics without going into them in-depth, so it is not clear how many of the participants are personally living with these health concerns and how many perceive these health issues as prevention concerns. Their responses, by population, are as follows:

YMSM:

- General health
- Protecting from HIV and other STDs
- Proper nutrition
- Appropriate weight
- Mental health
- Substance abuse
- Managing stress
- Obtaining health insurance

MSM:

- General health
- Protecting from HIV, Hep C and other STDs
- Living with HIV
- Substance abuse
- Mental health
- Heart disease
- High blood pressure

Diabetes
Proper nutrition
Smoking
Weight management

Women:

Access to health care
Childcare
Difficulty prioritizing self-care
Protecting from HIV and other STDs
Living with HIV
Substance abuse
Mental health
Managing stress
Weight loss
Smoking
Cancer
Asthma

Psychosocial Issues

All populations described struggling with mental health issues because of multiple stressors:

All populations: Depression

YMSM and MSM: acceptance, disclosure of sexual orientation, isolation, self-esteem, incarceration, child abuse

YMSM: unequal relationships with older men

Women: domestic violence, safety, unequal relationships with men, self-esteem, substance abuse, concern for kids and grandkids, relationships with Down Low and incarcerated men, child sexual abuse

Substance Abuse

Though there were no questions that specifically addressed this issue, all populations described substance abuse as a common behavioral risk factor for themselves and members of their community. Many participants described the use of alcohol and drugs as a frequent component and contributor to engaging in sexual risk-taking. Though many participants, particularly women, spoke about drugs in the general sense, a number did specify which drugs they and members of their communities use, as follows:

YMSM: Alcohol, marijuana, methamphetamine, ecstasy, crack, pills

MSM: Alcohol, marijuana, methamphetamine, ecstasy, cocaine, crack, pills

Women: Alcohol, heroin, crack, ecstasy, pills

Women: “I think drugs, especially crack cocaine, because I know it's taken me personally to some places I never thought I'd go. And sex with some Tom, Dick, and Harry's, you know?”

IV. Social and Community Issues

African American Community

YMSM and MSM populations were asked what the African American community does not understand about them as men who have sex with men. Participants were very vocal about the need for acceptance, equality, respect for, and education about the realities of their lives. Repeatedly, participants stressed that they are human beings, that they are men, that their lives are not over, and that they are responsible members of the African American community. Participants often described taking care of their families and communities, even when they were not respected or cared for by them.

YMSM: “I think a lot of times people in the black community think that all gay men are about sex, drugs. The person in my life right now has been a really big influence on me, as far as what I want to do, school-wise and getting a job, and making sure my priorities are lined up. I think that's what the black community doesn't understand.”

YMSM: “The biggest misconception is that it's my personal choice to be attracted to another man. Now, it is my choice to act on that attraction, but I really don't feel like it's my choice to have that attraction to another man. So that's the biggest question I've gotten from both my parents and just from people in my life in general, is why would you choose to be gay.”

YMSM: “My Mom, she thinks that it's her fault, so that's another big misconception that black people have. My Mom is like, ‘What did I do wrong? I knew I should have had you with your father. I knew I should have done this, and I knew I should have done that.’ I'm like, ‘You did an excellent job. How dare you say, What did you do wrong?’”

Family

Though there were no questions that specifically asked about this topic, all populations spoke about the importance of family, and described struggles that they are having with members of their families. YMSM and MSM populations spoke to issues of homophobia and varying levels of acceptance by parents and other family members. Many women described the hurt that family members exact upon them because of misconceptions and stigma associated with HIV. They also lamented their desire to live for their kids and grandkids, and their frustration with too much responsibility for the care of children.

YMSM: “Well, my two brothers, they turned out to be horrible boys. They sell drugs; they're just horrible. So I told my Mom, ‘Well, I could be like that, or I could just have sex with another man, but be able to take care of you when you turn 60.’ She's like, ‘Oh well, you know, you have a good point. You probably could take care of me now.’”

MSM: “When I came out it just really destroyed my family to a point where I lost my dad. He don't even love me anymore. He turned his back on me. It hurts right now.”

MSM: “I went through the long, long period with my family. Like my brother, who's a minister, and he could accept everything but the fact that his youngest brother is gay. And I said, okay, at the time my nephews were young, he doesn't want me taking them anywhere. I'm still the same person, still the same brother that I was before you knew.”

Women: “Women come into our groups and they talk about they disclose to their families or haven't because of the stigma and how they're going to get treated and the fear of rejection. ‘Here's your cup, here's your fork, here's your plate,’ and they bleach behind after you use the bathroom, you know, stuff like that, and it hurts.”

Church

Though the focus group questions did not specifically inquire about this issue, MSM and YMSM participants repeatedly described the powerful influence of homophobia in the church and its effect on the larger African American community, the hypocrisy of down low pastors, and the reality of church as a meeting place for many MSMs. The church was portrayed as a complex entity that, despite community yearnings for spirituality and its positive elements, is often perceived as destructive to African American men who have sex with men.

MSM: “I don't want to jump on our religious people, but because of our religious beliefs and all the lies we tell about each other, until we as individuals stand out there and be seen as human beings, as total human beings, then the down low brothers and sisters are going to stay like that.”

YMSM: “I've been from church to church because the churches that I've been going to lately have not been the churches for me. It's like every time I walk in there and they see me, they always have something to say about a gay person, and I don't understand why. It just always happens.”

MSM: “I go to church like everybody else, I've heard so many pastors preach a lot of different things, and I know a lot of pastors that have done a lot of things, and so it is the education part of it all. And who are you to say what I'm doing is wrong?”

MSM: “Church is one of the messiest places on earth.”

Incarceration

Again, though participants were not specifically asked about this issue, all populations described having some experience with incarceration. Participants described both positive as well as negative experiences with the prison system. Women, in particular, indicated that prison provided sound education about HIV transmission and excellent peer counseling, from which they benefited. MSM and YMSM populations described prison as offering opportunities for sex with multiple male and transgendered partners; YMSM were introduced to sex with men while incarcerated as minors.

Male participants indicated that one can obtain anything in prison, and that even though condoms are available in the yard, there is limited or no condom use. Female participants indicated that there is limited HIV testing unless requested by the inmate, and limited HIV/AIDS medical care. Both male and female participants also indicated recidivism as a concern.

In this first quote the participant self-disclosed what many participants, both male and female, described as a common concern in the African American community: sex with multiple male partners on the down low.

MSM: “Well I had about fifteen different men in prison and then I had my wife. Oh yeah, they identify as straight heterosexual. But then when I come out here, I see two people yesterday, I'm with my wife. Well, she don't know this.”

MSM: “I've experienced a lot of men behind the walls of prison. They're lonely. So, they want someone laying beside them, they want someone that they can become a little more intimate with.”

Women: “And I don't believe you sit in there and not having sex and masturbating. So it's not just stereotyping, because not every black male is in that situation, but I think we need to start being truthful. And I don't want to tell them to get tested while they're in there, because they are ostracized, they are singled out. But I think they should be tested on the way out, so that they know. And I think, as women, I know, for me, sometimes, in the beginning, I used to do Russian Roulette. So I didn't use the condoms. I was young. It's like, I'm free. What do I worry about?”

MSM: “A lot of men out here that do mess around, they come from prison. They grew up in the streets out here like a lot of dudes that I know, that I grew up with that was gang-banging. They get out under the DL because they've been locked up since like 16 or 17. They've been locked up for 10 years, and when they get out that's all they know. It's all on the DL. When they get out they are on the prowl.”

Identity for MSMs

YMSM and MSM populations were asked how they and members of their community describe their identities as men who have sex with men. They used numerous terms and expressions, with some variation by region:

YMSM: gay, bisexual, same gender-loving, straight, punk, DL thug, pimp, girl, trisexual, bitch, slut

“I mean, some people, you know, when they're around other young African American males who like males, they're gay. When they're around straight people or whatever, they're bi. When they're at home, they're straight. So I mean, for some people, it depends on who they're with and where they're at.”

MSM: gay, bisexual, same-gender loving, DL, straight, queer, man, sister man, transgender, androgynous, uncle, family, other, unidentified

“I have friends who say they're straight and they've only been with men. And they say they're straight and they're gonna get married to a woman someday.”

“By being a member of the community for ten years now, I've been able to accept who I am and be around different types of -- there are different categories of gayness, I've learned. There's just not one category. You know?”

A Note on Transgender Issues

Though there were no specific questions that addressed gender identity, some of the YMSM and MSM participants identified and lived as transgendered persons. In one group (YMSM), participants referred to each other with female pronouns and mentioned presenting as female at least some of the time, but did not use transgender-specific terms to describe themselves, referring to themselves as “gay,” “bitch,” and “slut.”

There is some overlap between the identities and HIV-related concerns of male-to-female (MTF) transgendered persons, especially those who have not transitioned to a full-time cross gender identity and presentation, and MSM populations. Sometimes research on transgendered individuals, however, is mistakenly conflated with MSM identities. During the planning phase, it was decided that this project would specifically focus on MSM populations, relying on the self-identification of respondents. While a few of the participants were on the MTF transgender spectrum, all of the participants in MSM groups identified as MSM, so there was no conflation of MTF populations with MSM populations.

MSM: “You know transgender? Androgynous right now. You know, when I finally get my work done that I want, then I probably won't be able to come to no more of these things. You know, when I do what I'm going to do with my life. So androgynous.”

Relationships with Down Low Men

Though the focus group questions did not specifically ask women about this issue, a few women did choose to disclose their experiences with male sexual partners on the down low. Their descriptions varied from more direct, in this first example, to more vague, in this second quote.

“I've been with the same man for five years, one man -- five years. I'm not reckless, but I'm scared all the time. I have heard, on his voice mail, a man on there. My man has done six years in the penitentiary before our relationship began. I never knew that he had any tendencies, you know what I'm saying? And I heard a man on there telling my man, ‘Happy holidays’ and ‘Again, I love you.’”

The facilitator did clarify that the woman speaking in the following quote was in fact describing her relationship with a down low man. Her indirect manner is illustrative of how she appears to cope with the knowledge of her situation:

“I tend to maybe ignore some things. Like maybe there are gaps in the reality of my relationship and I just ignore them. I ask a question. Huh. Well, I know that's not the truth, but then maybe it is because that's not my truth. You know, things just don't fit all the time.”

V. Protecting from HIV

All populations candidly described multiple challenges protecting themselves from HIV despite education about transmission. In addition to the need for accurate, accessible information about HIV transmission, participants described a myriad of psychosocial and economic issues that contribute to behavioral risk for themselves and members of their community. Participants discussed lack of motivation for self-care, denial, fear of stigma, substance abuse, trust issues, unequal relationships, economic survival, intentional infection of others, and access to benefits as contributors to sexual risk-taking behavior.

Misconceptions about HIV

Though some participants were confident that the issue is not that people are uninformed, there were indeed participants primarily from the women and YMSM populations who had questions and inaccurate information about HIV transmission and treatment. These focus groups provided an opportunity for the exchange of information and referrals after the close of the recorded session.

Women: "It's like one minute they say, 'Okay, you can't get AIDS from kissing.' Now five years from now, they'll go, 'Oh! Oops! Our bad. You can get AIDS from kissing.' You feel me?"

Women: "If there ain't no blood on the toy, how you going to get it?"

Women: "I don't know if you can sit on a public toilet seat and get it. You might have a cut on your leg and then somebody just got finished urinating and then you don't know there's urine on the seat."

YMSM: "A lot of the young MSM think that if they make the guy pull out, then they're not going to contract it. Or if they let a guy ejaculate in their mouth while performing oral sex, as long as they spit it out, they're not going to contract it."

YMSM: "I'm going to tell you like this, my opinion of HIV. HIV is a man-made disease to me that they got from some type of animal that they found out in the wilderness somewhere. They decided they wanted to inject it in some black person and just try to wipe us out. It got wild and loose, and didn't go the way they wanted it to go. And they have a cure for it."

Lack of Motivation for Self-care

Participants described their personal behavioral risk as largely related to broader issues surrounding their experience as African American people in the United States. Depression, lack of motivation, fluctuating self-esteem, low expectations for getting their needs met, and expectations surrounding masculine and feminine gender roles, were all discussed as stubborn barriers to their own self-care.

MSM: "A lot of anger and disappointment in the way their life is going. I think a lot of it has to do with just giving up. They just don't care anymore if they catch it or not. There's nothing happening in their life anyway that makes them excited or motivated.

It's a matter of that and their addiction if they have a drug addiction. They go together, hand in hand. I believe the black culture plays a role in some of it. You aren't being a man unless you spread the seeds all over the place.”

Women: “A lot of it has to do with how black American women interact with black American men, or any men, for that matter, because what's gone on in the history of the United States and where black American women are at emotionally. Okay, so they accept a lot from their partners that women in other ethnic groups, basically, would say hell no. Everybody thinks that black American women are these strong sisters, but when they get behind closed doors, that's a whole other ball of wax.”

Women: Maintaining Relationships with Men

Women described being in situations where they knew they should protect themselves, but for various reasons, did not. Female participants emphasized issues of fluctuating self-esteem, the need for attention from a man, the need to maintain a relationship, and the outcome of child abuse as issues that negatively affect their ability to care for and protect themselves. Some participants said that the effect of growing up in a violent, unloving, hostile family environment was that they were desperate for love and ill-equipped to judge when a man was not treating them well.

Women: “We have so much low self-esteem that we're at the point where we will take a risk in order to please a man or to get a man.”

Women: “My sister passed away from HIV in '93. So I know all the risks and everything, and I still, and I don't even know why, I still have unprotected sex. The guy can start off with a condom on and I'll let him take it off.”

YMSM and MSM: Denial and Fear of Stigma

YMSM and MSM populations stated that they and/or members of their community did not use condoms because doing so would be an acknowledgement of their sexual desire for men and/or HIV status, and that the stigma of living with HIV in the African American community affected their ability to use protection. Participants also acknowledged denial about their risk for HIV/AIDS. Though they were aware of the devastating HIV/AIDS epidemic in their community, some participants stated that they did not perceive themselves to be at risk if their sexual partner looked healthy, or if they did not know someone in their own family who was infected.

YMSM: “I think a big part of it -- maybe not in this circle, but in more of the down low type of guys, is the accidental sex. You know, because if you're prepared for it, if you have a condom and lube, then you have the intent to have sex, or you have the intent to have sex with another man. So that creates the whole concept of their rationalizing in their head whether they're gay or not.”

MSM: “A lot of people are having sex and not using a condom. A lot of black people out here, if they got HIV infected, they don't know. They don't know the risk that they're at when they're out there having sex. But, then, a lot of guys that are HIV

positive, they are scared to tell people they are HIV positive because of the alienation that they get from the black community. So they don't use condom protection. It's like nothing ever happened."

MSM: "These cats that have now gotten infected, have got on their meds, have got in the gym, and are now buff and looking fabulous. I'm going to assume that you don't have it 'cause you look all right. You don't look like you trick. You don't look like you do drugs or IV, all that kind of stuff. You look healthy. So I don't mind being with you and you know the brothers don't like wearing condoms, so that's just an easier way to go with it."

Substance Abuse

Though all populations stated that substance abuse was a concern for them and members of their community, women, in particular, described it as a major contributing factor to their behavioral risk picture. Many female participants made references to their participation in a cycle of sex work and substance abuse. They described engaging in sex with multiple partners because they were abusing drugs, and engaging in sex work in order to support their addiction. MSM populations described foregoing condom use while using and abusing drugs and alcohol.

Women: "I feel like first of all drug use, being out there in our addiction because there are so many of us out there in our addiction, and doing whatever it takes. And I'm one who did those same things, was out there sucking, fucking and doing whatever I had to do to get my next hit, and that's all I focused on 24/7, and I didn't care how I had to do it. If it came to not using a condom -- and there were sometimes where it was like I didn't even think about using a condom. 'I'm just going to get this money.'"

The Heat of the Moment

Participants from all populations described the absence of condom use as partially attributed to split second decision-making "in the heat of the moment." Participants described going into situations prepared to use and negotiate condoms, but foregoing their use.

YMSM: "When it's the heat of the moment, you don't really be thinking like, 'Ooh, I feel so good right now. Let me reach back and grab this condom real quick,' you know what I'm saying? You don't be thinking that, you just be in your little zone, your little sexual zone."

Condom Use as a Barrier

Male participants stated that they did not like using condoms because it did not feel the same for them physically and emotionally. They stated that using condoms made them feel less intimate with their partners and less "normal" in their lives.

YMSM: "You want to feel like you have as normal a life as possible. You want to feel like everybody else gets to feel, like you can be intimate with your partner, like

everybody else is intimate with their partners -- and myself included. I'm not going to stand on a soapbox. Even though I know as much as I do, with my partner, we don't practice safe sex all the time.”

MSM: “For me, when I was drinking, really having sex is an emotional thing. Condoms take off the intensity. I took it off because it felt like I was making love without it. With it, it seemed so formal.”

Trust Issues

YMSM and women indicated that issues of love and trust, and relationships with dishonest partners, contributed to their personal risk pictures. Many female participants described male sexual partners who were not honest with them about their sexual activities with men. YMSM participants discussed their concerns about being less guarded with partners who they love.

Women: “My little brothers, when they were in prison, they’d call me and ask me if I slept with so-and-so or so-and-so. And I was like, no, why? ‘Because the dude is sleeping with a dude up in prison.’ A lot of women don’t know what time it is up in there. So when their man comes home, they go back to basics. All the while, he done been with this other brother. And then when you ask, they lie.”

YMSM: “This is kind of sappy, but it's true. My risk is being in love. Because when you are in love, and when you are in a relationship with someone and you have gotten to the point where you can honestly say you love that person, you start trusting them with your body in a way that you know that you won't let anybody else. And I think in a way that can blind your decision to be safe. And I tell friends of mine all the time, ‘Feelings aren't the worst thing that you can catch.’”

Women and YMSM: Unequal Relationships

Women and YMSM populations described being in relationships, past or present, where they did not have full control over condom use. Many female participants described difficulty negotiating condom use in unequal relationships that sometimes involved domestic violence. YMSM participants described being in sexually receptive situations where their partner either did not stop to put on a condom, or took it off, without their consent.

Women: “I know there are some women that let a man talk to them any kind of way, treat them any kind of way, and they have a lot of fears about leaving them, you know, or the fears of leaving them because they might get killed or the fears of not having nobody to take care of them, feeling like they can't take care of themselves because they've been like that for so many years.”

YMSM: “In my last relationship, I used a condom every time I had sex, but one time he had took it off while we were having sex and it like scared me, you know? I had to jump back because I was like, ‘Come on, now.’ I'm not used to having sex without a

condom, and it really shocked me for somebody to do that to me. It really scared me, so I had to get tested six months later then.”

Survival: Condom Use vs. Economic Survival

All populations described personally being involved in situations where economic need and social isolation took precedence over their need to assert their right to sexually protective behavior. They described not having the power to negotiate condom use because they were economically disadvantaged in the relationship.

Women: “If I make him wear a condom, he might leave and I really need my rent paid.”

MSM: “A lot of people when they decide they're going to be gay, they leave home and don't know anybody. If the trick or the dude you're trying to mess with is offering you some money and you're broke, and you know you've been broke all week and you're out there on your own in a city to where you don't know anybody else but the people around you, you do whatever you've got to do to get your money.”

Intentional Infection of Others

YMSM participants stated that some seropositive members of their community disregard the sexual safety of their seronegative sexual partners by purposely infecting them. There was a perception that these infected individuals are so angry about their experience of being infected that they want to infect others as an act of revenge, and that they don't care about protecting others because they feel hurt that they were infected by people who did not protect them. It is unclear how prevalent this phenomenon is.

YMSM: “When I first came here, I jumped into being a drag queen and started living a life like that or whatever, and you know, they do a lot of hanging out on the streets and sex, whatever, that kind of stuff. So we were hanging out, and I used to hear them all the time be like, ‘Well, since I got it, I don't really care about giving nobody else it because they didn't care about giving it to me.’ And that used to really do something to me deep down because it would just be like, ‘Whoa.’ Yeah, like some of the girls be like, ‘Girl, I just got out of the car with him and I just gave him his dose.’”

Access to Benefits

Participants alarmingly described the drive to seroconvert as simply an expedient way to access an array of benefits, including SSI, Medi-Cal and other health benefits, housing assistance, and other resources. These benefits directly relate to the basic survival issues that all populations emphasized as priorities in their lives. Because so many are desperately struggling with dire economic realities, they have come to view living with HIV as an incentive; many do in fact engage in sexual risk-taking because of the perception that their lives will be easier after seroconversion. Ironically, the services that are needed to prevent HIV are the services that are provided to people living with HIV.

MSM: “The other day I was standing outside. And the young man was like, ‘I don't think it's fair that the HIV people get all these benefits and get all these services, and

everybody is just left hung dry.’ And the other dude told him that was sitting next to him, ‘Well, the only thing you've got to do is go catch it. Just catch it.’ ”

VI. Reasons for Accessing HIV Services

Participants described choosing to access services at organizations and programs that made them feel supported and comfortable in a family-oriented environment. Staff at these organizations were described as sensitive, caring, compassionate, and fun. They appreciated opportunities to meet others who are African American and have HIV, and receive education, counseling, and housing assistance. Participants appreciated incentives, such as cash and tickets to events, as well as food and beverages.

Comfort and Support

Participants stated that they attended programs because they made them feel comfortable to be themselves, with people who were like them and understood them. They liked programs that provided education and support within a low-key, social setting.

YMSM: "I love the BMX because it was a forum that didn't just focus on a specific age group. You were able to come and discuss and get a wide variety of opinions, and get information from people who've been in the life for 40 years to someone who just barely came out. It was a really, really good forum for people to create friendships without the stigma of having to fuck or having to buy you a drink, or being like, 'Oh, I'm going to take you home tonight.' It was just, I'm here, you're here, we have the same interests, how you doing? And the friendships that were created. I liked it."

MSM: "The comfortability of it all. A whole lot of people in this area only feel safe and will disclose and talk about problems with other black people."

Women: "I think the fact that I could meet positive people like me and I'm struggling with the disease every day, and it gave me hope. And now I can speak to people. I'm happy. Now I help people, new positive people."

Staffing Approach

Participants stated that they attended programs whose staff were caring, compassionate, sensitive, supportive, non-judgmental, and spiritual. YMSM participants discussed the importance of having young people on staff who can relate to and effectively work with young people.

Women: "I think that they're supportive, they're sensitive to our needs, very empathetic, not sympathetic, but empathetic. And there are some people that work here at FAP that will go 100 percent and beyond and go way out for you, you know? They'll do cartwheels, whatever."

YMSM: "They're hiring youth now. There's not a bunch of old people telling me, 'You need to wrap it up.' They're hiring young people that have a young approach on things."

MSM: "Well, for me BBE has a very strong spiritual base. And that's just very powerful."

Education

Participants stated that they appreciated programs that provided HIV education with a fun, accessible, visual approach. They benefited from learning environments with peers as well as peer counselors.

Women: “[I like] how he teach the class. And he makes it fun for me to -- because, like, some people learn by visual, hands on, or just like this, whatever. And the way he puts it out here, he makes it interesting for me, and so I'm focusing in on what he's saying because the way he brings it to me.”

MSM: “And you always can learn something and be around other people that are going through something similar to what you're going through. And you can also share your experience.”

Incentives

Participants stated that they attended programs that provided incentives for their participation. Incentives described included: free services, cash, and tickets to sports and concert events.

MSM: “They would pay you \$5 if you attended their meetings. They'd talk to you about sexually transmitted diseases and how you can contract them.”

Comprehensive Services

Participants discussed the importance of comprehensive HIV services that provide an array of services, including counseling and assistance with housing, health care access, disability benefits, and childcare.

MSM: “They help you with a list of locations for housing, so even though it's so damn expensive, but still, they at least offer that information for you.”

Refreshments

Participants stated that they appreciated programs that served food and beverages.

MSM: “You can have dinner and talk about different topics also.”

VII. Reasons for Not Accessing HIV Services

Participants described various problems accessing HIV prevention and care services in their areas. Many simply lacked awareness about programs available to them. Participants from all populations and regions also described the lack of, or limited numbers of, African American staff and services as a barrier to their participation. There was much discussion about mistreatment by providers, including unreliable, impersonal, and unwelcoming services. There was also considerable discussion about incompetence and a perceived lack of caring at HIV service organizations.

Participants expressed disappointment that programs are under-funded and unable to deliver quality, sustainable services, and that organizations appear to be misappropriating funds intended for African Americans. They also expressed concern about communication and confidentiality issues, as well as community fears about knowing their HIV status. Participants from all populations stated that did not feel confident that providers would not disclose their HIV status, and they feared stigma if they were seen at an organization that provides HIV services. A few female participants also stated that they were uncomfortable at organizations that were associated with the gay community. Female participants also stated that they and members of their community did not participate in HIV prevention programs because they did not perceive them to be relevant for them.

Lack of African American Staff and Services

All populations from all regions, especially participants from isolated communities where there is little or no support for African Americans, expressed a strong interest in African American staff and services. Participants emphasized that the lack of HIV service providers that look like them and have similar experiences as them is a barrier to the provision of competent services for the African American community, and consequently, participants' willingness to seek services.

MSM: "We need a black facilitator that's going to have a black group. And we don't have that here. We don't have anybody that comes in and just wants to have an all-black men HIV group. All black men, gay men, whatever."

Women: "No black woman go up to the counter and see these white people always talking about, 'Well, we can help you.' No, you can't even relate to what I'm going through right now because we don't even look the same."

MSM: "Nine times out of 10 when I go to these functions, it's only me or another black person there. In a room of 15 people or whatever."

Mistreatment by Providers

Participants from all populations and regions described experiences of mistreatment from prevention and care service providers, including staff at HIV prevention community-based organizations and medical facilities. Providers were described as cold, impersonal, unwelcoming, insensitive, judgmental, and rude. Some participants also stated that they

did not participate in programs out of fear of discrimination and inadequate care, regardless of whether or not they had had bad experiences with the specific organization.

Women: "I haven't been to one hospital yet that hasn't down talked me because I have this thing on my arm from me abusing drugs, drug of my choice, you know, and I'm saying this is your job. You're supposed to have this bedside manner and you're supposed to treat everybody equally. I would love to be able to go to the hospital and them treat you like you ain't shit."

MSM: "They're a racist group that have never wanted to deal with anything but white people. They claim and verbalize they are a white gay organization."

MSM: "Very nasty, very inconsiderate. I said, 'Can I get a cup of water?' and they said, 'Give me fifty cents.'"

MSM: "The question to be asked: Why is it that the agencies do not want to serve black men?"

Staff Competency Concerns

Participants emphasized the need for staff members that fit well with consumer needs, with regards to knowledge and skill level, caring and compassionate approaches, and gender presentation. MSM participants, in particular, expressed concern that they are better informed about resources than case managers whose job it is to serve them. Participants emphasized the need for caring, compassionate staff, and the funding to help them stay in their jobs and deliver quality services.

MSM: "Why isn't her staff better educated than the clients? Why do we have to be the resource person for her case managers and nurse case managers when they're supposed to provide us resources?"

MSM: "When you are hiring people, you're hiring people who care about the community. Not a person that, because they went to school, and they have an education in case management, make them case manager. Because it takes a lot to deal with someone who walks into your office that is sick, that is ill, that has some problems. That way, when a person comes in, no matter what color they are, they can help them."

MSM: "If I need to talk to a queen, send me a queen. If I need to talk to Mr. Macho, send me -- you know, because the down-low brothers aren't going to feel comfortable talking to some queen."

Funding Issues

Funding was a common concern that was not limited to a particular region. Concerns centered on organizations that receive funding to serve African Americans but are perceived as misappropriating funds and not upholding their commitment. There were also concerns about the difficulty of delivering quality, sustainable services with limited

funding for programs and organizations. In addition, adult MSM participants in different regions lamented that the focus on YMSMs has taken away from programs for MSMs over age 25. Participants in regions with African American-specific programming discussed the need to consolidate services under one umbrella organization.

MSM: “I think it's just that you shouldn't say you're going to serve someone and not serve them.”

MSM: “It's that the funding's not there, so you get turnover, you don't get quality staff, you don't get staff that cares. Or you get staff that are overworked. And I know with most of the agencies that are out there right now, they're not getting enough money to staff appropriately and to keep those staff living at a quality of life that they can stay at that job for years and years and years and give the quality service they need.”

MSM: “A lot of the groups they do have are targeting towards the youth. They don't have anything for anyone that's 25 and over.”

MSM: “I feel that they need to boost up a little bit more and bring all the African American organizations together under one umbrella so that they can network and work together.”

Communication Issues

Participants expressed disappointment that staff at HIV service organizations are unreliable and uncommunicative, and that their approach is culturally inappropriate for them. Participants expressed the need for reliable, respectful, confidential communication from providers.

MSM: “That's a good thing, that's a good feeling, to get a response back, if you call somebody, and they say, ‘Well, call me and leave a message.’ I used to hate to leave a message for anybody, 'cause you never get a response back.”

MSM: “A lot of us don't want to be told what to do. We've been told what to do forever. We want to be asked what to do. We want to be encouraged to do some shit that's positive and that makes more sense.”

Confidentiality

All populations expressed concerns about confidentiality. Participants feared disclosure of their HIV status or sexual orientation by service providers, or that their confidentiality would be breached during the process of seeking services (such as filling out a form with their personal information). They also feared that community members who have seen them at HIV organizations would disclose their serostatus and/or sexual orientation.

Women: “Even in the hospital when they ask you to fill out the form. I can see them talking, ‘Oh, she's HIV-positive.’ You know?”

Women: “I didn’t want nobody seeing me going to no places like that. It took me five years just to come to terms with this shit inside me.”

YMSM: “I think people probably don't participate because they don't want to be outed. Say somebody might see them, word of mouth gets around. You know how that is. I think that's the primary reason why people don't want to participate.”

Lack of Awareness about HIV Prevention Services

Some female participants were not aware of HIV prevention services in their neighborhoods and counties. The focus groups provided an opportunity for the exchange of information and resources.

Women: “You see, I’d never heard of the places she just named because I wasn’t going in there anyway.”

Location

Participants stated that they do not participate in HIV services because they are not in their neighborhood, they don’t have transportation, and they cannot rely on others to drive them. To address these limitations, mobile testing services and intervention programs need to be provided in neighborhoods where African Americans live and socialize.

Women: “The people I know would be like, ‘I ain't got time to take you over there.’”

Lack of Time

Some participants stated that they don’t participate in HIV programs because they are too busy with school, work, and family.

Fear of Knowing their Status

Participants stated that some members of their community do not participate in HIV services or get tested because they don’t want to know their HIV status.

YMSM: “Some people just can't handle it. You know what I'm saying? I have friends that are like, ‘If I got it, I got it. I just don't want to know. Just let me just die.’”

Fear of Stigma

Participants stated that they and members of their community do not seek services out of fear of stigma from their community. Women who were not part of the lesbian, gay, bisexual, and transgender (LGBT) community expressed discomfort and fear of stigma associated with participating in programs identified with the LGBT community, even when their experience with these organizations was overwhelmingly positive.

Women: “Most people, when they get it, that's why they get sick, because they get ashamed. They don't want to go tell.”

Women: “People don’t want to be judged. It’s the biggest stigma in the African American community.”

Perception that HIV Services are Not Relevant

Female participants stated that they and members of their community do not participate in HIV prevention services because they do not perceive them as relevant for them. They expressed concern that many seropositive African American women are not accessing necessary treatment because they do not know their HIV status.

Women: “Now sometimes it don't pertain to us. Like this lady she has AIDS, so she's participating in all kinds of stuff where, you know, I don't, so like why should I?”

Women: “A lot of them are positive, so they're not getting any HIV treatment because they probably don't know they're positive, so no medication is available if you don't know you've got a problem. You've got a drug addiction that you're dealing with that keeps you in a state of mind of homelessness, so where's the solution?”

VIII. Suggestions for Improvement

Clearly, participants provided a wealth of suggestions for improvement for community HIV prevention programs serving African Americans. They were particularly enthusiastic about receiving online HIV information geared towards African American populations, and provided creative, specific ideas about how to present information and resources. Participants also provided helpful programmatic suggestions that could broaden the scope of populations served and address larger social and community issues.

Online Information

Participants provided numerous suggestions for how to present online information about HIV. Though a number of female participants, and some men, described having limited access to computers and/or computer illiteracy, the majority of participants were excited about the use of the Internet as a tool for information gathering, distribution of resources and referrals, and social support.

Participants were overwhelmingly interested in seeing creative depictions of HIV and STD transmission with visuals, cartoons, and/or interactive video. They felt that this visual approach would appeal to visual learners, address illiteracy, and be entertaining for consumers. Participants from all populations also stated that they are moved and inspired by testimonials and pictures of African American people living with HIV, those who've died, and those who've known someone. They emphasized the need to see stories of people who look like them and who share similar life circumstances. Participants also noted the need for statistics about African American populations and mapping of incidences of HIV, so that they can type in their zip code and see what's going on in their neighborhood. Participants stressed the need to educate young people with images they can relate to.

Women: "I just saw a commercial in my head. 'Genocide is not something that is being done to us, we're doing it to ourselves. HIV.'"

Women: "For black people, it has to be a shocker." "It's like that commercial. 'This is your brain. This is your brain on drugs.' They crack the egg on the skillet. All the people he ever slept with start deteriorating."

YMSM: "That one out of every three black men has AIDS. I think that might scare them a little bit more. Because a lot of times with black men, you need to scare them straight before they'll ever get the picture."

YMSM: "Show me somebody with an IV in their arm, laying on their death bed, talking about, 'Yeah, I have HIV.' Don't make them all gay. Don't make them all white. Don't make them all men."

Participants also discussed other needs, including concrete information about medications as well as region-specific referrals to local resources such as testing and clinic resources. Participants from all populations stated that they need referrals to health and wellness

resources, including support groups, nutrition information and stress management resources.

All populations described the need for a chat room for anonymous social support. Many MSM and YMSM participants discussed participating in online social support systems for African American men, and welcomed more. Women described themselves as having limited or no access to online support and were especially enthusiastic about opportunities for online social support geared towards African American women.

YMSM: “What I'd like to see is where close to me can I go to get tested. Can I type in my zip code and it gives me the closest location to me? Information would also include what types of tests they do there. Is it a blood-drawn test, is it an oral test? How much is it going to cost me? How long do I have to wait for the results?”

YMSM: “If the Web site could refer me to a support group in my area, for someone who's positive and someone who's negative. You know, if you're negative, a support group for staying negative. Having that support structure to help you deal with the pressure of having unprotected sex and what not, or if you're positive, how to not seroconvert, how to not make your situation worse than it already is, and how to live with the disease.”

Women: “A black female has a lot of stress. The majority of the black single mothers are, like they said, running around trying to keep up with this man because you don't want to lose him, it's still a lot of stress. Just society today is a lot of stress. So stress removal or ways of dealing with stress -- I'd like to see that online because it is an issue with your health that concerns your health when you're living with HIV.”

Participants discussed the need for online scenarios that illustrate condom negotiation and that can support them in their efforts to engage in safer sexual practices.

YMSM: “Scripts or ideas on how to talk to my partner about using condoms. If you haven't started having sex yet, or if you've already been having sex without using condoms, how do I now go and talk to my partner, five months into our sexual relationship about now using condoms all of a sudden?”

YMSM: “I'd like to see on that Internet site specifically, you know, some ideas about what other than anal sex I can do to be pleasing to my partner.”

Programmatic Suggestions

Participants provided considerable feedback and suggestions for organizations and programming, many of which were documented in the “Reasons for Not Accessing HIV Services” section. In addition, participants provided programmatic suggestions about at-risk populations to target (teenage girls), and program content. Participants repeatedly emphasized the need for programs that address self-esteem issues and give community members motivation and a sense of hope.

Women: "I think we should even get the young women, you know what I'm saying? Because I have a fourteen year-old daughter-in-law whose got two kids by my son, and he's got this other girl who's seventeen who's pregnant too. But we need to get the youth people before they have sex and get them educated."

MSM: "I think one of the biggest downfalls of black gay men -- especially downtown -- is low self-esteem. It's not the job. It's not the training. It's low self-esteem and the lack of believing that they can get farther away from where they're at. They don't have no more dreams. Put some excitement back into their lives and motivation."

MSM: "They have to put something about the hope -- that there is hope and don't be scared."

Visions of an Ideal Program

All populations were asked to describe their vision for an ideal HIV prevention program for African Americans in their community. Participants were instructed not to worry about funding issues but describe a dream program. All populations described one-stop wrap-around services that are delivered in a homey, family-oriented environment, where they feel comfortable and empowered to be themselves and make healthful decisions. Participants discussed the need for programs to emphasize economic issues, education, empowerment, assertiveness, counseling, social support, case management, medical care, job training, housing, spirituality, refreshments, and childcare.

YMSM: "I would definitely pick a spot where young black men who are fucking up men go. But I would like it to be very comfortable, so nice couches, and plasma-screen TVs, and have different sections, so you do have a condom store and you have a wall of different pictures and what not of how to have great sex without having anal sex. Different offices where they can go in, one-on-one, and get counseled on whatever, support groups. And then, of course, provide them with food and drinks, and give them a little store where they can go find t-shirts and make a little profit off of that."

MSM: "I feel that case management, therapy, onsite therapy, job planning, housing -- all under one umbrella. Also a doctor that can relate to the issue of HIV -- an HIV doctor. Spirituality. Let's not forget that because that's most important."

Women: "I could see a whole building for African American women and it's a drop-in center there where people can go in and socialize and talk. And then they have classes for all kinds of different stuff, not just HIV and AIDS education but self-esteem, stress management, different classes."

IX. Recommendations

Based on these findings, we propose the following recommendations for organizations that provide HIV prevention services for African Americans.

Organizational

- Develop systems for coordinating and collaborating with other organizations and programs for seamless provision of multiple supportive services
- Conduct in-house cross-training with staff to develop awareness of programs, resources, and referrals
- Conduct regular program evaluation
- Provide opportunities for consumers to give feedback in-person, in writing, and online; respond to criticisms and suggestions for improvement
- Hire staff members who are diverse with regards to race, class, gender, and life experience
- Develop staff cultural competency on African American, LGBT, MSM, down low, HIV, youth, substance abuse, sex work, incarcerated populations, and other issues; use appropriate language and behavior when interacting with subgroups
- Develop staff skills, including case management, outreach, counseling, and fiscal management
- Use funds appropriately

Programmatic

- Provide and coordinate wrap-around services that address employment and financial stability, health care access, medical care, case management, housing, mental health counseling, education, social support, transportation, medication, testing, and childcare
- Locate programs in neighborhoods where African Americans live and socialize
- Provide culturally appropriate, supportive, family-oriented African American-specific programming
- Provide programs for African American men who have sex with men of all ages, including men on the down low

- Provide programs for African American teenage girls and young women
- Provide HIV education in a fun, visual, accessible manner
- Provide opportunities for peer education and support
- Focus on building self-esteem, assertiveness training, life skills, community building, and spirituality
- Provide opportunities for socializing, including dinners, movies and a drop-in space
- Augment faith-based HIV prevention programs
- Provide incentives for participation in programs
- Provide childcare and refreshments

Outreach and Communication

- Use creative, visual approaches to provide online information and resources directed towards African American populations
- Conduct outreach directly in the community; go to where African Americans congregate
- Provide HIV incidence mapping, testing, and health resources by region or zip code
- Emphasize one-on-one personal contact
- Acknowledge different subgroups and use appropriate language in materials and interactions
- Be empathetic, respectful, and nonjudgmental
- Maintain confidentiality in all communications with consumers; build confiding relationships
- Be reliable and trustworthy; have good follow-through

X. Dissemination

In addition to utilizing these findings to direct technical assistance efforts, One Love developed a dissemination plan to systematically deliver the results back to the community that participated in the study, to local health jurisdictions to inform their action plans, and to other interested parties. Clearly there are a number of individuals and organizations that want to access the findings in order to prioritize community needs, inform strategic planning processes, facilitate advocacy efforts, and other purposes. The dissemination plan includes Town Hall meetings or forums in each of the five regions, and presentations at the California African American HIV/AIDS Summit, and with strategic partners such as the Center for AIDS Prevention Studies, UC San Francisco.

All concerned entities are invited to the regional presentations, including: county health departments, coalitions, planning councils, community-based organizations, HIV/AIDS service organizations, activists, study participants, consumers, and other community members. This is an opportunity for all of these individuals and groups to coordinate and collaborate on the event, promote their work, network, inform, engage, and recruit. Most are using the presentation as an opportunity to launch into action planning following the session. We hope that this focus group project will be the catalyst for critical community-building, coordination, advocacy, and capacity building in California-based African American communities affected by HIV/AIDS.

XI. Technical Assistance Opportunities

The One Love Project provides cost-free training, technical assistance, and consulting services, including:

- Strategic Planning
- Resource Development
- Organizational Capacity/Infrastructure Development
- Identification of Culturally Competent and Linguistically Appropriate Materials and Services
- Population-Specific Program Development
- Community Mobilization and Coalition Building

For more information, and to find out how to apply for these services, call (916) 498-1885 or toll-free: (888) 900-9599. Visit the One Love Project at www.oneloveca.org.

One Love Focus Group Screening Form

Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Best times to call: _____

Alt. Phone: _____ Best times to call: _____

Email: _____ Fax: _____

1. What is your age? _____

2. What is your racial or ethnic background?

- a) African American
- b) African / Afro Caribbean
- c) Asian/Pacific Islander
- d) American Indian/ Native American
- e) Biracial / Multiracial (specify): _____
- f) Caucasian/White
- g) Latino/a
- h) Other (specify): _____

3. What best describes your gender identity?

- a) Male
- b) Female
- c) Transgender Male-to-Female
- d) Transgender Female-to-Male
- e) Genderqueer
- f) Intersexed
- g) Questioning
- h) Other (specify): _____

4. What best describes your sexual orientation?

- a) Gay
- b) Lesbian
- c) Bisexual
- d) Same Gender Loving (SGL)
- e) Queer
- f) Questioning
- g) Heterosexual/Straight
- h) Other (specify): _____

5. Have you had sex with a man in the past year? Yes No

If respondent is male, skip Questions 6-9 and go to Question 10.

If respondent is female, continue.

6. How many sexual partners would you say you have had in the past year? _____

7. Do you have a male sexual partner who you believe has sex with men?

Yes No Maybe

8. Do you have a male sexual partner who has been recently incarcerated?

Yes No Maybe

9. Have you or your sexual partner injected drugs in the past year?

Yes No Maybe

10. Do you know your HIV status? If you feel comfortable, can you tell me your HIV status?

- a) Positive
- b) Negative
- c) Don't know
- d) Decline to State

11. What is your estimated annual income?

- a) 0 to 20,000
- b) 20,000 to 40,000
- c) 40,000 to 60,000
- d) 60,000 to 80,000
- e) 80,000 and above

12. How did you hear about us?

- a) Regional coordinator
- b) Local Provider (specify): _____
- c) Flyer
- d) Email
- e) Other (specify): _____

Recruiter Notes

Date Screened: _____

Group Status: Yes No Maybe

Group Date: _____

Confirmation Date: _____

Reminder Call Date: _____

One Love Focus Group Instrument: Young Men who have Sex with Men

1. What cities/neighborhoods do you and other young African American gay/bisexual/same gender loving men in your community live and socialize in? Why these cities and neighborhoods?
2. How do young African American men who have sex with men identify themselves? (Gay, bisexual, “down low,” straight, queer?)
3. As young African American gay/bisexual/same gender loving men (or other terms that they’ve just used to describe themselves), what do you think are the most important issues in your lives right now (you and other young African American men who have sex with men in your community)? What do you think are the most important health issues in your lives right now?
4. What does the African American community not understand about you being a young man who has sex with men?
5. Why do you think the incidence of HIV/AIDS is so high among young African American men who have sex with men?
6. Where do you get information about how to protect yourself from HIV/AIDS? What kind of information do young African American men who have sex with men need?
7. Do you think that young African American men who have sex with men are aware of what puts them at risk? What do you think those risks are?
8. What do you think prevents young African American men who have sex with men from protecting themselves from HIV/AIDS?
9. What do you think your personal risks are? Do you feel that you are well-prepared to protect yourself from risk?
10. If information about African American men who have sex with men and HIV/AIDS was available online, what specific info would you like to see? (sexual health, safer injection practices, clinical trials, research studies, etc.)
11. What HIV prevention organizations and programs do you participate in? (Support groups/prevention for positives/community events/educational activities/retreats/conferences/fundraisers/faith-based organizations) Are any of them in your neighborhood? Do any of them have programs specifically for young African American men who have sex with men?
12. What do you like about these organizations? What makes you want to participate in their programs and services? (What do you think is working with regard to their

- approach/outreach methods/program/staff skills/communication style/organizational structure?)
13. What makes you (or other young African American men who have sex with men) *not* want to participate in their programs and services? (What's not working with regard to their approach/outreach methods/program/staff skills/communication style/organizational structure?)
 14. How do you think these organizations could improve their programs so that they're more helpful to you and your community?
 15. If you can imagine an HIV prevention program specifically created for young African American men who have sex with men, what would it be like? What issues would it address?
 16. Is there anything we forgot to ask that is important for us to know?

One Love Focus Group Instrument: Men who have Sex with Men

1. What cities/neighborhoods do you and other African American gay/bisexual/same gender loving men in your community live and socialize in? Why these cities and neighborhoods?
2. How do African American men who have sex with men identify themselves? (Gay, bisexual, “down low,” straight, queer?)
3. As African American gay/bisexual/same gender loving men (or other terms that they’ve just used to describe themselves), what do you think are the most important issues in your lives right now (you and other African American men who have sex with men in your community)? What do you think are the most important health issues in your lives right now?
4. What does the African American community not understand about you being a man who has sex with men?
5. Why do you think the incidence of HIV/AIDS is so high among African American men who have sex with men?
6. Where do you get information about how to protect yourself from HIV/AIDS? What kind of information do African American men who have sex with men need?
7. Do you think that African American men who have sex with men are aware of what puts them at risk? What do you think those risks are?
8. What do you think prevents African American men who have sex with men from protecting themselves from HIV/AIDS?
9. What do you think your personal risks are? Do you feel that you are well-prepared to protect yourself from risk?
10. If information about African American men who have sex with men and HIV/AIDS was available online, what specific info would you like to see? (sexual health, safer injection practices, clinical trials, research studies, etc.)
11. What HIV prevention organizations and programs do you participate in? (Support groups/prevention for positives/community events/educational activities/retreats/conferences/fundraisers/faith-based organizations) Are any of them in your neighborhood? Do any of them have programs specifically for African American men who have sex with men?
12. What do you like about these organizations? What makes you want to participate in their programs and services? (What do you think is working with regard to their

- approach/outreach methods/program/staff skills/communication style/organizational structure?)
13. What makes you (or other African American men who have sex with men) *not* want to participate in their programs and services? (What's not working with regard to their approach/outreach methods/program/staff skills/communication style/organizational structure?)
 14. How do you think these organizations could improve their programs so that they're more helpful to you and your community?
 15. If you can imagine an HIV prevention program specifically created for African American men who have sex with men, what would it be like? What issues would it address?
 16. Is there anything we forgot to ask that is important for us to know?

One Love Focus Group Instrument: Women

1. What cities/neighborhoods do you and other African American women you know live and socialize in? Why these cities and neighborhoods?
2. As African American women, what do you think are the most important issues in your lives right now (you and other African American women in your community)? What do you think are the most important health issues in your lives right now?
3. Why do you think the incidence of HIV/AIDS is so high among African American women?
4. Where do you get information about how to protect yourself from HIV/AIDS? What kind of information do African American women need?
5. Do you think that African American women are aware of what puts them at risk? What do you think those risks are?
6. What do you think prevents African American women from protecting themselves from HIV/AIDS?
7. What do you think your personal risks are? Do you feel that you are well-prepared to protect yourself from risk?
8. If information about African American women and HIV/AIDS was available online, what specific info would you like to see? (sexual health, safer injection practices, clinical trials, research studies, etc.)
9. What HIV prevention organizations and programs do you participate in? (Support groups/prevention for positives/community events/educational activities/retreats/conferences/fundraisers/faith-based organizations) Are any of them in your neighborhood? Do any of them have programs specifically for African American women?
10. What do you like about these organizations? What makes you want to participate in their programs and services? (What do you think is working with regard to their approach/outreach methods/program/staff skills/communication style/organizational structure?)
11. What makes you (or other African American women) *not* want to participate in their programs and services? (What's not working with regard to their approach/outreach methods/program/staff skills/communication style/organizational structure?)

12. How do you think these organizations could improve their programs so that they're more helpful to you and your community?
13. If you can imagine an HIV prevention program specifically created for African American women, what would it be like? What issues would it address?
14. Is there anything we forgot to ask that is important for us to know?